The Clinical Psychologist

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Update and Future Plans

When elected President, I promised to keep members informed of the activities of the Society. We have just completed a Board meeting in Washington, and this column primarily reports on that meeting. The meeting comprised three phases: reports from each of the Directorates of APA; future planning for the Society; and, the standard Society business.

The meetings with the APA Directorates were enormously profitable. In addition to being updated by the individuals who are at the core of the action of APA, our Board had a chance for discussion and input regarding APA initiatives. The atmosphere of the meetings was most positive and constructive, and should lead to a more successful collaboration between the Society and the APA. We were encouraged to appoint members of the Society to positions in which they will play significant roles in the activities of APA and affiliated groups.

The Board spent much of the Saturday meetings developing a future plan for the Society. These planning sessions, in conjunction with the Directorates reports, allow the Society to become more proactive. A tentative plan was developed and a final plan will be adopted at the fall Board meeting, which occurs in early October. I am presenting several key aspects of the plan as developed, and we seek your input for additions and modifications of these ideas.

The first set of suggestions center on the organization itself. For example, the Board would like to add new sections. Although two of our most active and energetic sections recently "swarmed" to form Divisions 53 and 54, we have recently added two new sections: 7—Emergencies and Crises; and, 8—Association of Medical School Psychologists. Sections provide opportunities for professional relationships of members, diversity of viewpoints for Board consideration, and variety and quality to our APA program so the Board feels this is an important way to grow the Society. Other organizational plans include moving toward electronic publications and increasing student involvement (e.g., through a

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President's Column

"Sections provide opportunities for professional relationships of members, diversity of viewpoints for Board consideration, and variety and quality to our APA program"

speaker's bureau, and a student conference) as student members of the Society.

A second major area of planning involves relationships with other professional groups. The Board would like very much to increase the Society's involvement with CAPP, and has been asked to appoint a liaison to their meetings. Although the Society may not see "eye-to-eye" with all the activities of the Practice Directorate, this office is successfully engaged in numerous efforts that affect our members. Therefore, we plan on a more active future involvement with the Practice Directorate, especially through the Administrative Director for Professional Practice and divisional liaison, Randy Phelps. We will provide input to the recently completed report of the Commission on Education and Training Leading to Licensure in Psychology. This Commission has met once, and addressed a number of issues relevant to education and training as well as post-doctoral supervision, and a subsequent meeting is planned. The Society president will continue to attend the State Leadership Conference, and the president-elect will attend the Divisional Leadership Meetings. In addition, the Society will take initiatives in recommending members for various governmental task forces and scientific review boards of funding agencies.

The Society will undertake several new initiatives on its own. These include developing better models for continuing education (CE). The Board and members in communication with us have become increasingly concerned about the long-term impact and quality of CE. Other plans include the development of a speaker's bureau and consideration of developing "distance technology".

The final area of future-planning concerns "membership". As noted in an earlier report, I have appointed a Task Force to consider methods of increasing membership. This Task Force will report at the October Board meeting. The Board, in particular, wishes to take steps to increase the membership and activities of professionals between 1 and 10 years post-training. Most of our loss in membership over the past six years has been due to retirements, so it is important that this Society participate in the professional development of newer professional psychologists including those in academic communities as well as practice communities.

On Sunday morning, much of the "standard" business time was concerned with financial matters. Decreasing revenues (primarily because of fewer members) and less than expected income from our major journal have forced us to address cost-cutting methods in order to have a balanced budget. Because of the decreases in membership for each of the past three years, it has become increasingly difficult to conduct the business of the Society and maintain a balanced budget. We have had a net loss of 149 members in 1998, 185 in 1999, and the best estimate for 2000 remains at about 250. Within the general context of professional society membership, and the loss of two sections, these figures are not too bad. For the past few years, we have managed to cut costs while maintaining most of our activities, and thereby have paid the bills. Over the past decade, we have developed adequate reserves. However, the decreases in numbers of members underscore the importance of the Task Force on membership. As we develop plans to participate in new important activities, it will be necessary to reevaluate some of the activities in which the Society has been involved.

In addition to business matters, the Board heard enthusiastic reports regarding the program to be offered at APA; both the division and the sections have arranged what should be a stimulating and educational program, parts of which will be of interest to different segments of our varied membership. The sections are alive and well, with each engaged in activities that address the professional concerns of their members. The two new sections have provided a new level of energy to the section activities, and the previous sections have been enthused by these activities. Sections conduct much of the more specific work for clinical psychology. It would be a good idea for you to look at the list of sections because they provide a meaningful "home" for many members as well as serve as a port of entry to Society activities.

I look forward to seeing many of you at the APA meetings in Washington. As noted, we have a varied program (thanks to Cindy Meston and section program chairs), a distinguished list of Awardees, and an outstanding CE program (thanks to Emily Richardson and Mark Whisman). The Society will maintain a suite in which divisional and section activities can be scheduled; watch for announcements at the meetings. We are planning on a great and enjoyable social hour!

The Board invites your input into the "future plan" of the Society. We specifically delayed adopting this future plan to allow members to have input into the final plan. Thus, I hope you will take seriously this request, and send along your ideas. You may email me at ecraighead@psych.colorado.edu or fax any suggestions to the divisional office at (303) 652-2723. I close by thanking Lynn Peterson, our Administrative Officer, for the wonderful job she does. She completes the day-to-day operations of the Society with an almost unbelievable degree of kindness, efficiency, and effectiveness. I am sure that anyone who has contact with our central office must share this viewpoint. Finally, thanks to all of you for your continued involvement in the Society. ∎

Evidence-Based Practices in Inpatient and Residential Facilities

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I am pleased to receive this recognition from my colleagues in the APA Society of Clinical Psychology, especially from those who embody the "bolder Boulder model" (see Davison, 1998). Division 12 has been my organizational home since I was a graduate student. As my publications have been identified among those forming the foundation for the evidenced-based practices movement, it is gratifying to see this trend emphasized in convention presentations by such luminaries as Dave Barlow, Alan Kazdin, Peter Nathan, Tom Ollendick, Jackie Persons, and Lynn Rehm as well as in many symposia. I am also gratified to see an active APA task force on the seriously mentally ill, currently chaired by my friend, Dale Johnson, and to see this convention's emphasis on persons with severe and chronic problems. People with psychoses and the mental health systems that serve them have been a focus of my clinical research for more than 30 years.

Although my conceptual work and early research on anxiety-related problems were more individual endeavors (see Paul, in press), this later and continuing pursuit has been a collaborative effort with a host of co-workers who share this honor with me (see Acknowledgements). Most of this paper is devoted to the products of our clinical efficacy/effectiveness/efficiency research on behalf of individuals whose problems are so severe that they require inpatient services. This effort has produced two sets of technology–a comprehensive psychosocial treatment program that works and a computerized assessment/information system to support ongoing administrative, regulatory, and clinical decision-making. I first will make a few comments about the status and conceptual underpinnings of the "evidence-based" movement. I then will note the technologies that have resulted from the research and development efforts of our group. These technologies can improve the quality and effectiveness of evidence-based practices for each of us who work in residential settings and, consequently, improve the lives of the clients whom we serve.

The "Evidence-Based" Movement

The movement to identify and promote evidence-based practices is widespread, not only in clinical and additional branches of psychology but in other professions and disciplines as well. Task forces and regulatory bodies concerned with both physical and mental health services have emphasized the need for assessment and treatment procedures to be based on scientific evidence (see Paul, Stuve, & Cross, 1997). The evidence-based movement in physical health care actually preceded extensive efforts in mental health (e.g., see Gambrill, 1999; Raskin & Maklan, 1991).

While lagging behind our physical health colleagues, the evidence-based movement in mental health also has become pervasive. The past decade shows a remarkable amount of effort and commentary on initiatives to identify and promulgate empirically supported treatments, science-based practice and policy guidelines, or more generally, evidence-based mental health practices (see Hayes, Follette, Dawes, & Grady, 1995; Ollendick, 1999a, 1999b; Paul, Stuve, & Cross, 1997). Recently, a journal of abstracts for *Evidence-Based Mental Health* was introduced by the publishers of *Evidence-Based Medicine* (Geddes, Reynolds, Striener, Szatmari, & Wilczynski, 1999). Even the last reorganization of the National Institute of Mental Health (NIMH) was partly to support aspects of the evidence-based movement (see Norquist, Lebowitz, & Hyman, 1999).

I endorse the past decade's extensive efforts to identify empirically supported treatment procedures as well as the fledgling work on empirically supported assessment. Science-based practice and policy guidelines and evidence-based practices should be good for the profession and good for the public. However, the movement is not without controversy and potential pitfalls. Tom Ollendick's (1999a, 1999b) recent editorials note that special issues and/or sections of all the major clinical journals have been devoted to commentaries on controversial

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aspects of the movement. These commentaries have focused on the nature of the criteria used to identify and sanction clinical procedures, the generality of "manualized treatments," the utility of "efficacy versus effectiveness" research, and "allegiance effects" on outcomes of scientific studies.

Unfortunately, the terms describing these controversial aspects of the movement, even "evidence-based" and "empirically supported," often are used as buzzwords with inconsistent meaning–a frequent occurrence when labels or catch phrases replace careful descriptions. This has allowed proliferation of so-called "evidence-based" guidelines that are little more than consensus codification of subjective judgements or of research that is severely restricted by political or guild interests. The following brief summary of conceptual contributions to the historical underpinnings of the movement should help orient my further comments on its controversial aspects.

"The ultimate clinical question" is likely the best known part of my conceptual work that has contributed to the foundation of the evidence-based practices movement (Hayes, 1991). I proposed that the primary goal of clinical work could be reduced to empirically derived answers to the question(s): "What treatment, by whom, is most effective for this individual, with that specific problem, under which set of circumstances, and how does it come about?" (Paul, 1969, p. 44). That question can, of course, never be entirely answered. It was, and still is, intended to guide investigators and practitioners in the identification of influencing factors that are relevant to both the internal and external validity of clinical research. It is as pertinent today as it was 30 years ago.

I originally formulated the question to summarize the domains and classes of variables needing description, measurement, or control for firm evidence to be obtained and accumulated across psychotherapy studies (Paul, 1967). The same domains and classes of variables are important for extracting evidence from the scientific literature to apply in practice (see Paul, 1974). The later extension of the question and conceptual scheme to explicitly include psychotropic drugs and other biomedical treatments, inpatient psychosocial programs, and entire facilities and systems of service has also proven useful over the years (see Paul, 1969, 1986a; Paul & Lentz, 1977, 2000; Paul, Mariotto, & Redfield, 1986a; Paul & Menditto, 1992).

Here I can provide only the briefest listing of the domains and classes of variables to give a flavor of the conceptual structure for contrast with other approaches. In all cases, information is relevant from three domains: *clients* (or patients or residents), *therapists* (or clinical staff or change agents) and *time*. Three classes of variables are significant in both the client and therapist domains. In the client domain, *problem behavior* is the most important class. It includes assets as well as specific change-worthy deficits and excesses in clients' motoric, ideational, and emotional functioning that are the focus of treatment. The other two classes of variables in the client domain are clients' *relatively stable personal-social characteristics* (e.g., demographics and psychiatric diagnoses) and their *physical-social life environments*. These latter classes are important as potential moderators and setting events.

Parallel classes of variables in the therapist domain are *therapeutic techniques* (specific psychosocial procedures and biomedical treatments intended to change client's problem behavior), therapists' *relatively stable personal-social characteristics*, and the *physical-social treatment environment*. As with the client domain, the latter two classes of variables in the therapist domain are important as potential moderators of treatment–possible sources of interaction between the application of explicit therapeutic techniques to specific motoric, ideational, or emotional problems of clients. The time domain serves to further clarify the "set of circumstances" for assessment and interpretation of relations among variables in other domains and classes.

Identification of the domains and classes of variables that are relevant to sound intervention research and practice naturally led to examination of the best ways to measure them. Our conceptual work on evidence-based assessment is less familiar to most professionals as it has emphasized practices in residential and inpatient settings. Broader implications for assessment and clinical decision-making practices emerged over a 10-year period as Marco Mariotto, Joel Redfield, Mark Licht, Chris Power and I undertook that analysis (see Paul, 1986c, Preface, pp. *xv-xvii*). Our approach ultimately involved a fundamental reanalysis of the entire clinical assessment/decision-making enterprise. This included identification of the full range

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of decision problems and the information needed to support rational action not only by clinicians, but by mental health administrators, regulators, and researchers as well.

Although hundreds of decisions are required every day, our analyses identified a limited set of decision problems that account for the majority of them in clinical operations (see Paul et al., 1986a). These include placement and disposition decisions for clients and staff, client problem identification and

description, staff development and utilization, concurrent monitoring of operations, absolute and comparative program evaluations, legal and ethical regulation and documentation, and specific research questions. The facts from each of the previously identified domains and classes of variables that were needed to support decisions in every category were then identified. The logic of decision theory and generalizability theory was used to develop decision rules for determining the potential value of any information gathering or assessment procedure for a particular purpose. This resulted in the "4-Rs" of assessment procedure utility to guide development and selection–replicabilty, representativeness, relevance, and relative cost.

Careful programmatic research and clinical implementation of findings guided by the conceptual analyses just described can go far in resolving many of the concerns about the more controversial aspects of the evidence-based practice movement. For example, so-called "allegiance effects," in which investigator biases are thought to differentially influence outcomes in treatment studies, can be controlled and evaluated within experimental designs that properly attend to the relevant domains and classes of variables. My early attempts to demonstrate the effectiveness of my favored psychodynamic approaches, in fact, resulted in clear "anti-allegiance effects," which were influential in shifting my own theoretical orientation and clinical practice (see Paul, in press).

Similarly, the "efficacy versus effectiveness" distinction loses meaning when experimental designs properly specify the aspect of the ultimate question being addressed and account for the relevant domains and classes of variables in "real-life" clinical operations. In this way, studies of psychosocial interventions can provide both internal and external validity of findings–not one or the other (see Paul, Stuve, & Cross, 1997). I am pleased to offer the design and procedures presented in the Paul and Lentz (1977, 2000) monograph as a practical model for the kind and scope of clinical research that is needed to establish the comparative effectiveness of psychosocial and biomedical treatments for inpatient and residential facilities. As noted later, the assessment procedures developed on the basis of the forgoing analysis provide the means to monitor the integrity and generalizability of implementations in ongoing service systems for treatments that were originally found effective in highly controlled, small-sample studies.

The potential pitfalls of "manualized treatment" should be lessened by clear specification of the variables in both the client and therapist domains, including the level at which intervention procedures are operationalized for different purposes.

Our colleagues in applied behavior analysis are good models in this regard (e.g., see Baer, in press). In our inpatient work, manuals were developed to operationally define two comprehensive unitwide treatment programs (see Paul & Lentz, 1977, 2000). Because of the detailed specification and assessment of variables, these overall manuals provide definitions of structure and therapeutic procedures at a level allowing staff training in the artful application of established principles and techniques, without being oversimplified "cookbooks." In contrast, detailed procedural memos within each program are intended to be "cookbooks" for the application of specific therapeutic techniques to specific problem behaviors in specific settings–contingent on specific times and/or responses of clients.

A major part of the controversy surrounding treatment manuals is based on a failure to specify and assess the problem focus at an appropriate level. Jerry Davison (1998), for example, points out that marrying manuals to DSM diagnostic categories is hard to reconcile with the functional analyses needed for science-based case formulation. Our own analysis–*What Signs Versus Samples Mean for Content: The Place of Traits and Diagnostic Categories*–shows how the lack of specificity of traditional psychiatric diagnostic categories fails to support evidence-based interventions (Paul, Mariotto, & Redfield, 1986b, pp. 35-39). On a related note, as part of the International Classification of Functioning and Disability, the World Health Organization (WHO) is undertaking one of the more promising developments for official codification of functioning rather than putative disease categories for behavior problems (see http://www.who.int/icidh/).

The criteria used by professional groups to identify and sanction clinical procedures is the most contentious aspect of the evidence-based movement and the place where I see the greatest problems (see Ollendick, 1999b; Paul, in press). Rather than undertaking a construct-validation approach, which fits the task, committees often develop rigid categorical checklists to ease their work. The limitation of the domain of evidence to publications in peer-reviewed journals, done by task forces in both psychology and psychiatry, automatically excludes long-term studies of psychosocial interventions that are published in books and monographs. It seems ludicrous to later include such studies on the basis of brief summaries or follow-ups that are published in journals. The lack of utility of guidelines that focus on treatment for specific DSM categories was noted earlier as was the misrepresentation of consensus subjective judgements as scientific evidence. Multiple converging science-based rules of evidence should be employed in these undertakings.

Few would disagree with the premise that assessment and treatment activities should be based on the best available evidence from systematic research, artfully integrated in a careful case formulation and applied with clinical expertise. Application of intervention techniques as ongoing, hypothesis testing procedures, with continual evaluation of their impact, should separate the science-based practitioner from others in the mental health field. To me, that is the essence of evidence-based practice (see Paul, 1974). Of course, the ultimate effectiveness of the overall enterprise should also be regularly evaluated, but this is quite different than requiring a pretested "off-the-shelf" intervention for every problem. In a discussion of "The McFall Manifesto" (see McFall, 2000) on the Society for a Science of Clinical Psychology listserv (Section 3, Division 12, APA), Lee Sechrest put it the following way:

[Many seem] to think that evidence-based practice means that practitioners must sit around waiting for "a study" to be done on any and every problem they face . . . In a true science-based practice . . . when the right studies do not exist, the science-based practitioner is not at sea . . . The science-based practitioner is obliged to be familiar with and to apply, not necessarily uncreatively, what is known and, beyond the limits of what is known, to apply the best theory that is supported by the science of the field. (Lee Sechrest, personal communication, SSCPNet, 5/7/99).

Given the conceptual orientation underlying our programmatic research and development efforts, I will try to briefly familiarize the reader with the major sets of resulting technologies.

A Comprehensive Treatment Program That Works

The first of two sets of technologies that resulted from the efforts of our clinical-research group is a comprehensive treatment program that works–the *Social-Learning Program* (SLP) with integrated declining-contact aftercare. Paul Stuve, Tony Menditto, and I recently synopsized the nature of the SLP and the evidence supporting its effectiveness (Paul, Stuve, & Menditto, 1997).

The SLP is a comprehensive unitwide residential program that was explicitly designed to rehabilitate the most severely and persistently disabled adults who are chronic residents of mental institutions. Individualized treatment goals are established for each client, or resident, by identifying the changes in functioning that have been empirically determined to be those needed to "get out and stay out" of mental hospitals. Ongoing objective assessments are critical for identifying and monitoring unique areas for change in concrete terms for each client as well as for monitoring the precision and consistency of staff-client interactions and program effectiveness. These

assessments include a Clinical Frequencies Recording System (CFRS) as well as the TSBC/SRIC System, which is described later. The CFRS is used by clinical staff in the course of ongoing activities to record low-frequency critical events (e.g., assaults), client's setting-dependent behavior (e.g., attendance), and subsequent staff response (e.g., prompts).

In contrast to the usual organization of psychiatric units, which are modeled after medical hospitals for the physically ill, SLPs require a decentralized, competency-based unitwide organization with permanent assignment of clinical and auxiliary staff. Through restructuring staff responsibilities and thorough training, every level of clinical staff is empowered to use objective information and apply consistent principles to guide their actions as "change agents." Aide-level personnel, with less than RN or BA degrees, constitute about 80% of SLP clinical staff. All staff need to be organized and trained by at least one knowledgeable professional, but the numbers required for both inpatient and aftercare operations are no greater than those of most other inpatient units. Such efficient staff organization and training, combined with ongoing assessments, usually allow conduct of SLPs without increases in typical operating costs.

Individualized reeducation, training, and normalization of functioning for each client are accomplished by applying an overriding set of response-contingent psychosocial procedures. These procedures are followed by all staff with all clients, using therapeutic interactions that are derived from consistent theoretical principles. Individual, group, and unitwide modalities are based on social-learning theory, including instrumental, associative, and cognitive-behavioral procedures. "Illness" concepts are actively downplayed in favor of a biopsychosocial explanatory model that emphasizes responsibility and problem solving by "clients," or "residents," rather than "patients." Psychotropic drugs are regularly titrated to the lowest effective dosage, with formal studies showing complete withdrawal for all but 11% of clients in one implementation.

The SLP uses a tiered token-economy structure to schedule response-contingent social and material reinforcers for use by all staff with all clients. Procedures for increasing skills (e.g., modeling, shaping, cognitive training) and for reducing excesses (e.g., graduated exposure, response costs) are organized in a curriculum of functional periods, using ordinary daily activities as training settings as well as classes, meetings, and therapy groups. Psychotic and other maladaptive excesses are treated by consistent principles at all times by all staff as well as being the focus of specific therapy sessions conducted by senior clinical staff. Content focus varies with each client's needs, but it regularly incorporates generalization training and ongoing evaluation. The functional-period structure, with on-

going assessments, allows explicit experimentation on procedural components of SLPs to continually improve ongoing program effectiveness. It also allows incorporation and evaluation of new evidence-based practices from other sources.

> *The SLP's superior efficacy, effectiveness, and cost-efficiency are well established for chronically disabled clientele with excesses in psychotic and maladaptive behavior, deficits in adaptive functioning, or both.*

Clients are systematically helped to develop the proficiencies essential for successful community living through successive approximations to "normal" functioning. The SLP structure introduces delay of gratification and training for generalization to less structured environments and natural support systems as part of the program. Clients are weaned from tokens as they progress towards discharge. Family and friends are included in predischarge groups as well as declining-contact aftercare whenever possible to help bridge transitions to the outside community.

The SLP operational manuals and recommended procedures in the Paul and Lentz monograph (1977, 2000; Chapters 6, 8, & Appendixes) are based on years of work by hundreds of other field and laboratory researchers. The principles on which the program is based are sound and powerful. In fact, a system-level study of 22 treatment units found that unit-effectiveness was discriminable by the degree to which staff-client interactions were similar to those of an "ideal" SLP, even in the absence of explicit program structure (Menditto, Paul, Mariotto, Licht, & Cross, 2000).

The multiyear randomized comparison of competing programs, reported in the Paul and Lentz monograph (1977, 2000), is still the most thoroughly controlled and documented investigation of psychosocial treatment effectiveness yet published. The SLP treated more clients, produced greater improvement, and discharged a larger percentage than other programs with equated client functioning, staff, and resources. Paul and Menditto's (1992) review of the literature found the established effectiveness and promise of the SLP continued to receive empirical support from the reports of others. Since then, several publications from Tony Menditto and his coworkers at Fulton State Hospital have documented continuing effectiveness with a variety of important problems, including expansion of the SLP to forensic services (see Paul, Stuve, & Cross, 1997).

The SLP's superior efficacy, effectiveness, and cost-efficiency are well established for chronically disabled clientele with excesses in psychotic and maladaptive behavior, deficits in adaptive functioning, or both. It is also one of the two comprehensive programs that are the most promising for less extensively disabled, acutely admitted clients in short to intermediate-stay settings. Client attributes that have historically predicted outcomes of hospital treatment–overall functioning level, chronicity, and premorbid competency–often predict speed of response in SLPs, but not absolute effectiveness. A significant majority of treated clients has carried a diagnosis of "schizophrenia," but traditional DSM diagnoses have little predictive power for response to SLPs.

To summarize, the following highlights the current status of the evidence for a fully implemented Social-Learning Program with integrated declining-contact aftercare.

· 100% effective in improving functioning for the most severely disabled people with mentally ill diagnoses and lengthy hospital stays–their clear "treatment of choice."

· Highest rates of successful discharge (>90%).

· Lowest rates of recidivism or rehospitalization (<3%).

· Empowers clients through self-determination and competency training.

· Ensures the least-restrictive interventions for each individual.

· A promising approach for less severely disabled clientele with shorter hospital stays.

· Self-improving by ongoing discovery/incorporation of emergent evidence-based procedures.

· Applicable in public and private hospitals, mental health centers, and community facilities.

· Requires no greater numbers or levels of staff than are present in most existing operations.

· Cost-efficiency that is better than three times that of alternative approaches.

Those willing to invest the effort to introduce the organizational infrastructure, assessment procedures, and staff training to properly implement the SLP and aftercare, as operationalized in Paul and Lentz (1977, 2000), are nearly guaranteed more effective and cost-efficient services than are provided through their current operations.

A Computerized Assessment/Information System to Support Ongoing Decision-Making

An objective assessment and information system for practical support of ongoing clinical, administrative, and regulatory decision-making is equally important as having a treat-

ment program that works for the previously untreatable. Based on the "4-Rs" for determining maximum utility, Marco Mariotto and I detailed a comprehensive paradigm for the coordinated application of formal assessment strategies to support these decisions in ongoing clinical operations (Paul & Mariotto, 1986). Core strategies of that paradigm are fulfilled by the second set of technologies resulting from our research and development efforts–the *Computerized TSBC/ SRIC Planned-Access Observational Information System*–or TSBC/SRIC System, for short.

The TSBC/SRIC System is an integrated set of procedures for continual gathering, processing, analyzing, and distributing objective information on client, staff, and program functioning. The *TSBC/SRIC* and *Observational* parts of the title refer to the direct observational coding instruments on which the system is based–the *Time-Sample Behavioral Checklist (TSBC)* and *Staff-Resident Interaction Chronograph (SRIC)*. The *Computerized* portion of the title indicates that computers are necessary to store, combine, summarize, retrieve, and document data from the TSBC, SRIC, and other sources (biographical, financial, and medical). The *Planned-Access…Information System* part of the title signifies that the procedures for information gathering, processing, and retrieval are arranged as an interrelated set to provide timely access to data through standard and individually tailored visual and printed reports.

Full-time, independent, noninteractive technician-level observers use the TSBC and SRIC on stratified-hourly schedules that time-sample all client waking hours, 16 hours/day, 7 days/week. Through low-inference coding, observers continually collect detailed time- and situation-specific assessments of functioning for every client and every clinical staff member on implementing units, from their moment of entry through their moment of departure. A single cadre of observers can typically cover two or more 20- to 50-bed wards, averaging two full-time equivalents (FTEs) per ward, with one BA-level supervisor for as many as 11 or 12 high-school level personnel. Daily entry of incoming data to permanent files, for later production of requested scores and reports, can be done by night-shift clinical staff using a desktop computer on each treatment unit. Because the TSBC/SRIC System provides so much objective data to efficiently support operations, observer positions usually can be obtained through reallocation rather than new funds (see Paul, 1986b).

The TSBC is the primary instrument in the system for providing the database on the assets, deficits, and excesses in functioning of every client and on how and where clients and staff spend their time. TSBC observations cover every client and staff member on each hourly sample. The SRIC is the pri-

mary instrument for providing the database on psychosocial activities of clinical staff and treatment programs–the nature, amount, content, and distribution of interactions between staff and clients. Unlike the brief observations used with the TSBC, each SRIC observation employs continuous coding of a single staff member and all client interactants for 10 consecutive minutes. One or two SRIC observations each hour usually gives adequate weekly coverage of a treatment program, with representative sampling of all clinical staff and activities over time.

Computer scoring aggregates data across observations for specified time periods to provide easily interpretable reports on individuals, identified groups, and entire treatment programs. Standard weekly reports provide most of the information needed for ongoing clinical and quality assurance purposes, but the database supports individualized searches to generate or test hypotheses over periods ranging from an hour to a fiscal year or more.

The documented psychometric properties and practical utility of system data for clinical and other purposes has been exceptional. Observers are trained to a criterion of 100% coding agreement on a full shift for each instrument (a minimum of 200 TSBC and 15 active SRIC observations). Ongoing use is monitored with day-to-day reliability checks. Consequently, the replicability of any score from the system is excellent (median omega squares in the high .90s, counting observer level-differences as error). The trustworthiness of the data is unequalled.

The validity-related evidence for the multiple intended uses of system data is also remarkable. For example, TSBC scores account for nearly all the reliable variance in data from other approaches. They not only predict which clients receive successful discharges (with better than 95% accuracy), but also client levels of functioning in the community up to 18 months following discharge (with $\underline{r}$s in the .60s to .70s). SRIC data have shown unparalleled utility for predictive and discriminative purposes. These include correlations over time between specific classes of SRIC-identified staff-client interactions and client improvement ($\underline{r}$s in the .50s to .90s) as well as the ability of SRIC profiles to discriminate effective from ineffective treatment programs.

Complete information on the TSBC/SRIC System is presented in a 5-part series. *Part 1* (Paul, 1986c) includes the conceptual analysis of decision needs in clinical facilities and the principles underlying the approach. *Part 2* (Paul, 1987a) and *Part 3* (Paul, 1988) are the technical manuals for the TSBC and SRIC, respectively. Each provides the instrument's observer manual, scoring procedures, and supporting evidence showing the proper use and the limitations of the resulting

data. *Part 4* (Paul, 2000b) is a user's guide to implementation, maintenance, and interpretation of data to support decision-making at every level, from clinical staff and research-evaluation personnel to unit directors, facility administrators, and policy makers. *Part 5* (Paul, 2000c) is an implementation package that contains detailed supervision and training manuals, videotapes, and computer programs needed to install and maintain all components of the system. Part 4 and Part 5 are being updated to incorporate upgrades and field-testing of more powerful user-friendly databased-management programs that can run on desktop computers. Barring unforeseen delays, the "turnkey" TSBC/SRIC System (Version 4.1) package should be available within 2 years.

Although the TSBC/SRIC System is required for proper implementation of the Social-Learning Program, our multi-institutional feasibility/generalizability studies have documented its utility and practicality with the full range of inpatient/residential treatment programs in mental hospitals and community facilities. Based on evidence from more than 30 years of clinical research and development with the Computerized TSBC/SRIC Planned-Access Observational Information System, inpatient and residential facilities soon can have at their disposal a practical assessment and decision-support information system that provides the following.

· Quality data with unsurpassed replicability, representativeness, relevance, and relative cost.

· Facts to support *any* inpatient/residential treatment program that serves adults with problems typically characterized as mental illness, mental retardation, or alcohol/substance-abuse.

· Continuous monitoring of effects for *any* intervention–biomedical, drug, or psychosocial.

· Data needed to implement the Social-Learning Program and monitor its operational integrity.

· Ongoing information on client assets as well as deficits and excesses in functioning.

· Data needed for individualized treatment programming and ongoing goal-oriented records.

· Objective guidelines for determining client's discharge-readiness (>95% success).

· Continuous support for rational utilization, development, and training of clinical staff.

· Ongoing data on staff and clients for absolute and comparative program evaluations.

· Continual data that allows research to be an integral part of ongoing service operations.

· Documentation of staff, client, and program functioning for legal and human rights protection.

· Benefits that typically allow implementation without marginal increases in annual budgets.

My colleagues and I are optimistic that the TSBC/SRIC System "provides a vehicle for service operations to approach the status of an applied science–an applied science in which effective treatment technologies become the rule for all populations rather than the exception" (Paul, 1987b, p.199).

Conclusion

Please take the time to become familiar with these technologies, their underlying evidential support, and implementation recommendations (see Mariotto, Paul, & Licht, 1995; Paul, 1987b, 1990, 2000a; Paul, Stuve, & Cross, 1997; Paul, Stuve, & Menditto, 1997). Then join my coworkers and me in implementing and disseminating them to help staff help the people who are most in need of evidence-based practices. That would make this award from the Society of Clinical Psychology a truly important honor.

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Acknowledgements

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Blood, Sweat, and Careers II: Marsha Linehan and C. R. Snyder Offer Stories and Advice for Graduate Students

David B. Feldman
University of Kansas

In the previous issue of *The Clinical Psychologist*, I introduced what will be an ongoing feature of the Student Forum: a series of interviews entitled "Blood Sweat and Careers." In these interviews, successful psychologists offer stories and guidance to help nascent colleagues more competently navigate the graduate-school experience and the field of psychology itself.

In this edition, I am pleased to present my conversations with Marsha Linehan and C. R. Snyder.

An Interview with Dr. Marsha Linehan

Marsha Linehan is perhaps best known for her work on the treatment of seriously suicidal clients and individuals diagnosed with Borderline Personality Disorder. In all, she has published over 100 research articles and chapters in psychology and psychiatry journals and texts; she has also written three books, including two treatment manuals on Dialectical Behavior Therapy (DBT), her treatment for Borderline Personality Disorder: *Cognitive-Behavioral Treatment for Borderline Personality Disorder* and *Skills Training Manual for Treating Borderline Personality Disorder*.

Dr. Linehan is currently Professor of Psychology and Adjunct Professor of Psychiatry

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and Behavioral Sciences at the University of Washington. She is also the Director of the Behavioral Research and Therapy Clinics, a consortium of research projects developing new treatments and evaluating their efficacy for severely disordered and multi-diagnostic populations. Her primary research is on the application of cognitive and behavioral models to suicidal behaviors, drug abuse, and borderline personality disorder. She is also working to develop effective models for transferring efficacious treatments from the research academy to the clinical community. In this short interview, she shares with us stories about her interesting route through graduate school, as well as advice for beginning psychologists.

David Feldman: *Where did you attend undergraduate and graduate school?*

Marsha Linehan: Loyola of Chicago. Actually, as an undergraduate, I went to night school at the University of Tulsa, then I went to night school at Loyola University. Then, I quit my job and decided to go full time.

DF: *So you went to Loyola for both your undergraduate and graduate work?*

ML: Yes. That's because I was rejected from every graduate school I applied to.

DF: *Could you tell me a little about that?*

ML: Well, I was the college nominee to the University of Illinois. Loyola University used to select three graduating seniors from the whole university who were viewed as the best students for entry into the University of Illinois graduate school. My understanding was that, throughout history, no college nominee had been rejected from graduate school, ever. So, as soon as you were college nominee, you knew you were going to get into graduate school at the University of Illinois. But, my first-choice school was Yale and my second was the University of Illinois. And I wanted to get a Ph.D. in social psychology. So, I didn't apply to anywhere else because everyone just assumed I would get in. But, I didn't get into to either one of them. And, I'd never even thought of something else to do with my life, so I didn't have another plan. I went to the psychology department chair's office in tears (to put it mildly), and started telling him all about it—about how terrible it was—and asked "What am I going to do?". I'll never forget

it; he said, "I don't know why you're so upset. We'll just take you here." . . . Before I accepted, I thought that I would check out the University of Chicago too, because it was also in Chicago and it had a really good social psychology program. . . . I went down and talked with a professor whose name I can't remember. He said that he would really like to have me for a student, but that he couldn't guarantee me money at the moment. . . . And, he said that a bird in the hand was worth two in the bush. I asked, "Well, don't you think that I should try to go to a better school [than Loyola] or something?". And he said, "Look, all you need in graduate school is a good library.". . . So, I went back and I accepted. . . . And I got my Master's in social psychology in two years and my Ph.D. in one more year. I switched areas, though, into experimental personality [for my Ph.D.].

DF: *So why did you decide to re-specialize in clinical psychology?*

ML: See, I was going to medical school; that was the plan. I was pre-med. all the way through college. . . . What I knew was that I wanted to be a therapist. And I wanted to be a psychiatrist, but I wasn't sure I was smart enough. So, I figured that if I wasn't smart enough to be a psychiatrist, I'd be a psychologist. . . . This is how I thought at the time. It never occurred to me that there was a problem in that kind of thinking. . . . But, in my senior year I had applied to about ten medical schools, when one day it suddenly dawned on me that we didn't know much about how to do therapy. And, if I went into psychiatry, I would be a therapist. . . . And if I was a therapist, I wouldn't know what to do, because we didn't know what was effective. Therefore, I knew I had to be a researcher. And if I was going to be a researcher, I had to go into psychology instead of psychiatry. So, I talked to my professors about this, and they told me that if I wanted to be a researcher I should absolutely not go into clinical, because nobody knew what they were doing. If I wanted to learn how to do research, I had better go into social psychology, and then I could do a postdoctoral internship in clinical. . . . And it never entered my mind to question any of this! So that was the plan.

DF: *Where did you do your postdoctoral internship?*

ML: Well, the problem was that I was again rejected from every single internship I applied to. I applied to every single internship that would take anyone postdoctorally, but every one of them turned me down. It had also never occurred to me that this would happen; so I felt like I was really in trouble. But, it happened to be that there was a clerical position open at the crisis clinic in Buffalo. And I happened to meet the director of the clinic and told him that if he would hire me and let it be an internship that I would be more valuable than a clerical person.

. . . So, as far as I know, I'm the first and last intern ever in his life. So, I walked in, never having had a clinical course in my life, and immediately had eight suicidal patients.. . . . But it didn't bother me [at the time] very much, because I figured I had Bandura [Behavior Modification] and Mischel [Social Learning Theory]. And with Bandura, in particular, I thought I could do anything. No kidding. It didn't even occur to me that I didn't know what I was doing. It's my claim to fame in life that none of them died. . . And then I ended up doing one year of behavior modification training at Stony Brook, also.

DF: *What kind of advice would you give to graduate students who, like you once were, are just starting their clinical work?*

ML: My opinion is that the biggest problem for first-year clinicians is that they try to act like therapists. In fact, trying to act like therapists is their downfall. Unfortunately, many of their supervisors try to teach them to act like clinicians. But, if they would act like themselves, they would [be better off]. . . . As soon as you quit acting like a therapist, you're going to do better, because people who get into clinical graduate school already know a lot about how to help people, how to solve problems, and how to be effective. So, the secret is to remember that you already know a lot, and all you are trying to be is simply one human being trying to help another human being. That's all this is.

DF: *Looking back on your years in graduate school from the perspective of what you are doing now, what kinds of things do you think prepared you the best?*

ML: Social psychology. If I could do it all over again, I'd do exactly what I did. I would not go into a clinical training program; I would go into a social/personality empirical research program. Social psychology is the study of interpersonal influence, and psychotherapy is the practice of interpersonal influence. It's hard to think of anything more relevant to clinical psychology than social psychology. So, I think I got a fabulous background. . . . The other really useful thing that I did was that I taught undergraduate personality and undergraduate intro. classes. It really made me love teaching and gave me a chance to get a lot more secure about teaching. . . . Going through it [teaching anxiety] as a graduate student is a lot easier that going through it later. So I think that getting all the teaching experience you can get as a graduate student is really essential.

DF: *What kinds of things would you recommend that current graduate students in clinical psychology do during their graduate careers that maybe you didn't do, but that you feel would prepare them for careers in your professional specialty?*

ML: Know the value of having a mentor. Because I had mentors, but they were in social psychology, they really didn't know what I needed to get a job. So, I just went straight through. . . . It's hard to say, though, because I feel like I had the most wonderful faculty in the world. I've spent my whole career just trying to be like the faculty at Loyola University of Chicago. . . . So it's hard to see anything wrong [with my graduate education] . . . But, I didn't really have a clinical mentor. . . . I did all of my research on suicide with a social psychology faculty member who wasn't really able to be very helpful in that field. So, I had some real problems in the research that I did at that time. My career opportunities in clinical completely turned around when Jerry Davison and Marv Goldfried at Stony Brook became my mentors.

DF: *You mentioned that one of the things you would suggest for graduate students is that they find a mentor who can give them advice about how to get a job and establish themselves in the field of clinical psychology. As a mentor yourself, what kinds of advice do you give to your students?*

ML: First of all, of course, you have to be reasonably good at what you do and what you want to do in your career. So, you have to do what is necessary to learn as much as you can. Humility, integrity, and passion are requisite qualities if you want to make major contributions. Then, I think that what you have to do is find people that you can either e-mail with or talk with by going to meetings. You have to talk not only about that person's work, but also your own work. And you have to find a way to discuss your own ideas and what you're doing with other luminaries. I've watched some of my graduate students do this, and they have half the country mentoring them now. . . . The mistake I see a lot of people make is that they go [to conferences], but they either only ask questions about the famous person's research or only talk about their mentor's research, without either owning some part of their mentor's research or expressing any of their own ideas or excitement about ideas or research. So, what you have to do is get out there and add your own ideas to the discussion. (Of course, you have to be socially savvy when you do all this, but if you have a good idea, a critical eye, or passion for research, you need to find a way to add it to the interaction.) Then, you can get to know people and network, because a lot of success in any field is in the ability to network, have colleagues, have friends, and have people who know you.

DF: *How would you, in your own words, characterize what you're doing now in your career?*

ML: I'm doing what I've been doing since the first day of my career. I have never changed. I am a treatment development researcher. My basic passion as a researcher has been to develop an effective treatment for seriously suicidal people. And I've done that my whole career. The other part of my career has been as a professor and teacher: I've always taught advanced personality theory and research. Teaching this has been the single most important thing in my research career also, because it has kept me up to date on basic research. . . . So, I treat patients, have students, teach classes, and do research. I love it all.

DF: *As we enter the new millennium, what do you think the future of psychology will be? In what ways would you like to see it change?*

ML: I'm not sure how I think it will change, because clinical psychology has a real ability to work against itself with all the battles that are fought within it. It's become, in some ways, like a religion with religious warfare. So, I'm hoping that ultimately dies down. And my belief is that, in the end, facts will win. I think that the wall between psychiatry and psychology—the biological and non-biological—will drop, and we will become far more holistic in our views and our knowledge of what's going on. That has already started. What would impede that, though, are all the "religious" wars going on between the disciplines. But I doubt that they will continue forever.

DF: *Are there any particular things that you find help you to succeed on a day-to-day basis in this ever-changing field? Any mental tricks? Characteristics? Habits? Skills?*

ML: First of all, almost all of the things that you're supposed to do to succeed, I'm not very good at. I've read probably 18 books on how to organize your time. I always get them for Christmas. But, the one thing I've done my whole career is [to remember] the old Zen saying, "If you're on your own path, and you knock on the door, the door will open. But, if you're on anyone else's path, when you knock on the door, the door will not open." The one thing I've done my whole career is to stay on my own path. So, if you ask me what the single most important thing to do is, that would be it.

An Interview with Dr. C. R. Snyder

C. R. Snyder is presently Professor of Psychology and Director of Clinical Training at the University of Kansas, where he has been on faculty since 1972. Over this 28-year career, he has produced 17 books, 55 chapters, 19 book reviews, and 116 journal articles. His ideas have bridged several areas in psychology, and he was one of the first scholars to break from the usual focus on pathology by advancing a psychology of positive human motives. He is best known for four major scholarly contributions. First, he charted the individual-differences and situational factors that lead to short and long-term acceptance and incorporation of self-referential information. Second, he

developed need for uniqueness theory, which suggested that being different can be viewed in a positive light, rather than negatively, as "deviant." Third, Snyder developed excuse-making and reality-negotiation theory, which elucidated the processes by which people handle negative and discrepant self-referential feedback. Finally, in his most recent research, he has posited hope theory, a model of goal-directed thinking and it's effects on positive life outcomes. His work has been featured on CNN and Good Morning America, as well as in the New York Times and even a Doonsbury cartoon. In this short interview, he discusses many of his experiences in graduate school and offers guidance for beginning theoreticians.

David Feldman: *Where did you attend Undergraduate and Graduate School?*

C. R. Snyder: For undergraduate, I attended Southern Methodist University, where I was on the baseball team. . . . I spent my first two years just trying to stay afloat. I didn't even buy my books in college for the first two years. However, I found that to be counterproductive. . . . So, I basically had a "gentleman's C" for the first two years in college. Then I stopped my emphasis on baseball, and I lived my last two years in a really bare-bones existence. At one point, I was actually *living* in the psychology laboratory, taking care of about 1200 white albino rats. I didn't have the money to pay for a place to live, so my roommates were 1200 rats. . . . So, my last two years, I bought books and did better. But, I basically came out of undergraduate school (this was 1967), with a B average. The only way that I got into graduate school was that I did very well on the Graduate Record Examination [GRE]. I also did quite a bit of research and had published as an undergraduate. But, I felt very, very lucky to have gotten in. . . .

I went to [graduate school at] Vanderbilt. I started in 1967, and I thought I was going to be drafted in the Summer of 1968. So, I went as fast as I possibly could to get a Master's degree by that summer. And I did. So, I prepared to go into the army, because I had been drafted. But when I went down for my induction physical, because of my total color blindness, . . . just before I thought we were going to be loaded on the bus to go to basic training, they told some of us to go over to a small room. . . . And the sergeant comes in and says, "Men, I have some disappointing news. And that is, you're not fit for the Army. You'll all be classified 1-Y." . . . So, I went back to Vanderbilt. And because I had done so much work so quickly, I was basically able to finish my Ph.D. by 1971.

DF: *Where did you do your internship?*

CRS: It was a combination of various things at Vanderbilt Medical Center and the counseling center there. And my [postdoctoral] experience was also, in many ways, like an internship.

DF: *Where did you do your postdoctoral study?*

CRS: I went to Langley Porter Neuropsychiatric Institute at the University of California Medical Center for my Postdoc.

DF: *What specifically did you like about your graduate education?*

CRS: First of all, I'll say that I'm probably unusual in that I really loved graduate school. I'd never before had a time where I had enough money to live. I had a stipend and then later on I wrote an NIH research fellowship. So, part of it could be colored by the fact that I had a good place to live and I had food. But, I also thought that my fellow graduate students were sensational. They were fun, intellectually challenging. It is a privilege, to this day, that I was able to interact with them. . . . So, I liked the camaraderie. . . . I spent an enormous amount of time trying to plot the next research project, the next theory, or whatever that I wanted to do. A friend of mine and I, every night, had a time where we would either continue talking about a theory we had worked up, or we would start a new theory.

DF: *What specifically did you dislike about your graduate education?*

CRS: I think that, at times, there was an atmosphere that was predicated on the fact that among these excellent people, a certain percentage of us would, by necessity, be flunked following the first semester. And I remember that this happened. I would say that nearly a third, maybe up to a half, were gone. And one of them was one of my best friends. . . . While that had its negative repercussions, it also had the following impact on me. I vowed that when I got somewhere in my academic job, . . . that I would do what I could do to establish an atmosphere where people would sense that, once they were selected, we were all in this thing cooperatively to help them do their best, so as to graduate and go on to do the best they could. I just never dreamed that I would be able to do this so quickly. I was made the acting [University of Kansas] clinical program director in 1974 and the year after that became the program director. So I was only 28 or 29 years old.

DF: *What do you think are the most important things that students should do and learn in graduate school?*

CRS: I think that you should work on your specialness. It's probably not by chance that one of my first theories was uniqueness-seeking theory. I think that what you need to do is to carve out a place you can call your intellectual home, where nobody anywhere knows more about that area or is more excited about it than you. And, don't be seduced by the library.

(I have to be careful how this can be construed.) I think the library can really be a constraining factor in the way you think. I would suggest the people get excited about their <u>own</u> ideas and try to develop them, rather then spending however many hours it would take to comprehensively review the literature. I think it's better to err in potentially reinventing the wheel than it is to spend all your time in the library reading about wheels. There's a quote that sticks with me by an Englishman named Critchley; he said, "No matter what you say, somebody has probably said in some version before."

To some extent I believe that, but to some extent I don't. And so, I have lived my career with the idea that I create my own turf—theories that I find exciting, theories about which I have passion. And I'm not an expander of the next small cell or the next level of someone else's paradigm. I guess that all boils down to: I think that the people who really make a contribution and have fun are the ones who take a chance and don't worry about what's in the library. I'm not saying that you never, at some point, relate to the literature; of course you do. But I think that it can't constrain the way you view reality.

DF: We've been talking about how students can expand psychology by proposing new ideas and theory. As we enter the new millennium, what do you think the future of psychology will be, as people continue to change and expand it? In what ways would *you like* to see it change?

CRS: Well, I don't know, but *nobody* knows, so my guess is as good as yours. So, I think that the 21st century has the potential to be the most exciting time in the field of psychology and the most exciting century ever. I think that, generally, we as psychologists have been pretty passive about taking our ideas to people and showing America and the world why psychology is exciting, why it makes a difference, why it will be related to our future. Every research program has this potential if some of the lead investigators pay more attention to it. . . . Also, I think that we need to build our science of theories. This is not inconsistent with what I said earlier about taking a chance. I believe in the leap model of research, where you go out, not knowing if there's a net, and make a change and leap off of some older theory. But, in doing so, you expand what has been done previously. And, I think that in the 21st century, there will be more people that try to expand psychology in this way—by thinking of theories that, as we sit here in the year 2000, we haven't even thought about yet. . . . That's very exciting. So, I'll be able, with some degree of hope, to participate in the first part of that. Also, I would be remiss if I didn't say that I have, in my entire career, advocated a positive psychology—a psychology that looks at the strengths of people rather than their deficiencies or problems. And, I think that has a real possibility of taking hold. What a wonderful thing that could be if it

were to take off in psychology and apply to people. Another thing that I wish would happen, but I don't know if it will happen, is that we would break down the artificial barriers between disciplines. Those do nothing but stop good thinking. I believe that some of the best thinking that has ever been done has been done by people, across disciplines, who are sharing ideas and arguing, but then coming to some kind of consensus that several minds can do much better than one.

DF: *I'm finished asking my prepared questions. Do you have anything else that you would like to share with graduate-student readers?*

CRS: Yes. First, I think that graduate students can profit by having a killer instinct. What I mean by "killer instinct" is that, if you have an idea for a project, get it done. Jump on it; do what you have to do to get it out. Don't be a perfectionist. Write a first draft and show it to somebody. Don't wait. Leap; and I think that you'll get much more done than sort of trying to think it all through. Second, write, write, write, write. Take courses in writing. I think that writing is now and will continue to be the central vehicle by which you will communicate your ideas. Unfortunately, we psychologists are generally not very good writers. Become superb writers and you will immediately have an advantage.

What the experts are saying:
Trends across interviews

In this and the previous issue of *The Clinical Psychologist*, I have shared with you conversations between myself and four well-known psychologists. These four individuals, in many ways, could not be more different. Judith Beck and Marsha Linehan are consummate clinicians, primarily interested in the development, validation, and delivery of effective psychotherapy, while Christopher Peterson and C. R. Snyder are often mistaken by green colleagues for experimental social and personality psychologists (and indeed, in some capacity, they are). Moreover, among these four clinical psychologists, one encounters three different graduate degrees—Linehan and Peterson hold degrees in social psychology, Beck in education, and Snyder in clinical psychology. Despite these vast differences in research interests and degrees held, it is impossible to ignore the substantial overlap in the advice and guidance they have offered to graduate-student readers of these interviews.

First, all four interviewees emphasized the need for greater integration within the field of psychology and across psychology's boundaries with other disciplines. Beck commented, "I think in general people are better off . . . getting a wide range of professional experiences and getting more life experience. . . . They shouldn't just specialize in one area at the

expense of being a generalist to some degree as well;" Peterson advised us to "be more broadly aware of what our brothers and sisters are doing on other floors of our buildings;" and Linehan speculated that in the future "we will become far more holistic in our views and our knowledge of what's going on." But nobody voiced this idea more succinctly than Snyder, when he implored, "I wish . . . we would break down the artificial barriers between disciplines. Those do nothing but stop good thinking."

Along with this more synthetic, cross-disciplinary view of psychology, two interviewees urged nascent psychologists to think "outside of the box," and follow their creative instincts rather than their tendency to conformity. Snyder advised us not to be overly concerned by the notion that "No matter what you say, somebody has probably said in some version before." We should, according to Snyder, "get excited about [our] *own* ideas and try to develop them" by taking creative leaps off of the ideas of past researchers and theoreticians. Linehan echoed this sentiment when she recalled the old Zen saying, "If you're on your own path, and you knock on the door, the door will open. But, if you're on anyone else's path, when you knock on the door, the door will not open."

While we're following our own research paths, however, we shouldn't be too monomaniacal in our love of the laboratory. According to the interviewees, psychologists shouldn't sacrifice teaching and clinical practice at the altar of research. Beck argued that it is "essential" for clinical researchers to continue seeing clients, because "you need to get first-hand data about patients and about therapy in order to make good research hypotheses that you then can test;" and Peterson lamented, "My work would be better if I saw clients." Linehan made a similar case for teaching: "Teaching this [advanced personality theory] has been the single most important thing in my research career also, because it has kept me up to date on basic research." Whatever one's motivation for temporarily leaving the laboratory, however, Peterson quipped, "Don't cop out and give up the practice for the science."

On the subject of clinical practice, two of the interviewees, Judith Beck and Marsha Linehan, had a lot to say. Their comments can be at least partially condensed to the phrase, "use your common sense." According to Beck, beginning therapists shouldn't be fooled by the sometimes mystery-cloaked nature of psychotherapy. "A lot of people have the idea that psychology should be esoteric, . . . even convoluted," she commented. "I've found the opposite to be true: The more logical and accessible ideas are, the more they make sense to you, the more likely it is that you'll be able to progress yourself

and help your patients." Linehan added that beginning therapists should remember that treatment consists of "simply one human being trying to help another human being," and that "as soon as you quit acting like a therapist, you're going to do better, because people who get into clinical graduate school already know a lot about how to help people, how to solve problems, and how to be effective."

I hope that these interviews have, in some small way, given you further insight into how to be more effective during your graduate career and beyond. In case they have not magically brought utter perfection into your life, however, you may find it helpful to recall Judith Beck's words: "Accept your weaknesses and work on them if they're important to you. No one is good at everything."

American Psychological Association Convention
Division 12 Program Summary Sheet

Friday, August 4, 2000

Award Ceremony
8/4 Fri: 9:00 AM - 10:50 AM
Washington Convention Center Meeting Rooms 4 and 5

Conversation Hour
8/4 Fri: 10:00 AM - 10:50 AM
Washington Convention Center Meeting Rooms 1 and 2
Richard G. Heimberg, PhD

Conversation Hour: Education and Training in Behavioral Emergencies
8/4 Fri: 11:00 AM - 11:50 AM
Washington Convention Center Meeting Rooms 1 and 2
Phillip M. Kleespies, PhD
Robert I. Yufit, PhD

Symposium: Virtual Reality Exposure Therapy in the Treatment of Anxiety Disorders
8/4 Fri: 11:00 AM - 12:50 PM
Grand Hyatt Washington Hotel Roosevelt and Wilson Rooms
Page L. Anderson, PhD
Barbara O. Rothbaum, PhD

Symposium: New Conceptual, Theoretical, and Methodological Tools for Vulnerability Research
8/4 Fri: 11:00 AM - 12:50 PM
Washington Convention Center Meeting Room 21
Darcy A. Santor, PhD

Poster Session: Child, Adolescent, Adult, and Geriatric Psychopathology
8/4 Fri: 12:00 PM - 1:50 PM
Washington Convention Center Hall A

Presidential Address: End-of-Life Decisions, Assisted Suicide, and the Psychologist's Role
8/4 Fri: 1:00 PM - 1:50 PM
Washington Convention Center Meeting Room 20

Invited Address: [Rice]
8/4 Fri: 2:00 PM - 2:50 PM
Grand Hyatt Washington Hotel Arlington and Cabin John Rooms
Gloria B. Gottsegen, PhD

Invited Address: [Spielberger]
8/4 Fri: 2:00 PM - 2:50 PM
Washington Convention Center Meeting Rooms 25 and 26
Robert I. Yufit, PhD

Symposium: Prescription Privileges and Clinical Psychology—A Faustian Bargain
8/4 Fri: 3:00 PM - 4:50 PM
Washington Convention Center Meeting Room 22
Dominic A. Candido, PhD

Discussion: Enhancing Collaborations to Address Violence-Related Problems in Youth
8/4 Fri: 3:00 PM - 4:50 PM
Washington Convention Center Meeting Room 21
Michele Cooley-Quille, PhD

Symposium: Validity Scales for the NEO-PI-R
8/4 Fri: 4:00 PM - 5:50 PM
Washington Convention Center Meeting Rooms 1 and 2
Ruth A. Baer, PhD

Saturday, August 5, 2000

Invited Address: Distinguished Scientist Award
8/5 Sat: 9:00 AM - 9:50 AM
Washington Convention Center Meeting Room 30

Symposium: Comparison of Medication, Psychotherapy, and Combination Treatment for Chronic Depression
8/5 Sat: 10:00 AM - 11:50 AM
Grand Hyatt Washington Hotel Constitution Ballroom A
Bruce A. Arnow, PhD

Symposium: Explanatory Models for the Gender Difference in Adolescent Depression
8/5 Sat: 11:00 AM - 11:50 AM
Grand Hyatt Washington Hotel Constitution Ballroom B
Eric M. Stice, PhD

Symposium: Diversity in Psychology—Considerations for Women and Ethnic Minority Graduate Students
8/5 Sat: 11:00 AM - 12:50 PM
Washington Convention Center Meeting Room 20
Faith-Anne Dohm, PhD
Cheryl A. Boyce, PhD

Poster Session: Assessment and Diagnosis
8/5 Sat: 12:00 PM - 1:50 PM
Washington Convention Center Hall A

Presidential Address: [Dohm]
8/5 Sat: 1:00 PM - 1:50 PM
Grand Hyatt Washington Hotel Constitution Ballroom C and D
Natalie Porter, PhD

Symposium: Psychology Training at Academic Health Centers—Problems and Prospects
8/5 Sat: 2:00 PM - 2:50 PM
Washington Convention Center Meeting Room 22
Gerald Leventhal, PhD

Presidential Address: [Craighead]
8/5 Sat: 2:00 PM - 2:50 PM
Washington Convention Center Meeting Room 30

Symposium: Preclinical Detection of Alzheimer's Disease—Contributions From Neuropsychology and Neuroimaging
8/5 Sat: 3:00 PM - 3:50 PM
Washington Convention Center Meeting Rooms 10 and 11
Alfred W. Kaszniak, PhD

Symposium: Psychologists—Clinical System Architects in an Era of Care Management
8/5 Sat: 3:00 PM - 4:50 PM
Washington Convention Center Meeting Rooms 4 and 5
Frank A. Ghinassi, PhD

Sunday, August 6, 2000

Symposium: Behavior Therapy for the 21st Century—Foundations, Values, Future Directions
8/6 Sun: 10:00 AM - 11:50 AM
Renaissance Washington DC Hotel Grand Ballroom Central
Cyril M. Franks, PhD
Carole A. Rayburn, PhD

Invited Address: [Berman]
8/6 Sun: 12:00 PM - 12:50 PM
Grand Hyatt Washington Hotel Constitution Ballroom C and D
Phillip M. Kleespies, PhD

Poster Session: Psychopathology
8/6 Sun: 12:00 PM - 1:50 PM
Washington Convention Center Hall A

Invited Address: [Clark]
8/6 Sun: 1:00 PM - 1:50 PM
Grand Hyatt Washington Hotel Constitution Ballroom C & D
James M. Jones, PhD

Symposium: Predictors of PTSD Following Fire-Related Trauma
8/6 Sun: 1:00 PM - 1:50 PM
Washington Convention Center Meeting Room 20
Russell T. Jones, PhD

Invited Address: Mentor Award
8/6 Sun: 2:00 PM - 2:50 PM
Grand Hyatt Washington Hotel Roosevelt and Wilson Rooms

Symposium: Cognitive Neuroscience Paradigm—Implications for Clinical Psychology
8/6 Sun: 2:00 PM - 3:50 PM
Grand Hyatt Washington Hotel Arlington and Cabin John Rooms
Stephen S. Ilardi, PhD

Presidential Address: [Hinrichsen]
8/6 Sun: 3:00 PM - 3:50 PM
Grand Hyatt Washington Hotel Roosevelt and Wilson Rooms

Symposium: Prostitution, Violence, and PTSD—A New Look at the Oldest Profession
8/6 Sun: 4:00 PM - 4:50 PM
Washington Convention Center Meeting Room 27
Lenore E. Walker, EdD

Symposium: Clinical Geropsychology in Medical Settings—Prevention, Assessment, Intervention, and Training
8/6 Sun: 4:00 PM - 5:50 PM
Washington Convention Center Meeting Room 29
Suzanne M. Norman, PhD

Monday, August 7, 2000

Symposium: Extending Practitioner Training Toward Applied Research
8/7 Mon: 9:00 AM - 9:50 AM
Grand Hyatt Washington Hotel Franklin Square and McPherson Square Rooms
Lorraine Mangione, PhD

Conversation Hour: Clinical Psychology Internship—Issues and Strategies for Year 2000 Applications
8/7 Mon: 10:00 AM - 10:50 AM
Washington Convention Center Meeting Rooms 4 and 5
Donna B. Pincus, PhD
John D. Otis, MA

Symposium: Assessments and Interventions for Culturally Diverse Young Children
8/7 Mon: 10:00 AM - 11:50 AM
Washington Convention Center Meeting Rooms 10 and 11
Michael L. Lopez, PhD
Kimberly Hoagwood, PhD

Invited Address: [Wedding]
8/7 Mon: 11:00 AM - 11:50 AM
Washington Convention Center Meeting Rooms 23 and 24
Leonard J. Haas, PhD

Paper Session: Eating Disorders
8/7 Mon: 12:00 PM - 12:50 PM
Washington Convention Center Meeting Room 15

Poster Session: Clinical Psychology—General
8/7 Mon: 12:00 PM - 1:50 PM
Washington Convention Center Hall A

Presidential Address: [Willis]
8/7 Mon: 1:00 PM - 1:50 PM
Washington Convention Center Meeting Rooms 1 and 2
Victor De La Cancela, PhD

Symposium: Gender Differences and Similarities in Sexual Coercion—Mechanisms of Psychopathology
8/7 Mon: 2:00 PM - 2:50 PM
Washington Convention Center Meeting Room 27
Gordon C. Nagayama Hall, PhD

Symposium: Feminist Therapy—Is It Just Good Therapy?
8/7 Mon: 3:00 PM - 3:50 PM
Grand Hyatt Washington Hotel Franklin Square and McPherson Square Rooms
Judith P. Worell, PhD

Symposium: Improving Clinical Judgment—Strategies for Training and Practice
8/7 Mon: 3:00 PM - 4:50 PM
Washington Convention Center Meeting Room 29
J. David Smith, PhD

Symposium: Color Consciousness Among African Americans—Perspectives and Prevention
8/7 Mon: 4:00 PM - 4:50 PM
Washington Convention Center Meeting Rooms 4 and 5
Guerda Nicholas, PhD

Symposium: Cognitive Styles and Psychopathology
8/7 Mon: 4:00 PM - 5:50 PM
Washington Convention Center Meeting Room 20
Lauren B. Alloy, PhD
John H. Riskind, PhD

Tuesday, August 8, 2000

Symposium: Research and Practice Opportunities in Academic Health Science Centers
8/8 Tue: 9:00 AM - 9:50 AM
Washington Convention Center Meeting Rooms 25 and 26
Barry A. Hong, PhD

Discussion: Health Psychology and Surgery—A Natural Alliance for Training
8/8 Tue: 9:00 AM - 9:50 AM
Washington Convention Center Meeting Room 37
John D. Robinson, EdD

Symposium: Acute Psychiatric Inpatients—Assessing Symptomatic Change and Predicting Service Utilization
8/8 Tue: 9:00 AM - 10:50 AM
Washington Convention Center Meeting Rooms 13 and 14
Mark E. Maruish, PhD

Paper Session: Depression
8/8 Tue: 10:00 AM - 10:50 AM
Washington Convention Center Meeting Room 21

Symposium: Wide-Range Intelligence Test—A New Cognitive Measure
8/8 Tue: 10:00 AM - 10:50 AM
Washington Convention Center Meeting Room 22
Wayne V. Adams, PhD

Symposium: What Should the Clinician Trust—Research? Theory? Clinical Knowledge?
8/8 Tue: 11:00 AM - 12:50 PM
Washington Convention Center Meeting Rooms 13 and 14
Alvin R. Mahrer, PhD

Symposium: Vail and Boulder Training Models
8/8 Tue: 1:00 PM - 1:50 PM
Washington Convention Center Meeting Rooms 13 and 14
Kai Morgan, MS

Society News

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

APA Society of Clinical Psychology

POST - DOCTORAL INSTITUTES - CE CREDIT
Pre-Convention August 2-3, 2000 Washington, D.C.

One-Day Workshops, Wednesday, August 2, 2000
TBA Hotel - 7 CE Credits, $185

Neurodevelopmental Assessment of ADHD Across the Lifespan
  Jan L. Culbertson, PhD

Ethics and Risk Management
  Annette Brodsky, PhD

Frontal Lobe Dysfunction In Neurologic and Psychiatric Disorders
  Paul Malloy, PhD. and Mark Aloia, PhD

Violence and Youth: Expanded School Mental Health Approaches
  Mark Weist, PhD

Motivational Interviewing: Preparing People for Change
  William R. Miller, PhD

Advanced Competence: Preparing for the ABPP Examination
  Norman Abeles, PhD

The Understanding and Treatment of Marital Infidelity: An Integration of Cognitive-Behavioral and Developmental Perspectives
  Donald H. Baucom, PhD, Cristina Coop Gordon, PhD, and Douglas K. Snyder, PhD

Dialectical Behavior Therapy for Borderline Personality Disorder
  Cynthia Sanderson, PhD

Appetite Awareness Training in the Treatment of Eating/Weight Concerns
  Linda Craighead, PhD

One-Day Workshops, Thursday, August 3, 2000
TBA Hotel - 7 CE Credits, $185

Neuropsychological Assessment of Learning Disabilities Across the Lifespan
  Jan L. Culbertson, PhD

Forensic Psychology: Principles and Practices
  Robert Kinscherff, J.D., PhD, and Eric Drogin, J. D., PhD, ABPP

Assessment and Treatment of Abusive Relationships: Guidelines for Practitioners
  Daniel O'Leary, PhD, Ileana Prias, PhD, Richard Heyman, PhD, and Alan Rosenbaum, PhD

Child and Adolescent Anger Management
  Eva L. Feindler, PhD

Family Focused Treatment of Bipolar Disorder
  David J. Miklowitz, PhD

Cognitive Therapy for Personality Disorders
  Judith S. Beck, PhD

Cognitive Behavior Therapy for Panic Disorder and PTSD
  Michael W. Otto, PhD

Assessment and Treatment of Childhood Obsessive-Compulsive Disorder
  Greta Francis, PhD and Rod A. Gragg, PhD

Chairs: Mark Whisman, PhD and Emily Richardson, PhD
Contact: Division 12, PO Box 1082, Niwot, CO 80544
303-652-3126 Fax 303-652-2723 E-mail: lpete@indra.com

New Fellows

Linda Craighead, PhD, Society of Clinical Psychology Fellowship Committee Chair, reports that Division 12 nominated six individuals for initial APA Fellow status. They are:

> Russell A. Barkley, PhD
> Patrick W. Corrigan, PsyD
> Thomas Joiner, PhD
> James B. McCarthy, PhD
> Melinda A. Stanley, PhD
> Mark A. Stein, PhD

In addition, the following individuals who are already APA Fellows in other divisions were approved for Fellow status in Division 12:

> John Briere, PhD
> Victor De La Cancela, PhD

The members of the 2000 Society of Clinical Psychology Fellowship Committee are: Russell Jones, PhD, Samuel Turner, PhD, Asuncion M. Austria, PhD, Dean Kilpatrick, PhD, John C. Linton, PhD, and Linda Craighead, PhD (Chair).

Clinical Psychology Brochure

The popular brochure "What Is Clinical Psychology?" is available from the Division 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: Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. Phone (303) 652-3126. Fax (303) 652-2723. E-mail: lpete@indra.com

Call for Nominations

2001 Theordore Blau Award

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

> W. Edward Craighead, PhD, Chair
> 2000 Awards Committee
> c/o Division 12 Central Office
> P.O. Box 1082
> Niwot, CO 80544-1082

Deadline: October 30, 2000

The award will be presented at the 2001 APA Convention in San Francisco, CA

Call for Nominations

2001 David Shakow Award for Early Career Contributions

The recipient will be a psychologist who has received the doctoral degree in 1992 or later and who has made noteworthy contributions both to the science and to the practice of clinical psychology. Letters of nomination should include the nominee's vita and a summary of his/her contributions. Send nominations to:

> W. Edward Craighead, PhD, Chair
> 2000 Awards Committee
> c/o Division 12 Central Office
> P.O. Box 1082
> Niwot, CO 80544-1082

Deadline: October 30, 2000

The award will be presented at the 2001 APA Convention in San Francisco, CA

Call for Nominations

Division 12's 2001 Distinguished Contribution Awards:

Florence C. Halpern Award for Distinguished Professional Contributions to Clinical Psychology

Award for Distinguished Scientific Contributions to Clinical Psychology

Send nominee's name, recent vita, and a concise (1-2 page) typewritten summary of his/her achievements and contributions to:

> W. Edward Craighead, PhD, Chair
> 2000 Awards Committee
> c/o Division 12 Central Office
> P.O. Box 1082
> Niwot, CO 80544-1082

Deadline: October 30, 2000

The awards will be presented at the 2001 APA Convention in San Francisco, CA

Division 12 Net

This is an e-mail net available to Divison 12 Members only. To subscribe, write to
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and in the text of your message
(not the subject line) write:
Subscribe Div12 [First name & Last name]

Division 35 and Division 12, Section IV Joint Task Force on Process and Outcomes in Psychotherapy with Women: Final Report

Concerns about accountability and effectiveness in the field of psychotherapy have converged on the need for increased integration of research and practice (Kiesler, 2000; Lambert, 1998). To date, the prolific literature on feminist approaches to counseling and therapy has illuminated the broad range of issues that women bring to the therapeutic encounter. Many authors have proposed innovative intervention strategies to facilitate women's growth and well-being. Visibly missing from this rich literature is a firm foundation of empirical studies to support the theories and techniques that are being applied (Worell, in press).

To address these concerns, the 1997-98 presidents of APA Divisions 35 (Judy Worell) and 12, Section 4 - Clinical Psychology of Women (Annette Brodsky) organized a joint Task Force to consider topics related to the challenge of empirical validation. The Task Force included six clinical teacher/researchers and one doctoral candidate, all of whom specialize in issues related to the well-being of women. The goals developed by the Task Force included (1) establishing a data base on current practices with women clients, and (2) facilitating research that focuses on process and outcomes in psychotherapy and counseling with women. Specifically, we sought to answer the following questions:

(1) To what extent are women clients being served with practices that have been identified in previous studies as woman-friendly?

(2) Does the occurrence and frequency of these practices vary with respondent gender, ethnicity, age, geographical region, work setting, or theoretical preferences?

(3) What outcome criteria do clinicians consider in assessing client progress in psychotherapy and counseling with women? Do these criteria correlate with any of the above variables?

(4) Are there unique strategies that have been identified in outcome assessment with women? Are such strategies available for dissemination and evaluation?

With financial support from both Divisions 12 and 35, members of the Task Force developed a two-page mail-in survey that was published in the summer 1998 newsletters of both

Correspondence concerning this article should be addressed to Judith Worell, PhD, Education and Counseling Psychology, 235 Dickey Hall, University of Kentucky, Lexington, KY 40506-0017

divisions. The targeted population was clinicians who were currently involved in clinical training or who work with women. The questionnaire included brief demographics and four sections asking about preferences in clinical practice. Section A included a list of 22 statements relevant to practice with women, such as "in conducting therapy, I explain my theoretical approach to my clients during the first session". Section B asked respondents to rate the frequency with which they used each of nine approaches, such as "client report in session" to assessing therapy outcomes. Section C asked respondents to rate how they assessed therapeutic outcomes on 17 items that listed possible criteria such as "symptom reduction or improvement". Section D asked for specific measures that respondents used or were aware of that were designed specifically for outcome assessment of therapy with women.

Procedures and Brief Results

We received 209 usable surveys by mail, 81 from Division 35 and 128 from Division 12. Across the two divisions, respondents were equally divided by theory and practice, such that we obtained 104 who self-identified as feminist or woman-centered (WC), and 105 who identified otherwise (OC). Of the total respondents, 182 were female and 27 were male. Analysis of demographics indicated no differences between the two groups on age, years of practice, or major professional activity. The results reported here represent a preliminary analysis of the available data. A more inclusive report will be presented at a symposium on Monday, August 7, 2000 at the annual convention of APA. The completed data will be submitted for journal publication.

Section A responses regarding practices of relevance to women clients, indicated an internally reliable scale. Principle components analysis revealed the following six usable factors (in order of factor strength): Affirming the Client, Gender-Role Awareness, Woman-Centered Activism, Therapist Self-Disclosure, Collaborative Planning, and Egalitarianism. On five of the six factors (all but Collaborative Planning), the Women-Centered (WC) group scored significantly higher than did the Other (OC) group.

Section B responses a revealed no differences between the two groups on the nine suggested approaches to monitoring outcomes.

Section C revealed that the WC group scored higher than the OC group on frequency of assessing the following four

criteria of positive outcomes: Improved self-esteem and self-regard, Improved well-being or quality of life, Flexible use of gendered behaviors, and Client taking action toward social change for women.

Section D asking for new assessments related to interventions for women did not produce any new information. In contrast, several respondents requested such information from us.

Conclusions

Although our sample of usable responses represents only a small fraction of the total membership of both divisions, we did draw some tentative conclusions. First, it is evident that there is considerable overlap between the reported practices of those who self-identify as feminist or woman-centered and those who do not. Second, most respondents from the WC group tended to report combining their commitment to women's issues with strategies from such major theoretical orientations as psychodynamic or cognitive-behavioral. Third, our analysis also indicated considerable differences between the WC and OC groups on a number of self-reported intervention strategies and goals for outcome assessment, some of which are summarized above. Finally, we were most disappointed with the absence of suggestions for novel and creative strategies of outcome assessment by either group.

 The survey results reported here, combined with a complete analysis of the data, will provide further understanding of the range of current practices as they relate to (a) selected therapist variables, (b) the nature and extent of outcomes assessment with women clients, and (c) support for the next level of research to evaluate the effectiveness of current practices and assessment strategies with women clients. We thank both Divisions 35 and 12 for their sponsorship of this project.

Joint Task Force members: Annette Brodsky, Redonna Chandler, Sharon Jenkins, Dawn Johnson, Natalie Porter, Brenda Toner, Judith Worell, Karen Wyche.

References

Kiesler, C. A. (2000). The next wave of change for psychology and mental health services in the health-care revolution. *American Psychologist, 55,* 481-487.

Lambert, M. J., Okiishi, J. C., Finch, A. E., & Johnson, L. D. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology, 29,* 63-70.

Worell, J. (in press). Feminist interventions: Life beyond symptom reduction. *Psychology of Women Quarterly.*

A New Certificate for Cognitive Therapists

Jacqueline B. Persons, PhD, Director

San Francisco Bay Area Center for Cognitive Therapy

Consumers of psychotherapy often encounter considerable difficulty obtaining evidence-based clinical care, as Division 12 members know. Another aspect of the problem of providing consumers with top quality, evidence-based care is the quality of treatment. Providers who may or may not have been trained to competency—or trained at all— are often eager to describe themselves as competent to provide treatments that consumers request. This problem is worsened by the very fact, positive in itself, that consumers are increasingly educated about effective psychosocial treatments (in part due to the efforts of Division 12 members) and can ask assertively for specific treatments that they know to be supported by efficacy data. Cognitive therapy is one of those treatments.

The Academy of Cognitive Therapy (ACT) was recently established to address the issue of treatment quality. A major goal of the ACT is to establish a set of standards and an evaluation process that will identify competent cognitive therapists. Aaron T. Beck serves as Honorary President of ACT, which was founded by a prominent group of clinicians, researchers, and educators. ACT began working in 1998 and on March 1, 2000 began accepting applications for certification.The advantages to certification include:

· Inclusion on the ACT list of certified cognitive therapists;

· Referrals of patients seeking cognitive therapy through ACT's international referral database;

· Listing of members and their practices on the ACT website;

· Promotion of the effectiveness of cognitive therapy to insurers, managed care companies, behavioral healthcare institutions, and other consumers;

· Documentation of competence in cognitive therapy for employment, promotion, or tenure;

· Favorable consideration by insurers and managed care panels;

· Opportunities to guide the development of cognitive therapy by serving on the governing board and committees of the ACT;

· Participation in continuing education programs sponsored by the ACT.

The certificate in Cognitive Therapy is awarded to mental health professionals who meet certain standards for training and experience in the practice of cognitive therapy and who demonstrate skill at practicing cognitive therapy. There are two levels of membership in ACT. Obtaining the first level of membership, *Certified Member*, requires two steps. First, the applicant must provide documentation indicating s/he is licensed as a mental health professional, has obtained certain minimal training in cognitive therapy, and has treated a certain minimum number of clients with cognitive therapy. A minimum of forty hours of training in cognitive therapy is required.

Applicants who meet these criteria are invited to submit materials for the second part of the certification process. This step of the certification process evaluates an applicant's competency at the practice of cognitive therapy. Thus, ACT standards are performance-based. The applicant submits a written case summary and formulation, using the ACT Guidelines, of a patient the therapist has treated, and an audiotape of a cognitive therapy session the therapist has conducted. The case writeup and therapy session need not focus on the same client. These materials will be reviewed by a committee of Fellows of the Academy and will be evaluated using an objective rating system which has been developed to measure competence in research studies of the efficacy of cognitive therapy.

The second level of membership, *Fellowship in the Academy of Cognitive Therapy*, is awarded to those who have made substantial contributions to the field of cognitive therapy. The contribution of an Academy Fellow can be evidenced by significant and enduring work in research, teaching, and/or clinical practice.

ACT differs from other groups offering certification in cognitive therapy in that ACT certifies all disciplines of mental health professionals, not just psychologists. The procedures of ACT's application process ensures that exacting, research-based standards are met by its members. This process provides assurance to clinicians and consumers that ACT-certified therapists posses the training, experience, and skills necessary to practice cognitive therapy competently.

ACT is a non-profit organization and officers, board members, and committee members serve without compensation. Nominal fees are paid to evaluators who review tapes and case summaries. ACT's application fees are determined by the cost of operating the certification process; the primary cost is that of the administrative operation required to keep the organization functioning, and especially to process appli-

cations. To obtain more information about ACT and to obtain an application, interested parties are encouraged to contact:

The Academy of Cognitive Therapy
One Belmont Avenue, Suite 700
Bala Cynwyd, PA 19004-1610
Phone:(610) 664-1273
Facsimile:(610) 664-5137
E-mail:information@academyofct.org

Information can also be obtained from our Web site:
www.academyofct.org

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Position Openings

ASSISTANT/ASSOCIATE PROFESSOR IN CLINICAL PSYCHOLOGY AT THE UNIVERSITY OF HAWAII (84940S & 84848T) with emphasis on research and evaluation in the public mental health system, to begin approximately 1/16/2001, full time, 11 month appointment, non tenure track. These are annually renewable contracted positions funded through a non-general fund agreement with the State Department of Health, Adult Mental Health Division (AMHD). Duties: At AMHD (80%) provide technical assistance and conduct mental health services research and evaluation, work with a variety of professional and non-professional staff to define and conduct empirically-based quality improvement studies, define and develop technical reports, manuscripts, management reports, grant applications, and publications which contribute to areas of public mental health policy and service, contrib-

ute to the development and functioning of a Statewide management information system, perform other management and administrative duties as required. At UH (20%) participate in specialty training program with the Clinical Studies Program in the area of psychosocial rehabilitation for individuals suffering from serious mental illness, teach one course per academic year, collaborate with students and faculty in research in the area of serious mental illness, attend Clinical Studies Program and other meetings as required. Minimum Qualifications: Assistant Professor: Ph.D. in Clinical Psychology from a university-based or affiliated APA-accredited training program or foreign equivalent and record of scholarly achievement. Associate Professor: In addition to that of Assistant Professor, four years full time college or university teaching at the rank of assistant professor or equivalent. Rank to be de-

termined upon qualifications. Desirable Qualifications: Demonstrated ability to develop and coordinate research activities in the area of serious mental illness, demonstrated ability to successfully obtain extramural funding in evaluation of programs of treatment for serious mental illness, broad knowledge of policy and practice of federal and state mental health agencies, advanced computer skills including database management and analysis and graphic presentation of data. Annual Salary Range: Assistant Professor: $40,524-$59,976. Associate Professor: $51,264-$75,888. Salary commensurate with level of experience. To Apply: Send letter of application, resume and three letters of recommendation to Director of Clinical Studies, Search Committee, Department of Psychology, 2430 Campus Road, Gartley 110, Honolulu, Hawaii 96822. Closing Date: 09/30.

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, e-mail address: wandakapaun@att.net, 3810 South Rivershore Drive, Moorhead, MN 56560-5621.

Instructions to Authors

*The Clinical Psychologist i*s 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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