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IN THIS ISSUE

The Founding of the International Society of Clinical Psychology

In San Francisco on August 12, 1998 a new organization came into being, the International Society of Clinical Psychology (ISCP). Its objectives are to provide a vehicle for global communication among clinical psychologists, to enhance the development of knowledge in clinical psychology through research and its dissemination, to support the education and training of clinical psychologists in all countries, and to facilitate the use of clinical psychology to contribute to human life. Its initial membership consists of clinical psychologists from many countries around the world including Australia, China, Germany, Israel, Japan, Mexico, Spain, and the U.S., most of whom were attending the International Congress of Psychology at the time. In the future, the ISCP will meet each year in conjunction with some other established international organization. In August 1999, for example, the ISCP will meet in Salem, Massachusetts with the International Council of Psychologists. In 2000 it will meet in Stockholm, Sweden, with the International Union of Psychological Science. In 2001, it will meet with the International Council of Psychologists once more. And in 2002, it will meet in Singapore with the International Association of Applied Psychology. These annual meetings will feature invited addresses, symposia, and other presentations. In addition, the ISCP will sponsor a newsletter, a website, and a listserve on the Internet to facilitate communication among its members.

I came to realize the need for an organization such as ISCP through a rather unexpected chain of events, beginning with the plans for the APA centennial celebration back in 1992. As part of the celebration of its own 100th birthday, APA encouraged each of its divisions to write their histories, and I was asked by Division 12 to serve as its historian. In the course of writing Division 12's history, I became aware of the impending 100th anniversary of the founding of the world's first psychology clinic by Lightner Witmer in 1896 at the University of Pennsylvania. With the encouragement of my Division 12 colleague Charles Spielberger, and in order to publicize the worldwide celebration of the centenary of the

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President's Column

"Its objectives are to provide a vehicle for global communication among clinical psychologists, to enhance the development of knowledge in clinical psychology through research and its dissemination, to support the education and training of clinical psychologists in all countries, and to facilitate the use of clinical psychology to contribute to human life."

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founding of Witmer's clinic, I submitted a poster to the International Association of Applied Psychology and went to its meeting in Madrid, Spain, in 1994. There I met Fanny Cheung of the Chinese University of Hong Kong, who was just completing her term as president of the IAAP's Division of Clinical and Community Psychology. She asked if I would be willing to serve as president-elect of this division. I did so, and have just now in 1998 begun my 4-year term as its president. Since the IAAP meets only once every 4 years, I had considerable time to reflect on the fact that clinical psychology has no international organization of its own and no functional means of global communication in between IAAP meetings. Given that clinical psychology is considered to be the largest specialty area within psychology worldwide, I thought that founding such an organization was long overdue.

The formation of such an independent, international society fulfills the goal of the Division 12 task force on international clinical psychology co-chaired by Frances M. Culbertson, of Madison, Wisconsin, and Arthur N. Wiens of the Oregon Health Sciences University in Portland, Oregon during the last two years. The task force had previously invited international colleagues to a meeting in Chicago at the APA convention in 1997, but few of them showed up. It is obvious in view of the success of the 1998 meeting that an attempt to launch a new international organization requires an international meeting such as the one that just occurred in San Francisco.

About 40 persons attended the meeting in San Francisco. Most of them filled out membership application forms for the ISCP and paid their dues of $20. The group appointed an executive committee consisting of myself as president, Arthur Wiens as secretary, Frances Culbertson as treasurer, and Susan Frauenglass of Northern Illinois University as newsletter editor. Those who wish to receive information about joining the society should contact

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The tasks now being undertaken by the executive committee include getting out a newsletter, setting up a web page and a listserve on the Internet, planning the August, 1999 meeting, having draft bylaws written, and arranging for the election of officers for 1999. ■

Join a Division 12 Section

Division 12 has six sections that reflect the wide range of interests in the Division. There are separate memberships, and dues vary. If interested, contact the Section Membership Chairs listed below or the Division 12 Central Office.

Clinical Child Psychology (Section 1)
John Piacentini, PhD, UCLA Neuropsychaitric Institute, 760 Westwood Plaza, Room 68-251A, Los Angeles, CA 90024

Clinical Geropsychology (Section 2)
Peter Litchenberg, PhD, Rehabilitation Inst. Of Michigan, 261 Mack Boulevard, Detroit, MI 48201

Society for a Science of Clinical Psychology (Section 3)
Michael E. Addis, PhD, Dept. of Psychology, Clark University, 950 Main Street, Worcester, MA 01610

Clinical Psychology of Women (Section 4)
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Society of Pediatric Psychology (Section 5)
Kathleen Lemanek, PhD, Depts. Of Psychology, Human Development and Family Life, University of Kansas, Lawrence, KS 66045

Clinical Psychology of Ethnic Minorities (Section 6)
Michelle Cooley-Quille, PhD, Department of Mental Hygiene, Hampton House, Johns Hopkins University, 624 North Broadway, 8th *Floor, Baltimore, MD*

Call for Programs

The Society of Clinical Psychology would like your participation in the 107th. ANNUAL CONVENTION OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, August 20-24, 1999, Boston, MA.

APA themes for the convention are ethnic diversity and cancer. The Division 12 theme is empirically supported interventions and assessment. Only symposia and posters will be considered. Preference will be given to thematic submissions. DEADLINE for submissions is December 2, 1998.

All proposals should be forwarded to:

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Pseudoscience in Contemporary Clinical Psychology: What it is and what we can do about it

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This article is Dr. Scott O. Lilienfeld's acceptance speech of the 1998 David Shakow Award for early career contributions to clinical psychology. This award was presented at the American Psychological Association Convention in San Francisco this past summer. See article this and other Society of Clinical Psychology awards on page 24.

I'm deeply honored to have received the David Shakow award for early career contributions to clinical psychology, and I'm very grateful to the Division 12 awards committee for inviting me to speak with you today. In struggling with what I wanted to present today, I ultimately decided that I would do something a bit unorthodox. Specifically, I decided that rather than talk about my research, I would speak about an issue that has become something of a hobby-horse of mine – the ever-present and increasingly troubling problem of pseudoscience in contemporary clinical psychology.

I suspect that little, if anything, I will say today will be perceived as novel. And with good reason: the problem of pseudoscience has been with us for centuries and is in reality nothing terribly new. What is largely new, I will argue, is that pseudoscience poses an increasingly major threat to both the welfare of the general public and the integrity and reputation of our profession.

In further pondering what to talk about today, I struggled with finding something that I thought might best honor the memory of David Shakow, whose legacy the award I have received today commemorates. Shakow emphasized that the scientist-practitioner, or what he liked to call the scientist-professional, was first and foremost a clinical scientist – a critical thinker who places a high premium on healthy skepticism. In a 1976 article in American Psychologist, Shakow argued that the ideal scientist-professional embraces what Jacob Bronowski called the "habit of truth." As Shakow noted, "this habit is manifested in the constant effort to guide one's actions through inquiry into what is fact and verifiable, rather than to act on the basis of faith, wish, or precipateness" – in other words, to base one's beliefs on critical rather than wishful thinking.

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Pseudoscientific Practices in Modern Clinical Psychology

Yet if we look at the psychotherapeutic and assessment practices of many of our clinical brethren in the sprawling world outside of the academy, we find precisely this propensity toward uncritical acceptance of claims that Shakow so presciently warned us about over two decades ago. Moreover, as a field, we in clinical psychology seem to have shown surprisingly little interest in doing much about the problem of pseudoscience that has been festering in our own backyards. As Paul Meehl (1993) recently noted:

"It is absurd, as well as arrogant, to pretend that acquiring a PhD somehow immunizes me from the errors of sampling, perception, recording, retention, retrieval, and inference to which the human mind is suspect. In earlier times, all introductory psychology courses devoted a lecture or two to the classic studies in the psychology of testimony, and one mark of a psychologist was hard-nosed skepticism about folk beliefs. It seems that quite a few clinical psychologists never got exposed to this basic feature of critical thinking. My teachers at Minnesota … shared what Bertrand Russell called the dominant passion of the true scientist – the passion not to be fooled and not to fool anybody else … all of them asked the two searching questions of positivism: "What do you mean?" "How do you know?" If we clinicians lose that passion and forget those questions, we are little more than bedoctored, well-paid soothsayers. I see disturbing signs that this is happening and I predict that, if we do not clean up our clinical act and provide our students with role models of scientific thinking, outsiders will do it for us (pp. 728-729).

As clinical psychologists in turn-of-the-century America, we are confronted with the specter of pseudoscience in many guises. The past decade alone has witnessed (a) an explosion of largely unvalidated and in some cases bizarre treatments for trauma (e.g., thought field therapy, emotional freedom techniques), (b) a proliferation of demonstrably ineffective treatments for infantile autism and related disorders (e.g., facilitated communication), (c) the continued use of inadequately validated assessment instruments (e.g., human figure drawing tests and several other questionable projective techniques), (d) the widespread use of herbal remedies for depression and anxiety whose efficacy has often yet to be tested, let alone demonstrated (e.g., kava, ginkgo), (e) the marketing of subliminal self-help tapes that have repeatedly been found to be of no value in the treatment of psychopathology, (f) a burgeoning industry of self-help books, many or most of which make unsubstantiated claims, and the (g) use of highly suggestive therapeutic techniques to unearth memories of child abuse (including satanic ritual abuse) and the purported "alter" personalities of dissociative identity disorder (multiple personality disorder). And this, of course, is only a partial list. As Martin Gardner (1957) noted in his classic book *Fads and Fallacies in the Name of Science*, the field of psychology has long had an intimate acquaintance with questionable scientific practices (see also Leahey & Leahey, 1983). But the modern information age, ushered in by the popular media and Internet, has allowed these practices to flourish with unprecedented intensity and vigor.

I don't want to imply that all of these practices are necessarily harmful or devoid of value. It is possible, for example, that some of the new and controversial therapies for trauma will ultimately turn out to possess some efficacy. It is also possible that a subset of recovered memories of abuse will turn out to be genuine – and Jonathan Schooler (1996) has some suggestive but still preliminary data consistent with this possibility. But what is disconcerting about the claims of these practices' most vocal proponents is that they are often made without an adequate appreciation for either the importance of controlled research evidence or for the human mind's propensity to draw premature conclusions in the absence of convincing data.

So let me be clear: the bone I am picking is not primarily with the validity of the claims I've discussed, as some of these claims (e.g., the efficacy of herbal remedies) have yet to be subjected to adequate tests. As scientists, we should of course keep an open mind to all largely untested assertions. Instead, the bone I am picking is with the ways in which these claims have been marketed and promoted.

My central thesis is that clinical psychology, more than ever, has become a world divided. Carol Tavris (1998) has recently written eloquently about the widening split between the world of academic clinical psychology and the world of the couch, and of the disconcerting discrepancy between what we have learned about the psychology of memory, suggestibility, hypnosis, clinical judgment, and psychopathology, on the one hand, and the practices of many clinicians in the real world, on the other. We see a similarly widening gulf between academic and popular psychology, between the world of research as we understand it and the world of mental health as understood by the general public. The problem is not that all of popular psychology is necessarily pseudoscientific. To the contrary, I'll argue later that as academic clinical psychologists we have not done enough to popularize our findings and to communicate the scientific side of our discipline to the general public. Instead, the problem is that we have done little to assist the public with distinguishing those practices within popular psychology that are scientific from those that are not.

Science versus Pseudoscience

Before proceeding, it is first necessary to say a bit about the distinction between science and pseudoscience. In reality, this distinction is almost certainly one of degree rather than kind. Both science and pseudoscience are probably best viewed as Roschian concepts, which are characterized by indefinite boundaries and an absence of singly necessary and jointly sufficient features (see Rosch, 1973). But this absence of clear-cut boundaries does not imply, as some of the more radical deconstructivists might have us believe, that the distinction between science and pseudoscience is meaningless, or that a line of demarcation cannot be drawn between these two concepts for practical purposes. As the psychophysicist S.S. Stevens noted, there may be no qualitative difference between day and night, but that does not preclude us from making a distinction between day and night for pragmatic reasons.

As most of us know, many philosophers of science would probably concur with Karl Popper (1959) that falsifiability is an important, if not central, characteristic of the scientific enterprise, and that what distinguishes scientific from metaphysical questions (e.g., the existence of the soul) is their susceptibility to refutation. In contrast, pseudosciences, as Lakatos (1978) and others have noted, are disciplines whose advocates have effectively immunized their claims from falsification. Pseudoscientific claims are unfalsifiable not in principle – like metaphysical claims – but rather in practice, because their proponents have found innu-

merable escape hatches with which to protect their cherished beliefs from refutation.

Pseudoscientific disciplines are characterized by a variety of characteristics. These characteristics are probably best viewed as stochastic rather than strictly nomological, but they can be thought of as useful warning signs for the scientific consumer. The more such features a given discipline exhibits, the more it begins to cross the fuzzy but nonetheless pragmatically useful boundary that demarcates science from pseudoscience (see Table 1).

Table 1

Common Characteristics of Pseudosciences

(1) Overuse of ad hoc hypotheses to escape refutation

(2) Emphasis on confirmation rather than refutation

(3) Absence of self-correction

(4) Reversed burden of proof

(5) Overreliance on testimonials and anecdotal evidence

(6) Use of obscurantist language

(7) Absence of "connectivity" with other disciplines

(from Bunge, 1984)

First, pseudosciences tend to be characterized by an overuse of ad hoc hypotheses to escape refutation. As Lakatos noted, ad hoc hypotheses are sometimes defensible in science, but only when they are content-increasing and enhance a theory's capacity to generate successful predictions. In the case of most pseudosciences, neither of these conditions is met. Second, pseudosciences tend to place primary emphasis on confirmation, rather than refutation. If the physicist Richard Feynman was correct that the hallmark of science is bending over backwards to prove oneself wrong, most pseudosciences seem to bend over backwards in precisely the opposite direction. Third, in contrast to sciences, which tend to be self-correcting over the long haul, pseudosciences typically pursue a confirmation-based strategy until the bitter end, and rarely engage in self-correction. Fourth, proponents of pseudosciences typically place the onus of proof on critics, rather than on themselves. For example, they may insist that critics demonstrate conclusively that a novel treatment technique is ineffective. Fifth, pseudosciences tend to overrely on testimonials and anecdotal evidence – including informal clinical experience – as a means of testing hypotheses. As a consequence, they confuse Reichenbach's (1938) context of discovery with the context of justification or, in somewhat different terms, the wellspring of hypothesis generation with the crucible of hypothesis testing. Sixth, pseudosciences often utilize obscurantist language, much of which is sprinkled liberally with scientific-sounding terms intended to provide these disciplines with the veneer of scientific rigor and respectability. Seventh and finally, as Mario Bunge (1984) pointed out, many pseudosciences are characterized by an absence of "connectivity" with other disciplines. In other words, they often purport to construct entirely new paradigms in the absence of compelling evidence, and do not build on extant scientific knowledge.

Academic and Popular Psychology: The Widening Gap

I mentioned earlier that the divide between academic and popular psychology is enormous, and that it may be growing. To provide us with a sense of the magnitude of this gap, let me present some revealing comparisons from a Web search I recently performed in the comfort of my own office using a widely available Internet search engine. If one accepts the face valid premise that the Internet provides a least a rough indicator of the pulse of public interest, these results may tell us something about what's on the mind of the general public as opposed to what's on the mind of those of us within the halls of the academy. The methodology I've used is admittedly somewhat crude and could surely be called into question. For example, not all Web sites dealing with questionable or pseudoscientific topics deal with these topics in an uncritical fashion, although it is clear from my inspection of these sites that the overwhelming majority provide little or no critical commentary. Moreover, the exact numbers I'll present would of course change if a different search engine were used, although I can assure you that the overall pattern of results would remain very much the same.

In the next two tables, I've presented some findings that should perhaps give pause to those of us in academic clinical psychology (see Table 2). Following each topic is the number of Web Hits I obtained. In parentheses follow

ing this number is the number of PsychLit citations for each topic. These two numbers are not directly comparable, of course, because PsychLit uses different criteria for identifying sources than Web search engines. On the right is what is probably a more meaningful statistic for comparing across topics: the ratio of Web hits to PsychLit citations in each case. This ratio provides a rough index of the amount of popular attention received by a topic relative to the amount of research attention it has received. As you can see in this Table, I've plugged in a number of standard terms for widely researched treatment and assessment techniques. As you can

Table 2

Comparions of Web Hits and PsychLit citations for several widely researched treatment and assessment techniques (PsychLit citations in parentheses)

Topic	Web Hits	Ratio
Systematic desensitization	272 (2144)	.13
Token economy	182 (845)	.22
Minnesota Multiphasic Personality Inventory/MMPI	1187 (7371)	.16
California Psychological Inventory/CPI	62 (847)	.07
Beck Depression Inventory	*306 (3472)*	*.09*

see from the ratios on the right, there are far fewer Web hits than PsychLit citations in each case, with ratios ranging from .07 to .22. Nothing terribly surprising here.

As one can see in the next Table (see Table 3), in contrast, I've plugged in a number of terms reflecting treatment and assessment techniques that are either demonstrably invalid – such as subliminal self-help tapes – or inadequately researched – such as St. John's Wort. Here the results are remarkably different – with ratios of Web hits to PsychLit citations ranging from 34 for Thought Field Therapy to infinity for rebirthing. Those of you engaged in psychological assessment research might be interested to know that Enneagrams received 1408 Web hits, which means that it beats out the MMPI by over 200 Web hits.

The Self-Help Industry

Another indication of the ever-widening gap between academic and popular psychology is the burgeoning popularity of the self-help industry. One widely quoted estimate has it that self-help books are appearing at a rate of approximately 2000 books per year (see Rosen, 1993). My informal survey of large commercial bookstores in Atlanta revealed that self-help and recovery books outnumber traditional psychology books by a factor of at least 3 to 1. Moreover, this ratio is almost surely an underestimate, because a number of books in the psychology sections of these bookstores are in fact of the self-help variety, whereas the converse is not true. There is also a growing industry peddling unvalidated self-

Table 3

Comparisons of Web Hits and PsychLit citations for several treatment and assessment techniques in popular psychology (PsychLit citations in parentheses)

Topic	Web Hits	Ratio
Past life regression	1328 (6)	221.3
St. John's Wort (Hypericum)	5867 (13)	451.3
Kava	5844 (17)	343.8
Thought field therapy	102 (3)	34.0
Rebirthing	933 (0)	∞
Inner Child/Inner Child Therapy	2737 (44)	62.2
Facilitated communication	9652 (50)	193.0
Subliminal self-help tapes	406 (2)	203.0
Enneagrams	1408 (10)	140.8

help audiotapes and videotapes for almost every imaginable psychological malady. Moreover, there is some evidence that self-help programs are receiving less, rather than more, research attention over time. In literature reviews conducted by Glasgow and Rosen (1979, 1982), the ratio of studies conducted on self-help books to self-help books themselves decreased over a two year period from .86 to .59 – and there is scant indication that this downward trend is changing.

On the positive side, research on self-help programs shows that some of them, particularly those grounded on well-established psychological principles, can be helpful (Kutzweil, Scogin, & Rosen, 1996). But we also know from the literature reviews of Rosen and his colleagues (e.g., Glasgow & Rosen, 1979; Rosen, 1987) that self-help materials can be harmful in some cases. Moreover, even seemingly minor changes in an effective self-help treatment program have been found to reduce or even eliminate that program's efficacy. To address these problems, an APA Task Force headed up by Gerald Rosen in the 1980's offered a number of quite modest and reasonable suggestions for curbing the excesses of the self-help industry – such as developing guidelines for the development and evaluation of self-help materials comparable to those for psychological tests, and involving APA and other organizations in endorsing self-help books based on sound psychological principles and adequate research - but these suggestions have heretofore gone unheeded.

Why Should We Care?

So it is clear that there is a huge other world out there, one that most of us in research settings are blissfully unaware of and have been reluctant to peer into, let alone do anything about. But why should we care? If the general public wants to believe in the efficacy of subliminal self-help tapes and herbal remedies, why should we lose sleep over it? One major reason, of course, is that many of these techniques may prove to be harmful to the general public. The recent fiasco regarding facilitated communication for infantile autism serves as a much-need reminder of the serious damage that can result when novel psychological treatments are disseminated without adequate critical scrutiny – and, on the positive side, of how the research and writings of academics can play a crucial role in falsifying dangerous and pseudoscientific claims (see Jacobson, Mulick, & Schwartz, 1995). Moreover, even those techniques that prove to be innocuous can lead consumers to spend money and waste time on useless interventions that could better be spent seeking and obtaining adequate care. And, not least of all, the damage to the reputation and integrity of our profession is difficult to estimate.

But why is it our job or even our business to police these problems? It is both our job and our business, I would argue, because we, as clinical psychologists, are in a unique position. If there is one thing that sets our field apart from allied disciplines, it is our capacity to conduct and interpret research, and to impart this understanding to the general public. Yet with some notable exceptions, this has been a responsibility that our field has been reluctant to shoulder.

Has the APA Helped?

In fact, some critics might contend that as a field we have actually nurtured or even provided support for questionable psychological practices. When the APA purchased Psychology Today in 1983, it did so in conjunction with a companion Psychology Today Tape Series, featuring a large number of self-help audiotapes that had never been subjected to empirical tests. These audiotapes included weight loss, mental imagery, and body image improvement programs of unknown efficacy, and were accompanied by the following statement: "Backed by the expert resources of the 87,000 members of the American Psychological Association, The Psychology Today Tape Program provides a vital link between psychology and you" (Rosen, 1993).

Moreover, even a casual perusal of recent editions of the APA Monitor reveals that the APA has been accepting advertisements for a plethora of unvalidated treatments, including Thought Field Therapy and Imago Relationship Therapy, two techniques for which no published controlled research exists. In addition, among the recent workshops for which the APA has provided continuing education credit are courses in Thought Field Therapy, calligraphy therapy, Jungian sandplay therapy, and the use of psychological theatre to "catalyze critical consciousness." Although the APA might maintain that advertisements of products or workshops do not constitute endorsements, this practice inevitably tarnishes the reputation of APA and fosters the impression of an organization unable or unwilling to police its own membership.

What Can We Do Differently?

Thus far, my talk has probably sounded very much like a Jeremiad. Up to this point I have said little, if anything, about recommendations for dealing with this problem. So let me try to end on a constructive and hopefully more positive note. Assuming that we care about the burgeoning problem of pseudoscience in our field - and I hope that I've convinced at least some of you that we should - what can we do differently?

First, I would suggest that APA become more actively involved in the evaluation and even debunking of

pseudoscientific techniques. One possibility might be for APA to set up a watchdog group or division to critically investigate claims in popular psychology. Like the Committee for the Scientific Investigation of Claims of the Paranormal, the organization that publishes one of my favorite journals, the *Skeptical Inquirer*, this watchdog group would keep an open mind to any and all claims, but subject them to careful scrutiny and communicate its findings to the general public. Debunking is sometimes viewed as a purely negative activity, one that entails harsh criticism and little else. But as Stephen Jay Gould has pointed out, debunking has an unappreciated positive side, because in debunking one claim one is necessarily affirming others.

Second, I would suggest that the APA and other professional organizations assist with setting up explicit guidelines for the evaluation of self-help materials. As noted earlier, this might include developing standards similar to those for psychological tests. In his 1969 Presidential Address to the APA, George Miller argued for "giving psychology away" to the general public. By this he meant providing the public with the fruits of psychological science so that they could better learn to help themselves. Unless we do a better job of assisting the public with distinguishing legitimate from illegitimate self-help methods, Miller's dream of giving psychology away is almost certain to remain unfulfilled.

My third suggestion – and perhaps the one most likely to be controversial - concerns what those of us in clinical psychology programs can do to tend to the problems within our own house. Although it might be tempting to dismiss the pseudoscience problem as not of our own making, clinical psychologists have not been immune from making unsubstantiated claims. In the pages of this newsletter several years ago, Richard McFall (1991) argued that we should encourage clinical graduate programs to develop their own creative ways of meeting APA accreditation requirements. I agree. But diversity in training can go too far, and I fear that it has. In granting clinical programs considerable flexibility in finding ways to meet APA curriculum requirements, we may have neglected to ensure that certain critical issues receive the coverage they deserve. I find it disconcerting to see bright and intellectually curious students graduating with PhDs and PsyDs from APA-accredited clinical programs knowing little or nothing about the limitations of clinical judgment and clinical prediction, the effect of base rates on clinical decision-making, the fallibility of human memory, and fundamental issues in the philosophy of science. APA should encourage creativity in meeting basic curriculum requirements, while also insisting on a core set of knowledge to ensure that the clinical psychologists of the next generation emerge with a modicum of critical thinking skills.

We in academia need to find ways of rewarding, rather than punishing, our colleagues who take the time to popularize the findings of their profession and who are talented at it.

Fourth and finally, I would maintain that as clinical psychologists we have not done enough to popularize our findings and methods to the general public, and to convey to outsiders both the excitement of our scientific enterprise and the successful applications that have been derived from it. Popular psychology need not be a nonscientific psychology. There is precious little encouragement for those of us in academia to communicate our science to the public in the way that the late Carl Sagan, for example, did so effectively for astronomy and related disciplines. To the contrary, on several occasions I've actually seen academic psychologists who have attempted to follow Sagan's lead maligned as "popularizers" by their colleagues. We in academia need to find ways of rewarding, rather than punishing, our colleagues who take the time to popularize the findings of their profession and who are talented at it. I consider myself fortunate to have had as my graduate mentor a psychologist – David Lykken – who not only conducted active research on the polygraph or so-called "lie detector" test, but also spent a good deal of his career educating lawyers, legislators, and the public about its misuses and dangers. Lykken was a valuable role model for me, and we need more role models that like in academia.

In closing, I would like to conclude with a quotation from Mario Bunge (1984) that I believe underscores the dilemma that we are presently confronting as clinical psychologists:

> Scientists and philosophers tend to treat superstitition, pseudoscience, and antiscience as harmless rubbish, or even as proper for mass consumption; they are far too busy with their own research to bother about such nonsense. This attitude is most unfortunate … superstition, pseudoscience, and antiscience are not rubbish that can be recycled into something useful; they are intellectual viruses that can attack anybody, layman or scientist, to the point of sickening an entire culture and turning it against scientific research (p. 46).

Only if we heed Bunge's warnings can we as a profession hope to safeguard the integrity and reputation that we have fought so long and hard to attain. Thank you. ■

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H. Aronson
University of North Texas

Myriad changes are occurring within the field of academic psychology. Two critical changes include the proportional increase of women who receive doctoral degrees in applied subjects, and the shift in accreditation interests placed on the practice versus the science of psychology. This survey of academic applied programs provides a snapshot of the current way in which status (e.g., Director of Training), roles (e.g., teaching seminars versus practicum), and privileges (e.g., voting on department policies) interact with one another as well as with demographics such as gender and race. These data suggest that women are under-represented in higher status faculty positions in comparison to the proportion of female students. Furthermore, various interactions between roles and privileges are noted. Our hope is that this research will encourage longitudinal studies investigating the forces related to academic status and roles in applied training.

Traditionally, even disciplines that have had substantially more female than male students have had a majority of male faculty (Rubin & Powell, 1987). Currently, the academic field of psychology has changed rapidly with a shift toward a higher proportion of women than men obtaining doctoral degrees (Aisenberg & Harrington, 1988). There are advantages and disadvantages to being employed in academia, and it would be of value to the field to track the privileges that are assigned to male and female faculty members within different realms of academia. One way to understand this process might be a study of the reallocations that occur during the "feminization of academic psychology" (Cantor, 1992). The present paper takes a step toward mounting such a study by identifying some of the variables within applied academic faculties that may be differentially distributed by gender. It also attempts to identify variables that may contribute to the expanding practitioner/academic schism. Individuals who teach practice-oriented courses, such as assessment and practicum, may gravitate toward those courses due to their own predilections or to assignments; and placement may be correlated with gender. Any widening division of the scientist-practitioner model is worthy of examination.

This report offers a view of opportunities in status, rights, tasks, and training that exist in applied psychology. The data discussed here were commissioned by Division 12 as part of a Task Force Report. We, as authors, hope that such processes will continue to be assessed to help understand the ways in which the change in gender proportions of those obtaining applied doctoral degrees might influence, or be influenced by, other changes in our academic community.

Method

Subjects

The Directors of Training within 277 APA accredited doctoral programs in applied psychology each received copies of a single page questionnaire and a stamped, addressed envelope in late 1993. A cover letter requested each Director's assistance with this Survey on "diversity in graduate training." Respondents' institutions were keyed by code number. After 12 weeks, institutions that had not responded received a reminder and a second copy of the questionnaire. The key was then destroyed, assuring full anonymity. In all, 160 directors (a response rate of 58%) returned surveys;[1] 93 were directors of clinical Ph.D. training programs (62%) and 9 of clinical Psy.D. programs (6%), the remaining 32% were direc-

Portions of this paper were presented at the 1994 annual meeting of the American Psychological Association (APA). We are grateful to the Training Committee Directors who took time from their busy schedules to complete and return our questionnaire. We appreciate comments from Amy Holtzworth-Munroe. Connie Popkey deserves special thanks for her exceptional help in conducting and tabulating the results from the survey. We are grateful to David Barlow for appointment of a task force on women in academia and appreciate the financial support for survey postage from Division 12 of APA. *Correspondence should be directed to Lizette Peterson, PhD, Department of Psychology, 210 McAlester Hall, University of Missouri-Columbia, Columbia, MO 65211.*

Table 1

Faculty Listed by Training Directors as Teaching Applied Program Content

Status	Males	Females
Demographics[a]		
Gender (N)	1101	655
Age (mean)	47	42**
Race (N)		
Asian	20	16
Black	43	57
Caucasian	987	534
Hispanic	24	30
Native American	5	4
Other	1	0
Memberships & Functions (%)		
Director of Training	12	6**
Votes on Clinical Training Program actions and changes	71	61**
Directs graduate research	72	61**
Evaluates prelims, qualifiers, and/or sits on orals committees	75	64**
Tenured or on tenure track[b]	70	57**
Part time, unpaid or adjunct[b]	27	38**
Course Assignment, Current Year (%)		
Taught basic assessment course	21	22
(e.g., how to give, score and use WIAS-R, MMPI, or Rorschach)		
Supervised required therapy or assessment practicum in campus agency	52	54
Supervised off-campus practicum	26	30*
Taught courses other than assessment or practicum	78	71**

[a]Gender and race not subjected to statistical analyses

[b]Full-time but not tenured or on tenure track are not listed

*$p < .05$

**$p < .001$ Effect of gender, corrected for age

tors in other applied fields (school, counseling, etc.). Of the 102 Directors of Clinical Training, 24.5% were female, a proportion comparable to national statistics (Paul Nelson, APA Director of Program Consultation and Accreditation, personal communication, March 3, 1993), suggesting a representative sample of respondents. The number of faculty members listed as teaching clinical courses ranged from 4 to 28, with an average of 10.7. Specific demographics of the sample are presented in Table 1.

[1] Three of the reports received were outliers in terms of number of faculty listed. One Director listed only one (himself) faculty member, one listed only two, and one listed a very large number of adjuncts. The data on faculty size are reported without these three Directors' reports.

Procedure

The program directors were asked to answer a list of questions in reference to each faculty member who currently taught clinical content courses. An example of how to code a faculty member was supplied to match a written description. The questionnaire offered one column of space for the Director to describe each faculty member. The survey addressed privileges,

roles, and status of each faculty member. It asked the respondent to indicate if each faculty member served as Director of Training, voted on training program actions and changes, directed graduate research, evaluated prelims, qualifiers, or oral exams. It asked if the individual's rank was tenure track or part-time (adjunct status), and requested information about his or her gender, race, and age. The survey then asked whether in the most recent year's course assignments the faculty member had taught an assessment course, supervised on-campus therapy, supervised off-campus therapy, or had taught courses other than assessment or practicum. To limit the time needed for response, the respondents were instructed to check "yes," "no," or "I don't know" for each question, other than age, about each faculty member.

Measures

Results have been organized in terms of Descriptors (gender, race, and age), Status (tenure track vs. adjunct), Roles/Privileges (Director, votes, directs research, evaluates prelims), and Teaching Duties (assessment, practicum, off-campus practicum, and other courses). The Practicum courses were considered to represent clinical application. "Other" courses were considered to reflect more traditional academic subjects, such as theory or research and were our rough estimate of "science."

Statistics and Results

Overview

Initially, we explored overall gender differences in demographics. Because age could be expected to be related to roles, privileges, and status variables, and because there were significant age differences between male and female faculty, age was held constant in the analyses. We first examined all applied programs and then focused on clinical programs.

Next, we used the courses taught rather than gender as a blocking variable, to assess if individuals who taught the clinical application courses were less likely than other faculty to have certain roles and privileges. As a highly controlled test of this question, we examined both clinical faculty in general and then tenure track faculty and nontenure track faculty within clinical and other programs specifically.

Overall Differences in All Applied Programs

As can be seen in Table 1, male faculty tended to be about 5 years older than female faculty. There were, overall, more men than women faculty represented in the sample, which was predominantly Caucasian. Caucasian men outnumbered Caucasian women nearly 2 to 1. For racial minority faculty, there were nearly equal numbers of men and women.

The gender differences tabulated may have been due to the fact that the male faculty members were older on average than the female members. Therefore, multiple regression analyses were performed to examine the effect of age. The resultant *t*s found significant age differences for Director of Training ($p < .005$), evaluating prelims, qualifiers and/or oral exams ($p < .04$), and being appointed to a tenure track line ($p < .001$). However, when the effects of age were held constant, gender was still an important variable. Women were less likely than men to be appointed Director of Training ($p < .0001$), to evaluate the various exams ($p < .0001$), and to be tenure track faculty members ($p < .0001$). Women were also less likely to vote on training program actions ($p < .0001$), to direct graduate research ($p < .0001$), to teach courses other than assessment and practicum ($p < .002$), and more likely to have part-time or adjunct status ($p = 0001$).

Thus, gender showed a significant contribution to many variables, independent of age. In fact, only one of the initial gender differences no longer remained when the effect of age was removed. Those individuals supervising off-campus practicum were younger ($p < .01$) but were only marginally more likely to be female ($p = .091$).

Gender and Tenure Track/Nontenure Track in Clinical and Other Applied Programs

Clearly, being on a tenure track line is associated with gender; more women than men accept nonregular appointments. Race and gender interact; within clinical tenured lines, there are twice the proportion of female minority faculty (15%) as male minority faculty (7%), $X^2 (1,6) = 10.58$, $p < .001$. Such differences are no longer significantly present when we examine clinical nontenured lines (18% females, 15% males). Within other applied programs, minority women outnumber minority men both in tenured lines; $X^2(1,6) = 4.26$, $p < .04$, and, marginally, in nontenured lines, $X^2 (1,6) = 3.18$, $p < .07$. Thus, although minorities are underrepresented, minority males are more underrepresented than minority females. This effect is strongest for clinical tenure track lines.

These data demonstrate that being on a nonregular line is strongly related to both gender and likelihood of teaching assessment and practicum courses. Analyzing the distribution of gender within faculty type to teach certain courses and to enjoy specific roles and privileges thus seems potentially elucidating. Odds ratios were used to compare gender within tenure track faculty or within adjunct faculty lines for both clinical and other applied programs. These analyses revealed

few differences in the gender distribution of those faculty who teach specific courses. Within clinical tenure track faculty, women were as likely as men to teach assessment, supervise practicum on or off campus, or teach other courses (*p*s range .38 - .78). The same was true for clinical nontenure track faculty (*p*s range .12 - .91). In other applied programs, tenure track women were marginally more likely to supervise practicum off-campus ($p < .06$) than tenure track men, and adjunct faculty women were significantly more likely than men to be employed as adjunct faculty to supervise practicum on-campus ($p < .0001$). Thus, for counseling and school psychology programs, type of appointment may account for disparity of the types of courses offered by gender, whereas this is not the case in clinical psychology programs.

Only one of the Privileges examined was even marginally influenced by gender within clinical programs. Tenure track women ($p < .06$) and nontenure track women ($p < .11$) were somewhat *more* likely than men within these two appointment types to supervise graduate research, although these differences did not reach statistical significance. Within the other applied programs, the only gender related status finding was that tenure track women were far less likely than comparably tracked men to serve as program director ($p < .003$).

Further Differences Between Clinical and Other Applied Programs

Table 2 notes the similarities between the APA accredited clinical (PhD and PsyD) programs and school and counseling

Table 2

The Functions of Male and Female Psychology Faculty in Clinical and Other Applied Doctoral Programs

	Faculty Members			
	Counseling or School		Clinical Programs	
	Males	Females	Males	Females
Number	242	170	859	485
Age				
Mean (SD)	47 (9.22)	42 (8.44)	47 (9.25)	42 (7.89)
Status (%)				
Tenure/Tenure Track[a]	80	79	67	53
Part Time[a]	19	21	29	44
Privileges (%)				
Directs Training	12	8	10	6
Votes on Changes/Policies	85	77	67	55
Directs Research	82	74	69	57
Evaluates Prelims, etc.	85	76	72	59
Race (%)				
Caucasian	89	81	92	84
African-American	6	13	3	8
Hispanic	3	3	2	5
Asian	2	2	2	2
Native American	1	1	0	0
Other	0	0	0	0
Taught Current Year (%)				
Assessment	26	26	20	20
Practicum	49	61	53	52
Off-Campus	39	44	22	26
Other Courses	77	77	78	70

[a]This section omits the faculty in departments that offer full-time employment but do not provide tenure. As a result, totals here may not sum to 100%.

Table 3

Distribution of Faculty Functions in Clinical and Other Applied Programs of Psychology[a]

Function	Number		Female (%)		Age (SD)		Tenure Track/Part Time (%)	
	Clinical	Other	Clinical	Other	Clinical	Other	Clinical	Other
Director of Clinical Training	110	64	24	21	48 (8.4)	48 (8.4)	98/2	98/2
Votes on Change	849	345	32	39	46 (9.4)	46 (9.5)	92/6	88/8
Directs Clinical Research	877	330	32	39	46 (9.1)	46 (9.2)	91/8	92/6
Evaluates Students	910	341	32	39	46 (9.3)	46 (9.5)	89/10	92/6
Taught Assessment	271	107	36	42	43 (9.4)	45 (9.1)	72/26	85/15
Taught Practicum	704	225	36	47	45 (9.3)	44 (9.4)	74/23	79/16
Taught Off-Campus	324	173	40	44	44 (8.0)	44 (8.9)	48/43	76/18
Taught Other Courses	1019	324	34	41	46 (9.3)	46 (9.4)	75/24	83/12

[a]This table omits the faculty in departments that offer full-time employment but do not provide tenure. As a result, totals here may not sum to 100%.

psychology programs. Because only 9 PsyD programs responded, we combined Clinical PhD and PsyD programs. In general, the same patterns are present in both clinical and the other applied programs, but in most cases the differences between male and female faculty are slightly larger in the clinical than in nonclinical programs for privileges and smaller for teaching functions. The conclusions noted above for all applied programs continued to hold when only clinical programs were examined.

Table 3 shows another way of viewing the data. It examines those who teach certain courses and asks what proportion are male versus female. These data suggest that, of those who teach clinical courses, nearly four times more men than women serve as DCTs. In other applied programs, the men/women ratio is 60/40 for voting on changes, directing clinical students, evaluating students, and teaching assessment and content (nonpracticum) courses. The split is closer to 55/45 for the other courses. These same patterns emerge, only more strongly, for the clinical programs, with more of a 70/30 split in roles and privileges, and closer to 65/35 for course work. Thus, although there are more men than women in all categories, the split appears more pronounced in the more prestigious memberships and functions in both kinds of programs.

Discussion and Conclusions

We have found a number of gender differences in applied graduate faculties. There were more men than women in tenure track appointments and more women in part-time or adjunct positions. A greater proportion of the men than women served as Director of Training, voted on training program actions, and evaluated prelims, qualifiers, or oral exams. Although the overall proportion of men and women who taught practicum courses and supervised practice on campus did not differ, there were more women who supervised off-campus practice. And, for school and counseling programs, more women taught practicum on campus as well. On the other hand, more men than women taught science courses. This may be because women who are selected more often to serve as adjunct faculty are hired specifically because of their practice experience, which would prepare them well to teach practicum courses, but not to teach theoretical or research-based material. Alternatively, teaching science-based courses may be another prestigious task disproportionately assigned to tenure track rather than adjunct faculty. Regardless of the reasons behind the differences, we found that although men officially were employed in the same occupation, they appeared to have achieved higher status and privileges than their female counterparts. Men were more likely to represent "science," with women more likely to cluster as "practice" models for graduate students.

Some experts in the field[2] have suggested that female adjuncts are often employed to augment the small number of female faculty. They are usually in practice and typically are well prepared to teach practitioner courses, but not theory or

[2] Suggestion of an anonymous reviewer.

seminar courses. However, a graduate student considering a teaching career may not perceive the distinction between adjuncts and regular faculty. He or she could easily decide to work the first several years after the degree, amassing contact hours to qualify for a license and to try out teaching as an adjunct. That choice would likely be interpreted by most academic departments as a demonstration of low motivation for academia. In addition, most of our clinical literature focuses on regular faculty and would not warn a reader of that display of apparent poor judgment. Because some graduate students may not discriminate between tenure track and adjunct lines, it seems important to examine changes across rather than within these domains.

There was a consistent age difference between men and women which was statistically controlled when gender was evaluated. However, that age difference is, in itself, of interest. Three potential hypotheses come to mind to explain it:

1. *Time.* Women are only recently in the majority as doctoral students. When they catch up, in a time lag, as faculty, the age difference will disappear.

2. *Rejection.* Women leave after a short time of teaching, after having become aware of their lower status on the job. Some may be terminated by the vote of a departmental or administrative committee. Some may predict their failure in the future and simply leave prior to an unsuccessful evaluation. If barriers to success were resolved (as in medicine; Osborn, Ernster, & Martin, 1992) this attrition could be lessened. With greater success, fewer young women would leave and the age difference would disappear.

3. *Other Attractions.* Women choose other personal (e.g., agency) or less prestigious faculty (e.g., adjunct) work in exchange for more flexibility to fulfill other socially directed and expected roles such as wife or mother. They make such decisions after a few years and leave tenure-track lines to be replaced by younger women who, in time, may make the same choice. The age difference is not likely to disappear if this is the case.

The other applied programs studied here have had a longer history of being taught in departments of education and/or of being chosen by women. Yet, their mean ages, when compared with that of the men in their field, are remarkably similar to the age differences found in the clinical programs. This difference, in fields with more females in their histories, reduces the likelihood that the first hypothesis listed above accurately explains the age disparity.

The other applied programs demonstrate many parallels to the clinical programs but appear to show weaker gender effects. Perhaps the strong differences attributed to the clinical faculty were partially due to the fact that very few responses were made by PsyD Directors of Training and, because they are listed by APA as training clinicians, we added the PsyD information to that provided by PhD Directors. We suspect but cannot confirm that the PsyD responses listed here represent university-housed programs since professional schools are likely to have larger faculties than the numbers described here.

It is obvious that we have raised many questions but provided few definitive answers. These data describe the field in the mid-1990s; the turn of the century may show new, more egalitarian trends as women's and men's roles become more diversified or may reveal a continuation of the current trends. We, as authors, hope that other researchers will continue to monitor the relationship of gender to the important dimensions within academic psychology. Future research requires the resources and person power not only to describe these differences, but also to form more concrete hypotheses about their source. ■

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Behavioral Marital Therapy (BMT) for Relationship Distress

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The following article is part of the continuing series on Empirically Supported Treatments. Treatments selected to be reviewed here are based upon the work of the Division 12 Task Force on Psychological Interventions. Correspondence/ suggestions concerning the series can be addressed to the series Editor: William C. Sanderson, PhD, Rutgers University, Department of Clinical Psychology, Piscataway NJ 08854.

I. Description of Treatment

Behavioral marital therapy (BMT) is a skills-oriented approach to treating relationship difficulties that is based largely on operant conditioning and social learning principles. Encompassing a broad array of intervention strategies, BMT emphasizes the need for a clear understanding of the reciprocal nature of relationship interactions and the development of specific skills necessary for modifying behavioral patterns in the relationship that contribute to dissatisfaction. BMT typically includes three principle components: (a) behavior exchange strategies, (b) emotional expressiveness training, and (c) problem-solving training. Several investigations have compared these specific interventions with each other or with the full BMT intervention that includes all three components. To date, no single BMT component has been identified as more efficacious than any other or more efficacious than the full BMT approach. Thus, the efficacy status of BMT has been established by considering it as a broad treatment approach with the following unifying principles: (a) a focus on the present, (b) attention to behaviors and interaction patterns that are within the couple's awareness, and (c) the facilitation of specific behavioral changes to promote more adaptive relationship functioning. The three main components of BMT are described below.

An underlying assumption of BMT is that satisfaction with one's relationship is a function of the number of positive and negative experiences in the daily life of the couple. As such, behavior exchange strategies are intended to help the partners increase the frequency of positive interactions in their relationship. For example, the partners might agree to take turns doing something nice for each other on alternating days ("love days"). The agreed upon behavior exchange strategies can be implemented in an informal manner or, in some cases, a contract between the partners may be adopted to enforce each partner's continued participation.

Emotional expressiveness training involves teaching partners a set of communication behaviors to facilitate the sharing of important thoughts and feelings, with the ultimate goal of enhancing mutual understanding and intimacy. Partners are taught both listening and speaking skills with a focus on the verbal and non-verbal aspects of effective communication. In addition, differential attention may be given to the expression of negative and positive emotions, depending upon the needs of the couple. The partners practice these skills during the session, with the therapist acting as a coach to reinforce progress or make suggestions as necessary.

Problem-solving training is intended to teach partners the skills necessary to confront areas of concern in the relationship and generate mutually agreeable solutions for them. The therapist typically provides the couple with a rationale for using effective problem-solving to resolve relationship conflicts, differentiates problem solving from expressive communication (as described above), and outlines a basic sequence of problem-solving steps. As with emotional expressiveness skills, in-session practice is used to guide the couple through the process of solving a relationship problem. Different types of contracts (e.g., quid pro quo, good faith, wholistic) are often used to enforce agreed upon solutions.

Implementation of BMT is accomplished using a number of therapeutic strategies, including psychoeducation, modeling, role plays, coaching, and homework assignments. Handouts may also be used to supplement the presentation of important concepts. Although it is not a time-limited treatment, BMT is generally regarded as a short-term therapy, with an average duration of 11 sessions in controlled investigations. In recognition of the fact that the utility of this approach is not limited to couples who are married, researchers and clinicians have begun to refer to it

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more generally as behavioral "couple" therapy (BCT). The treatment continues to evolve in terms of both its underlying theory and core intervention strategies (e.g., Jacobson & Christensen, 1996). These more recent advances await empirical validation.

II. Summary of Studies Supporting Treatment Efficacy

The efficacy of BMT has been evaluated in over 20 studies published between 1976 and 1993, and a number of recent reviews and meta-analyses (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Dunn & Schwebel, 1995; Hahlweg & Markman, 1988; Shadish, Montgomery, Wilson, Wilson, Bright, & Okwumabua, 1993) have summarized the findings to date. The bulk of the evidence indicates that, when compared with control conditions (wait list or nonspecific treatment), BMT is an efficacious intervention for treating marital distress. Mean effect sizes of .95 (Dunn & Schwebel, 1995; Hahlweg & Markman, 1988) and .79 (Shadish et al., 1995) have been estimated in independent meta-analyses. Based on their review, Hahlweg and Markman (1988) concluded that the average person who receives BMT has higher scores on posttest marital measures than 83% of those in the wait list or placebo control groups. In addition, available data indicate that between one third and two thirds of couples receiving BMT are likely to be in the "nondistressed" range of functioning at the end of treatment (Baucom et al., 1998). These conclusions are based on posttest data using measures of global marital adjustment and satisfaction as the primary outcome criteria. The long-term maintenance of treatment effects for BMT has not been well studied, although limited work thus far suggests that treatment gains are maintained for up to one year.

III. Clinical References

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IV. Resources for Training

The Association for Advancement of Behavior Therapy (AABT) often sponsors BMT seminars, workshops, and institutes that are presented by the field's leading clinicians and researchers. These training opportunities are APA-approved for continuing education credits and most typically take place at AABT's Annual Convention. For more detailed information about the most current offerings, contact the Association for Advancement of Behavior Therapy at 305 7th Avenue, 16th Floor, New York, NY 10001 (212-647-1890). ■

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Why You Should Consider Board Certification[1]

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When I was a boy about ten years old I visited my physician father's office, just south of Central Park in New York City. While waiting for him, I had the opportunity to look over his many diplomas and certificates on the wall. I was curious about what they stood for, and asked my father as soon as he was available. He patiently explained what each one meant. "Four years in college for this one, another four years of medical school for that, and so many years of internship and residency." And finally he explained the ones he was most proud of, those for board certification in internal medicine and Fellowship in the American College of Physicians. "And how many years for the last two certificates?" Actually, no extra years in school, he told me. He had received them after establishing eligibility just by passing an exam! His response surprised me, and I wondered why he was so proud of these two achievements, which apparently did not require the same time spent in school. Why is board certification important to health practitioners? What does it mean to be board certified, and what benefits do you get when you are boarded? How is this different from state licensure? These are the issues I will attempt to address in this column.

As it happens, after completing my doctorate in clinical psychology at Penn State, an APA-approved internship at the VA, and a postdoctoral fellowship at Stanford, I went on to take my boards in clinical psychology from the American Board of Professional Psychology (ABPP). I have served for many years as an ABPP examiner, and I am currently on the board of directors of the Academy of Clinical Psychology, the membership organization of board certified clinical psychologists. The Academy of Clinical Psychology is one of the psychology organizations that are analogous to the various Colleges of Physicians. We use the signature designation of "FAClinP" whereas my father's colleagues use "FACP."

My father told me an interesting story. Prior to World War II, most physicians were general practitioners, or "family doctors." Specialists were in the minority. As the field of medicine advanced, physicians could no longer master the diversity of skills and techniques that evolved. Many chose to pursue additional training in order to specialize in one area of medicine. In one generation or so, the majority of physicians were practicing as specialists rather than generalists. How could someone tell which physicians had what training? By their board certification, of course, and fellowship in one of the Colleges of Physicians.

In psychology, as in medicine, most states award a generic license to health practitioners in a particular discipline after the practitioner has established a minimal level of competence. The interest of the state is primarily to protect the public. Licensure or certification does not identify specialty. In many states health care providers can obtain a license with minimal clinical training. Board certification, however, demonstrates to the public and professional community that the practitioner has established an advanced level of competency in a particular psychology specialty.

In 1947 when ABPP was first organized, there were very few identified specialties in Psychology. First there were Clinical Psychology, Counseling Psychology and Industrial/Organizational Psychology, then School Psychology. Psychologists had not yet developed specialized tools and techniques to a degree that would justify more specialties. The postdoctoral experience required by most states now was not typically part of psychologists' training. Today, ABPP examines candidates in the following specialty areas in psychology:

Behavioral Psychology
Clinical Neuropsychology
Clinical Psychology
Counseling Psychology
Family Psychology
Forensic Psychology
Health Psychology
Industrial/Organizational Psychology
Psychoanalysis in Psychology
Rehabilitation Psychology
School Psychology

[1] This article was originally published in *The California Psychologist*, October, 1998, and is reprinted here with permission.

Dr. Kenigsberg serves on the Board of Directors of the Academy of Clinical Psychology, the membership organization of ABPP board certified clinical psychologists. He has been a staff psychologist at the Long Beach V.A. Medical Center for the past 18 years. Correspondence with the author may be addressed to Martin I. Kenigsberg, PhD, PACLinP, ABPP, VAMC Psychological Services 116B, 5901 E. 7th. Street, Long Beach, CA 90822-5201. (310) 494-5604.

More specialties are on the way. The American Psychological Association has several committees devoted to the identification and accreditation of specialty training programs in psychology. There is also an interagency organization, the Council of Specialties in Professional Psychology, which deals with specialty issues in Psychology. Specialty training is probably one of the most important issues in professional psychology today.

For example, the most important legislative priority of the California Psychological Association is prescriptive privilege. For current practitioners, the new skills in psychopharmacology that this would require lead to the issue of additional training and certification. APA policy states that specialty training should occur at the postdoctoral level. In medicine, there is one organization the American Board of Medical Specialties that oversees the board certification activities of each of the individual specialties. In psychology, the American Board of Professional Psychology serves this function.

Consider that only about 16% of eligible specialists in psychology are board certified, as compared to about 58% of eligible specialists in medicine. If a family member or friend needed to see a specialist in psychology, and you did not know of a local specialist, what information would you want to review to insure that he or she is referred to a qualified practitioner? You might begin by asking the following questions:

Where did the psychologist do his/her doctoral training and internship? Was the training approved by the APA? What were the nature and content of the psychologist's graduate and postdoctoral training? What sort of pre-and postdoctoral evaluations did he or she receive? What did colleagues in the same specialty think about his/her practice? What was the exact status of his or her license or certification? Were there any prior disciplinary actions, or pending actions? To be really thorough and comprehensive, you might want to be able to review a professional work sample, such as a psychological report. Wouldn't it be informative to be able to listen to an actual therapy session? In the best of all possible worlds, if you had the opportunity to watch the psychologist examine an actual patient, spend time discussing the case, and ask any questions about the other information you had collected, wouldn't that assure you that you were making the right referral?

When a psychologist is assessed by ABPP in clinical psychology, this is essentially the evaluation that he or she goes through. Paper credentials and recommendations are carefully reviewed prior to entering candidacy, and then the psychologist is examined by three qualified peers in the same field. Board certification by ABPP saves you and any other member of the public the exhaustive and expensive evaluation that I have just described. While there is a significant cost to complete this certification (current fees for the clinical psychology examination are $700 total - consisting of a $100 application fee with $50 discount for Division 12 APA members, $200 work sample review fee, and $400 examination fee), these fees are often much less than the cost of attending a convention out of state. The costs are usually tax- deductible, and the certification is something that you carry with you for your entire professional career.

If a family member or friend needed to see a specialist in psychology, and you did not know of a local specialist, what information would you want to review to insure that he or she is referred to a qualified practitioner?

Additionally, there are other advantages to being board certified. Many prospective employers and third party payers look favorably upon board certification. Psychologists employed by the Department of Defense receive extra incentive pay for being board certified. The Congress has passed legislation allowing incentive pay for VA psychologists. Many other agencies provide extra pay for board certification. Approximately two-thirds of the states recognize ABPP board certification when psychologists apply for reciprocity. When credentials are carefully scrutinized in a judicial setting, board certification provides a significant advantage in professional credibility. In terms of a peer review of competence, the ABPP diploma provides a much more reliable measure of competence than merely a state license or National Register listing.

When you have decided to go ahead and apply for board certification, you can obtain an application by writing to the

American Board of Professional Psychology
2100 E. Broadway, Suite 313
Columbia, MO 65201
(573) 875-1267 (phone)
(573) 443-1199 (fax)
www.abpp.org (web site)

If you prefer e-mail, you can reach the executive officer, Nicholas Palo, with the following E-mail address: npalo@abpp.org. Just tell him that Marty sent you! ■

Society News

Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. Telephone (303) 652-3126. Fax (303) 652-2723.

Letter to the Editor

I received my Summer 1998 Edition of *The Clinical Psychologist* and read with particular interest, Dr. Donald Routh's President's Column, "Should Psychologists Be Allowed to Prescribe Medications?" I would like to offer my own commentary in response. First, let me say that as a practitioner I am a vigorous proponent of prescription privileges for clinical psychologists and I applaud Dr. Routh's writing about this vital issue. I do, however, take issue with his promulgation of the false dichotomy that there are psychologist-practitioners and then there are the psychologist-scientists. I am a practitioner and I consider myself a behavioral scientist as well. To infer that somehow we practitioners are unscientific or somehow lacking in empirical training is untrue. Dr. Routh is correct in his view that the opposition to RxP (prescription privileges) among the body of psychologists has come principally from those psychologists employed in academia. As a practicing clinical psychologist who earns 110% of his daily bread from practice and is directly responsible for the care of many psychologically ill patients, I find it both ironic and offensive that psychologists, such as those represented by groups like AAAPP and CUDCP who so passionately want to deprive me of the ability to enhance my scope of practice to benefit my patients, are precisely those psychologists who do not treat patients. Their effort to dictate practitioner scope of practice is especially egregious. I also agree with Dr. Routh's suggested resolution "that each group stick to what it knows best. Those who make their living through the practice of psychology may be in the best position to know how they would like to modify their scope of practice." Indeed. I would like to see my colleagues in academia support we practitioners in our effort to obtain RxP, if not through direct advocacy, then by agreeing to cease and desist from outright obstruction and sabotage.

Letter from the Editor

APA President-elect Dick Suinn has announced his intention to focus on two major issues during his presidency. These are cancer and ethnic minority issues. In support of this initiative, a special invitation is extended to all authors. If you have ideas or data relevant to these topics, please consider submitting a paper to be considered for publication in The Clinical Psychologist.

The Clinical Psychologist is a publication of the Society of Clinical Psychology, a division 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 Society. Review, conceptual, or position papers are welcome. Submissions are subject to peer review. Manuscripts should be approximately 20 pages including references and tables. Submissions are preferred in electronic form. They can be submitted via email to rokke@plains.nodak.edu or via regular post to the address listed below.

Paul Rokke, PhD
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Division 12 Net

This is an e-mail net available to Divison 12 Members only. To subscribe, write to LISTSERV@LISTSERV.NODAK.EDU and in the text of your message (not the subject line) write:
SUBSCRIBE DIV12 [First name & Last name]

Division 12 Board of Directors Approves Section on Clinical Emergencies and Crises

Phillip M. Kleespies

At the Division 12 Board of Directors meeting on May 30-31, 1998, in Alexandria, VA, the Board voted unanimously to approve a proposal with an accompanying petition to establish a new Section on Clinical Emergencies and Crises (Section VII). This innovative Section gives recognition within the organizational structure of the Division to the difficult clinical work that Psychologists do with patients or clients who engage in life-threatening behaviors. Such behaviors include potential suicide, the perpetration of violence, and the risk of victimization.

Although Psychologists who work in crisis clinics or on mobile crisis teams or in emergency departments may see such patients most frequently, there is no guarantee that any clinician might not be confronted with a patient or client who presents with a behavioral emergency. During their training years alone, nearly 97% of the Psychologists in the survey by Kleespies, Penk, and Forsyth (1993) worked with patients who had either an episode of suicidal ideation, a suicide attempt, or a suicide completion. More than 1 in 4 had a patient make a suicide attempt, and 1 in 9 had an actual patient suicide. In a national survey of patient violence, Pope and Tabachnik (1993) found that 83% of their sample of Psychologists had episodes in which they felt afraid that a patient might attack them, and 89% had episodes in which they felt afraid that a patient might attack a third party.

Psychologists have long responded to the professional responsibility of evaluating and managing crises and emergencies that arise with their clients or patients. Yet, within the structure of the American Psychological Association, there has been no organizational entity that specifically acknowledged this very important and intense clinical work and promoted its further study and understanding.

The problem, of course, has been more extensive than a lack of representation within APA. Graduate training in Clinical Psychology has been remiss in not requiring training in emergency services for its students and/or interns. Thus, for example, Kleespies et al. (1993), in their study of the stress of patient suicidal behavior during clinical training, reported that an estimated 55% of their sample of former graduate students in Clinical Psychology had some form of didactic instruction on suicide in their graduate school years. The instruction (when given) was typically minimal (i.e., one or two lectures). In a study of patient violence, Guy, Brown, and Poelstra (1990) reported that Psychologists in their national sample had a mean of one hour of clinical training on the management of patient violence during their pre-doctoral training years.

Not only do Clinical Psychologists need more systematic training in the evaluation and management of patient suicidal and violent states, but they also need better preparation for handling the affects that are aroused by work with such conditions (Pope & Tabachnik, 1993) and for dealing with the psychological aftermath of events like patient suicidal behavior or patient violence (Kleespies et al. 1993; Guy et al. 1990). The same, of course, can be said in terms of working with those patients who run the risk of becoming victims of violence or who have been acutely victimized and could be re-victimized.

It would seem that the exchange of information and the promotion of research and training in the evaluation and management of emergencies and crises can only make for more complete and competent professional Psychologists. It would also seem that it can only enhance the standards of the discipline of Clinical Psychology to inform and train its practitioners more fully in the best ways to deal with those sometimes frightening, often difficult and trying, instances when patients or clients are at risk. You are invited to assist in advancing the clinical and scientific understanding of psychological/behavioral emergencies and crises as well as the clinical abilities needed to evaluate and manage them by joining this newly formed Section on Clinical Emergencies and Crises.

For information or an application form contact:

Phillip M. Kleespies, Ph.D.
Section VII Representative (Pro Tem)
Psychology Service (116 B)
VA Medical Center
150 South Huntington Ave.
Boston, MA 02130
Tel. (617) 232-9500, X4106
E-Mail: Kleespies.Phillip_M_PHD@Boston.VA.GOV

References

Guy, J., Brown, C., and Poelstra, P. (1990). Who gets attacked? A national survey of patient violence directed at psychologists in clinical practice. *Professional Psychology: Research and Practice, 21,* 493-495.

Kleespies, P., Penk, W., and Forsyth, J. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice, 24,* 293-303.

Pope, K., and Tabachnick, B. (1993). Therapists anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice, 24,* 142-152.

Announcements

Clinical Psychology Brochure

The popular brochure "What Is Clinical Psychology" is available from the Society 12 Central Office. It contains general information about Clinical Psychology, and is suitable for both the general public and high school/college students. The cost is $15 per 50 brochures. Orders must be pre-paid. For more information, contact: Society 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. (303) 652-3126. Fax (303) 652-2723, Email: <lpete@indra.com>

Interested in Applying for Initial APA Fellow Status?

Because of changes made by the APA Membership Committee, deadlines for initial applicants are now earlier than in the past. The deadline for initial Fellow applications for 1999 will be December 1, 1998. For persons who are already APA Fellows through other Divisions, the deadlines will continue to be February 15, 1999. Applications and information can be obtained from the Division 12 Central Office.

Membership Committee Approves 238 New Members

Dr. Holly Waldron, Membership Chair, announces that for the 1998 membership year, the Committee approved the applications of 238 Clinical Psychologists for membership to the Society. Also in 1998, there were 853 graduate psychology students affiliated with the Division. Members of the 1998 Membership Committee are: John Colletti, PsyD, Linda A. Abeles, PhD, Michael G. Perri, PhD, Asumcion Miteria Austria, PhD, Toy Caldwell Colbert, PhD, John D. Robinson, EdD, MPH, Ex-Officio member Miguel Ybarra, and Chair Holly Waldon, PhD.

The Society also approved a new International Affiliate Membership in its recent ballot. As an international clinical psychologist with an international membership in APA, or with demonstrated interest in practice and research in the field, applicants are invited to become affiliated with the Society through the International Affiliate Program. As an international affiliate, members will have greater access to the activities and issues that are of interesst to clinical psychologists.

The annual international affiliate fee of $40 includes subscriptions to the Society's journal, *Clinical Psychology: Science and Practice,* and its publication *The Clinical Psychologist.*

Seymour B. Sarason Award

Nominations sought for the Seymour B. Sarason Award for Community Research and Action. The award winner will present an address at the annual convention of the American Psychological Association in Boston in August, 1999, and receive $1,000. The award recognizes those working in the conceptually demanding, creative, and groundbreaking tradition of Seymour B. Sarason. This tradition includes: 1) novel and critical rethinking of basic assumptions and approaches in the human services, education, and other areas of community research and action; 2) major books and other scholarship that reflect these approaches; and 3) action-research and other action efforts. People may nominate themselves or others. Along with the name of the nominee, please send a detailed paragraph of support for the nominated individual and, if possible, a copy of the person's curriculum vitae by December 1, 1998, to:

Professor Cary Cherniss, GSAPP
Rutgers University
52 Frelinghuysen Road
Piscataway, NJ 08854

Society Honors Psychologists at Award Ceremony

The Division presented four awards at the 1998 Award ceremony, held at the Marriott Hotel in San Francisco, August 15th

David Shakow Early Career Award

Scott O. Lilienfeld, PhD

President-elect Thomas H. Ollendick (r) presents the award to Dr. Lilienfeld

Dr. Scott Lilienfeld is an outstanding young investigator in the field of psychopathology, with special reference to the personality and anxiety disorders. Not content to investigate the ordinary or commonplace, his research has turned some interesting and vexing issues on their heads. For example, he has shown that psychopathy, as well as some of the features associated with it (e.g., fearlessness), predispose individuals to prosocial behaviors such as heroic acts or altruistic acts, as well as toward less endearing antisocial acts so characteristic of individuals with antisocial personality disorder. He has also challenged the common conception of anxiety sensitivity and its pivotal or unique role in the anxiety disorders. His critical thinking and intellectual prowess have led him (and us) to new insights about these disorders, as well as several publications of both theoretical and applied significance. In brief, his dedication to the science and practice of Clinical Psychology make him an ideal choice for the 1998 David Shakow Award for Early Career Contributions.

Award for Distinguished Scientific Contributions to Clinical Psychology

Marvin R. Goldfried, PhD

Past President Lynn P. Rehm (r) presents the award to Dr. Goldfried

Dr. Goldfried exemplifies the attributes that this award was meant to honor. For over 30 years he has been a consistent contributor to the field. He has published over 150 articles and book chapters. He has served on editorial boards and has been a member of grant review committees. For over 25 years, he has been the continuous recipient of research grants.

Facts and numbers, however, do not convey the outstanding and unique nature of his contributions. Dr. Goldfried has contributed to many areas from early work on psychodiagnostic assessment to pioneering contributions to the field of behavior therapy. His work on self-control therapy procedures and their clinical application are especially noteworthy. In recent years he is best know for his seminal work in psychotherapy integration. He has researched and written about common principles of therapeutic change, and in doing so has moved the field in the direction of overcoming theoretical barriers and limits. To further these efforts he became one of the founders of the Society for Psychotherapy Integration.

*Marvin Goldfried's contributions to theory and research, as well as to practice, to teaching, and to the pro*fessional community, make him a well deserving recipient of this award.

Award for Distinguished Professional Contributions to Clinical Psychology

Carolyn Schroeder, PhD

President Donald K. Routh (l) presents the award to Dr. Schroeder

As a clinical psychologist, Carolyn Schroeder represents the rare combination of a scientist, a practitioner, and one who has through her activities contributed to the general welfare of her community. She set up her practice in collaboration with a large group of pediatricians in Chapel Hill, North Carolina and ultimately headed her own team there, including colleagues in child psychiatry and social work. This practice demonstrated how psychologists and other mental health professionals can work with primary care physicians to benefit thousands of children and their families. Her work has served as a national model for psychology colleagues who are now moving into practice in primary care medical settings.

Dr. Schroeder incorporated research components into her practice activities from the first and carried out follow-up studies to monitor the effectiveness of the services she delivered and their acceptance by the children and families involved. She facilitated the involvement of her physician colleagues in basic psychological research on children's knowledge of sexuality and their ability to recall the details of pediatric examinations. With medical colleagues, she set up one of the first routine protocols for the individual double-blind crossover evaluation of the effects of psychotropic medication on children.

Finally, Dr. Schroeder helped establish Annie Sullivan Enterprises, a private, non-profit corporation for assisting children with developmental disabilities and severe emotional and behavioral disturbance and their families. This service has been willing to accept children no one else would take and to learn how to help families and community members to manage the child's difficulties successfully.

For all these reasons, the Society of Clinical Psychology is proud to honor Dr. Schroeder with this award.

Theodore H. Blau Early Career Award

Elizabeth A. Todd-Bazemore, PhD

Council Representative Diane J. Willis (r) presents the award to Dr. Todd-Bazemore

Dr. Elizabeth A. Todd-Bazemore is an outstanding young psychologist who has provided a positive impact on health delivery systems in Indian country through the development of creative educational programs for practice.

Specifically, Dr. Todd-Bazemore has produced several films dealing with the topics of disaster and children's mental health, mental health work with American Indians, and on serious mental illness in Indian country. Her research on American Indians fills a gap in knowledge that has existed for years.

Of importance is Dr. Todd-Bazemore's development of mentoring programs for American Indian students, and the expansion of her ideas to be inclusive of all ethnic minority students. In her role as a faculty mentor, teacher, and researcher she has given her time to many tribes and organizations as a consultant. As a young psychologist she has already served on Council within the American Psychological Association, and she has been a member of the Commission on Ethnic Minority Recruitment, Retention, and Training. Currently, Dr. Todd-Bazemore is an elected member of the Board for the Advancement of Psychology in the Public Interest (BAPPI), and she serves on a Task Force on Serious Mental Illness, both of which are sponsored by the American Psychological Association (APA). Her hard work, dedication and innovation, and her productivity, not only among American Indians, but within APA, makes her an ideal choice for the 1998 Theodore H. Blau Early Career Award for Outstanding Contributions to Professional Clinical Psychology.

Society of Clinical Psychology
American Psychological Association

Distinguished Awards for the Contributions to the Science and Profession of Clinical Psychology

1958	John G. Darley
	Frederic L. Wells
1959	Starke R. Hathaway
	David Shakow
1960	David Rappaport
	David Wechsler
1961	Samuel J. Beck
	Henry A. Murray
1962	Stanley D. Porteus
	Carl R. Rogers
1963	Edgar A. Doll
	Jean Walker McFarlane
1964	Norman A. Cameron
	Robert White
1965	George A. Kelly
	Bruno Klopfer
1966	Nicholas Hobbs
	Harold Hildreth (Awarded Posthumously)
1967	William A. Hunt
	Paul E. Meehl
1968	Jerry W. Carter
	Julian B. Rotter
1969	Noble H. Kelly
	Seymour Sarason
1970	John E. Bell
	Nevitt Sanford
1971	Rollo R. May
	Silvan S. Tomkins
1972	E. Lowell Kellyx
	Anne Roe
1973	Florence C. Halpern
	J. McVicker Hunt
1974	Robert Holt
	Evelyn Hooker
1975	Gardner Lindsey
	O. Hobart Mowrer
1976	Sol L. Garfield
	Eliot H. Rodnick
1977	Norman Farberow
	Edwin S. Shneidman
1978	Erich Fromm
	Bernard Kalinkowitz
	Sheldon Korchin
	Benjamin Wolman
1979	Bruno Bettelheim
	Erik Erikson
1980	Molly Harrower
	Karen Machover
1981	Hans Strupp
	Carl N. Zimet
1982	Alan O. Ross
	Janet T. Spence

Award for Distinguished Scientific Contributions to Clinical Psychology

1983	Joseph D. Matarazzo
1984	Mary D.S. Ainsworth
1985	Saul Rosenzweig
1986	Lester Luborsky
1987	Oscar A. Parsons
	Morris Parloff
1988	Ronald E. Fox
	Norman Garmezy
1989	Charles D. Spielberger
1990	Herman Feifel
1991	No Awards Granted
1992	Alan E. Kazdin
1993	K. Daniel O'Leary
1994	G. Terence Wilson
1995	Herbert C. Quay
1996	Edna B. Foa
1997	Lizette Peterson
1998	Marvin R. Goldfried

Award for Distinguished Professional Contributions to Clinical Psychology

	Jack G. Wiggins
	Louis D. Cohen
	Harold L. Raush
	Jeanne Phillips
	Robert A. Harper
	Robert D. Weitz
	Ronald E. Fox
	Norman Garmezy
	Patrick H. DeLeon
	Rogers H. Wright
	No Awards Granted
	Donald K. Routh
	Robert J. Resnick
	Kenneth S. Pope
	Allan G. Barclay
	Diane J. Willis
	Arnold Lazarus
	Carolyn S. Schroeder

David Shakow Award for Early Career Contributions

1994	Susan Nolen-Hoeksema
1995	Judy Garber
1996	Thomas N. Bradbury
1997	Thomas Joiner
1998	Scott O. Lilienfeld

Theodore Blau Early Career Award

1998	Elizabeth Todd-Bazemore

Other Awards

1966	Joseph Zubin	*Outstanding Educational Contributions to the Post Doctoral Institutes*
1983	Stanley F. Schneider	*Unique Leadership in Furthering the Training of Clinical Psychologists*
1988	Frank J. Sullivan	*Outstanding Public Service to Clinical Psychology*
1992	Jules Barron	*Posthumous Award for Professional Contributions*
1994	Jonathan Kellerman	*APA Division 12 Media Award*
1996	Hans J. Eysenck	*Special Centennial Award (for outstanding contributions to field)*
1996	Paul E. Meehl	*Special Centennial Award (for outstanding contributions to field)*

Editor's Note: It has been common practice to publish a complete list of Division 12 Award winners in the summer or spring issues of TCP, at the time when the annual award winners are recognized. Somewhere in the history of this tradition a few errors were unwittingly introduced to the list and have been perpetuated in the annual reprinting. Thanks to our resident historian and current president, Donald K. Routh, these have been corrected. Above is a list of all awards presented by the division.

Call for Nominations

Division 12's 1999 Distinguished Contribution Awards

1999 David Shakow Award for Early Career Contributions

The recipient will be a psychologist who has received the doctoral degree in 1990 or later and who has made noteworthy contributions both to the science and to the practice of Clinical psychology. Letters of nomination should include the nominee's vita and a summary of his/her contributions. Send nominations to:

Donald K. Routh, PhD, Chair
1999 Awards Committee
c/o Division 12 Central Office
P.O. Box 1082
Niwot, CO 80544-1082

Deadline: October 30, 1998

The award will be presented at the 1999 APA Convention in Boston.

Theodore Blau Award

This award is being funded by PAR (Psychological Assessment Resources), and began in 1998. The award will be given to a Clinical Psychologist who has made an outstanding contribution to the profession of Clinical Psychology. Given the difficulty of making such contributions very early in ones career, the award will be given to a person who is within the first 10 years of receiving his or her doctorate. Letters of nomination should include the nominee's vita and a summary of his/her contributions. Send nominations to:

Donald K. Routh, PhD
1999 Awards Committee
c/o Division 12 Central Office
P.O. Box 1082
Niwot, CO 80544-1082

Deadline: October 30, 1998

The awards will be presented at the 1999 APA Convention in Boston.

Society of Clinical Psychology Elects Fellows

Russsell T. Jones, PhD, Society of Clinical Psychology Fellowship Committee Chair, reports that Division 12 nominated five individuals for initial APA Fellow status. The following candidates were elected to APA Fellow Status effective January 1, 1999:

Clifford M. DeCato, PhD
Howard N. Garb, PhD
Thomas L. Jackson, PhD
Catherine Lord, PhD
Lee H. Matthews, PhD

In addition, the following individuals who are already APA Fellows in other divisions were approved for Fellow status in Division 12 (effective Janauary 1, 1999):

A. Toy Caldwell-Colbert, PhD
Willis F. Overton, PhD
Ronald H. Rozensky, PhD
Stephen Strack, PhD
Jerry J. Sweet, PhD

The members of the 1998 Society of Clinical Psychology Fellowship Committee are: Samuel M. Turner, PhD, Ralph Barocas, PhD, Alfred J. Finch, PhD, Florence Kaslow, PhD, John C. Linton, PhD, and Russell T. Jones, PhD (Chair).

APA Boards and Committees

The 1999 Call for Nominations for APA Boards and Committees will be out in January 1999. If you are interested in obtaining Division 12's support for an APA Board or Committee position please let us know asap. Contact:

Michael A. Goldberg, PhD
Chairperson, APA Governance Committee
49 Walpole Street, Suite 5
Norwood, MA 02062
Email: Goldberg_MI@a1.tch.harvard.edu

Minutes of the Division 12 Board of Directors Meeting*

October 10-11, 1998

The meeting was called to order by President Dr. Donald K. Routh at 8:30 a.m., October 10, 1998, in Atlanta, Georgia. Minutes of the May, 1998 Board meeting were approved with minor modifications. Treasurer Dr. W. Edward Craighead reported on the probable end of year finances and provided a proposed budget for 1999. He noted that the PDIs in San Francisco had been more financially successful than expected. In contrast, dues were behind previous years, which led to no net change in the budget and an expected end of year balanced budget. Finance Committee Chair Dr. Charles Spielberger reported that at the January Board meeting consideration of dues income relative to division expenses needed to be explored more completely.

The Publications Committee had several items on the agenda. The current backlog of articles for the journal will need to be addressed. Options include increasing the issue size and increasing the number of issues per year. Final decisions were deferred until a meeting where editor, Dr. David Barlow, could be present. Publications Chair Dr. Lawrence Siegel provided a "mock up" of a proposed brochure on clinical psychology for use with prospective clients and referral sources. Suggestions for modifications were made. His committee also noted the decrease in institutional subscriptions to the journal and methods of addressing this decline were discussed.

President-elect Dr. Thomas Ollendick discussed sites for the 1999 Board meetings. The June meeting will be held in conjunction with the Canadian Psychological Association's convention. Several board members will participate on convention panels. He also named committee and task force personnel for his presidential year.

Drs. Spielberger and Routh addressed international issues in clinical psychology. They summarized the IAAP meetings in San Francisco, discussed future international meetings, and announced that the new clinical section of that organization will meet in conjunction with the International Council of Psychologists in Salem, Massachusetts just prior to the 1999 APA convention in Boston.

Dr. Peggy Greco provided a final oral report on the 1998 Division 12 convention program and made some observations for use by 1999 program chair Dr. Ross Greene. Dr. William Sanderson's 1999 PDI report was discussed, as was the issue of presenters who cancel at the final moment.

The Division 12 apportionment letter was discussed. It was noted that Division 12 had lost a seat on council for the coming legislative year and that if it was not regained in the coming ballot period there would be no vacancies in the next election.

Reports were received from liaisons to various APA governance groups as well as from the Council representative. During standing committee reports it was noted that Division 12 had over 800 student affiliates and the work of APAAGS liaison and former Membership Chair Dr. John Robinson in this area was lauded. Ways to keep senior, dues-exempt, members more involved in the group were discussed and an ad hoc committee will be appointed to further explore this topic.

Dr. Routh noted that nominations were being received for the 1999 Division 12 awards. Further information will be conveyed at the next meeting.

Dr. Paul Pilkonis provided an extensive written report on the work of the Committee on Science and Practice. He discussed various possibilities for future directions of this committee as well as funding sources.

During Section reports, it was noted that Section 1's petition for separate APA division status will be on the agenda of the APA Council of Representatives in February, 1999, and the Section V's petition is likely to obtain sufficient signatures to be on the August, 1999, agenda. Implications of these sections becoming separate APA divisions were discussed as well as whether or not there would also continue to be specialty sections addressing children's issues within Division 12.

Dr. Carl Zimet, representing the Academy of Clinical Psychology, reported on their activities including a motion currently moving through the APA governance process which addresses the importance of board certification for clinical psychologists. He noted that there seemed to have been a recent increase in the number of people applying for the clinical ABPP exam, the upcoming joint CE program with the APA Insurance Trust, and the importance of maintaining a close relationship between the Academy and Division 12. Dr. Jerome Resnick, Division 12 liaison to the Academy provided further information on their activities. Dr. Ollendick asked that a cross tabulation of the membership of the two organizations be conducted.

It was announced that Ms. Lynn Peterson, Division 12 Administrative Officer, had recently assumed a similar function for APA Division 29. The precedents for such multiple service were discussed and she was congratulated for her good work for Division 12.

The interactions between Division 12 and other practice divisions of APA were discussed. Dr. Diane Willis will bring a proposal for increasing such contact to the January 1999, meeting.

The next meeting of the Division 12 Board will be January 8-10, 1999 in Savannah, Georgia.

Respectfully submitted,

Janet R. Mathews, PhD, ABPP
Secretary

**A complete set of minutes of this meeting will be available from the Division 12 office once they have been approved at the January 1999 Board meeting.*

1998 Postdoctoral Institutes A Success!

The Society of Clinical Psychology and Postdoctoral Institute Chair, William C. Sanderson, presented fifteen Continuing Education workshops this summer just prior to the APA convention. The workshops were held both at the Moscone Center and the Parc 55 Hotel. We had a group of outstanding presenters, and had a record-setting registration total of 508. The presentations were as follows:

Neurodevelopmental Assessment of ADHD Across the Life Span	Jan Culbertson, PhD
Behavioral Treatment of Childhood Anxiety Disorders	Deborah Beidel, PhD
Cognitive-Behavioral Therapy for Late-Life Depression	Dolores Gallagher-Thompson, PhD, ABPP
	Larry Thompson, PhD
Sport Psychology: Striving For Excellence	Robert Singer, PhD
Innovations in Cognitive Therapy of Difficult Patients: A Schema-Focused Approach	Jeffrey Young, PhD
Dialectical Behavior Therapy for Borderline Personality Disorder	Marsha Linehan, PhD
Neuropsychological Assessment of Learning Disabilities Across the Life Span	Jan Culbertson, PhD
Child and Adolescent Anger Management	Eva Feindler, PhD
Comprehensive Treatment of Childhood/Adolescent ADHD	William Pelham, Jr., PhD
Cognitive-Behavior Therapy for Depression	Jacqueline Persons, PhD
Recent Advances in the Psychological Treatment of Anxiety Disorders	C. Alec Pollard, PhD
Psychopharmacology Review: Drugs, Principles and Applications	Morgan Sammons, PhD
Computer Survival Guide	Thomas Kramer, MD
	Robert Kennedy, MA
Relapse Prevention and Harm Reduction in the Treatment of Addictive Behaviors	G. Marlatt, PhD
Evaluation of Sexually Abused Children and Adolescents	William Friedrich, PhD
	Diana Elliot, PhD

The student volunteers for the program this year were outstanding. Valerie Hartman, a student of Jan Culbertson's in Oklahoma, coordinated the participation of several students from the Oklahoma University HSC. We also had four volunteers from the local area. The students were Ben Balderson, Nancy Cohen, Kathleen Donohue, Bernard Fuemmeler, Valerie Hartman, Kevin Hommel, Ginger King, Erica Mondro, Kristen Valus, and Nicole Wordlaw. "Thanks" was not sufficient for the assistance these students gave us. Next year's Institutes in Boston will be chaired by Greta Francis, PhD. We look forward to another successful year.

Information Request

1999 Postdoctoral Institutes
August 18–19, 1999 (Pre-APA Convention)
Boston, MA

Please add my name to the mailing list for 1999 Postdoctoral Institute workshops.

Name: _____

Address: _____

Telephone: _____

Email: _____

Mail this information to:
Division 12 Central Office
PO Box 1082
Niwot, CO 80544-1082
Or fax to (303) 652-2723

Position Openings

CLINICAL PSYCHOLOGY: The Department of Psychology at the University of Arkansas-Fayetteville invites applications for one and possibly two tenure-track, Assistant Professor positions in our APA-accredited Clinical Psychology Ph.D. training program. We are especially interested in receiving applications from women and minorities. We are interested in applicants who have a strong commitment to scientist-practitioner graduate training. The successful applicant(s) must have significant research accomplishments demonstrated by publications in peer-reviewed journals and the ability to establish and maintain productive, independent research program(s) that will be competitive for extramural funding. We are particularly interested in recruiting applicants with expertise in one of two specialty areas.: (1) assessment of and psychotherapy with children and adolescents, or (2) multicultural and ethnic diversity issues. The successful applicant(s) will also be expected to contribute to the strong teaching mission of the Department by offering undergraduate and graduate courses in their area(s) of expertise and demonstrating broad competencies for supervising clinical practica. Internal research grants are available from a major endowment to the department to serve as initial research support, research assistantships, and seed-money for extramural funding-seeking. Preference will be accorded those applicants who can contribute to the recently-established Center for Research on Aggression and Violence, a major area of focus for the program and department. Candidates should be graduates of an APA-accredited Ph.D. program and have completed an APA-accredited internship. Licensure in the State of Arkansas as a Psychologist within the first two years of residency is required for continued employment. Review of applications will begin on January 1 and will continue until the position(s) is/are filled. Starting date for the position(s) is August, 1999. Please send curriculum vita; (p)reprints; statement of research, clinical, and teaching interests; and three letters of recommendation to Clinical Search Committee, Department of Psychology, Memorial Hall 216, Univ. of Arkansas, Fayetteville, AR 72701. The University of Arkansas is an Equal Opportunity/Affirmative Action Institution.

ASSISTANT PROFESSOR IN CLINICAL PSYCHOLOGY, UNIVERSITY OF KANSAS The Department of Psychology seeks applications for a tenure track position to begin August 18, 1999 in clinical psychology with specialization in health psychology. To qualify, the candidate should have a PhD from an APA-accredited clinical psychology program or formal respecialization in clinical psychology that meets APA guidelines, as well as an APA-accredited internship. Evidence of potential for high quality research and teaching in health psychology (e.g., health psychology assessment, health-related behaviors, biopsychosocial etiology of major medical disorders, intervention in health psychology), as well as grant-getting potential are desirable. Send curriculum vitae, graduate transcripts, three letters of reference, statement of research and teaching interests, and representative reprints/preprints to: Annette Stanton, Clinical Search Committee, Department of Psychology, University of Kansas, Lawrence, KS 66045-2160; (785) 864-9804. Review of materials begins January 8, 1999 and continues until position is filled. Applications are especially welcome from members of underrepresented groups. Position is contingent on final budgetary approval. EO/AA employer.

THE UNIVERSITY OF MARYLAND AT COLLEGE PARK has an opening for a faculty member at the Assistant Professor (tenure track) level in Clinical Psychology. The Department seeks an individual with a strong clinical science background and with evidence of a program of research that can be sustained by external support. Candidates should have a minimum of one-year postdoctoral experience. Applicants whose interest is in the development of psychopathological states, development and evaluation of treatment interventions, or the interaction of biological and psychological variables in psychopathology are of particular interest. All specialties will be considered but there is particular interest in those who focus on child externalizing disorders, health psychology, neuropsychology, or major adult psychopathological states. The clinical training program at the University of Maryland at College Park is in the process of building a scientist-practitioner program with a strong emphasis on psychopathology and empirically derived and supported intervention strategies. Thus, in addition to a program of research, the successful candidate will have the expertise and desire to provide clinical supervision of graduate students. Other duties will include graduate and undergraduate teaching and supervision of student research. Please send a vita, statement of research interest, and arrange to have three letters of recommendation sent to: Dr. Samuel M. Turner, Clinical Search Committee, Department of Psychology, University of Maryland, College Park, MD 20742. Women and minorities are encouraged to apply. The University of Maryland actively subscribes to both a policy of affirmative action and equal educational and employment opportunities. For best consideration, all of the above application materials should be received by 15 January 1999.

UNIVERSITY OF OTTAWA: Psychology. The School of Psychology of the University of Ottawa anticipates one tenure-track position to be filled as of July 1, 1999, at the Assistant Professor level. Priority will go to applicants in the areas of clinical psychology (with a specialty in adolescent, child or family) and quantitative methods in psychology. Applicants should meet the following minimum requirements: Doctorate in Psychology and research competence. Fluency in French and English (i.e., ability to teach in both languages) is essential. The minimum salary for the current academic year is $43,978. Applications should be received before January 15, 1999. Submit a letter of application, curriculum vitae, names and addresses of three individuals who will be sending us letters of reference, and two recent publications from refereed journals or other visible evidence of scholarly publication to: Dr. Catherine Bielajew, Assistant Director, School of Psychology, University of Ottawa, Ottawa, Ontario, Canada, KIN 6N5. In accordance with Canadian immigration requirements, this advertisement is directed to Canadian citizens and permanent residents. Equity is a University policy, and as such, the University strongly encourages applications from women.

THE BEHAVIORAL SCIENCE DIVISION OF THE NATIONAL CENTER FOR PTSD has an opening for a psychologist with research and clinical interests in the area of post-traumatic stress disorder or related topics. The National Center is a seven-site consortium funded by the Department of Veterans Affairs to conduct research on PTSD, and to provide education about the disorder, its prevention and treatment. The Behavioral Science Division is located at the Boston VA Medical Center and has a staff of 25-30, including 10-12 PhD psychologists and 2-4 post-doctoral fellows who are part of an NIMH-funded training program. The Division has a congenial and energetic staff, supported by extensive resources for research, educational, and clinical activities. National Center activities focus on military veterans with combat-related trauma, but candidates who have experience with and interest in other trauma populations are strongly encouraged to apply. Candidates with other specialties (e.g., behavioral medicine, gerontology, personality, lifespan development) that may be applied to the study of traumatic stress are especially welcomed. Requirements for the position are a PhD and clinical internship from APA accredited programs, demonstrated research and grant writing skills, eligibility for licensure in Massachusetts, and capability

for supervising pre-doctoral psychology interns who are training in an APA-accredited program. The successful candidate can expect an academic appointment with Boston University School of Medicine and a salary in the range $441,192-$76,319, both commensurate with experience. Send a curriculum vita with accompanying reprints/preprints, a letter stating professional interests and plans, and three letters of recommendation to Terence M. Keane, PhD, National Center for PTSD (1116B-2), Boston VA Medical Center, 150 South Huntington Ave., Boston, MA 02130-4817. Applications will be accepted until the position is filled, but submission of materials before January 1, 1999 is recommended. The Department of Veterans Affairs is an Equal Opportunity Employer.

PEDIATRIC PSYCHOLOGIST. Nemours Children's Clinic in Jacksonville, Florida announces an immediate opening for a Pediatric Psychologist. Minimum requirements include a PhD in Clinical Psychology from an APA-approved training program and additional training or experience in clinical child or pediatric psychology. The ideal candidate will possess at least one year of postdoctoral experience in a pediatric medical setting with chronically ill children and adolescents. Salary and benefits are competitive. Applicants should submit a letter of interest and a curriculum vitae, and have 3 letters of recommendation sent to: Tim Wysocki, PhD, Nemours Children's Clinic, 807 Nira Street, Jacksonville, FL 32207. Materials may also be submitted by e-mail to: twysocki@nemours.org. Candidates who are invited for interviews will be reimbursed for their travel expenses. Applications will be considered until the position is filled. The Nemours Foundation is an Equal Opportunity Employer.

ASSISTANT PROFESSOR. PEDIATRIC/ CLINICAL CHILD PSYCHOLOGY. THE UNIVERSITY OF KANSAS. Tenure-track position to begin August 1999, in the doctoral program in Clinical Child Psychology, an interdepartmental program of the Departments of Psychology and Human Development and Family Life. Applicants should be PhD graduates of an APA-accredited program and should have completed an APA-accredited internship by the time the position starts. We seek a person capable of supervising research and clinical activities of graduate students and teaching courses at the graduate and undergraduate levels. Applicants should be research-oriented clinicians with specialty training in pediatric psychology/clinical child psychology and programmatic interests in various aspects of research and applications. We have a preference for a person with expertise in pediatric or child health psychology and who shows evidence of the ability to sustain a research program that is externally supported. Applicants should be eligible for eventual licensure in clinical psychology in the state of Kansas. This position is contingent upon final budgetary approval. The University of Kansas is located in Lawrence within commuting distance of Kansas City and Topeka, the state capital. The University is a major research university with an outstanding tradition of child research and service in the Human Development Department and a distinguished Clinical Psychology Program in the Psychology Department. The program maintains strong community ties for research and clinical practicum with the KU Medical Center, Children's Mercy Hospital, Bert Nash Mental Health Center, Lawrence School District, and Menninger Clinic. A letter of application describing teaching, research, and clinical interests, a current vita, and representative reprints should be sent to Michael C. Roberts, PhD, Director of Clinical Child Psychology Program, 2006 Dole Human Development Center, University of Kansas, Lawrence, KS 66045. Email: MROBERTS@ukans.edu. Three letters of recommendation also should be sent directly to the Program Director. The review of applications will begin on December 15, 1998 and will continue until the position is filled. The University of Kansas is an Equal Opportunity/Affirmative Action Employer.

WILLIAMS COLLEGE DEPARTMENT OF PSYCHOLOGY: seeks candidates for an anticipated tenure-track position in Clinical Psychology beginning July 1, 1999. The appointment will be at the Assistant Professor level, with the expectation of the Ph.D. in hand or to be completed by September 2000. In exceptional circumstances, a senior appointment will be considered. Area of specialization is open. The normal yearly course load consists of a survey course on Psychological Disorders, the psychopathology section of a team-taught Introductory Psychology course, an advanced research seminar in the candidate's area of interest, and either a Research Methods course or an upper level seminar. We seek gifted teachers and scholars who can involve students in their research. We offer excellent facilities, research support, highly capable students, and competitive salaries. Applications will be processed on a rolling basis. Deadline is November 15, 1998. Send vita, three letters of reference, selected reprints or preprints, and information on teaching experience and effectiveness to: Dr. Laurie Heatherington, Chair, Clinical Psychology Search Committee, Department of Psychology, Williams College, Williamstown, MA 01267. An Equal Opportunity Employment/ Affirmation Action Employer, Williams College encourages application from women and minorities.

THE DEPARTMENT OF PSYCHOLOGY AT MICHIGAN STATE UNIVERSITY is seeking an outstanding clinical neuropsychologist or clinical-neuroscientist for a tenure system appointment at the rank of assistant professor effective August 16, 1999. We seek a clinical psychologist with a neuropsychological, cognitive, and/or cognitive-neuroscience orientation to the study of psychopathology who has the potential to be a highly productive scholar and effective teacher for our undergraduate and graduate programs. Out preference is for candidates who combine an information processing approach (broadly defined) with techniques for illuminating brain function, such as dense-array EEG, functional MRI, or psychopharmacology. However, a broad spectrum of neuropsychologically oriented researchers will be considered to find the strongest candidate. Researchers interested in adolescent or adult psychopathology or problems of older adults and major mental disorders would best complement existing strengths in our clinical neuropsychology program. Preference will be given to candidates with a PhD in clinical psychology from an APA-accredited program who also have postdoctoral training. Review of applications will begin November 15, 1998 and continue until the position is filled. Send vitae, copies of representative publications, and three letters of recommendation to: Professor Anne Bogat, Department of Psychology, Michigan State University, East Lansing, MI 48824. Minority and women candidates are especially encouraged to apply. MSU is an EO/AA employer.

Want ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of The Clinical Psychologist. Ads will be charged at $2 per line (approximately 40 characters). Submission deadlines are February 15, May 15, September 15, and November 15. Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, and advertisement to Wanda Kapaun, Assistant to the Editor of TCP, wkapaun@plains.nodak.edu, North Dakota State University, Department of Psychology, Minard Hall 115, Fargo, ND 58105-5075.

APA Science Directorate Accepting Proposals for Occupational Health Psychology Curriculum Development

The APA Science Directorate is now accepting applications from universities interested in developing courses or curricula in the area of occupational health psychology (OHP). In the broadest terms, OHP refers to the application of psychology to protecting and promoting safety, health, and well being of workers, and to improving the quality of work life. Awards are expected to range between $18,000-$22,000. Currently funded sites may submit new proposals for a possible second-year continuation of their program (depending on quality and feasibility of the proposal). Completed applications must be received by March 1, 1999. Administration of the grants will be staffed through the APA Science Directorate. Individuals and departments interested in obtaining application materials should contact

Adonia Calhoun or Heather R. Fox, PhD
American Psychological Association
750 First Street NE
Washington, DC 20002-4242
acalhoun@apa.org
hrfox@apa.org

Applications can also be found on the APA web site after October 15 at http://www.apa.org/science/ohp.html.

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