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IN THIS ISSUE

- President's Column:
Clinical Science and
Clinical Practice: Where
to from Here? 1
- Clinical Psychology and
our Society: Retrospect
and Prospect 4
- Assessment for the
Twenty-first Century: A
Model Curriculum 10
- The Value of Scientist-
Practitioner Training in
Dealing with Changing
Professional Demands:
What do ABPPs Think? .
..... 21
- Empirically Supported
Treatments and Related
Contemporary Changes
in Psychotherapy
Practice: What do
ABPPs Think? 23
- Society News 32
- Position Ads 34

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Clinical Science and Clinical Practice: Where to from Here?

Fifty years ago, the National Institute of Mental Health and the American Psychological Association sponsored a conference on the content of training of clinical psychologists in Boulder, Colorado. For two weeks in August, conferees from universities, mental health agencies, and allied professions hotly debated a host of issues including the nature and role of abnormal psychology, psychological assessment, psychotherapy, and prevention in the training of clinical psychologists. For our purposes here, they also labored over the role of science in clinical practice. Reaching a consensus was not an easy matter (Raimy, 1950). Little did the organizers of this conference - or the conferees in attendance - realize that this conference, the *Boulder conference*, would have such a lasting impact on the discipline. In subsequent meetings in Miami (1958), Chicago (1965), Vail (1973), Salt Lake City (1987), and, most recently, Gainesville (1990), decisions reached at Boulder served as a focal point, if not a lightning rod. Even to this day, 50 years later, many of us refer to ourselves as *scientist-practitioners* and as having been trained in, and affiliated with, "Boulder model" training programs. Pride associated with such training is deep, not unlike that associated with athletic teams from your (my) favorite university ("Go VT Hokies!").

It should be noted that recommendations for the role of science in clinical psychology training programs coming out of the Boulder conference emphasized the notion that research methodology ought to be taught in the context of clinical problems. In the words of Raimy (1950, p. 87), "The problems of human beings may demand approaches other than those used in studying lower animals. If rigorous thinking can produce good research in animal psychology, equally rigorous thinking should be possible where humans are concerned." To some extent, advances in single case methodology, clinical replication series, and group outcome designs for both efficacy and effectiveness clinical trials have addressed this challenge and the bridge between science and practice is being partially realized. However, as many authors



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President's Column

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have noted, this bridge is frail and has not, as of yet, been fully tested nor met the test of time.

Perhaps the most important theme to come out of this conference was the notion that students should receive training in both research and practice in order to develop interests and a background in both areas, despite the fact that some might concentrate on only one of these areas in their subsequent careers (Barlow, Hayes, & Nelson, 1984). Development of an analytical mind was valued and all psychologists were expected to be *consumers and evaluators* of research; some, but not all, were expected to be *producers* of research. Subsequent conferences, although placing varying emphases on the role of research and practice in training of clinical psychologists, essentially endorsed these ideas. In short, the practice of clinical psychology was founded on, and continues to rely upon, scientifically demonstrated principles and techniques (Stricker, 1975; Strickland, 1988).

In this regard, clinical psychology is not unlike engineering and can be defined as an applied science (Kihlstrom & Canter Kihlstrom, 1998). Engineers put scientific knowledge to use: they rely on the scientific principles of physics and geology to build a bridge that stands under varying conditions and carries diverse traffic over it. As Maher (1966, p. 112) noted: "In order to build a bridge over a certain river, we must know the details of the soil mechanics, water flow, prevailing winds, topography, traffic usage, availability of labor and materials, and so on. When we consider all these, the total picture might not be like any other bridge that has ever been built. Nevertheless, none of the principles or assumptions that go into the final decisions could be made in contradiction to the laws of physics, economics, and the like." To do otherwise would result in an unsound structure that would most likely collapse upon use, if not before its use was even authorized. Recent earthquakes in Taipei, Taiwan remind us of how such principles must be used in construction of buildings as well. Shortly following this tragedy, a developer of three apartment buildings was arrested for using crumpled vegetable oil cans in place of bricks during construction. The end result: the collapse of the buildings, burying about 300 persons.

However, as Kihlstrom and Canter Kihlstrom (1998) further note, clinical practice is an art as well as a science. It is an art much like architecture. The individual clinician frequently needs to adjust his or her scientific knowledge and understanding to accommodate the particular individual who presents at the clinic door. Intuition and creativity come into play. Still, intuition and creativity are not wanton nor unconstrained; rather, they are grounded in basic principles of science. Architects, like engineers, need to design buildings

that fit their sites. Organic architecture such as that found in Frank Lloyd Wright's prairie style embody this notion well – the architecture hugs the land and the furnishings therein echo it. The building is part of the land, and does not merely sit upon it. Of course, the final test of whether an architect has done her or his job well is whether the building stands and is a comfortable and pleasant place in which to live. Crumpled vegetable oil cans do not a safe building make.

Where to from here? Although I do not recall the source, I remember hearing the following quote on the Brady Bunch in the 1950s: "As a wise man once said, 'Wherever you go, there you are.'" Similarly, Yogi Berra, in his typically understated fashion, is said to have quipped, "If you don't know where you're going, you will end up somewhere else." Where *do* we want to go? Do we want a profession based in and on science, or do we wish something else to govern our development and progress in the next millenium? As with architects and engineers, it seems to me that clinical psychologists need to conduct their practice within the confines of scientific knowledge. Of course, much remains to be learned in the practice of clinical psychology and we do not know all that we need to know. It will be very important for practitioners and researchers to harness their collective energies to resolve the many riddles that remain. Such knowledge is likely to be obtained from working with clients and clinicians in the clinical setting to design practices that hug the terrain of clinical reality and are not merely superimposed upon it. We can learn much from our colleagues in architecture and engineering. However, this much we do know: the psychological equivalents of crumpled vegetable oil cans do not good clinical practice make.

In our Society's public information brochure published in 1992, we state "The field of clinical psychology integrates science, theory, and practice to understand, predict, and alleviate maladjustment, disability, and discomfort as well as promote human adaptation, adjustment, and personal development." It appears to be time to get on with the business of realizing these admirable, if not elusive, aspirations. Science that is richly informed by the knowledge and nuances of clinical practice will serve us well in reaching our goals. As 2001 APA presidential candidate Jerry Davison (1998) has suggested, it is time to be "bolder" with the Boulder Model: it is time for us to be more forceful and more assertive in bringing our teachings and clinical practices more in line with science. To do otherwise would seem to neglect the basic mission of our Society and to ignore the many conferences that have endorsed the role of science in our training programs and profession. What a better time to reaffirm our roots than upon the Golden Anniversary of the Boulder model and the beginning of the new millenium!

Farewell and Thanks

Finally, in my last column as president of the Society of Clinical Psychology, I wish to thank the many individuals who have made my year such an exciting and personally rewarding one. The time has gone by much too fast (and I have become a grandparent). I have enjoyed working with members of the Division 12 Board, chairs of the various committees and subcommittees, and the membership at large. I have learned much in my interactions with each of you. I also wish to thank Lynn Peterson. As administrative officer of the Society, I can assure you that she is incredibly lively, energetic, dedicated, and responsible. She does her job well – it is up to us, however, to make sure that the Society stays the course to achieve its goals and to meet the many challenges that lie ahead. Best wishes for the holiday season and the new year. ■

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American Psychological Foundation Randy Gerson Memorial Grant

The American Psychological Foundation (APF) announces the Randy Gerson memorial Grant to be given in 2000. For the 2000 cycle of the grant, practitioners, academicians, or researchers are invited to apply. The grant has been created to advance the systemic understanding of family and/or couple dynamics and/or multi-generational processes. Work that advances theory, assessment, or clinical practice in these areas shall be considered eligible for grants through the fund.

Projects using or contributing to the development of Bowenian family systems theory will be given highest priority. Priority also will be given to those projects that serve to advance Dr. Gerson's work (*Genograms Assessment and Intervention*, 1999, McGoldrick, Gerson, & Shellenberger; W.W. Norton; "The family life cycle: Phases, stages and crises," in *Integrating Family Therapy*, Mikesell, Lusterman, McDaniel, 1995, APA; "Family systems theory and Imago Therapy: A theoretical interpretation," *Journal of Imago Relationship Therapy*, 1996, 1, 19-41; "Family of Origin Frames in Couples Therapy," *Journal of Marital and Family Therapy*, 1993, 19, 341-354).

Who is eligible:

Applicants from a variety of professional or educational settings are encouraged to apply. Applicants must have a doctorate (e.g., PhD, PsyD, EdD, MD). Awards will be given in alternate years to students and professionals. The 2000 grant will go to a professional.

Applications must include:

- Statement of the proposed project
- Rationale for how the project meets the goals of the fund
- Budget for the project
- Statement about how the results of the project will be disseminated (published paper, report, monograph, etc.)
- Personal reference material (vita and two letters of recommendation)

Applicants must submit seven (7) copies of their entire application packets. Send application packets by February 1, 2000, to the APF Awards Coordinator (address below).

Amount of Grant: \$5,000.00

Deadline: February 1, 2000

For additional information:

Contact the Awards Coordinator/Gerson, 750 First Street, NE, Washington, DC 20002-4242. Telephone (202) 336-5814. Internet: foundation@apa.org.

The APF encourages applications from individuals that represent diversity in race, ethnicity, gender, age, and sexual orientation.

Clinical Psychology and our Society: Retrospect and Prospect

Address of the Recipient of the 1999 Award for Distinguished Professional Contributions to Clinical Psychology

Jerome H. Resnick
Temple University



Being familiar with the names of previous recipients of this Award for Professional Contributions to Clinical Psychology—names from the earliest years in which this award was established (in 1958)—I present myself to you today in a state of combined pride with deep humility—very deep humility. (Included are such names as David Wechsler, Henry Murray, Carl Rogers, Bruno Klopfer, Nevitt Sanford and Rollo May. The list continues with 30 more clinical psychologists, many of whom are now still actively productive.) The 1973 recipient was Florence C. Halpern after whom this award is now being titled. This adds all the more to my sense of gratitude to the Society of Clinical Psychology to be honored in this way. (And we are indebted to Dr. Gloria Gottsegen for originating and leading the effort to have this award named in honor of Dr. Halpern.)

It is customary in response to this honor to offer reflections, and then, perhaps, projections, as one looks over the past, and into the future—to reminisce and then to crystal ball—and I would like to take this opportunity to join in that mode. I wish especially to tell you something about Florence Halpern, because she represents almost the metaphor of clinical psychology and of this Society, as her life and times reflected so much the fulfillment, but still the promise of what we are about. (On a personal note I will say that she and I had developed a friendship in the early to mid-1970's and she became a mentor for me, an added pleasure for me to acknowledge *her* contributions as she helped to define *us*.)

Let me state at the outset that, since the founding of this Division (Now: Society) in 1945, as the Division of Clinical and Abnormal Psychology, Division 12 of APA, until 1967 when she was elected its president, some 22 years later, she was only the third woman to hold that post. Only Jean McFarlane in 1955 and Anne Roe in 1957 preceded her. Astonishingly as we look to our history since her election and into the year 2000, representing 33 years, only one other

woman, Bonnie Strickland, was elected president of the Society. This is not to say that many women have not been nominated to that post, but rather, perhaps, that our membership needs to catch up to our realities so that Florence does not stand alone as representing our strength, but also perhaps a major weakness. As a positive aside, happily this year a woman was voted president-elect, since the slate for that position was composed of just four such outstanding individuals. Karen Calhoun will follow Edward Craighead as the president in 2001. (Perhaps hopefully in the immediate years to come, ethnic and other minorities also will hold positions in the very top leadership roles.)

Not only does Florence stand in the rarity of her company as an elected president but also as one of just six women to be honored over 41 years for this Professional Contributions Award. She was the *first* woman to receive it following 15 years since its inception. She is unique, and indeed, when I read over her own address in response to this award (delivered a quarter century ago) I thought I could simply quote it in its entirety as my own address and it would be as fresh and current today as it was then. This is a statement both of her prescience, but also, perhaps unkindly to state, of our failure to move on significantly beyond that time to the turn of the millennium facing us tomorrow. In a closely related address to her award response, her opening sentence wonderfully captured an aspect of her personality: "Accustomed to receiving flack from both the left and the right, I am once again sallying forth, an ancient Don Quixote, with what probably sounds like an impossible dream." She dreamt: "I would like to reminisce and hand out to the younger generation the advice that we oldsters always think will benefit them even though we know that it will not be heeded." And what is that advice: that "Change comes, bringing with it important shifts in our perceptions and our performance. For example, we are gradually moving away from what for so long was our concern with pathology, with what was "*wrong*" with an individual and his environment. Indeed we look for the strengths that can be developed, while at the same time trying to anticipate and prevent the many disturbances that currently plague humanity. Similarly we have learned to abandon our shortsighted ethnocentricity, recognizing that for different cultures there

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are different realities, different values and different lifestyles; and that these must be understood and respected, not subordinated to what we may regard as the only acceptable outlook and adjustment." That was written 25 years ago and could be written today. In fact it is being written most eloquently in the recent addresses and articles of our APA past president, Martin Seligman and in the words of another APA past-president and herald of the future: George Albee, both, centrally, also president of Division 12.

One more word about Florence Halpern as the exemplar of the very best of us and again, why I feel so honored to be the first recipient of the award in her name: not only was she the first woman to receive this honor from this Division (now Society) but the first person so honored to be heavily engaged in the *clinical* aspect of our field, not just the academic and scientific. She broke that mold too. She was a *clinician* of the first rank and her insights about children, her specialty, remain current. Further she was no *token* female, but an *outspoken* woman, even though, among 20 or so members of the Division 12 Board of Directors, over the years, she was just about the only woman *ever* to serve on it during her lifetime.

Her devotion to what she knew to be correct was embodied, astonishingly, in her behavior when she was 68 years old. At that age (and especially 30 years ago) when most of us are retired or thinking about it, she moved lock, stock and barrel, (some clichés are useful) from her faculty position at New York University and clinical position at Bellevue Hospital in Manhattan, to Mound Bayou, Mississippi where, for three years, she worked as a staff psychologist at the Tufts Delta Health Center located in the back country of that region. In her Award citation it is noted that "There she worked with the poor blacks and whites in the share-cropping poverty regions of rural Mississippi sharing their concerns and contributing her skills and her desire to ease their lives. Problems become very basic under such conditions and psychological conflicts are often integrally tied with the pangs of hunger and the ills of malnutrition." Returning to New York following this experience she wrote a book about her experience "Survival: Black/White."

To me, her life personifies where we have been and where we need to go on this road from past to future, a road filled with monumental milestones. Before I venture into the future (a wonderfully safe place to be in an address like this) permit me to comment on some of these rites through which our Clinical Society (then: Division) and profession have passed. In Toronto, in 1987 we celebrated our centennial, dating our birth from the founding of the Psychological Clinic at the University of Pennsylvania by Lightner Witmer. Witmer was most concerned with children and especially with their de-

velopmental and learning difficulties and he is rightly claimed as the parent of School Psychology at least as much, if not more so, than that of clinical. My prediction for the future is that so much of what clinical psychology will become—*must* become—the health profession for society will be through the venue of the schools and the focus on children. If this happens it will be a fitting tribute to this remarkable figure and then to us.

With the founding of Division 12 so too over the years developed the establishment of sections within the Division, the sections being a vital arena for spawning and nurturing developing specialties, as our field became ever broader and more robust. Now, in APA exists independently of Division 12, the Division of Group Psychology and Psychotherapy, and the just established Divisions of Child Clinical Psychology and of Pediatric Psychology. These Divisions, once sections of our Society, are testimonies to this trend, and especially, again, to the recognition of the psychology of children.

I might add that the Division of Psychotherapy, and the Division of the Psychology of Women were founded by psychologists who were deeply involved in Division 12. To my mind it is clear that *our* Society of Clinical Psychology has and continues to fulfill a critical role in fostering this broadening evolution. I envision that other current sections of the Society will also in time become APA Divisions in their own rights. The newly established Division 12 section of Clinical Geropsychology (Section 2); the deeply rooted Society for Science of Clinical Psychology (Section 3); and the recently established sections of Clinical Psychology of Ethnic Minorities Section 6; and Section 7: Clinical Emergencies and Crises likely also will become so.

With such diversity and ever-expanding horizons emerge problems consistent with, and a *consequence* of, the *solutions*. To my mind, foremost among these was, at the time and perhaps to reopen, the deeply embarrassing problem that consumed the Division actively and continuously for perhaps 20 to 25 years: We simply could not agree on a definition and description of ourselves - - of clinical psychology - - despite the establishment of at least four-to-five high powered task forces designed to address that overriding issue. As the years went by, and, as we haggled, other fields and specialties were defining themselves; each thereby in turn encroaching on our own distinctiveness by virtue of claims for themselves. We see this now as a wonderfully complex and dynamic issue!

Many implications followed from this stalemate: one seemingly innocuous, but still profound impediment was that we could not develop so much as a brochure composed of

even the simplest terms for the public, or our clients, as to what a clinical psychologist is, and what to expect in terms of service. Dr. Bonnie Strickland has written extensively about this history (I note incidentally that APA is honoring her this year for the Distinguished Professional Contributions Award). She indicates that the first of these task forces was established by the Board of Directors in 1981 (following years of discussion in the 1970's). They met for three consecutive days in June 1982, reporting back to the Board that: "We cannot easily define clinical psychology as either the generic professional practice of psychology or a specialty area with a defined knowledge base and standards of practice." Still another report in January of 1983 resulted in no formal action. Dr. Strickland, the author of a report, "What is Clinical Psychology", stated "More recently clinical psychology has expanded its interests beyond just a consideration of the emotionally or mentally disturbed. This orientation has led us into a concern with health and the advancement of human functioning. Clinical psychology, though both a science and a practice has developed theories of human behavior which encompass all aspects of human interaction." I will return to that theme soon.

Still another task force was established by the Board of Directors in 1984 in which it was noted that "Although clinical psychology is a recognized discipline there has been no uniform definition of this term that is widely accepted in our profession." It stated further: "As other specialties define themselves...they indirectly define clinical as well, a job we must do for ourselves." Still another task force was established in February 1985 with predictable results. Then in 1989 under the presidency of Dr. Charles Spielberger, the Division Board of Directors established yet one more task force to address this same issue. Its members were Janet Wollersheim, Nathan Perry, Lynn Rehm, Russell Adams (Drs. Rehm and Adams had served on a previous task force). Karen Calhoun and Ray Lorian represented the Council of University Directors of Clinical Psychology. Finally in 1990, following extensive discussion over two separate meetings of the Division 12 Board, the recommendations of this task force were accepted unanimously and have subsequently been incorporated into the by-laws of the Society. As it turned out, this was critical for events which were not foreseen at that time, but which became the literally defining issue for our field, when just last year in 1998, the APA Council of Representatives formally accepted our definition and description and archived it into its formal structure. This followed long negotiations with the APA body in charge of making such recommendations, the Committee on Recognition of Specialties and Proficiencies in Professional Psychology, known as CRSPPP, taking only 100 years since its inception and at least 15 years

of working on this that we now are recognized by the APA Council of Representatives. Recognized ironically, perhaps oxymoronically, as a *general* specialty. Be that as it may, I am proud to have chaired this last task force and to have successfully worked for recognition of clinical in the APA Council.

And -- as it may -- as I foresee it, *this* defining document is no doubt already far outdated, as we continue to evolve. We move on, because, paradoxically -- indeed -- for our profession of clinical psychology, the *defining* feature is that we keep changing faster than we can identify ourselves. So what is *so* bad about perpetual adolescence?! If anything I have learned since entering this field as a CCNY sophomore, the *one* definition that seems consistent over the years is that this is the field that exists *in order to* keep redefining itself, as knowledge expands, and as the quality of our students keep increasing exponentially. As we have moved from a sole focus on assessment through our battles and successes with consulting in one-on-one psychotherapy, through our battles for legal recognition through state licensing laws, now with battles concerning managed care, and our debates with regard to prescription authority, I believe that the future holds something very different for us.

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I believe that we are destined to become the premier health profession for our society at the parameters of our population, and in the format both of preventive intervention for those vulnerable to disorder and, perhaps more importantly, by addressing issues of society at fundamental levels. I remain highly impressed with the work of George Albee, an early pioneer, who has recently written about this (in an *American Psychologist* article published in 1996) where he speaks eloquently of the need for psychologists, in effect to raise the tide of well-being for all, so as to strengthen resistance against the array of ills that then lead to after-the-fact interventions. He quotes Senator Daniel Inouye in 1984 who "suggested that one of the greatest inventions in the history of public health was an adequate sewer system." Albee spoke at a conference on international health promotion in Honolulu where "Other speakers cite safe drinking water, better and varied nutritious food, and *loving attention to infants and children*

as forces that all combined to improve dramatically the quality of human life and health that reduced morbidity and mortality. It is instructive to note that none of these positive interventions is disease specific. Building stronger, more secure, and more optimistic people makes them resistant across the board.” (I might note also a recent *NY Times* article on smallpox and its planetary elimination as a plague by the development of an inoculation vaccine. Prior to this development, cites the article, smallpox killed ½ billion people; not ½ million but 500 million people. One wonders what miracles *psychological* inoculation could bring.)

This is a position, to my mind quite similar to that of Dr. Seligman’s where, whatever we do, we should do it within the framework of strengthening the *well-being* of people, especially of children in the schools by identifying those positive qualities characteristic of *content* and productive individuals. We must turn the forces of clinical psychology to the enhancement of those positive qualities. I see clinical psychology as leaving the intrusive interference of managed care issues receding in its wake as we continue to broaden ourselves in creating a healthier society. Florence Halpern knew this at least some 25 years ago and this remains still a beacon for us to follow in her quest.

But how do we discuss our future? How do we move towards a goal of promoting and improving well-being in our society? I gave this question much thought and I decided it was not one which I should attempt to address alone. After all, this future belongs to those who are now just beginning their careers. This future will be both their burden and their opportunity to bear. So, it was with this in mind that I asked a number of my present doctoral students to aid me in addressing this question. It is with this integrated voice, that I speak to you now about my vision for the future of our profession of clinical psychology.

To answer the question of the future, must we leave behind what we know as *psychology*, blazing ahead to something new? Or, can we assimilate the knowledge that we have gained in this past century and apply it to the problems of our future? We are in a wonderful position to provide answers and *help*, from our experience as psychologists dealing with the *problems of living* that we have become so familiar with. We *can* apply this knowledge of confronting problems to preventing these problems, and more importantly, promulgating a sense of emotional health.

Clearly, when we think of prevention of emotional dysfunction and the promulgation of emotional health, we cannot help but turn our attention to the youngest members of our society. If we were in the medical profession, we would

make recommendations for children *to not be* raised in homes with asbestos peeling from the ceilings. Likewise, as clinical-psychologist-health-professionals, we want to promote supportive and enriched childhood environments in our homes and schools. Lately, such places as representing healthy environments often seem quite foreign to us.

One cannot help but think of the tragedy of Littleton, Colorado. *Our* children besieged by their own feelings...acting out and causing so much more heartache. Everyone in this country has been wondering what went horribly wrong causing two teenage boys to undertake such ruthless acts that could happen again and again and again. The media and politicians offer a host of culprits including: the overabundance of violent images on TV, movies and the internet that bombard us daily; the ready access to deadly weapons; the lack of parental supervision; and the disintegration of religious communities, to name a few. In combination these forces all probably had an impact on the outcome in Colorado but they speak little to the inner lives of our youth. One must ask, what is their suffering? How are they handling their first defeats? Their first unrequited longings? Prevention is not about “catching them before they go bad, sad or scared.” Rather, it is about helping them before their “badness, sadness, or scariness” overtakes them and defines them. Essentially, it is about our children embracing emotional health while learning to understand their own emotional struggles.

It is my belief that human emotions have the ability to completely overwhelm rationality both in terms of the emotions that lead the killers to their deadly deeds and in terms of the emotional reaction of all who have witnessed the tragedy. We *all* have the capacity to be overwhelmed by our emotions, and we always have. The emotions are the key to understanding this tragedy and they are the key to the future of psychology.

As a culture, we have a long history of marginalizing emotional experience and those associated with them. The inability to be completely governed by rationality has been a cause for shame in our society. Emotions have been thought of as a threat to the law and order of society. During the Enlightenment when rationality reigned supreme, emotions were impulses to be squelched. During the 19th Century emotions were celebrated. During the first half of this Century, Behaviorism while acknowledging emotions did not give them any special status as different from all other forms of behavior, and during the second half of this Century the Cognitive-Revolution in psychology has attempted to recast emotion as an epiphenomenon of cognition. I believe that psychology is on the cusp of an Emotional Revolution. Here’s my vision for this Revolution:

We must teach our children to understand their inevitable frustrations, their turbulent families, their erratic peer experiences. Teach them to allow themselves to react to these situations. Teach them to know what this reaction means. Teach them when to lean towards their emotional reactions and when to lean away from them. Teach them to see their options, to embrace their possibilities. They are not helpless. Most of all, teach them they are not alone in their experiences.

Emotions would no longer be thought of as something to categorically control or eliminate, and they would no longer be subordinate to actions and cognition. Developmental psychologists studying emotion regulation have already begun to recognize that emotions are fundamentally *adaptive* phenomena. They are monitors of the progress, or blockage of progress, in the relationship between the person and the environment. The ideal is no longer the reduction of emotion, rather it is flexible, regulated emotional experiences and reactions that are sought after.

Daniel Goleman spoke so eloquently about this in his address at the APA convention last year in San Francisco. He spoke about the need to move comfortably and flexibly in the emotional domain. He defines this as "emotional intelligence," and calls on clinical psychologists to help people maximize their emotional intelligence. There are many different avenues to this goal. In his book, *The Heart of Parenting*, John Gottman, a developmental psychologist shares his wisdom with parents about how to raise an emotionally-intelligent child. He explains how parents can become an "emotion coach." These types of connections are so-needed, and are so often not present. These lessons of emotional health cannot be learned in a vacuum. Our children must see that their emotions are not just private events. They exist in interactions with other kids...with parents and teachers. They must learn how to communicate their needs and respond to others needs. These are the lessons of "prevention," prevention of the atrocities we have witnessed, as well as prevention of the "private" emotional problems we have become so familiar with as practitioners.

But this can only occur when a culture accepts emotional health as a vital goal to move our society ahead. So, educating parents, educators, lawmakers, consumers, and of course the children themselves about the need to examine emotional issues is essential. We must continue to "spread the word" about how emotional troubles and emotionally turbulent environments can lead to emotional disorders and "mental illness".

This Emotion Revolution will also lie in a fuller embrace of the essential fact that the mind and body cannot be consid-

ered separate entities. They are simply different places that we, the proverbial blind men, are touching and sensing a single elephant. Again we listen to Florence Halpern speaking of this trend to overly specialize in isolated domains as we study people and their behavior. She stated so eloquently so long ago "There seems to be little if any awareness on the part of these isolationists that a human being is a most complex entity, like a tapestry made of many interwoven threads. Studying one single thread, no matter how carefully it is explored, will not furnish a valid picture of the whole person. Neither will adding together any number of such threads provide other than a limited and often distorted concept of the individual. It is the inter-relatedness of the many threads that provides the final picture, unique for each person, and only when such pictures are developed and understood can we come up with significant answers regarding the nature and meaning of human behavior." We must stop engaging in the self-defeating behavior by pitting ourselves against the M.D.'s. Instead of fighting them, we need to work together to promote general emotional health and intelligence. This would mean a change in the way we as psychologists view health care and its delivery.

I envision, collaborative health centers where physical and mental health are viewed as multi-pronged approaches to human health. They would be almost like, "wellness centers/groups." Here, children could, would, and should come for regular checkups, seen by both a general physician and a general mental health care worker such as a psychologist. A child would be expected to go for a general psychological check-up every year when younger, and maybe every couple of years when older. The generalist could then refer children to a specialist if they need more help. A radical notion for now, maybe not for a quarter century from now.

How is this different from current day practices with HMO's? The difference is an important one. Psychologists and physicians would be working in the same offices, or at least, regular check-ups with psychologists would be expected. In this way, Psychology as a practice would become integrated into the fabric of society. The stigma of going to a mental health professional would rescind, because it would be associated with "good health practices." "Well, everyone goes to the psychologist," they'll say. "It's important to get your emotional regulation checked," parents will cajole.

These changes cannot occur solely in our institutions such as schools and medical centers. These changes would signal the need for our culture to pay greater attention to their emotional selves. It would mean developing more and more ways of helping the individual to optimize his or her poten-

tial and capabilities, be they emotional, intellectual, creative, or performance oriented. In many ways, this has already begun. The public's voracious hunger for discovery is made plain by the hundreds of infomercials, self-help books, and video and audiocassette packages designed to help people "unlock their potential."

There is a need for psychology to become more active in the area of self-improvement with an emphasis on providing techniques and exercises for home practice such that we begin to enable more and more people to do more and more out of the therapy room, out of the hospital, and out of the specialists' clinic. The shift will be into the home, into the workplace, and onto the sidelines where, and the instinct for my own self-preservation bristles at the thought of it but, psychologist's direct involvement decreases.

What I am talking about are programs for improving emotional awareness through concentration, improving memory, recognizing problems before they become bigger problems, and getting more organized. These are not necessarily new areas for psychology, but the way that psychology approaches them will be new. One such example has been the recent interest in using mindfulness meditation to prevent depression relapse. Mindfulness meditation involves an incorporation of an established tradition of cultivating the powers of the conscious mind to attend to every moment of the day, to increase concentration, and reduce judgmental resistance to uncom-

fortable experiences such as unpleasant emotions like sadness, anger, and anxiety. Mindfulness meditation and living is a centuries-old practice which individuals have used to great benefit. Such a program would harness the individual's will to create a change in his or her life and establish a personal program whereby this practice is incorporated into his or her life outside the psychology clinic.

Research has now shown us that individuals who utilized their mindfulness training had half the ratio of relapse as the group with no mindfulness training, and this protective factor persisted over a 12-month period. The individuals who participated in the mindfulness-training program significantly changed their relationship to emotionally arousing situations. They were able to notice their emotional reaction without getting drawn in and effected a wider perspective on their cognitive and emotional experiences.

These lessons of emotional health do not come solely from our knowledge of where we need to go. They do not come from a redefinition of our mission to the future of prevention. Rather, they are also products of lessons from our past. They come from our vast knowledge of emotional turbulence that we have learned over the past century. The time has come to apply this knowledge to imparting emotional health to our children and ourselves. As we move into a new century, let us provide our next generation with the knowledge that we have worked so hard to gain actively in this century. ■



Dr. Jerome Resnick with a number of his senior doctoral students and family members, including his wife, three sons, and granddaughter.

Assessment for the Twenty-first Century: A Model Curriculum

American Psychological Association Division 12 (Clinical) Presidential Task Force "Assessment for the Twenty-First Century" (Note 1)

We present the report of an APA Division 12 (Clinical) Presidential Task Force convened by Martin Seligman, charged to develop a model assessment curriculum suitable for use in university-based clinical training programs. We proceeded in three steps: nomination of candidate items for the model curriculum, revision of items, and rankings of proposed items. Summed rankings, normed to obviate strategic rating behavior, were calculated, reflecting the relative importance of curricular items. A suggested implementation of the model assessment curriculum is presented.

Psychological assessment is the oldest area of endeavor in the clinical area of applied psychology. Tests, interviews, and observational procedures are continuously developed and revised, and integrated into clinical training and research. Doctoral psychologists spend a substantial portion of their time performing assessment (Tipton, 1983), with considerable stability of test use frequency (Watkins, 1991). There are some discrepancies between test popularity and research support, which may sometimes reflect failure to practice competently. Practicing competently requires psychologists to "maintain knowledge of relevant scientific and professional information related to the services they render. Psychologists make appropriate use of scientific [research]" (APA, 1992, p. 1599).

Assessment practice is conducted in an economic context. Constraints on services from policies of third party payors may influence assessment as much as do scientific research or ethical principles. It is in both clients' and payors' interests that clients receive appropriate care, including psychological assessments. Appropriate assessment has the potential to guide intervention and reduce health care costs, but mis-assessment can cause harm (Lawlor, 1998, p. 111).

Research is the most reliable source of information for deciding what assessment procedures are appropriate, under various circumstances. Whatever the value of clinical experience and impressions, it should not take precedence over published, systematically gathered data of good quality (McFall, 1991; Meehl, 1997).

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In the next century, clinical psychologists' roles will change significantly from historical norms. It seems indubitable, however, that psychologists will continue to perform and to supervise assessments. What should we be teaching students, to prepare them for assessment practice in the next century? To answer this question, in 1994 Martin Seligman (then President of APA's Division 12) convened a Presidential task force chaired by William M. Grove, charged "to develop a model curriculum for use in doctoral programs in clinical psychology and to justify this model curriculum with appropriate review of the scientific and clinical literature.... The purpose of this document is not to promulgate standards..."

We were fortunately able to secure the cooperation of many psychologists eminent in various assessment fields (Table 1). Potential task force members were recruited if they were deemed eminent in assessment, especially if they had produced research in more than one area of assessment. If a potential member declined participation, they were asked (along with inquiries made of leaders in assessment, and in Division 12) to nominate another qualified expert. While Table 1 does not exhaust all the areas that could have been covered, we believe it covers most populations and assessment methods clinical psychologists confront.

Method

We first asked members to nominate curricular topics of any scope, emphasizing topics shorter than an academic term. This was to prevent obtaining a simple list of favorite course titles that members' home institutions taught, and thus give us a fresh look at curriculum development. The instructions were:

1. Members were: Gwynneth M. Boodoo (Educational Testing Service), Bertram J. Cohler (University of Chicago), W. Grant Dahlstrom (University of North Carolina), Robyn M. Dawes (Carnegie-Mellon University), David Faust (University of Rhode Island), Deborah W. Frazer (Philadelphia Geriatric Center), William M. Grove (University of Minnesota), Wayne H. Holtzman (University of Texas, Austin), William G. Iacono (University of Minnesota), Muriel D. Lezak (University of Oregon), David Lubinski (Iowa State University), Joseph D. Matarazzo (Oregon Health Sciences University), Paul E. Meehl (University of Minnesota), Peter C. Mundy (University of Miami), Gerald R. Patterson (Oregon Social Learning Center), Herbert C. Quay (University of Miami), Thomas A. Widiger (University of Kentucky), and Jerry Wiggins (University of British Columbia).

Table 1
Assessment Domains with Names of Most Relevant Persons

Assessment Domain	Task Force Member(s)
Clinical judgment	Robyn Dawes
Family assessment	Gerald Patterson
General methodology, forensic assessment	David Faust
Gerontological assessment (mental health)	Bertram Cohler
Gerontological assessment (cognitive)	Deborah Frazer
Child/Infant assessment	Herbert Quay, Peter Mundy
Intellectual assessment	Joseph Matarazzo
Interviewing, diagnostic (adult)	Thomas Widiger, William Grove
Neuropsychological assessment	Muriel Lezak
Personality (non-projective), abnormal	W. Grant Dahlstrom
Personality (non-projective), "normal range"	Jerry Wiggins
Prediction models, clinical vs. statistical prediction	Paul Meehl, William Grove
Projective techniques	Wayne Holtzman
Psychometrics	Gwynneth Boodoo
Psychophysiological assessment	William Iacono
Test bias, vocational interests	David Lubinski
Liaison to APA	George Stricker (<i>ex officio</i>)

I am herewith soliciting your suggestions for topics which should be included in the model assessment curriculum. I request that these suggestions follow the following format:

1. Very brief topic title
2. Brief definition of topic
3. How many class meetings (assume a standard 1 to 1.25 hour class) would be required to teach this topic
4. One or two paragraphs explaining what would be taught. This may include readings, laboratory exercises, or anything else which contributes to readers' understanding what is involved.

Appended to this request were two examples of topics (these appear as items "Incremental Validity" and "Test Bias in Intelligence Testing" in the final curriculum).

Members suggested 105 items to the chairperson, who stripped author names (to allow blind review) and circulated them to all members for comment. Members' comments were sent to the chairperson, who relayed them to the item's author. Authors revised items as they saw fit, based on the comments. The chairperson decided not to collapse similar-sounding items, as it was not his place to select the best way of regarding any given topic.

Next, a card deck was prepared with one item per card (item order randomized). Copies of the deck were sent to members, who were asked to complete a sorting task using these items as stimuli. Task force members were asked to sort items in three stages: (1) read the whole deck, (2) place each item in one of three categories ("essential," "useful but not essential," and "less important," (3) within categories, sort the items from high to low according to perceived importance. "Essential" meant that no proper clinical training program should be without appropriate coverage of the item. "Useful" meant that including the item would greatly improve the curriculum, but it was not essential. "Less important" meant inclusion was inessential and would not greatly improve the curriculum.

Pilot testing by two task force members indicated that it was not practical to ask members for a complete ordering of items within each category. Instead, members were asked to divide each broad importance category into three subcategories, in descending order of importance. This generated, in effect, a nine-point rating scale on which the task force members rated each item. Task force members were not told to sort any certain number of items into each group, but were reminded that if too many items were placed in one category, discriminating information would be lost.

Data Analysis

Members' 9-point ratings were linearly transformed to mean zero and standard deviation one, to minimize effects of potential strategic ranking behavior. Interrater correlations were Q -factor analyzed to identify deviant raters (whose ratings would be eliminated or given less weight). If there were no deviant raters, item ratings were to be averaged across raters, giving a consensus importance measure. The Statistical Analysis System, version 6.10 (SAS Institute, 1994) was used for all analyses.

Results

Thirteen raters completed the sorting task. Leading eigenvalues of the Q -correlation matrix were 3.97, 1.11, and 1.01. We conclude that a single dimension of importance underlies inter-judge rating correlations. However, we conservatively retained three factors when estimating each raters' communality, to identify outlier raters (they would be expected to have low communalities). No judge's communality was significantly lower than the average (with required significance level .1, estimated by bootstrapped confidence interval; Efron, 1987; see also Note 2 herein). Cronbach's coefficient alpha for raters (aggregating across items) was .81, also suggesting that raters substantially agreed. Therefore, there was no need to eliminate outlying judges' ratings.

To obtain stable ratings, we averaged members' ratings for each item. In order to avoid potential strategic ranking (rating certain items very high or low, to counterbalance others' expected discrepant ratings) effects, and to minimize effects of response styles, we transformed ratings before averaging. First, we transformed ratings to z -scores, so each judge's ratings had zero mean and unit variance. Then we averaged z -scores within items across judges. Average rankings were then re-expressed as linear T -scores (mean 50, standard deviation 10), to aid interpretation. Higher T 's denote more importance.

Table 2 lists those curricular items, having the highest-ranking scores, including all those with score of 50 or above. This was done so that the tabled items could be taught, with some squeezing together of like items, in a year-long thrice-weekly class. Space permits description of the items only by

the abbreviated titles shown. Items omitted from the sample curriculum range in score from 49.9 down to 25.4; they are listed in Table 3 but are not further discussed.

A typical line in Table 2, e.g. the first, is read as follows. For purposes of condensing the Task Force topics into a curriculum, three topics were lumped together: defining properties of mental tests, norms and standardization, and normality vs. abnormality in psychological assessment. The first of these had an average importance rating of 57.2, the second 56.8 and the third 55.0. It was deemed feasible to cover all these topics in one class period. To keep track of how much time the topics are adding up to, as an aid in dividing the material into courses, Table 2 shows a cumulative total classes column.

Discussion

Clearly, Table 2 emphasizes general facts about assessment, as well as learning specific testing skills. Some aspects of curriculum implementation could be handled fairly easily, by having mini-courses covering certain areas, e.g., "Clinical judgment." For other topics, major reorganizations of material in existing courses might be required. Obviously, the indicated arrangement of material is not the only one possible. Material could be included from Table 3, to make a more comprehensive course.

Objections

Skeptics might say that the results are invalid, for either of two reasons. First, the task force that created the items and made the ratings was unrepresentative. Second, many task force members were rather senior in the field, and so may represent an "old guard" in assessment.

There is no completely satisfactory answer to objections about representativeness, absent a proper sample survey. We will simply say that our group is a reasonable selection of well-reputed figures in assessment.

As to the notion of an older generation having out-of-date ideas, we distinguish assessment methodology from specific assessment instruments. The foundations of assessment theory were laid down earlier this century, mostly in the context of intelligence and personality measurement. Since then,

2. Bootstrapping involves treating the sample as a finite population, and repeatedly sampling from it, with replacement, to generate an estimate of the sampling distribution of a statistic. Since sampling is with replacement, a single observation can be drawn more than once. This makes the (transposed) Q -correlation matrix singular. To prevent this, the ratings were jittered. Jittering is a process whereby the data are perturbed by amounts much smaller than any reasonable estimate of probable error. In this case, the integer ratings (ranging from 1 to 9 as explained above) were perturbed by adding to them uniformly distributed random numbers, spanning the range $\pm .01$. The jittering prevented outright singularity of correlation matrices. The jittered ratings were then Q -factor analyzed. Because the size of the added noise is small compared to the original data, jittering will scarcely influence the results.

Table 2
Curricular Items, in Sample Syllabus

Curricular Item	Mean T-score	Class periods	Cumulative class periods
Mental tests, defining properties	57.2	1	1
Norms and standardization	56.8		
Normality vs. abnormality in psychological assessment	55.0		
Reliability: History and use in clinical assessment	65.3	3	4
Practice effects vs. true change and measurement error	51.0		
Standard error of measurement of test score	63.5		
Handy formulas and constants to memorize	52.3		
Scatter/pattern analysis	57.0	1	5
Latent/manifest distinction	53.5	1	6
Construct validity	70.9		
Redundancy of additional information	52.3	1	7
Incremental validity	58.8		
Validity of assessments: Effect of extraneous factors	60.0	1	8
Departing from standard testing procedures	51.9		
Deception and malingering	56.4	1	9
Cultural influences on test scores	60.2	3	12
Bias in mental testing	56.9		
Types of errors, cutting scores, utilities	71.3	2	14
Base rates and quantitative decision making	65.9		
Bayes Theorem and related topics	69.2		
Sources of clinician error	61.9	2	16
Probabilistic vs. categorical thinking	52.7		
Biases affecting clinical judgment	61.1		
Advantages and limitations of clinical experience	60.9		
Clinical vs. statistical prediction	69.0	2	18
Adult intelligence assessment;	65.6	12	30
Aptitude and achievement testing	55.0		
Child intelligence assessment	60.7	12	42
Neuropsychological assessment;	55.2	4	46
Neuropsychological impairment, indications and screening methods	57.7		
Historical background for contemporary issues in personality assessment	50.2	10	56
Objective personality assessment (MMPI-2)	69.2		
Meaning of diagnosis	59.4	2	58
Categories vs. dimensions in psychopathology	56.6		
When is a diagnosis worth making?	51.7		
Reliability of psychiatric diagnosis	65.5	1	59
Sources of data for a diagnosis	53.5	3	62
Obtaining a history	60.3		
Structured vs. unstructured interviews	52.0		
Mental status examination;	55.3	6	68
Ratings of traits, signs, symptoms	52.7		
Structured interviews with children	50.2	3	71
Behavioral observations of children and adolescents	52.5		
Parent rating scales for assessing children	52.3	3	74
Acquisition of miscellaneous specific skills in assessment	53.8	10	84
Data integration and combination	55.9	3	87
Report writing	57.7		
Ethics of assessment	64.1	1	88
Psychology and law interface (overview)	50.8	2	90

Table 3
Curricular Items Omitted From Sample Syllabus

Curricular Item	T-score	Class periods	Cumulative class periods
Self-Report Measures of Child and Adolescent Psychopathology	49.9	2	2
Common Errors in Assessment	49.8	1	3
Assessment of Child and Adolescent Psychopathology: General Considerations	49.8	2	5
Documentation and Record Keeping	49.6	1	6
Clinical Biases: Corrective Methods	49.1	1	7
Problem of "Blind" Interpretation	48.8	1	8
Informing (Feedback) Interviews	48.7	1	9
Converging Measures in Diagnosing Children's Disorders	48.7	1	10
Determining Prior Levels of Functioning	48.3	1	11
Heritability	48.3	4	15
Computerized Testing and Interpretation	48.3	1	16
Differentiating Normal and Abnormal Personality	47.5	3	19
Testing Handicapped Populations	47.5	1	20
Approaches to Scale Construction	47.3	1	21
Conditional Independence	46.7	1	22
Observation of Children	46.4	30	52
Reporting Scores on Tests of Mental Ability and Cognitive Functions	46.1	1	53
Sources of Information: How to Obtain and Interpret Them	45.0	1	54
Sources of Information on Assessment; How to Access and Keep up with the Literature; Professional Development in the Assessment Area	44.4	1	55
Assessment of Personality in Children and Adolescents	44.1	2	57
Objective vs. Subjective Cue Use	43.9	1	58
Teacher Rating Scales	43.5	2	60
Trait X Treatment Interaction	43.4	1	61
Issues in Assessment with the Elderly	43.1	2	63
Introduction to Generalizability Theory	43.1	3	66
Assessing Antisocial Children	43.0	1	67
Learning Intellectual Assessment (Adults): Special Abilities	42.7	6	73
Vocational Interests	42.4	1	74
Neuropsychological Assessment of the Elderly	42.4	2	76
Learning Intellectual Assessment (Children): Differential Abilities	42.2	6	82
Learning Intellectual Assessment (Adults): Differential Abilities	42.2	6	88
Orders of Personality Dispositions	42.2	1	89
Utilizing Summaries of Research	41.8	2	91
Sequential Decision-Making	41.7	1	92
Diagnostic Thinking and Problem Solving; Reasoning Strategies	41.3	1	93
Interaction (in ANOVA sense)	41.2	1	94
Principles of Prediction and Risk Assessment	41.0	1	95
Assessment of Family and Parental Characteristics	40.8	2	97
Functional Assessment	40.6	1	98
Genotype-Environment Interaction	40.6	1	99
Structural Models of Personality Disorders	38.4	3	102
Learning Intellectual Assessment (Children): Special Abilities	38.4	6	108
Learning Personality Assessment: Projective—Rorschach (or related methods)	36.5	20	128
Unanticipated vs. Sought-After Findings	36.2	1	129
"Laboratory" Measures	34.9	1	130
Allied Disciplines	33.9	1	131
Learning Personality Assessment: Projective—Thematic Apperception	33.7	6	137
"Specialized Measures" in Child and Adolescent Psychopathology	33.6	2	139
Question as to Which Kinds of Diagnostic Inferences are Worth Making From the Practical Standpoint of Patient Care	33.0	1	140
Learning Personality Assessment: Projective—Drawing Tests	30.6	3	143
What's Wrong with Psychology	29.6	1	144
The Importance of Feedback About "Errors" in Concept Identification	27.9	1	145
Assessment Outside the Clinician's Office	25.4	1	146

new technologies have developed in psychophysiology, behavioral observation, computerized assessment (e.g., adaptive cognitive testing), and ecological assessment. Nevertheless, in all cases their evaluation and utility depends on fundamental principles that have not changed. Students trained with “invariants” like fundamental facts of reliability, validity, and data integration, are well situated to invent, research, and apply new assessment technologies to new assessment problems. It is such “invariants” that our Task Force tended to emphasize, over very specific assessment instruments that may go in and out of favor.

Another potential objection is that we might have invited people with pecuniary interests (e.g., authorship of a commonly clinically used commercial test) to join the task force. However, we did not. This decision deprived us of some first-rate members, but increased our credibility. One might also impugn our procedure, because a favored topic appears in Table 3 rather than Table 2, or does not appear at all. However, we attempted broad coverage even if it yielded an overabundance of items. We did not fear that by including quite varied items, we would risk improperly lauding an inutile procedure. We reasoned that poor approaches would be flagged by their low ratings. Two steps we took to increase coverage were, first, to solicit items from all members on all topics, not just items in a member’s specialty. Second, when members reviewed the first set of submitted items, they could add hitherto omitted topics. (In fact, the chairperson added an item on projective testing, since this area was initially not suggested by any member.)

One might object that a certain topic, test, or approach was under- or overvalued in comparison to the reader’s own estimation of it. In answer, we can only reiterate that the ratings fairly represent the aggregated opinion of the eminent and experienced researchers, teachers, and practitioners on the task force. Also, a low rating need not imply that an item should not be covered at all.

Future Directions

Finally, one might worthily object that the ratings do not reflect the empirically proven ability of a given assessment approach to contribute to client welfare. Ideally, we would

teach all (and only) assessment approaches that improve client outcomes. We would agree that research of this type is important for the future. However, at present such data are almost entirely lacking. Rather than stop teaching until we know which are the “assessments that work,” we prefer to offer the counsel of eminent assessment researchers and practitioners, as a reasonable first step in rationalizing the assessment curriculum. ■

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Cognitive Behavior Therapy to Assist Medication Discontinuation in Panic Disorder



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This 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.

Background and Description of Treatment

Many patients with panic disorder have difficulty discontinuing benzodiazepine therapy or relapse soon after discontinuation (Pecknold, Swinson, Kuch, & Lewis, 1988; Otto et al., 1993; Spiegel, Bruce, Gregg, & Nuzzarello, 1994). Initial attempts to improve these rates emphasized medication strategies designed to minimize taper-emergent withdrawal symptoms characteristic of these agents (e.g., Rickels, Case, Schweizer, Garcia-Espana, & Fridman, 1990). The most successful of these strategies, a slow flexible taper and supportive medical management, improved rates of discontinuation but not relapse (Spiegel et al., 1994).

Other studies have tested the effect of Cognitive Behavioral Therapy (CBT) on discontinuation and relapse (Hegel, Ravaris, & Ahles, 1994; Otto et al., 1993; Spiegel et al., 1994). These approaches treat withdrawal symptoms (and other feared sensations and situations) as phobic cues capable of prompting the kind of fear and avoidance that could complicate discontinuation or precipitate relapse. In these studies, a slow flexible taper has been integrated into adaptations of Panic Control Therapy (Barlow & Craske, 1989; Craske & Barlow, 1990) to help patients transition from a pharmacologic to a cognitive behavioral emphasis to overcoming their panic disorders. This model treats the medication as a safety cue which is gradually waned during exposure. Accordingly, each step downward on the taper schedule serves an arena for testing fearful predictions, decreasing fear of sensations, and building self-efficacy.

Although further research is needed to ascertain active procedures (see Spiegel & Bruce, 1997 for a recent review), the following general therapeutic practices have been common to these treatment protocols:

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Education and a Biopsychosocial Rationale

Patients learn about panic disorder and agoraphobia, the initial temporary role of benzodiazepines in stabilizing symptoms, and the role of CBT strategies in the longer term maintenance of change. Realistic expectations for change, therapeutic considerations introduced by the medication, and strategies for managing those are common emphases.

Medication Adjustment

Some studies have included this phase in which benzodiazepine therapy is adjusted to provide temporary relief of marked anxiety or panic attacks. In two studies (Hegel et al., 1994; Spiegel et al., 1994), blockade of full panic attacks was targeted and accomplished at an approximate mean dose and schedule of .5mg/s four times a day alprazolam (or equivalents). Use of minimum therapeutic dosing to produce the desired relief has been the common practice.

Somatic Calming Strategies

Standard progressive muscle relaxation training and diaphragmatic breathing are taught during this phase.

Cognitive Restructuring

In addition to restructuring fears common to panic disorder, attention is paid to fears introduced by medication use (e.g., side effects and taper-emergent symptoms). Methods are used to help patients shift attributions of treatment success from the medication to themselves, the former of which has predicted relapse after combined pharmacologic and exposure-based treatment (Basoglu et al., 1994).

Coping Skills Development

Cognitive and somatic coping strategies for managing anxiety and panic are taught.

Sensation Exposure

Interoceptive exposure involving sensation-inducing exercises is conducted during this phase.

Medication Taper

Shortly after the initiation of sensation exposure, medication is tapered on a slow flexible decreasing decrement taper schedule. This taper schedule removes the same proportion of medication (e.g., 25-33%) from the *current dose at each taper step*. The duration of each taper step has averaged approximately one week, with the option of extending it if the patient desires. This differs from traditional taper schedules that have removed the same total amount of medication (e.g., .5mg) from each dose step, resulting in removal of a higher proportion of drug as taper proceeds. The decreasing decrement schedule has been associated with higher discontinuation rates and fewer withdrawal symptoms than traditional schedules (Spiegel et al., 1994).

Situational exposure

As interoceptive exposure progresses and the taper continues, patients begin situational exposure. This phase was excluded from initial discontinuation trials, but is recommended for treating agoraphobic avoidance.

Follow up, booster, and relapse prevention

One discontinuation studies (Hegel et al., 1994) included these sessions which focused on helping patients problem-solve potential risks and strengthen strategies serving to maintain gains.

Summary of Studies Supporting Treatment Efficacy

Otto et al. (1993) tapered subtherapeutic doses of benzodiazapines either with or without concurrent group CBT. Seventy-six percent of those who received CBT, but only 25% of those who did not, were able to discontinue scheduled drug use. At three month follow up, 59% of CBT group had remained clinically improved and free from scheduled use of medication.

Spiegel et al. (1994) tapered therapeutic doses of alprazolam using a slow flexible drug taper and supportive medical management with or without concurrent individual CBT. Both groups were able to taper the medication at high rates (80% and 90%, respectively). At six month follow-up, however, half of those who had discontinued drug without CBT had relapsed, while none of the CBT group had.

Hegel et al. (1994) tapered therapeutic doses of alprazolam from a single group of patients using a decreasing decrement schedule and individual CBT plus booster sessions. They found an 85% discontinuation rate out to one-year follow-up. Similar successes have been reported in a more recent study as well (Schmidt, et al., 1997).

Bruce et al. (1999) conducted a long-term follow-up of patients from previous studies (Hegel et al., 1994; Spiegel et al., 1994) and found that 75% and 76% of respective participants who had discontinued medication with the assistance of CBT remained medication-free, therapy-free, and maintained their clinical gains throughout this two- to five-year follow-up period. In predictive analyses of these patients' outcome, decreases in anxiety sensitivity during treatment has emerged as the only significant predictor of discontinuation success and long-term recovery (Bruce et al., 1995; Bruce et al., 1999), consistent with CBT formulations (Barlow, 1988; Clark, 1986). ■

Clinical References Describing the Approach

Descriptions of the respective approaches can be found in their original reports.

Practical patient and therapist manuals describing the use of CBT for medication discontinuation are as follows:

Otto, M.W., Pollack, M.H., & Barlow, D.H. (1995). *Stopping Anxiety Medication: A workbook for patients wanting to discontinue benzodiazepine treatment for panic disorder*. San Antonio, TX: Psychological Corporation.

Otto, M.W., Jones, J.C., Craske, M.G., Barlow, D.H. (1996). *Stopping anxiety medication: Panic control therapy for benzodiazepine discontinuation (Therapist Guide)*. San Antonio, TX: Psychological Corporation.

Resources for Training

Training in these protocols has been offered through various workshops and institutes. The following sources can be contacted for information on upcoming programs:

The Anxiety and Mood Disorders Clinic
University of Illinois College of Medicine
5407 N. University Street, STE C
Peoria, IL 61614
ATTN: Continuing Education

Cognitive-Behavior Therapy Program
WACC-812; Massachusetts General Hospital
15 Parkman Street
Boston, MA 02114
ATTN: Clinician Training

For information on training in Panic Control Therapy and its applications contact:

The Center for Anxiety and Related Disorders
Boston University
648 Beacon Street
Boston, MA 02215

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Elder Abuse and Neglect: In Search of Solutions

This 20-page free brochure was recently produced by APA's Office on Aging. Written for consumers, but useful to anyone who wants to know more about elder abuse, topics covered include: what are the different types of abuse and neglect; why abuse occurs; what can be done to prevent abuse; and where to go for help. Copies may be obtained by contacting: APA Public Interest Directorate, 750 First Street, NE, Washington, DC 20002; Telephone: (202) 336-6046; Internet: www.apa.org/pi or E-mail: publicinterest@apa.org.

Call for Nominations

The Publications and Communications Board has opened nominations for the editorships of *Behavioral Neuroscience*, *JEP: Applied*, *JEP: General*, *Psychological Methods*, and *Neuropsychology* for the years 2002-2007. Michela Gallagher, PhD; Raymond S. Nickerson, PhD; Nora S. Newcombe, PhD; Mark I. Appelbaum, PhD; and Laird S. Cermak, PhD, respectively, are the incumbent editors.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2001 to prepare for issues published in 2002. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations are also encouraged.

To nominate candidates, prepare a statement of one page or less in support of each candidate and send to:

- Joe L. Martinez, Jr., PhD, for *Behavioral Neuroscience*
- Lauren B. Resnick, PhD, and Margaret B. Spencer, PhD, for *JEP: Applied*
- Sara B. Kiesler, PhD, for *JEP: General*
- Lyle E. Bourne, Jr., PhD, for *Psychological Methods*
- [TBD] and Michael F. Enright, PhD, for *Neuropsychology*

Address all nominations to the appropriate search committee at the following address:

Karen Sellman, P&C Board Search Liaison
Room 2004
American Psychological Association
750 First Street, NE
Washington, DC 20002-4242

First review of nominations will begin December 6, 1999

Scientific Standards in Continuing Education

Larry E. Beutler

University of California Santa Barbara

Lynn P. Rehm

University of Houston

Should Continuing Education programs be restricted to presentations of clinical methods on which there is some minimal level of scientific support? Should ads in the *APA Monitor* be required to comply with a similar standard? These are important questions and ones that recently came before the Board of Directors of the Society of Clinical Psychology. These questions arose from the officers of Section III (Society for a Scientific Clinical Psychology), and reflected a growing concern among section members that the ethical principle that binds practice to scientifically verified methods is being ignored. Many CE offerings are of new techniques or of techniques that have achieved some popular appeal, but are devoid of a body of research. The Board of Directors of the Section as well as many Section members have expressed concern that APA is not doing enough to ensure that practitioners can meet their ethical commitment to practice procedures for which there is sound scientific evidence.

It is important to point out that we acknowledge that there are many legitimate CE offerings for which the principle of empirical support does not apply. For examples workshops on ethics, legal issues, professional issues, etc. It should also be noted that whether empirically supported or not, many CE offerings do not claim to teach new techniques to a level of mastery. For example, a half-day introductory CE workshop on Cognitive Therapy would not be sufficient to train people as cognitive therapists.

In response to the concerns about unsupported techniques being offered as CE workshops that may be advertised in the *Monitor*, we took the matter to APA Council. In the February meeting, we began an informal, two-pronged process of informing ourselves about the way that CE offerings are selected and monitored and the way that advertisements are processed for the *Monitor*. In addition to gathering information about current policies, we also sought to determine, informally, whether there was sufficient sentiment among Council members to gain approval for a policy that would bind APA CE activities and journal advertisements to those for which there is scientific evidence. Rehm assumed the responsibility for obtaining further information about CE offerings and Beutler took the responsibility for learning and evaluating the practices by which the *Monitor* reviews and selects

advertisements. Our paths converged as we discovered that these processes were intimately related.

APA Monitor

The first task in exploring advertising policies of APA was to seek information about the policies that governed certain advertisements with which the Section membership had expressed concern. Ray Fowler kindly agreed to review representative advertisements and to inform us about the policies that were followed in allowing their publication in the *Monitor*. Thus, we identified several advertisements that had been published within the previous six month period in the *Monitor* and submitted these to Ray. Advertisements were selected that had either been suggested by one or more members of the Section (through SSCPnet, the Section listserve) as being problematic or for clinical procedures for which we found no supportive evidence in an initial search through PsycLIT®.

Ray reported back to us as to the status of these advertisements. In every instance of an advertisement that was considered to be suspect for representing a clinical procedure for which there was little or no supportive evidence from scientific investigation, it was determined that an approved CE sponsor had placed the advertisement. *Monitor* policy permitted advertisements of these educational offerings from approved sponsors without further qualitative review. By policy, advertisements of CE activities are accepted. Indeed, we could not see how the *Monitor* could logically be made to refuse to advertise a course that had previously been designated as approved for credit through the APA Continuing Education Committee. Thus, it appeared that the problem with *Monitor* advertisements were largely a problem of CE policy.

Before diverting energy from the *Monitor* to a closer inspection of CE policy and procedures, we initiated two more actions designed to test the interest of APA Council to impose a new policy to govern advertisement in the *Monitor*. Beutler filed a motion to direct the APA Board of Directors to examine current policies regarding advertisement. Then, we initiated a discussion with Council members, particularly those in science related caucuses, to determine the level of support that the motion would likely obtain. It quickly became apparent

that Council members viewed a policy change either negatively or with little interest. We rapidly concluded that there would not be a basis of support for such a proposal and the proposal was withdrawn. Instead, we directed our efforts to the activities and policies governing the approval of continuing education offerings.

Continuing Education

Rehm spoke to committee members and staff within the Education Directorate. The APA Education Directorate has recently undergone a review of its CE policies and processes and of the sponsor approval system. Except for convention CE workshops, APA does not directly review and approve CE offerings. Instead a committee approves sponsors of CE who then review and offer specific workshops or other forms of CE. The sponsor approval system was reviewed and compared to the way in which other professions do CE approval. After long study and discussion the review group recommended that the current system of sponsor approval be continued. With 600+ approved CE sponsors offering 10,000+ CE offerings nationally each year it was not considered feasible to centrally review each individual offering at APA. Other professions (for example, language, speech and hearing; medicine; dentistry; and pharmacy) similarly, do sponsor approval rather than individual offering reviews for the same reasons. One of the factors that went into the decision was that APA, in fact, receives very few complaints about CE content. When complaints do come in they are much more likely to be about the mechanics of workshops (cold room, certificates sent out late, etc.) than about the nature of the content.

Other recommendations that are being implemented include combining the current Continuing Education Committee (which develops CE policy and reviews convention programs) and the Committee for the Approval of Continuing Education Sponsors (which review sponsors). This is seen as a way of bringing together all APA CE functions in a more coordinated way. The sponsor approval system will also be changed in couple of ways. The process will increase scrutiny of new CE sponsors with an initial provisional approval period of two years. Second, greater emphasis will be placed on complaint response and review. The tradeoff will be to spend less time on reviewing ongoing approved sponsors. Approved sponsors will be reviewed less frequently if no complaints are received regarding their offerings.

Conclusions

Our efforts convinced us that little can currently be achieved through initiating an effort to change APA policy regarding either advertising or CE sponsorship. It is clear that the advertisement of CE offerings cannot and should not be

excluded from the *Monitor*. Doing so would be illogical. At the same time, it is clear that the Continuing Education Committee has viewed these activities as educational rather than as training. They value the principle of allowing attendees to determine the nature of the offerings rather than imposing a standard on these presentations. While they have asserted that each presentation should include information on the scientific status of the information being presented, they do not favor a policy that would monitor and enforce a predetermined quality of the scientific data. They point out that many offerings are theoretical presentations and many more are designed to present early, newly developed procedures and techniques for consideration. Thus, the Committee views their task as being informational rather than contributing directly to clinician skill building. Thus, they provide knowledge rather than procedural facility and they operate on a principle that values exploration of knowledge and information from a variety of sources. They do not see a way that they could monitor the content of the CE courses, economically, or to police the offerings to ensure that there is compliance with a standard of scientific evidence.

APA Council, at the same time, is not disposed to develop a different policy at the present time. There is and has been little evidence of discontent in the form of complaints from psychologists regarding the nature and content of CE offerings or the nature of advertisements in the *Monitor*. Unless there is a greater expression of dissatisfaction little can be done to affect the policy. Thus, we recommend two courses of action for those who are concerned about either of these two issues.

1. There is room for a second review body that takes on the responsibility of assessing the quality of CE offerings and advertisements. Such a body, perhaps a Section or Section task force, could offer endorsements of offerings based on their meeting certain defined standards of empirical support. This would conceivably represent a parallel body to the CE approval process, but an informal one that would inform attendees about the nature of the evidence that supports the clinical methods being taught. In effect it could offer its seal of approval for high quality CE offerings.

2. Since there is little motivation to change current policy in the absence of significant complaints regarding either advertisements or CE approval policies, it is important that members complain directly to the Education Directorate regarding CE advertised in the *Monitor* or elsewhere. Complaints should articulate the reasons why a particular CE offering seems inappropriate. When approved sponsors have to defend their unsupported offerings, they may have to desist or lose their approval. ■

The Value of Scientist-Practitioner Training in Dealing with Changing Professional Demands - An Opinion Survey of Clinical Graduates

John P. Garske and John R. McNamara

Ohio University

In order to ascertain the extent to which clinical training has prepared students to function in today's managed care marketplace and cope with future professional demands, the Department of Psychology at Ohio University conducted a survey of all of its doctoral clinical graduates for the last 15 years. Since its inception more than three decades ago, the clinical program at Ohio University has adhered to a scientist practitioner model, with specialty emphases in general, child, or health psychology.

The survey, consisting of structured- and free-response items, was sent to 102 graduates who received their PhDs between 1982 and 1997. Of the 97 surveys that reached the addresses, 64 (66%) were returned. The final sample had 55% female respondents and 45% male, and a median range of 37 years, ranging from 28 to 53 years,

About half of the sample completed their PhDs between 1982 and 1990. Most of the graduates were trained in the general clinical track (73%), while the remainder received training in the child (17%), or health (10%) track. Eighty-three percent were APA members, with less than half belonging to state and regional associations. Membership in managed care panels was at 42%. The positions and employment settings of the sample were remarkably diverse--57 different positions were reported. Their duties and activities were also varied, but primarily related to mental health and clinical populations, though 11% held academic positions, and 17% were administrators.

The vast majority of the sample (87%) stated that their current positions had been affected by managed care and/or health care reforms. More than half of the sample (57%) stated that managed care had affected their job security very much or somewhat, and slightly less than half (45%) said that it had negatively affected their income. Seventy-eight percent of the sample indicated that they have faced major professional

challenges because of managed care and/or other changes in health-care policies. However, the picture was not entirely negative. Some noted that they had to acquire new skills, learn time-efficient protocols and clinical innovations, and become acquainted with research that was pertinent to health-care policies and reforms.

The respondents' views of how graduate training had helped them deal with these challenges were uniformly positive. They felt well-prepared for the managed-care environment. It is interesting that among 47 different responses, there was only minimal reference to the clinical skills that they had acquired. However, there were many specific references to course work, especially in clinical content areas, ethics and professional issues, clinical research and program evaluation, as well as to the degree to which general research knowledge and acumen had been acquired.

When asked about what courses or areas would be essential or important if they were beginning graduate training today, the students' responses mainly reflected what was presently offered in our clinical program. The designation of the need for specific, clinical skills training in techniques, modalities or areas of concentration (such as health or child) was mentioned infrequently. The former students, however, emphasized the need for additional clinical content courses in several under-emphasized areas, including consultation, supervision, administration, management, and pharmacology.

The respondents appeared to express guarded concern with regard to the prospects for clinical psychology as a profession. When asked about their confidence in receiving a desirable position if they were to enter the job market at this time, 43% were confident and 45% were not confident. Over the next five years 60% of the sample thought that the profession of psychology would experience continued or limited growth.

Finally, former students were asked to provide ratings of satisfaction for several items related to how their training helped them function in the present-day environment. As a group, they appeared satisfied with their present circumstances with reference to professional earnings (65% satisfaction),

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lifestyle (83%), professional competence (98%) and capacity to change/adapt to job demands (91%).

The findings of the survey of our doctoral students over the past decade and a half revealed that they have been significantly, and to a large extent adversely, affected by managed care and other health-care, reforms. Even under these adverse circumstances, the former students appear to have established themselves professionally, remained somewhat optimistic about the future prospects of clinical psychology, and developed positive career and personal satisfaction.

While many clinical programs are either making or planning to make curricular changes in response to the demands of managed care. The results from this survey suggest that such changes should be carefully designed and not interfere

with the basic approach supporting scientist-practitioner training.

If past success is any indication of how we train for the future, then certain educational precedents should be followed. First, a balance of clinical content courses from traditional and emerging areas should be offered. Next, adequate clinical experience and research training needs to be provided. Finally, independent scholarship along with critical thinking and analysis should be nurtured.

The scientist-practitioner model has proven to be quite resilient over the years and has trained several generations of clinicians. The results from this survey suggest that the model is still a viable one by which to train students and prepare them for professional functioning in the coming millennium. ■

The American Psychological Association Public Policy Fellowship Programs Seeks Applicants for the 2000-2001 Program Year

Since 1974, APA has been offering fellowships to provide psychologists with the unique opportunity to experience first hand the intersection of psychology and public policy. APA Policy Fellows come to Washington DC to participate in one of three fellowship programs, which involve working in a federal agency or congressional office. Training for the fellowships includes a three-week orientation to congressional and executive branch operations, and a year-long seminar series on science and public policy. The training activities are administered by the American Association for the Advancement of Science for APA Fellows and for Fellows sponsored by nearly two dozen other scientific societies.

APA Congressional Fellowship Program

APA Congressional Fellows spend one year working as special legislative assistants on the staff of a member of Congress or congressional Committee. Activities may include conducting legislative or oversight work, assisting in congressional hearings and debates, preparing briefs, and writing speeches. Past Fellows have worked on issues as diverse as juvenile crime, managed care, child care, and economic policy.

William A. Bailey AIDS Policy Congressional Fellowship

APA and the American Psychological Foundation (APF) established the William A. Bailey Congressional Fellowship in 1995 in tribute to former APA staff Bill Bailey's tireless advocacy on behalf of psychological research, training, and services related to AIDS. Bailey Fellows receive a one-year appointment to work as a special legislative assistant on the staff of a member of Congress or congressional Committee. They focus primarily on HIV/AIDS and/or gay and lesbian issues, while engaging in the same types of legislative activities as other APA Congressional Fellows.

APA Science Policy Fellowship

In addition to the Congressional Fellowships, APA also provides a fellowship opportunity for psychologists who wish to gain an understanding of science policy from the perspective of federal agencies. The APA Science Policy Fellowship, begun in 1994, places psychologists in a variety of settings in science-related agencies. Participants in this program have worked in the Office of Science and Technology Policy (OSTP) at the White House, the Office of Behavioral and Social Sciences Research at the National Institutes of Health (NIH), and the National Science Foundation (NSF).

Applications

Applicants for the APA Policy Fellowship Programs must be members of APA (or applicants for membership) and must have completed a doctorate in psychology or a related field. Applicants must submit a current CV, and three letters of recommendation to: APA Congressional Fellowship Program,

Public Policy Office, American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002-4242. The deadline for applications is January 7, 2000. Annual stipends range from \$46,600 to \$58,900, depending on years of experience and the specific fellowship sought. For additional information, please contact Daniel Dodgen, PhD, at ddodgen@apa.org, (202) 336-6068 in the APA Public Policy Office.

Empirically Supported Treatments and Related Contemporary Changes In Psychotherapy Practice: What do Clinical ABPPs think?

Thomas G. Plante and Erin N. Andersen
Santa Clara University

Marcus T. Boccaccini
University of Alabama

A national survey of 500 (return rate = 43%, resulting in 211 usable questionnaires) Clinical Diplomates of the American Board of Professional Psychology (ABPP) regarding opinions on the development of empirically supported treatments (ESTs) and related contemporary psychotherapy practice issues was conducted during the fall of 1997 and winter of 1998. Results indicate that ABPPs are mostly supportive of the development of ESTs. However, they do not routinely use them in their practices. Moreover, findings indicate that practicing clinicians do not routinely utilize structured clinical interviews or objective outcome assessment measures. Findings further suggest that attitudes concerning these issues differ based on the primary work area of the professional (e.g., practice, research).

Psychotherapy practice has experienced a number of changes in recent years as an outgrowth of managed health care, shifts in training focus and theoretical orientations, the development of empirically supported treatments (ESTs), and other issues. The need for empirically supported treatments (Beutler, 1998; Chambless & Hollon, 1998; Kazdin, 1996; Montgomery & Ayllon, 1995), the utilization of treatment manuals and structured interviews in clinical practice (Addis, 1997; Chambless & Hollon, 1998; Strupp, 1997) and treatment outcome assessment (Eisen & Dickey, 1996; Lambert & Brown, 1996; Nickelson, 1995; Pfeiffer & Shott, 1996; Wells, Burlingame, Lambert, & Hoag, 1996) continue to receive substantial professional attention. The inclusion of a special section on the topic of empirically supported treatments in a recent issue of the *Journal of Consulting and Clinical Psychology* (February, 1998) is reflective of the continuing importance of these issues.

ESTs can be broadly defined as treatments using manuals and outcome assessment that have demonstrated efficacy by receiving published empirical support. The Division 12 (Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures has established specific criteria for identifying ESTs including Well Established Treatments and Probably Efficacious Treatments (see Chambless

et al., 1998 for criteria). Specifically, to be considered a well-established empirically-supported treatment (originally called empirically-validated), the treatment research must have used treatment manuals, provided clear characteristics of the patient samples, and must have at least two well designed independent studies demonstrating efficacy (i.e., treatment is superior to placebo or another treatment or equivalent to an already established treatment) or a large number of case study designs demonstrating efficacy. Similar but less rigorous criteria are used for determining a probably efficacious treatment. Moreover, the Task Force has compiled a list of such treatments (Chambless et al., 1998) and continues to gather research on new and existent psychotherapeutic interventions to evaluate their status with respect to the Task Force criteria (Beutler, 1998; Chambless et al., 1998). A treatment is not considered an EST until it meets the Task Force's criteria and is placed on their list.

Several prominent professionals have argued that when an EST exists for a specific problem, it is unethical to provide that patient with a non-EST as a first line treatment (Chambless, 1996; Crits-Christoph, 1996; Meehl, 1997; Rehm, 1997). Proponents of ESTs maintain that requiring practiced forms of therapy to be empirically supported maximizes treatment efficacy and protects clients from potentially harmful or ineffective forms of treatment. They suggest that practicing unsupported therapies is somewhat analogous to administering pharmacological interventions without requiring any evidence of their efficacy. Requiring empirical support for all psychotherapeutic interventions would serve to maximize good treatment outcomes and minimize or eliminate inert or

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harmful treatments before they become available or practiced. In adherence with this position, Wilson (1995) has argued that ESTs are not only important but "ethically imperative" (p. 163) in serving the client's right to safe and effective treatment.

While psychotherapy researchers highlight the advantages of empirically supported treatments (Barlow, 1996; Chambless, 1996; Crits-Christopher, 1996; Nathan, 1998), it is unclear if practitioners share their enthusiasm and are willing to only use ESTs in clinical practice. Available findings suggest that training in and utilization of ESTs among practitioners are low (Montgomery & Ayllon, 1995; Task Force, 1995).

The influence of managed health care has certainly fueled the development of ESTs (Beutler, 1998). Several commentators have expressed concern that efforts to maximize cost containment associated with managed care will lead to a field of professional psychotherapy characterized by brief session interventions driven by time limited behaviorally oriented manual based treatments (Montgomery & Ayllon, 1995; Strupp, 1997). Moreover, many clinicians fear that third-party payers may soon only reimburse those practices that use empirically supported approaches (Barlow, 1996; Brokowski, 1995). However, some have argued that ESTs can help create a quality standard of care to combat the pressures of managed care to decrease or eliminate needed services (Sanderson, 1998). The EST research can thus help practice in the face of cost cutting attempts.

A number of concerns and limitations surrounding the development of ESTs and their implementation in clinical practice have been voiced (see Garfield, 1996; 1998; Plante, Boccaccini, & Andersen, 1998; Silverman, 1996). Fundamental among practitioners' concerns surrounding ESTs is the implication that all treatments that are not on the Task Force's list are nonsupported treatments (Kazdin, 1996). If treating clients with ESTs becomes a mandate for reimbursement from third party payers, many clinicians may be forced to abandon their regular modes of practice amid concerns of financial loss. Furthermore, practitioners may be faced with the possibility that administering a nonsupported treatment when a supported treatment is available might be considered an ethical and legal violation (Montgomery & Ayllon, 1995).

An important issue concerning both researchers and practitioners is whether or not ESTs, which are generally established in a controlled research environment, can be effective in actual clinical settings (Calhoun, Moras, Pilkonis, & Rehm, 1998; DeRubeis & Crits-Christoph, 1998; Garfield 1996; Havik & VandenBos, 1996; Kazdin & Weisz, 1998; Morrow-

Bradley & Elliott, 1986; Weisz, Donenberg, Han, & Weiss, 1995). Members of the Division 12 Task Force have acknowledged that there is more to determining if a treatment has value than demonstrating its ability to produce change under controlled research conditions (Chambless & Hollon, 1998). However, the Task Force's current focus remains on identifying treatments that have demonstrated efficacy in well-controlled treatment settings, with the caveat that they will deal with issues related to effectiveness in actual clinical practice at some point in the future (Chambless et al., 1998).

Because ESTs are required to demonstrate efficacy in research settings but not in clinical practice, many practitioners maintain that ESTs fail to take into consideration the heterogeneity of both therapists (Beutler, Machado, & Neufeldt, 1994; Garfield, 1996; 1998) and clients (Davison, 1998). Samples used in clinical trials are often homogeneous, thus eliminating the comorbidity, complexity, and changing needs that are seen in the majority of clients who seek treatment (Seligman, 1995; Silverman, 1996; Wilson 1996). Likewise, practitioners in clinical settings vary widely in education, training, and professional experience, and practicing clinicians typically do not have comparable amounts of treatment specific training and supervision that are provided to therapists in research settings.

One of the challenging issues surrounding the transition of ESTs from research to practice settings is the use of treatment manuals. For a treatment to qualify as Well Established, experiments demonstrating its efficacy must be conducted with the use of a treatment manual (Chambless et al., 1998), thus implying that a manual is necessary for the effective implementation of treatment in clinical practice. A complete listing of treatment manuals for ESTs is available (Woody & Sanderson, 1998). Treatment manuals are generally recognized for their value in controlling threats to internal validity in clinical trials (e.g., Chambless & Hollon, 1998). Some practitioners feel that treatment manuals facilitate learning among psychotherapy students (Chambless, 1996; Moras, 1993) and guard clients from potentially harmful or ineffective forms of treatment (Beutler, et al., 1994). However, practitioners have argued that adherence to treatment manuals in clinical practice restricts the creativity and flexibility of therapists while minimizing the value and unique nature of the client-therapist relationship (Davison, 1998; Garfield, 1996). Some maintain that manuals can be beneficial, but are of "limited value" (Strupp, 1997, p. 92) and cannot replace the client-therapist relationship which is the foundation to psychotherapy.

The level of adherence to treatment manuals and protocols necessary to effectively implement an EST is of further

debate. Many clinicians fear that strict adherence to specific manualized treatment protocols for specific disorders reduces the practice of psychotherapy to finding a psychotherapeutic recipe in a "cookbook" (Garfield, 1998, p. 122) of interventions. Although some researchers have found that the level of adherence to therapy manuals is related to better treatment outcome (Frank, Kupfer, Wagner, McEachin, & Cornes, 1991; Luborsky, McLelloan, Woody, O'Brien, & Auerbach, 1985) others have not found such associations (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, & Binder, 1993). Thus, while even strong proponents of treatment manuals for practice indicate that they should not be slavishly followed (Chambless, 1996) it is unclear how far practitioners can deviate from the manual and still claim that they are implementing an EST.

Another major concern among practitioners is that identified ESTs are unrepresentative of the various useful interventions that exist. Approximately 90% of the Task Force's empirically supported treatments, well-established treatments, and probably efficacious treatments are behavioral or cognitive-behavioral in orientation (Andrews, Crino, Hunt, Lampe & Page, 1994; Brownell, 1994; Nathan, 1998). Yet a recent survey of 546 psychotherapists found that the most prevalent orientation is still an eclectic approach (Norcross, Karg, & Prochaska, 1997). The overrepresentation of behavioral treatments on the Task Force's list of ESTs presents a problem for the large number of psychotherapists who report to be eclectic or maintain non-behavioral orientations (Dobson & Shaw, 1988; Norcross, Prochaska, & Gallagher, 1989). Before the development of ESTs, many behavioral treatments incorporated data collection and treatment manuals, which has undoubtedly facilitated their ability to conform to the Task Force's criteria and garner EST status. Researchers and practitioners from other theoretical orientation (e.g., psychodynamic, existential, family systems) have been forced to incorporate treatment manuals and outcome assessment into their treatment protocols to accommodate the Task Force's guidelines. Thus, many non-behavioral treatments have been understandably slower in meeting and acquiring EST status as a product of methodologically inadequate treatment literatures and the time required to develop the treatment manuals and outcome measures requisite for achieving EST status. As a result, the current list of ESTs is clearly unrepresentative of the therapy approaches practiced.

Opinions and attitudes of Diplomates of the American Board of Professional Psychology (ABPPs) concerning clinical neuropsychology (Ryan & Bohac, 1996; Sweet, Moberg, & Westergaard, 1996) and counseling psychology (Couch & Childers, 1991) have been collected; only one previous sur-

vey (Plante et al., 1998) has attempted to assess the attitudes of ABPPs concerning topics in clinical psychology. Results from this survey suggested that ABPPs were displeased with managed health care as well as the independent practice of master's-level professionals and the development of freestanding professional schools of psychology.

A number of published reports have highlighted professional opinions regarding managed health care, (Anders, 1996; Cummings, 1995; Fraser, 1996; Graham, 1995; Karon, 1995; Newman & Taylor, 1996; Plante et al., in press; Saeman, 1996); few have surveyed opinions regarding empirically supported treatments. The purpose of this study was to survey clinical diplomates of the American Board of Professional Psychology (ABPP) regarding ESTs and related professional issues. ABPPs were selected because they represent important clinical psychology practice constituencies who have reached an advanced, post-licensure level of certification.

Methods

Participants

A list of the 1000 active clinical diplomates of ABPP was obtained from the national ABPP office in Columbia, MO for an initial ABPP survey conducted in December 1996 (Plante et al., 1998). In the current study, random samples of five hundred were mailed the survey along with prepaid self-addressed return envelopes in October 1997. Results were collected until January 1998. A 43% return rate was achieved with 216 surveys being returned. Age, gender, ethnicity, and degrees of the sample were consistent with the demographics of the entire Clinical ABPP population according to the ABPP national office. These Responses from five retired diplomates were not included in the final sample, thus resulting in 211 (42%) usable surveys. Retired diplomates were excluded since it was unlikely that they were actively dealing with the potential or actual use of ESTs in practice.

The Survey

The first section of the survey consisted of questions requesting demographic information including: age, gender, number of years licensed, number of years as an ABPP, ABPP specialty, graduate institution, year doctorate was awarded, degree achieved, primary work area (i.e., solo independent practice, group practice, medical center, outpatient clinic or agency, college or university, other), percentage of time spent in specific activities (i.e., psychotherapy, direct patient testing and diagnosis, direct patient service, teaching, research, administration, other), usage of tests (i.e., *MMPI*, *WISC/WAIS*, *MCMI*, *TAT*, drawings, *Rorschach*, other), and utilization of written consent forms.

Table 1
Descriptive Statistics

Question	Mean	SD	% Negative (N)*	% Positive (N)*
Do you think that the development of EVT's is a good trend?	6.40	2.71	35 (71)	65 (133)
Do you routinely use EVT's in your practice?	4.88	2.88	54 (106)	46 (90)
Do you routinely use objective outcome assessment measures in your practice?	4.66	3.15	59 (102)	41 (93)
What are your feelings about the use of treatment manuals in clinical practice?	4.98	2.59	54 (106)	46 (93)
Do you routinely use structured interviews in clinical practice?	3.00	2.73	79 (158)	21 (42)

* Responses were made on a 10-point scale where 1 = strongly negative or never and 10 = strongly positive or always. Scores of 5 and below were considered generally negative and scores of 5.5 and above were considered generally positive.

The second section of the survey asked participants to respond to questions concerning professional issues utilizing a 10-point scale (1=strongly negative or never, 10=strongly positive or always). Issues surveyed included opinions concerning the use of empirically validated treatments (EVTs), objective outcome assessments, structured interviews, and treatment manuals (see Table 1 for a list of survey questions). Note that the term "validated" was in use at the time of the survey and will be used here to reflect the wording used in the survey. The frequency of responses given by the usable sample ($N = 211$) for the 10-point questions were recorded. Scores of 5 and below were considered generally negative and scores of 5.5 and above were considered generally positive (see Table 1). Participants were also asked to list the reasons for their responses after each question. A final question asked participants to list what they felt was missing in contemporary graduate training.

The usable sample consisted of 211 members of the American Board of Professional Psychology (ABPPs: 167 males, 38 females, 6 unspecified), with a mean age of 57.83 years ($SD = 10.63$). Respondents had their clinical license for an average of 24.83 years ($SD = 8.80$). The majority of respondents possessed a PhD ($N = 182$, 86%), while only a very small minority possessed either a PsyD ($N = 5$, 2%) or an EdD. ($N = 5$, 2%). Nineteen respondents (9%) did not specify their degree received. Of the 211 respondents, 124 (59%) members specified that they obtained their doctorate from an APA-accredited university program, while 14 (7%) respondents received their doctorate from a non-APA-accredited program, and 5 (2%) respondents received their doctorate from an APA-accredited freestanding professional school.

Results

Practice Activities

The most commonly reported primary work setting was solo independent practice ($N = 83$, 40%), followed by college or university ($N = 35$, 17%), medical center ($N = 33$, 16%), other ($N = 22$, 10%), group practice ($N = 20$, 9%), outpatient clinic or agency ($N = 10$, 5%), not specified ($N = 8$, 4%), and retired ($N = 5$, 2%). Respondents spent approximately 44% of their time providing psychotherapy services, 15% of their time teaching, 12% of their time in administration, 11% of their time with testing and diagnostics, 7% of their time in other activities, 6% of their time conducting research, and 5% of their time direct patient service.

The majority of respondents used psychological tests in practice ($N = 137$, 65%). Of those who did use tests, the most commonly used tests were the *MMPI* ($N = 96$, 70%), *WISC/WAIS* ($N = 96$, 70%), *Rorschach* ($N = 71$, 52%), *TAT* ($N = 46$, 34%), projective drawings ($N = 40$, 29%), and *MCMI* ($N = 25$, 18%). The majority of respondents indicated that they used consent forms in practice ($N = 133$, 63%).

EVTs and Other Professional Issues Survey Results

Means, standard deviations, and medians for each 10-point question concerning professional issues are provided in Table 1.

Findings suggested that ABPPs viewed the development of EVT's as positive but generally did not use them in their practices (see questions 1 and 2, Table 1). ABPPs did not universally support the use of treatment manuals or outcome assessment measures in clinical practice (see questions 3 and

Table 2
Most Frequent Reasons for Responses Given on 10-point Questions

	Generally Negative (N)*	Generally Positive (N)*	Total N
The development of EVTs			
Limits creativity of treatment	47	7	54
Using EVTs gives order, efficacy, and guidance to treatment	2	51	53
Routine use of EVTs in practice			
Prefer to use own methods specifically designed to suit individual needs	37	7	44
Use combination of EVTs with other treatments	12	19	31
Routine use of objective outcome assessment measures in practice			
Quality of instruments are too lengthy and often unnecessary	42	7	49
Occasionally; best way to measure change	13	17	30
Feelings about the use of treatment manuals in practice			
Individual differences are not taken into account	44	5	49
Help guide and structure treatment for some individuals	6	23	29
Routine use of structured interviews in practice			
Measures are unnecessary and unhelpful	44	51	45
Use with specific groups	11	12	23

* Responses were made on a 10-point scale where 1 = strongly negative or never and 10 = strongly positive or always. Scores of 5 and below were considered generally negative and scores of 5.5 and above were considered generally positive.

4, Table 1). The majority of respondents did not routinely use structured interviews (see question 5, Table 1).

Reasons for responses on the 10-point questions were coded and tallied. The most frequent responses for each of the questions are listed in Table 2. The list is separated by those who reported being generally negative (i.e., scores of 5 and below) or positive (i.e., scores of 5.5 and above) regarding each item.

Many respondents indicated that EVTs limit psychotherapists' creativity, while others felt that EVTs give structure and guidance to treatment. Some respondents also stressed that EVTs were often used in combination with other treatments or not used at all. While some respondents felt that the use of objective outcome assessment measures was too time consuming and unnecessary, a small number felt that such measures were the best way to measure the influence of treatment. Many respondents lamented that treatment manuals do not take individual differences into account, but noted that they provide needed structure for some clinicians. The most frequent response given for why structured interviews are not routinely used was that structured interviews are unnecessary and unhelpful. However, other respondents use them for specific groups. Finally, ABPPs reported that more clinical experience as well as business training is needed in graduate training.

Pearson correlation coefficients were calculated between the 10-point questions and respondents reported percentage of time spent in psychotherapy, testing and diagnostics, direct patient service, teaching, research, and administration. Significant correlations at the .05 level are summarized as follows. The more time ABPPs spent providing psychotherapy the less likely they were to use ESTs in practice ($r = -.40$), while those ABPPs who spent more time conducting research were more likely to use ESTs ($r = .29$) and objective outcome assessments ($r = .32$).

Discussion

The most important finding from this survey is that ABPPs view the development of empirically supported treatments as a positive trend, but they do not routinely use them in actual clinical practice. Moreover, support for ESTs was associated with the amount of time spent in research activities, further indicating that researchers are generally more enthusiastic about ESTs than clinicians. It appears that practitioners are cautious about allowing research findings to govern their practices. Several reasons for clinicians' discomfort in implementing ESTs were discussed earlier; however, two limitations that are contributing to the observed discrepancy between EST support and use have plausible solutions.

First, practitioners' concern that ESTs may only be valid in controlled research settings can be ameliorated through an increase in clinical effectiveness research; effectiveness research examines the ability to apply efficacious interventions (established in controlled settings) in actual clinical settings. Indeed, the Task Force has acknowledged this need (Chambless et al., 1998), and publications of effectiveness research are beginning to appear in the treatment outcome literature (e.g., Shadish, Navarro, Crits-Christoph, & Jorm, 1997; Wade, Treat, & Stuart, 1998). In order for clinicians to embrace ESTs, this practical level of empirical support may be necessary.

Second, clinicians' hesitancy to implement ESTs because of the overrepresentation of behavioral and cognitive-behavioral treatments may relent as treatments founded on other theoretical models garner EST status. Since the majority of psychotherapists practice from an eclectic orientation (Jensen, Bergin, & Greaves, 1990; Norcross et al., 1997), it is understandable that many practitioners find the current list of ESTs inadequate. The degree to which practitioners from non-behavioral orientations will embrace the development of ESTs and encourage attempts to validate non-behavioral treatment approaches remains to be seen. Nonetheless, a more balanced list will likely increase the utilization rates of ESTs simply because long practiced treatment approaches may eventually gain the research necessary for EST status.

Another reason that has been proposed for the low utilization rate of ESTs is that practitioners receive insufficient training in these therapies (Montgomery & Ayllon, 1995; Task Force, 1995). Many ABPPs in this study reported that they do not use ESTs because they prefer more individualized treatments. However, if training in ESTs becomes a mandatory element of practitioner training, as some scholars think (Garfield, 1998), this preference for individualized treatments may subside. Regardless, as the list of ESTs expands and encompasses therapies requiring substantial amounts of training and resources [e.g., Linehan's (1991) dialectic behavior therapy for borderline personality disorder and Shapiro's (1997) EMDR for PTSD] no graduate or postgraduate training program will be able to adequately teach even a minority of existing ESTs. It has been suggested that the proliferation of ESTs may sway many training programs and facilities to cover only the most prevalent disorders (e.g., depression and anxiety) or force all practitioners to become specialists treating a few specific disorders (Garfield, 1998). Thus, the days of the general psychotherapy practice may be numbered.

The continuing demand for empirically supported and cost efficient treatments has fueled the need for documenting and recording both diagnostic impressions and treatment out-

come (Eisen & Dickey, 1996; Pheiffer & Shott, 1996; Plante, Couchman, & Hoffman, 1998; Wells, et al 1996). There appears to be a wide variety of opinions among ABPPs regarding the use of outcome assessment measures and structured interviews. Overall, our results suggest that the majority of clinical ABPPs do not use either structured interviews or outcome assessment measures in their practices. While a minority of ABPPs communicated that outcome measures are the best way to evaluate the effectiveness of therapy, others viewed them as time consuming or unnecessary. Thus, although ABPPs may agree with the mission and principles behind outcome assessment and may evaluate outcome informally through interview methods, they have been slow to routinely incorporate formalized outcome assessment into their practices.

Russ Newman (see Nickelson 1995), executive director of the Practice Directorate at the American Psychological Association, has expressed similar opinions. He has reinforced the need for such measures yet he cautions the degree of rigidity to which these measures should be utilized and interpreted. Newman suggests that for outcome measures to be used in therapy without eliminating the creative ability that therapists value, "[W]e must blend our profession's expertise in research and outcome measurement with practical reality in much the same way that we must blend our treatment with the practical realities of the marketplace" (p. 369). Thus, it is reasonable to suggest that rigidity in outcome assessment should be avoided.

A great deal of attention has been directed to the need for better lines of communication between researchers and practitioners (Beutler, et al, 1996; Borkovec & Miranda, 1996; Goldfried & Wolfe, 1996; Strupp, 1997). Debates surrounding ESTs are in part a manifestation of the divergence in beliefs between these two groups. One possible way of decreasing the tension between researchers and practitioners is to develop a task force with equal numbers of researchers and practitioners. A more representative task force would be able to address issues such as the different "languages" used in research and in practice as well as the different goals and constraints. Such a task force may be able to determine how practitioners can be encouraged to increase their input concerning the design, writing, and implementation of psychotherapy research. Moreover, the task force could work on discovering favorable ways of transitioning ESTs from research to actual practice settings.

If such a task force or other related measures are not taken to alleviate the tension between researchers and practitioners, the profession runs the risk of research results having minimal implications for clinical practice and practitioners offering minimal feedback to researchers on what results and informa-

tion is beneficial for clinical practice. Perhaps the professional status of ABPPs might allow them greater potential to encourage changes in the collaboration between these two divisions of psychologists.

The increased popularity of ESTs not only impacts the work of researchers and clinicians; ESTs will influence what is taught in graduate training programs. Furthermore, a large quantity of continued education credits for practitioners who are unfamiliar with ESTs are likely to become available over time. Individuals who value the creative freedom of psychotherapy are likely to view ESTs more as a detriment rather than an enhancement to treatment. While others, who view psychotherapy more as a science than an art are likely to view ESTs as a necessity for current state-of-the-art practice. An appreciation of psychology as both an art and a science is perhaps the best approach to take when questioning the emergence of ESTs in psychotherapy.

In conclusion, the differing support for ESTs, structured interviews, and objective outcome assessments between practitioners and researchers is of little surprise. It is interesting that clinical ABPPs feel that the development of ESTs is a good trend even though they are not routinely used in practice. Because our findings may be associated with the unique composition of the ABPPs surveyed, our findings must be viewed with caution. These diplomates are generally Caucasian men in their 50s and 60s who graduated from APA-accredited programs. Since the majority of these diplomates primarily participate in independent practice, the responses given may exhibit their reluctance towards changes that threaten their career choice. The current study was cross-sectional and thus did not examine the longitudinal changes in ABPP views regarding ESTs and other practice issues. The sizable number of correlations conducted in this exploratory study increased the changes of Type I errors and thus these results need to be considered with caution. Furthermore, ABPPs are only one of several psychotherapy constituencies. It is also noteworthy to consider that since almost half of the questionnaires were returned those who returned the questionnaires might be more likely to possess extreme opinions. The increased feminization and proliferation of freestanding professional school graduates in clinical psychology is likely to change the composition of ABPPs in future years. Thus, future studies may reveal very different views based on the increase in diversity of ABPPs. Future studies should explore the opinions and attitudes of a multitude of other psychotherapists, as well as ABPPs in other subspecialties (e.g., forensics, health psychology, counseling, neuropsychology) in order to elucidate therapists' opinions on these and other contemporary psychotherapy practice issues. ■

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Division 12's voice on APA Council is critical in the new millennium. The important and varied activities of the Society (e.g., advancing empirically supported assessment and treatment, encouraging international participation and advancing multicultural collaboration, sponsoring Post-Doctoral Institutes and workshops, and publishing our newsletter and flagship journal, *Clinical Psychology: Science and Practice*) must be continued. Moreover, the high esteem with which the Society is held within the governance of APA must be maintained. The society urges those concerned with the science and practice of clinical psychology to allocate votes to Division 12. Our participation at the APA Council table is vital!

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W. Edward Craighead, PhD, President-elect

Call for Papers Clinical Psychology: Science and Practice

The Journal is interested in receiving scholarly papers on topics within Clinical Psychology. Papers are welcome in any content area relevant to theory, research, and practice. The Journal is devoted to review and discussion papers and hence is not a primary outlet for empirical research.

For consideration for publication, please submit four (4) copies of the manuscript (APA Publication format) to: David H. Barlow, PhD, Editor, *Clinical Psychology: Science and Practice*, Center for Anxiety & Related Disorders, Boston University, 648 Beacon Street, 6th. Floor, Boston, MA 02215-2002.

Authors with queries about the suitability of a given topic or focus should direct correspondence to the above address.

Free Book Offer for Members of D-12

Oxford University Press will offer \$50 worth of free books to any D-12 member who gets their library to subscribe to *Clinical Psychology: Science and Practice*, the official journal of the Society of Clinical Psychology. The journal has quickly become one of the most frequently and widely cited journals in the field of clinical psychology.

It frequently takes a "personal" nudge to get libraries to subscribe as they receive many such offers. If you are successful in doing so, Oxford University Press will provide you a \$50 coupon for purchase of books from their wide selection of interesting and timely offerings. Library subscriptions to the journal, of course, help defray the cost of the journal to you and our other members.

For additional information contact Joy Cox at Oxford University Press (ph: 919-677-0977 x5279 or e-mail: jmc@oup-usa.org).

Join a Division 12 Section

Division 12 has several sections that reflect the wide range of interests in the Division. These are separate memberships, and dues vary. If interested, contact the Division 12 Central Office.

Section II: Clinical Geropsychology

Section III: Society for a Science of Clinical Psychology

Section IV: Clinical Psychology of Women

Section VI: Clinical Psychology of Ethnic Minorities

Section VII: Emergencies and Crises

Look for an announcement in an upcoming issue about the formation of a new section as the Association of Medical School Psychologists begins its formal associations with Division 12.

TherapyWorks Ad Here

Division 12 Net

*This is an e-mail net available to Division 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]*

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

Position Openings

ASSISTANT PROFESSOR, CHILD DIVISION (Child Clinical or Applied Developmental). The University of Miami Department of Psychology, fall 2000. Special focus on candidates with interest in community-based approaches to children's issues, especially those of minorities. Requires Ph.D. in Psychology and research record. More information at <http://www.psy.miami.edu>. Applications will be reviewed until the position is filled. Submit CV, reprints/preprints, statement of research and teaching interests and 4 letters of reference to: Child Faculty Search Committee, Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL 33124. The University of Miami is an Affirmative Action/Equal Opportunity Employer.

HEALTH PSYCHOLOGY/PSYCO-ONCOLOGY. The University of Miami Department of Psychology, in collaboration with the Sylvester Comprehensive Cancer Center, invites applications for a med-level tenure-track faculty position with a projected start date of January or August 2000. We are especially interested in a person with an interest in community-based approaches to cancer control, who has a track record of securing extramural funding, and who has interests in collaborating with an interdisciplinary team of behavioral and biomedical researchers. The position will have a primary appointment in the Department of Psychology, Health Psychology Division, as well as an appointment at the Sylvester Comprehensive Cancer Center. Requirements include a Ph.D. in Psychology and a track record in research, publication, and external research funding. Additional information is available at <http://www.psy.miami.edu>. Applications will be reviewed until the position is filled. All applicants should submit a

curriculum vita, representative reprints or preprints, a statement of current research and teaching interests and future directions, and four letters of reference to: Health Faculty Search Committee, Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL 33124. Minorities and women are encouraged to apply. The University of Miami is an Affirmative Action/Equal Opportunity Employer.

ASSISTANT PROFESSOR, ADULT CLINICAL PSYCHOLOGY. University of Miami, fall 2000. Especial interest in candidates with background in anxiety disorders and/or personality-social psych. Requires Ph.D. in Clinical Psychology and research record. More information at <http://www.psy.miami.edu>. Applications will be reviewed until the position is filled. Submit CV, reprints/preprints, statement of research and teaching interests, and 4 letters of reference to: Adult Faculty Search Committee, Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL. The University of Miami is an Affirmative Action/Equal Opportunity Employer.

THE PSYCHOLOGY DEPARTMENT AT THE UNIVERSITY OF MISSOURI-COLUMBIA (MU) is recruiting for five tenure-track positions (rank open) in the area of ADDICTIVE BEHAVIORS: (1) a treatment-outcomes researcher, (2) a cognitive or affective neuroscientist with expertise in the functional imaging of drug effects and/or vulnerability to addiction, (3) a cognitive/social/affective researcher with expertise in decision-making, motivation, and personality issues surrounding substance use and dependence, (4) a quantitative psychologist with substantive interests in the addictions, and (5) a developmental psychologist with interests in the

precursors of addiction or in developmental aspects of addiction. Demonstrated scholarly excellence and potential for securing extramural funding are required. Send vita, up to five representative reprints, a cover letter describing your research program and teaching interests, and three letters of reference to: Chair, Addictions Search Committee, Psychology Department, 210 McAlester Hall, University of Missouri, Columbia, MO 65211. Send inquiries to Ken Sher, 573-882-4279, SherK@missouri.edu.

POSTDOCTORAL PSYCHOLOGY FELLOWSHIPS IN PTSD. Two one-year fellowships available through the multidisciplinary PTSD Training Program at the National Center for PTSD, Pacific Islands Division of Honolulu Veterans Affairs Medical and Regional Office Center. Training includes working with veterans in outpatient and inpatient settings, weekly didactics in PTSD, and opportunities to be involved with PTSD research. Qualifications include: U.S. citizenship, earned doctorate in psychology from an APA-approved program by start date, and completed APA-approved internship. Appointment begins September 1, 2000. Stipend for the current year (40 hours per week for the full year) is \$37,000 before taxes, including ten paid Federal holidays, 13 days of annual leave, and 13 days of sick leave if needed. Request application packet from: Dr. Julia Whealin, Training Program Leader, Department of Veterans Affairs, NC-PTSD, Pacific Islands Division, 1132 Bishop Street, Suite 307, Honolulu, HI, 96813. E-mail: Julia.Whealin@med.va.gov. Phone: (808) 566-1546. Fax: (808) 566-1885. Completed applications must be received by February 25, 2000. The VA is an Affirmative Action/Equal Opportunity Employer.

PROJECT DIRECTOR. The Research & Development Department at PAR is continuing to expand to meet excellent customer response to a rapidly growing product base. This expansion includes the addition of a Project Director position. The successful applicant will be a dynamic, entrepreneurial Psychologist and will have the following qualifications: A PhD degree in clinical psychology, neuropsychology, I/O psychology, or a closely related field; a minimum of 2 years post-doctorate work experience; an excellent work ethic; experience and interest in applied test development; very strong writing and editing skills; and meticulous attention to detail.

PAR is a major psychological test developer/publisher located in the Tampa,

Florida vicinity. The 20-year-old company has experienced consistent growth since its inception and is seeking additional expansion of existing areas, as well as establishing new test development markets.

Specifically, Project Directors review submitted proposals and work with authors of accepted projects to ensure their reliability, validity, quality, and utility. Project Directors coordinate a multidisciplinary development team, guide product design, develop assessment items and forms in accordance with APA and PAR standards, direct ongoing test development projects, prepare and edit test manuals for publication, and provide input on software design and testing. Established skills in tests and mea-

surement, statistics, writing, and editing are a necessity. Experience in project management is a plus.

PAR offers a highly competitive salary, excellent benefits, generous relocation package, and an attractive working/residential setting in the Tampa Bay metropolitan area. To apply, please send or fax your vita to:

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Director of Product Development
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For more information, call (813) 968-3003

Instructions for Placing Ads

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:

January 15	(March 1 edition)
May 15	(July 1 edition)
September 15	(November 1 edition)
November 15	(January 1 edition)

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, Editorial Assistant, wandakapaun@att.net, North Dakota State University, Department of Psychology, Minard Hall 115, Fargo, ND 58105-5075.

Instructions to Authors

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

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

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