



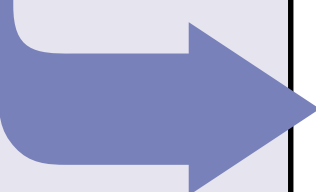
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A Final Message

It is hard to believe that it has been a year since I wrote the first President's column! As you know, I have used this column primarily to keep you informed of the "ongoings" of the Society. We began the year with considerable concern about loss of membership and a potential financial crisis. I am pleased to report that we have lost only a fairly typical number of members and that we are finishing the year in good financial condition. The Board of Directors has been extremely cooperative and creative in assuring this outcome. We end the year on an optimistic note, with an excellent plan to continue to meet members' professional needs and to recruit new members. Even though overall attendance was noticeably down at the APA meetings, most of our Society's functions were well attended. Under the excellent leadership of Scott Lilienfeld, we are planning outstanding and timely program offerings for the 2001 meetings in San Francisco. Emily Richardson and Mark Whisman have assembled an impressive group of presenters for our pre-conference clinical training Institutes. Within the Division we have focused much of our efforts during this year on improving the state of the organization. The number of members has been well sustained despite increasing numbers of previously active members of Division 12 entering retirement and the "swarming" of Divisions 53 and 54. Kent Hutchison and Pat Arean (Co-Chairs of a Task-Force on Future Membership) have devised an excellent plan for recruiting and retaining members who have recently completed their doctoral studies. I have redoubled our efforts to increase the number of student members within the Society. It is extremely important to our society's future that individuals become involved as students and continue as members during the early stages of their careers. Finally, we have established a better working relationship with the publisher of our Society journal, *Clinical Psychology: Science and Practice*. The Publications Committee and the Board of Directors have been disappointed with the manner in which the publisher has marketed the journal, but we



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President's Column

"We end the year on an optimistic note, with an excellent plan to continue to meet members' professional needs and to recruit new members."

now have hope that they have improved that process. Under the leadership of first Alan Kazdin and now David Barlow, the quality and impact of the journal are exceptionally high, and it deserves and needs to be in more libraries.

We have made excellent progress in building relationships with other professional organizations and activities, including those important to members in clinical practice and those in academic settings. The Society's relationship with APA has been improved, particularly through attendance of representatives of the various Directorates at our June Board meeting in Washington. Representatives of the Society have become increasingly involved in activities within APA. Your officers will continue to be involved in the State Leadership and Divisional Leadership Meetings in Washington. The Board of Directors is planning on meeting with representatives of each of the Directorates again in 2001. We have put in place and will maintain an active liaison relationship with the Practice Guidelines Coalition, Council of Specialties, and with CAPP (Implementation Work Group for Integrating the Diverse Practice Agendas); these represent significant and proactive steps by the Society to address needs of our members in clinical practice. The Society continues to make efforts to assist in the development of new sections, which allow members with common interests and goals to come together and address professional issues and advance their specific areas of interest within clinical psychology. Numerous Divisions of APA began as Sections of Division 12; this is an important aspect of the professional and organizational development of clinical psychology.

As we look to the future, several items are worthy of note. First, because of advanced planning, we are in excellent financial condition. Our Central Office under the able direction of Lynn Peterson is among the most effective and efficient of any professional organization with which I have been involved and is certainly among the best of any Division within APA; we are deeply grateful to her for continued service to the Society. Proportionally, we have done well regarding membership retention, but it will be essential to implement successfully the plan to recruit and maintain students and newly minted doctoral level clinical psychologists. It will be important to enhance the Society's relationship with trainers in our doctoral programs, especially as the number of applicants to our graduate programs continues to decrease. Efforts to assist our members involved in clinical research must be sustained, particularly with the emphasis on more clinically relevant effectiveness research. Ours is still the primary clinical division of APA that brings together and concurrently addresses issues of science and practice. Although some from the practice community have been critical of the scientist/practitioner orientation

of this Society, it is important to note that research activities of members of this Society have provided substantial support for the significant roles Clinical Psychologists fulfill in the delivery of services. Effectiveness studies, guided by efficacy outcome research, are even more likely to demonstrate the value of psychotherapeutic interventions either as "first line" or adjunctive treatments for serious psychological/psychiatric disorders.

My year as President of Division 12 has led me to feel strongly that more resources of APA (particularly through the Practice Directorate) need to be directed toward what we as Clinical Psychologists do best and what we are best prepared to do—namely, psychotherapeutic assessments and interventions. Surely support for the development and dissemination of effective psychotherapeutic assessment procedures and interventions are goals around which clinical psychology can unite. These are activities that could align us with colleagues of related disciplines rather than separate us. Unless it is viewed as a "zero sum game", then such increased activities need not detract from other priority efforts within our parent organization. Perhaps the greatest window of opportunity has passed us by, but it is my opinion that the situation for clinical psychology will only deteriorate further, unless this redirection of resources regarding clinical practice takes place. Finally, it is essential for our Society to be active in the current organizational developments of APA. For those who do not know, APA is creating a separate, related organization (APAPO) under the direction of the APA Board of Directors. APAPO (Tax Code-C6) will have greater freedom for professional and political activities. For example, we and others who wished to do so, have not been able to develop and publish guidelines for treatment, while other similar organizations outside psychology have, in fact, defined the guidelines for psychotherapeutic intervention. Even the publication of the Treatments that Workbook required a caveat regarding "guidelines" from the President of the Society. Through APAPO such legal limitations should be removed. The Society (collectively and individually) must have a voice to this new organization; otherwise the loudest voices of others will be of greatest influence on activities that will directly affect most of us in Clinical Psychology.

It has indeed been a pleasure to serve the Society in several ways over the past 15 years and culminating in this year as President. It has been a wonderful professional experience to have worked with so many dedicated, loyal, and distinguished leaders in clinical psychology. It has been an honor to represent you and the Society to many professional and societal activities over the past year, and I am grateful to you for having provided me this unique opportunity. ■

Clinical Interns' Perception of Psychology and Their Place Within It: The Decade of the 1990s

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Abstract

The majority of clinical psychologists are men who were trained in university programs. That may not be the case in only a few years. More women and Psy.D. students are being awarded clinical doctorates than at any other time. These demographically large student groups may have needs not met by current training. We surveyed future clinicians who were graduate students in training during the early 1990s, had completed the majority of their internships by the late 1990s, and were likely to begin their professional careers by 2000. Participants were divided into four groups based on gender and enrollment in Ph.D. or Psy.D. programs. They were questioned concerning their perception of their training, their mentors for theory as well as for practice, and their interests and priorities for post-graduate employment. Findings suggest a number of issues that differentiate women and Psy.D.s from men and Ph.D.s and that may be meaningful for training, recruitment and/or future employment.

The demographics of graduate students in psychology began to change rapidly and dramatically during the 1980s. By the late 1980s, the previous decade's gender ratio of three men to one woman had been altered and a greater number of women than men had begun to earn their doctorates in the field (Aisenberg & Harrington, 1988). By 1994, the percentage of women awarded doctorates in psychology had grown to 61.5% (J. Kohout, APA Research Office, 1999). An APA Task Force (1995) appointed to consider the demographic change taking place described the situation as the "feminization of academic psychology." Presently, men are still a majority of the psychologists in the field. That majority will not continue if current training demographics are maintained.

Clinical psychology has paralleled these changes in the gender shift of new doctorates. It has also begun to undergo a second major modification in its membership, a change not shared by the more academically oriented specialties. In 1991, of the 1,971 graduates in clinical psychology, 1,494 were awarded Ph.D.s. The remaining 477 doctorates, or 32% of the total, were awarded clinical Psy.D.s. By 1997, the percentage of new Psy.D.s in clinical reached 37% of the 2,002 clinical doctorates awarded. A further increase in Psy.D.s is likely with the addition of planned professional schools. The number of Ph.D. doctorates in clinical psychology earned between 1990 and

1997 has remained fairly constant, ranging between 1,261 and 1,494 (J. Kohout, APA Research Office 1992, 1996, 1999).

Both as an occupation and as an organized discipline which regulates a profession, psychology has undergone a wide array of changes over time. Included among these changes are: an organizational separation of the applied and experimental memberships; the discovery and application of computer techniques useful in quantification; the accommodation to health maintenance organizations; and various landmark legal victories and losses dealing with psychology as an independent service provider discipline. Despite a history of change, the field has been remarkably lax or unsuccessful in predicting the effect of change and preparing for its sequelae. Hindsight, while more accurate, is not usually as helpful as foresight. An awareness of emergent changes in graduate student demographics might enhance foresight.

A major training juncture for clinical psychologists occurs at internship. The 1990s witnessed the issue of availability of internship training opportunities (e.g., Thorn & Dixon, 1999). The literature has begun to attend to implications of supply and demand changes (e.g., Plante, 1998). As the profession looks to the future we may speculate about change by examining the perceptions and visions of those who will populate that change. A prediction of emerging membership needs might be made with a focus on the effects of demographic changes. A questionnaire was composed to survey future clinicians' training experiences and attitudes toward employment. Replies were examined for demographic differences.

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Intern Survey

Procedure

Our survey consisted of 31 multiple choice and/or short answer questions. In addition to demographic information regarding the respondent's age, gender, and program, it tapped areas of applied interest, such as preferences among patient populations, types of practice, and future career directions. With a focus upon their graduate years rather than their internship, it asked about the design and goal of their dissertations as well as the research of their mentors. The questions included the number and gender of each intern's clinical faculty and the gender of the person designated as most influential faculty member, i.e., his or her mentor for specific educational decisions. It questioned about each respondent's interest and level of comfort in conducting research. It asked that the interns identify tasks that they had become both more as well as less interested in pursuing since entering their graduate training. And, to check for their motivations in judging future alternatives, it listed potential career attractions and/or deterrents and asked them to pick the most salient.

By 1992, APA had accredited over 300 clinical internship sites. Packets of questionnaires were mailed to a randomly selected one-third of the clinical internship training sites listed, in time to arrive late in the internship year. Four years later, a second third of that same list, chosen by random selection from the remaining sites, was contacted. Each mailing was addressed to the Internship Director. Each was asked to distribute the enclosed questionnaire forms to each of their clinical interns, to collect the completed questionnaires, and to mail them back as a group in the enclosed self-addressed envelope. Overall, 274 sites were contacted and replies were received from 165, composing a 60% return rate. A total of 423 useable questionnaires were collected. A reply was designated as useable if the respondent completed questions concerning his/her gender and the degree (Ph.D. vs. Psy.D.) he/she was to be awarded. Participants were categorized into a gender (men vs. women) by program (Ph.D. vs. Psy.D.) matrix.

Respondents

Table 1 lists information about the respondents and their mentors. Results of a 2 (intern gender) X 2 (Ph.D. versus Psy.D.)

Table 1
Interns, Their Clinical Faculties and Designated Theory and Practice Mentors

| | Interns | | | | Total |
|-----------------------------|--|------------|------------|------------|------------|
| | Ph.D. | | Psy.D. | | |
| | Women | Men | Women | Men | |
| Sample | | | | | |
| N | 205 | 114 | 70 | 34 | 423 |
| % of total | 48 | 27 | 17 | 8 | 100 |
| Age: Mean (SD) ^a | 32.0 (6.1) | 32.9 (5.6) | 33.9 (7.5) | 35.5 (5.7) | 32.8 (6.3) |
| | <u>Estimated Number of Clinical Faculty at Graduate School</u> | | | | |
| Total Faculty | | | | | |
| Mean (SD) | 11.7 (9.8) | 10.6 (5.5) | 13.8 (8.7) | 18.0(12.8) | |
| Median | 9 | 10 | 11 | 14.5 | |
| Mode | 7 | 12 | 6 | 10 | |
| Women Faculty | | | | | |
| Mean (SD) | 4.6 (8.1) | 3.9 (4.8) | 7.8(12.5) | 7.2 (7.1) | |
| Median | 3 | 3 | 4 | 5 | |
| Mode | 2 | 2 | 3 | 2 | |
| | <u>Interns' Designated Practice Mentors^b</u> | | | | |
| Faculty Women | 39% | 20% | 37% | 12% | |
| Faculty Men | 57% | 76% | 54% | 82% | *** |
| Missing, other | 4% | 4% | 9% | 6% | |
| | <u>Interns' Designated Theory Mentors^b</u> | | | | |
| Faculty Women | 38% | 18% | 33% | 12% | |
| Faculty Men | 59% | 78% | 61% | 85% | ** |
| Missing, other | 4% | 4% | 6% | 3% | |

^a ANOVA findings for age between degree programs, $F(1,398) = 8.799, p < .003$. Gender differences and interaction findings were both non-significant for age.

^b Columns under each category should sum to 100% and may vary due to rounding.

X^2 (6df) determined mentor differences. ** $p < .01$, *** $p < .001$.

program) ANOVA reveal a significant difference in mean age between the programs. Some students spend years acquiring life experiences in sub-doctoral applied work or careers in alternative fields before returning to earn their doctorates (Norcross, Sayette, Mayne, & Turkson, 1998). Today, some graduate students had training as nurses or members of the clergy as well as terminal masters in psychology and were employed in that capacity. Perhaps the age difference found here may be attributed to a greater proportion of Ph.D. then Psy.D. students having chosen to enter graduate training directly after their undergraduate years. Neither the survey nor a review of the literature provide the underlying distinctions. In any case, the form of intellectual guidance as well as the level of supervision during practicum courses may be quite different for those who remained students in comparison to those who returned to training after exposure to applied behaviors.

Faculty

Table 1 also quantifies the respondents' estimates of the number of faculty in their academic clinical programs and their designation of mentors for practice and for theory from within that group. Their numerical estimates suggest that both the men and women were more aware of same sex faculty members than those of the opposite gender. However, each group readily perceived that there were considerably more men than women on their faculties. They, in general, perceived that the median faculty contained about three times as many men as women. As interns were not asked to do so, they did not differentiate between faculty available full versus part-time. A recent national survey of Clinical Directors agreed that the American clinical faculty includes significantly more men than women. It noted the further reduction of women when it listed 38% of the women and 27% of the men as part-time, unpaid or adjunct, and thus, less available to students (Peterson, Brown, & Aronson, 1998). Noted below are difficulties that can arise from a faculty gender ratio directly opposite that of a student gender ratio.

Mentors

Gender percentages for research and for theory mentors are remarkably similar. Our women respondents reported more than a third of their mentors to be women. On the other hand, more than three-fourths of the men reported their mentors to be men. Table 1 notes that gender differences related to mentor gender are significant for both practice and theory. If each intern who was a woman had preferred to chose or be assigned a research advisor of her own gender, a small number of women were likely to have been the first choice of the majority of students. Wyche and Graves (1992) indicate that academics who are women report heavier workloads and stronger stress than do the faculty men. Women tenure track faculty, fewer in number and, at present, both younger and with less status or experience in research than their counterparts (Peterson, Brown, & Aronson, 1998), may be especially vulnerable to overload. Until that situation changes men graduate students will generally have a greater selection of same-sex mentors with more ample research experience to impart and time to impart it than the women students.

Faculty Functions

Interns estimated the percentage of faculty men and women from the intern's academic program who actively engaged in research and who actively engaged in practice. These four estimates were submitted to a 2 (intern gender) X 2 (intern academic program: Ph.D. vs. Psy.D.) MANOVA. The main effect of the interns' programs was the only significant effect, $F(4,356) = 10.49, p < .001$. Univariate tests compared activities of faculty from Ph.D. and Psy.D. programs. Table 2 indicates Ph.D. interns perceived that a greater proportion of their faculty participated in research than did the Psy.D. interns. In contrast Psy.D. interns perceived a greater proportion of their faculty participated in practice than did the Ph.D. interns.

Next, the four intern groups were combined and matched sample *t*-tests were performed to explore whether interns

Table 2
Interns' Perceptions of Academic Program Faculty Behaviors

| | Clinical Program Faculty (Interns' Estimated Percentages) | | | | | |
|-----------------------------------|--|-----------|----------|-----------|-----------------------|--|
| | Ph.D. | | Psy.D. | | <i>F</i> ^a | |
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | | |
| Faculty women engaged in research | 82% | 65.9 | 66% | 60.0 | 12.71*** | |
| Faculty men engaged in research | 79% | 26.4 | 71% | 66.6 | 8.16* | |
| Faculty women engaged in practice | 72% | 49.8 | 92% | 41.1 | 9.02** | |
| Faculty men engaged in practice | 63% | 30.7 | 82.6% | 24.1 | 23.77*** | |

^a *df* = (1,361). **p* < .05. ***p* < .01. *** *p* < .001

Table 3
Research Interests of Interns and their Mentors

| <u>Research Subject Matter</u> | <u>Interns</u> | | | | <u>X² (6df)</u> |
|--|-------------------------|-----------------------|------------------------|----------------------|----------------------------|
| | <u>Ph.D.</u> | <u>Ph.D.</u> | <u>Psy.D.</u> | <u>Psy.D.</u> | |
| | <u>Women</u> (n=205) | <u>Men</u> (n=114) | <u>Women</u> (n=70) | <u>Men</u> (n=34) | |
| Intern's Dissertation Subject | | | | | |
| Patients or pathological populations, e.g., depressives, eating disorders | 35% | 39% | 39% | 38% | |
| General groups not designated as pathological, e.g., undergraduates, mothers, children | 60% | 56% | 34% | 30% | *** |
| Other, no human contact, e.g., literature reviews, animal study | 6% | 6% | 27% | 32% | |
| Designated Theory Mentor's Research | | | | | |
| Patients or pathological populations, e.g., depressives, eating disorders | 35% | 37% | 46% | 59% | |
| General groups not designated as pathological, e.g., undergraduates, mothers, children | 47% | 45% | 23% | 15% | *** |
| Other, no human contact, e.g., literature reviews, animal study | 18% | 18% | 31% | 27% | |
| Designated Practice Mentor's Research | | | | | |
| Patients or pathological populations, e.g., depressives, eating disorders | 43% | 47% | 43% | 62% | |
| General groups not designated as pathological, e.g., undergraduates, mothers, children | 29% | 30% | 17% | 15% | ** |
| Other, no human contact, e.g., literature reviews, animal study | 29% | 23% | 39% | 24% | |

Note: Columns under each category should sum to 100% and may vary due to rounding.

** $p < .01$

*** $p < .001$

thought a greater proportion of their men or women faculty members were involved in their own research or practice. Although interns did not perceive differences in the percentage of the men and women members of their program faculties who were involved in personal research, there was a significant difference in interns' perception of faculty members engaged in practice. Interns perceived more women than men clinical faculty to be engaged in clinical practice, $t(373) = 3.52, p < .001$. As a greater number of female than male faculty are part-time or adjunct teachers and have private practice as their major occupation, this finding is not surprising (Norcross, Hanych, & Terranova, 1996).

Research

The interns were asked to indicate the focus or subject matter of their own as well as their mentors' research. Multiple choice categories with low endorsements have been combined to form three major emphases: pathological subjects, non-pathological subjects, and content not directly involving human contacts, e.g., review of the literature. Table 3 shows that the two programs did not differ in the extent of their students' direct study of pathology. About one third of both the Ph.D. and Psy.D. students focused upon disordered individuals or groups. However, their research content proportions did differ

in the remaining dissertations, with more Ph.D. students engaged in the study of normal populations and more Psy.D. students engaged in reviews of the literature. If the research topics chosen by students and faculty (see below) reflect the focus of training, these differences suggest that Ph.D. programs more likely emphasize *potential* information (i.e., how to gather and examine previously unknown and useable information for critical evaluation and extension of theory) and Psy.D. programs appear more likely to focus on *established* information (i.e., how to organize previous findings to aid future application in practice).

“If our speculation is accurate, Psy.D.s should be quite knowledgeable about pathology and how to treat it.”

Except for the report by all four groups that their mentors are as interested as the interns themselves in studying pathological cases, program mentors' research is seen as focused on the same content areas as that of their students. That is, Ph.D. more often than Psy.D. interns perceive their theory and practice mentors to be interested in basically “normal” populations. And, Psy.D. more often than Ph.D. students' view their mentors as more likely to do “library” research. Such preferences reflect a commonly expressed concern that, with more clinicians educated as Psy.D.s, there will be fewer clinicians trained to contribute to our extension of theory and understanding of “normal” behavior. If our speculation is accurate, Psy.D.s should be quite knowledgeable about pathology and how to treat it. But, they may be less prepared than Ph.D.s to judge the evidence concerning the adequacy of new theories and techniques. With the growing number of Psy.D. recipients, the field might consider the importance of continuing education to keep practice-focused individuals updated on changing ideas as well as the research upon which they are based.

Group similarities

Various responses concerning the effect of their training did not differentiate the four intern groups. For example, 33% of the total group increased and 4% decreased their interest in doing consultation since their application to graduate training. In contrast, they rated their interest in research to have

been slightly diminished during training. The proportion who described themselves as having become less interested in that future activity was greater (25%) than the percent who had become more interested (20%). Asked if there was any topic sufficiently interesting to bring them to engage in research, 92% of the surveyed sample indicated there was with little variation among our four categories. Yet, when asked if there was a skill they had not absorbed that would limit or had left them less than adequately prepared to carry on research, 65% of Psy.D. and 55% of Ph.D. interns checked “yes,” with the men and women differing by less than two percentage points. The open-ended question that queried as to their impediments to carrying on research found statistics or research design to be the basis of 84% of the Ph.D.s' and 76% of the Psy.D.s' perceived deficiency. The survey, unfortunately, did not cover the degree to which the respondents felt competent to read and understand research produced by others.

Applied interests and goals

The interns were asked to indicate preferences for future work, such as most desired patient populations and preferred treatment modalities. As shown in Table 4, all four groups were, generally, drawn to work with adult clients, seen individually (rather than in groups) and in outpatient facilities. The majority of all four groups prefer treatment to diagnostic activities. The women respondents, regardless of degree pro-

“But they may be less prepared than Ph.D.s to judge the evidence concerning the adequacy of new theories and techniques.”

gram, indicated greater interest in working with children than did the men. Psy.D.s, regardless of gender, showed a stronger attraction to clinical practice than to teaching or research than did Ph.D.s. The men more often saw private practice as a future employment intention than did the women. In contrast, the women more often hoped to work in agencies than did the men. None of the groups showed a widespread attraction to teaching. Although the number with that interest was quite low, the men in both programs were more drawn to teaching and research than were the women.

Table 4
Interns' Preferences for Future Work

| Research Subject Matter | Interns | | | | χ^2 |
|--------------------------------|------------------|----------------|-----------------|---------------|----------|
| | Ph.D. | | Psy.D. | | |
| | Women (n=205) | Men (n=114) | Women (n=70) | Men (n=34) | |
| Patient Emphasis | | | | | |
| Child | 33% | 18% | 30% | 27% | |
| Adult | 52% | 74% | 59% | 59%** | |
| Mixed or other | 16% | 8% | 11% | 15% | |
| Preferred Setting | | | | | |
| Family or Group | 29% | 25% | 23% | 30% | |
| Individual | 52% | 62% | 59% | 68% | |
| Mixed or other | 18% | 13% | 19% | 3% | |
| Practice Function | | | | | |
| Treatment | 72% | 82% | 79% | 82% | |
| Assessment, mixed or other | 38% | 28% | 24% | 24% | |
| Severity Emphasis | | | | | |
| Outpatient | 72% | 82% | 79% | 82% | |
| Inpatient, mixed or other | 28% | 18% | 21% | 18% | |
| Employment Organization | | | | | |
| Private or group practice | 35% | 46% | 37% | 63% | |
| Agency, mixed or other | 66% | 54% | 63% | 39% | |
| Interests | | | | | |
| Private | 61% | 65% | 81% | 76% | |
| Research and/or teaching | 15% | 24% | 4% | 18% | *** |
| Mixed or other | 23% | 11% | 14% | 6% | |

* $\chi^2(3df), p < .05$
 ** $\chi^2(6df), p < .01$
 *** $\chi^2(6df), p < .001$

Employment attractions and deterrents

The interns were provided a list of 25 brief phrases describing an array of goals or opportunities which might influence their choice of post-graduate employment. They were asked to choose the five most important reasons which might motivate their acceptance of a new position and the five which might least influence their choice. If items were selected at random, each would be picked by 20% of the respondents. Table 5 lists those items that were considered either most or

least important, when choosing employment, by one-third or more of any category of intern. Information about items chosen by such a large proportion of the respondents might be useful to agencies that advertise for novice staff. As an example, a large segment of the sample did not prize publishing. In fact, 41% of the interns listed the opportunity to publish as a *least* important item.

To designate items that differentiated the four intern groups, a Chi Square of $p < .05$ was selected to indicate an

Table 5
Popular Reasons for Accepting or Rejecting a Position Once Internship Has Ended

| | <u>Interns</u> | | | | <u>Total</u> | <u>X² (3df)</u> |
|---|-------------------------|---------------------------------------|------------------------|---------------------------------------|--------------|----------------------------|
| | <u>Women</u> (n=205) | <u>Ph.D.</u> <u>Men</u> (n=114) | <u>Women</u> (n=70) | <u>Psy.D.</u> <u>Men</u> (n=34) | | |
| Reasons Checked as Most Important | | | | | | |
| Personal skills | 56% | 45% | 53% | 62% | 53% | |
| Variety or breadth | 54% | 52% | 53% | 41% | 53% | |
| Intellectual enrichment | 48% | 47% | 53% | 32% | 47% | |
| Income | 32% | 52% | 34% | 50% | 39% | ** |
| Geography | 39% | 42% | 28% | 35% | 38% | |
| Coordinate with spouse | 36% | 36% | 32% | 26% | 35% | |
| Opportunity for further training | 39% | 23% | 41% | 21% | 34% | ** |
| Want to impact system | 33% | 31% | 26% | 38% | 32% | |
| Opportunity to advance | 18% | 18% | 16% | 35% | 19% | * |
| Want to educate others | 17% | 22% | 6% | 53% | 19% | *** |
| Reasons Checked as Least Important | | | | | | |
| Hobby or other activity | 64% | 59% | 57% | 62% | 61% | |
| Less competition | 50% | 37% | 31% | 44% | 43% | ** |
| Status or prestige | 39% | 42% | 58% | 35% | 43% | * |
| Opportunity to publish | 37% | 32% | 55% | 65% | 41% | *** |
| Accommodate parent or child | 38% | 38% | 43% | 38% | 39% | |
| Shape psychology | 32% | 29% | 23% | 59% | 32% | ** |
| Fringe benefits, e.g., travel | 33% | 37% | 23% | 15% | 31% | * |

Notes

N = 417 for the most important and N = 413 for the least important list

Popularity was defined as being chosen by 33% or more of the total or any intern category

- * p < .05
- ** p < .01
- *** p < .001

interesting tendency among the more frequently chosen items. Hence, men regarded income as more important than did women, who viewed salary as less important than other factors. There was also a difference between programs regarding opportunity to publish as an element of a first job. Although 13% of the Ph.D.s considered the opportunity to do research as a plus, only 1% of the Psy.D.s agreed. In fact, it appears that few Psy.D.s would be attracted by a setting which advertises a research emphasis. Psy.D. men indicated that the opportunity to shape the field and Psy.D. women rated the opportunity to gain prestige to be less important than the other choices offered. When considering a career choice, the men, both Ph.D. and Psy.D., were less influenced than the women by jobs that offer further training. Responses indicated that 39% of the women and 23% of the men were interested in continuing their education while employed. If more women seem more interested in continued training than men, the reverse was found

when they were asked if they want to *provide* education and training. Here, 14% of the women and 29% of the men showed an interest in teaching. With the number of women students continuing to grow, interest in continued training might be addressed more strongly. And, with fewer women interested in being education providers, future students who are women may be hard pressed to find same-sex mentors on their faculties.

Social responsibilities

When considered as a whole, these students show a remarkable freedom from responsibility for others when making career decisions. About one third rated the coordination of job choice with that of a spouse as a major element in their decisions. Yet, less than 5% believed a parent's or child's needs were important considerations for choosing a job, 7% of the women and 1% of the men. Table 5, in fact, indicates that about

40% of the total group felt the need to accommodate a parent or child was of *minimal* importance. It might be the case that many were still childless. Surely, however, most still had families of origin. Those going into the clinical field appear to have few extended family responsibilities influencing their initial employment. In light of such few familial restrictions, interns would be free to relocate or seek employment nationwide. As to limitations based upon future security plans, only 2% listed retirement benefits a factor of some weight.

Implications and Applications

More women than ever before are obtaining doctorates in clinical psychology. Findings indicate that they are more likely to favor child clinic populations and work in agencies than are the men who are new doctorates. One might predict either (a) an increase in the recognition that such service is valuable and should be well funded, or, (b) an increase in the competition for employment for child agency slots. Such implications are suggested by the differences between genders. Although these findings may not be surprising, they can be useful in making manpower predictions. They may stimulate further examination of the magnitude and effects of expected training changes. For example, will the above difference be large enough to encourage more graduate departments to specialize in child and family problems to attract those women about to choose programs? Should programs warn their students away from the competition expected with child work? Or, should programs attempt to admit more students with alternative major interests to avoid future competition? If the behavior typical of training programs in the past predominates, an increase of training along the lines of student interest will most likely occur. Perhaps, the discipline might be most helpful to future clinical doctorates if it begins to advocate more strongly for monies to carry out child research.

“An increase in the availability of same-sex mentors to accommodate the increasing number of women in graduate training is warranted.”

An increase in the availability of same-sex mentors to accommodate the increasing number of women in graduate training is warranted. Most graduates of applied programs are expected to become practitioners. A few programs are more science oriented and hope to produce future researchers and

educators. They have had years of experience in pinpointing those men who apply who might become tomorrow's researchers. However, those programs which stress the science half of the science-practitioner may not have fully achieved that goal with their women applicants. These findings indicate that fewer women than men about to complete internship are interested in pursuing careers in teaching and research. Responses on changes they see in themselves since entering training suggest that differences in the pursuits of men and women are largely present when they enter their graduate programs and are not simply the result of going through those programs. If this is indeed a recruitment issue, then several things can be done. Perhaps other recruitment strategies are needed to discover women with a likely successful goal of tenure-track employment.

“The fact that our respondents, regardless of gender, were distrustful of their skill in statistics suggests the need for innovation with teaching of statistics.”

The fact that our respondents, regardless of gender, were distrustful of their skill in statistics suggests the need for innovation with teaching of statistics. Such consideration might lead to new and useful ways of producing future faculty.

The increased ratio of women entering the field is minimally due to a reduction of men receiving the doctorate. The shift is more the result of a general increase of graduates, the majority of whom are women. That gender change has occurred over a 20 year period and many of its effects are already noticeable. The changes likely due to the more recent increase of Psy.D.s awarded are less clear. That alternative can lead to an increase of Psy.D.'s attraction by graduates who might otherwise attend Ph.D. programs. That potential change has not been observable over the past 10 years. If the number of Psy.D. doctorates continues in its growth, resultant changes might be anticipated. For example, both applied and non-applied graduate students who might wish to fill future Psy.D. faculty slots should note skills or expertise that are likely to be attractive to Psy.D. departments.

No questions were included that would permit an examination of minority group factors. However, responses con-

cerning family needs suggest that the people who are currently being trained as clinicians are either from families in the financially comfortable middle class, or, are too young to plan far ahead. Few of the group were concerned about pension provisions with early employment. Perhaps the fact that people expect to change jobs or even careers more often than was done in the past may also limit their behaviors concerning plans for the extended future.

Limitations

The gender distribution of the present sample, 65% women, corresponds to that of the national reports. On the other hand, the sample did not constitute a proportionate selection of Psy.D. trainees. The number of Ph.D. as opposed to Psy.D. interns who participated in this survey (76% vs. 24%) leaves Psy.D. coverage almost 10 percent below expectation. The latter could reflect a greater reluctance of Psy.D. interns to fill out questionnaires. It is more likely due to the fact that some professional school students are provided internally organized internship sites which do not accept those trained elsewhere. Such internships do not usually come under the APA accreditation format and would not have been in the pool from which sites were selected for participation.

Our interns are grouped as men versus women and Psy.D. versus Ph.D. However, some programs are not as precisely distinguishable as our categories might imply. Some university based programs offer a Psy.D. as well as a Ph.D. track, with students in both tracks sharing courses. Additionally, several professional schools award occasional Ph.D.s. Such instances, while in the minority, make the differences between Ph.D. and Psy.D. training less clear cut than the APA statistics would suggest. The fact that some students share overlapping training experiences is likely to minimize or obscure program differences rather than suggest differences that are not present. These comparisons between programs may overlook natural differences that would emerge with more control and precision in sampling. Thus, these findings are more likely to underestimate than overestimate differences between programs. Further information from Psy.D. sources would help clarify this point. ■

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Clinical Integration

Should religious and spiritual values be incorporated in therapy?

Julia Taylor
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Traditionally, psychology has seen religion and psychotherapy as incompatible. Freud (1927) viewed psychotherapy as an empirical science that should not be influenced by a value-laden tradition like religion. He described religion as a universal neurosis that should be cast aside. Likewise, Albert Ellis (1986) argued that religion is irrational and a contributor to emotional disturbance, stating, "The conclusion seems inescapable that religiosity is, on almost every conceivable count, opposed to the normal goals of mental health...on the whole religious piety and dogma do much more harm than good..." (p. 42).

Nevertheless, interest in the confluence of psychology and religion has grown substantially since the mid-1980's as reflected in newly created professional organizations (such as the American Association of Christian Counselors), the growth of religious counseling centers, and an increasing number of publications on the subject (Worthington, Kurusu, McCullough, & Sandage, 1996). Psychologists have begun to investigate the prevalence of religious beliefs, the effect of religious coping on reactions to stress and trauma, and the ethicality of incorporating religious values into psychotherapy (or failing to do so) (Hall & Hall, 1997; Hawkins & Bullock, 1995; Koenig, Larson, & Matthews, 1996; Pargament, 1997). An exhaustive exploration of the incorporation of religious and/or spiritual values into psychotherapy (a process termed clinical integration by Hall and Hall [1997]) could easily fill a book (and has!).

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The goal of this article is to give a brief introduction to clinical integration—its relevance, benefits and disadvantages, and practice—and then to look more closely at its ethicality. Such a discussion might be especially important for beginning graduate-student therapists who are likely faced with myriad questions on the issue. Should therapists acknowledge their clients' religious belief systems in therapy? Should therapists make their own value systems, often drawn from or influenced by religion, explicit in therapy? What ethical questions does clinical integration raise? For example, how are clients' own senses of autonomy preserved or threatened by clinical integration?

Worthington and colleagues (1996) provide some definitions that are useful in clarifying the discussion of clinical integration. They define *religious individuals* as those who hold beliefs about what is important that are derived from an organized world religion. *Spiritual individuals*, on the other hand, "believe in, value, or are devoted to some higher power than what exists in the corporeal world," (Worthington et al., 1996, p. 449). A person may be spiritual, religious, both, or neither. In order to allow consideration of both constructs in this paper, I will use the word *religious* to encompass both religious and spiritual values and themes.

Why discuss religion and values in the context of psychotherapy?

Bergin (1991) argues that therapists must consider values (both their own and their clients') because there is no such thing as value-free therapy. The author states that therapists attempting to ignore the role of values in their therapy create either of two negative situations. First, the client may interpret the therapist's noncommittal moral stance as tacit approval. Second, because true objectivity is nearly impossible, the therapist's value system inevitably will emerge to influence the questions, reactions, and interpretations he or she chooses. For example, a therapist might wonder "Was I too encouraging when the patient announced that she intends to leave her husband?...Did

I appear morally censorious, enthusiastic, or pruriently curious when this man boasted of his sexual conquests?" (Holmes, 1997, p. 337). As argued eloquently by Bergin (1985):

It is vital that we be more explicit about our values because we use them, however unconsciously, as a means of therapeutic change. Although we may have been hesitant about this for fear of becoming manipulators of morals, being explicit actually protects clients. The more subtle our values, the more likely we are to be hidden persuaders (p. 107).

In addition to the fact that attempting to exclude values from therapy is likely to be unsuccessful, explicit incorporation of values may have several therapeutic benefits. For example, embracing values thought to be consistent with mental health and promoted by religion (such as trust, honesty, fidelity, and self-regulation) guides goal-setting and outcomes evaluation in treatment (Bergin, 1991). Acknowledging clients' religious lives also may enhance change processes by providing a moral frame of reference and broadening the range of therapeutic intervention options (Hall & Hall, 1997).

A second line of reasoning supporting the therapeutic benefits of incorporating values comes from the values convergence literature. Values convergence refers to a process in which clients' values become increasingly similar to those of their therapist over the course of therapy (Kelly, 1990). As the value systems converge, clients show significant symptom reduction (as rated by therapists). This improvement is heightened if the values of client and therapist are initially more dissimilar (Kelly, 1990). Optimal therapeutic outcomes appear to occur when values of clients and therapists are moderately similar (but neither identical nor sharply contrasting) (Holmes, 1997). Presumably, this is because values that are too similar do not get adequately explored and values that are too dissimilar strain the therapeutic alliance. Therapists who are explicit about values with their clients may facilitate the values convergence process, as clients are encouraged to examine their own belief systems and reconcile them with material being discussed in session. As a result, clinicians who make their values known may increase their therapeutic impact.

A final argument in support of incorporating values in therapy comes from data on the efficacy of religious versus secular interventions with religious clients. For example, Propst and colleagues (1992) examined the effectiveness of cognitive-behavioral therapy (CBT) when administered with and without religious content. Religious CBT was distinguished by the use of religious rationales for therapeutic techniques, religious arguments to combat maladaptive thoughts, and religious imagery in behavioral exercises. Propst and colleagues

(1992) randomly assigned depressed, religious patients to one of four conditions: religious CBT, secular CBT, pastoral counseling, or a wait-list control. Clients in both the religious CBT and pastoral counseling conditions showed statistically significantly less depression and better adjustment at two year follow-up in comparison with clients in the secular CBT and wait-list control groups.

Azhar, Varma, & Dharap (1994) compared the effectiveness of supportive therapy versus supportive therapy plus religious psychotherapy for the treatment of anxiety disorders among a group of Muslim clients. The religious psychotherapy component included individual prayer and scripture reading from the Koran. Both groups were given pharmacotherapy (benzodiazepines) in addition to psychotherapy. At three-month follow-up, the supportive plus religious psychotherapy group had statistically significantly lower scores on the Hamilton Anxiety scale (as rated by a psychiatrist unaware of group assignment). Although preliminary, these studies suggest that, among clients identified as religious, religiously oriented therapy may be more effective in treating affective and anxiety disorders (Koenig, Larson, & Matthews, 1996).

Links between Religion and Mental & Physical Health

Researchers also have begun to look at the risks and benefits of religion in terms of mental and physical health outcomes. I review these findings not to argue for the superiority of having a religious belief system, nor to argue that nonreligious clients should be encouraged to develop religious values. Rather, I review these findings to provide therapists treating a diversity of clients with information on the adaptiveness and maladaptiveness of various religious beliefs. Therapists who are aware of the data about what types of religious coping patterns are adaptive under what kinds of circumstances can make informed decisions about if, when, and how to approach the integration of religious values. The majority of these studies are focused on Western religions such as Judaism and Christianity; much less attention has been given to Islam, Buddhism, and other Eastern religions.

As early as 1983, Bergin conducted a meta-analysis in which he found that religion was slightly correlated with better mental health. No correlation was found between religion and mental illness (Bergin, 1983). Looking more closely at types of religious orientation, intrinsic religiosity (a sustaining, guiding faith that is internalized and manifested in one's life) has been linked to positive mental health markers such as self-control, sociability, well-being, and stress tolerance (Bergin, Masters, & Richards, 1987). Conversely, extrinsic religiosity (a utilitarian faith aimed at gaining status, support, or security)

has been linked to negative markers such as anxiety, low stress tolerance, and decreased well-being (Bergin et al., 1987).

Pargament (1997) found support for a model in which religious coping style (either positive or negative) mediates the relationship between religious orientation and outcomes after negative life events. Positive religious coping involves themes such as spiritual connectedness, a sense of spirituality and meaning in life, and a secure relationship to God. This religious coping pattern involves strategies such as benevolent religious reappraisal, seeking spiritual support, and collaborative religious coping (believing that God is one's partner in facing life's challenges). In contrast, negative religious coping is defined by an insecure relationship to God, a view of the world as threatening, and profound questions about the meaning of life. This religious coping pattern involves strategies such as punitive religious reappraisals, spiritual discontent, and self-directing religious coping (believing that God gave man the tools to solve his problems and now he must do so alone).

Patterns of positive religious coping have been associated with better adjustment, greater well-being, decreased perceptions of burden among caregivers, more positive and less negative affect, and measures of personal growth (Brant & Pargament, 1995; Mercer, Lorden, & Falkenberg, 1995; Park & Cohen, 1993; Wright, Pratt, & Schmall, 1985). Patterns of negative religious coping have been associated with greater depression, more PTSD symptoms, callousness, lower quality of life, poorer physical health, and more emotional distress (Pargament, Smith, Koenig, & Perez, 1998). Positive religious coping is more common than negative religious coping; it appears that people are more likely to "see God and their congregation as a source of love and support than as a source of pain and punishment" (Bearon & Koenig, 1990; Pargament, Smith, Koenig, & Perez, 1998, p. 712).

Additionally, a number of researchers have examined the role of religion in coping with illness and disease, particularly using cross-sectional study designs. Among a sample of symptomatic HIV-positive African-American women, greater use of religious coping strategies such as seeking comfort in their religion and placing trust in God was associated with significantly less depression and anxiety (Woods, Antoni, Ironson, & Kling, 1999a). Among a sample of mildly symptomatic HIV-positive homosexual men, greater use of religious coping again was found to be associated with less depression. Interestingly, higher levels of religious behavior such as prayer and attending church also was associated with better immune function (higher CD4+ counts and percentages) (Woods, Antoni, Ironson, & Kling, 1999b).

Even after controlling for confounding variables, patterns of positive religious coping have been linked to better physical functioning and better treatment compliance at one-year follow-up among 40 heart transplant patients (Harris et al., 1995), better interactions and better treatment compliance among 126 dialysis patients (O'Brien, 1982), significantly lower risk of mortality in the 6 months following open heart surgery (Oxman, Freeman, & Manheimer, 1995), and less depression over a 6 month period among medically ill, elderly men (Koenig et al., 1992).

Kausar and Akram (1998) found that terminal cancer patients were more likely to report using religious coping strategies than were non-terminal patients with a variety of illnesses. The authors found a strong relationship between religious coping strategies and acceptance of one's illness, suggesting that religious coping may help terminal patients come to terms with their mortality. Researchers have shown that elderly clients who are religious tend to have lower blood pressure, fewer strokes, less mortality associated with coronary heart disease, and longer overall survival rates as compared to the non-religious elderly (see Koenig, Matthews, & Larson, 1996, for a review).

A number of researchers believe that incorporating religious values into therapy may be particularly important with highly religious, elderly, and medically ill clients (Hall & Hall, 1997; Koenig, Larson, & Matthews, 1996; Pargament, 1997). Additionally, a meta-analysis by Pargament (1997) suggests that women, African-Americans, elderly, poor, and less educated individuals may benefit more from the incorporation of religious coping strategies than other groups, in particular because these groups tend to be more religious. Pargament suggests that the increased use of religious coping among these group members may be related to their traditionally less powerful role in society. Exploring the use of religious coping with these groups is recommended.

In sum, there is empirical support for the assertion that some religious beliefs and coping strategies are associated with positive mental and physical health outcomes for some portion of our clinical population. Specifically, religious coping may be particularly helpful for elderly and medically ill clients as well as clients who are particularly religious. It appears that regardless of whether the stressor is a common occurrence (such as contending with multiple role demands) or a traumatic event (such as diagnosis with a terminal illness), religious beliefs and coping strategies can be an important source of strength and solace.

Several caveats must be made when interpreting these results. First, effect sizes in these studies are generally small,

suggesting that although religious coping plays a role, it does not have a strong impact on outcome measures (Pargament, 1997). Secondly, these religious coping strategies do not appear to play a consistent role. In some studies, positive religious coping has been linked to negative outcomes (such as more negative affect), negative religious coping has been linked to positive outcomes (such as stress-related growth), and both types of religious coping have shown non-significant relationships to mental and physical health outcome markers in other studies (see Pargament, 1997, for a review). Given that this topic has been systematically studied only in recent years, many of these phenomena are not yet well understood. It would be premature to label one religious coping style as entirely good or bad at this time.

Religious Values among Clients and Therapists

How likely is it that a therapist will encounter a religious client appropriate for clinical integration? Survey research has provided important information about the prevalence of religious affiliation, the relative importance of religious beliefs, and attitudes about discussing religion in therapy. A 1985 survey conducted by the Gallup organization revealed that fully two-thirds of Americans rated religion as important or very important in their lives (Religion in America, 1985). Over 70% of those surveyed agreed with the statement, "My whole approach to life is based on my religion." In studies focused on coping after traumatic experiences such as breast cancer diagnosis, domestic violence, or surgery, 50% to 85% of participants reported that they found religion helpful in their coping efforts (Pargament, 1997). Quakenbos, Privette, and Klentz (1985) reported that 79% of their random sample thought that religious values should be discussed in therapy. These data suggest that religious beliefs are widespread in our society and that therapists are likely to have religious clients in their caseloads. As a result, "purely secular psychotherapy may be alien to many people's way of thinking" (Bergin, 1991, p. 386). Therapists may be able to connect more deeply with clients and foster more appropriate change if they understand the religious aspects of their clients' belief systems, fears, coping strategies, and goals.

Consideration of *therapists'* religious beliefs is also important in a discussion of clinical integration. In a survey of marriage and family therapists, social workers, psychiatrists, psychologists, Bergin and Jensen (1990) found that 41% attended religious services regularly and 46% agreed with the statement, "My whole approach to life is based on my religion." These percentages dropped to one-third when clinical psychologists were considered independently. While these data can be interpreted to mean that psychotherapists are less

religious than the general public, they also communicate that a considerable minority of psychotherapists have strong religious values that are likely to influence therapy (whether explicitly or implicitly). Do therapists poorly trained in addressing religious material avoid it to the detriment of their clients? Or do they address it without acknowledging the influence of their value systems? Do religious therapists practicing in secular settings feel constrained when clients raise religious issues? Do religious therapists in these settings feel inauthentic when they fail to address their clients' religious and spiritual concerns? These questions are important, and research aimed at addressing them may provide valuable insights about integrating religious values in therapy.

What does clinical integration look like in the therapy room?

Given that a substantial number of clients and therapists hold religious values that may have positive mental and physical health implications, how does a therapist interested in clinical integration implement it? How is religious material presented? Are the interventions used similar to traditional ones or unique to religiously integrated therapy?

Tan (1996) notes that clinical integration can be either implicit or explicit. When integration is implicit, the therapist's religious values inform therapy tacitly, the client's religious values are recognized and respected, and religious issues are discussed when initiated by the client. The therapist may pray for the client outside of session. In contrast, explicit clinical integration involves systematically addressing religious issues in therapy, using prayer or Scripture in session, or referring a client to church or a religious advisor (Tan, 1996).

Further, therapists explicitly integrating religious material can do so on a continuum. On one end of this continuum, therapists can address religious or spiritual content in session, which might involve taking a religious history or discussing spiritual doubt, forgiveness, and meaning and purpose in life (Hall & Hall, 1997). Therapists also may conduct religiously-oriented cognitive-behavioral therapy, marriage and family therapy, or existential therapy (Hall and Hall, 1997). On the other end of the continuum, the most explicit form of clinical integration makes spiritual growth (in addition to psychological growth) a goal of therapy. It involves the use of worship, prayer, fasting, solitude, and biblical lessons in therapy. In reviewing the literature on religious techniques used in explicit clinical integration, Hall and Hall (1997) found that prayer, use of biblical scripture or other sacred texts, and referral to religious groups and clergy were the most common. For reasons discussed below, this type of explicit integration is controversial.

What are the concerns about clinical integration?

Although it may be recommended with some clients, potential limitations and concerns demand that clinical integration be conducted with various points in mind. First, because most therapists do not receive formal training in the diversity of world religions that might be practiced by their clients, they may be unaware of unorthodox or foreign religious beliefs and practices (Schultz-Ross & Gutheil, 1997). This situation creates two difficulties. First, the therapist may inadvertently punish the client who divulges unfamiliar religious values by labeling him or her as pathological. Second, even if these religious beliefs are not seen as pathological, the therapist may have difficulty gaining an understanding of them and incorporating them into therapy (Schultz-Ross & Gutheil, 1997). This may leave the client wondering why he or she discussed these beliefs at all, and why they are not being referred to in therapy. Therapists choosing to integrate religious values into therapy have the responsibility of learning about various world religions, and further, need to become familiar with the specific belief systems held by their clients.

A second difficulty with clinical integration arises when the therapist does not have a fully articulated value system of his or her own (Schultz-Ross & Gutheil, 1997). It is difficult to help clients examine and reconcile their values when therapists have not done so themselves. Additionally, the therapist with unacknowledged or unclear values risks having those values surface and assert themselves unwittingly in session. Third, clinical integration may be counterproductive if the therapist and client hold similar religious beliefs and thus fail to explore important content areas (client and therapist both believe in life after death, creating a taboo against discussing the client's fears about death). (Schultz-Ross & Gutheil, 1997; Hall and Hall, 1997).

A fourth difficulty can arise when the lines between religious advisor and therapist get blurred, as is often the case in the most explicit form of clinical integration (Hall and Hall, 1997; Hopkins, 1995; Koenig, Matthews, & Larson, 1996). Clinical integration refers to acknowledging the religious values important to clients and helping them to explore how these values influence their lives (positively and/or negatively). It should not involve instructing clients in religious values or encouraging them to adopt one set of beliefs over another. Therapists should remain primarily focused on psychological adjustment and adaptive functioning, not spiritual development (Koenig, Larson, Matthews, 1996). Hopkins (1995) warns that trying to combine therapy and religion into one setting may result in confusion as to which aspect is primary. To remedy this, clients can be encouraged to consult with reli-

gious advisors before, during, and after they engage in religiously integrated therapy.

Ethical Considerations in Clinical Integration

If therapists are cognizant of the risks and choose to incorporate religion in therapy, what ethical issues does this raise? The discussion thus far takes the consequentialist perspective in that it assumes religious values will influence therapy and focuses on the consequences of this situation. The consequentialist viewpoint adds up the positive aspects of recognizing religious values in therapy (for example, better therapy outcomes with religious clients, and more relevant, holistic therapy for elderly, medically ill, and religious clients) and compares these to potential negative consequences (for example, failure to explore important issues because of similar value structures or blurring of lines between therapist and religious advisor). The consequentialist judges clinical integration to be ethical if the pros outweigh the cons.

A second school of ethical thought—deontology—analyzes ethical issues by examining the motives of the decision-maker rather than the consequences of the decision. Deontologists focus on universal moral principles such as beneficence (promoting health and welfare), nonmaleficence (doing no harm), and autonomy (respect for each individual's freedom), among others. Considering core ethical principles from the deontological framework as well as reviewing the formal code of ethics set forth for psychologists enhances the consequentialist ethical analysis undertaken thus far.

Considering clinical integration from the vantage point of beneficence, the therapist who chooses to incorporate religious values in therapy may see this approach as the best way to promote health and well-being for his or her religious client. Attuned to the importance of religious beliefs and practices in the life of the client, the therapist recognizes the importance of honoring those beliefs in any system that promotes personal change. Exploring religious values and beliefs openly and without judgment in therapy may allow these clients to establish a better therapeutic alliance and to discuss a wider range of concerns.

Considering clinical integration from the vantage point of nonmaleficence, therapists are forced to ask themselves the following questions. If we omit any religious discussion, are we providing the maximally therapeutic environment? Are we potentially causing harm by failing to acknowledge religious issues? A therapist who is unwilling or unable to discuss religious concerns with, for example, religious clients who are elderly or who are coping with a terminal disease may risk exacerbating the client's feelings of anxiety, fear, despair, and

confusion. At a minimum, psychologists should cultivate an awareness of which types of clients are most likely to struggle with religious issues, outcomes associated with different types of religious coping, and local religious resources available to clients.

Just as failure to use clinical integration when appropriate could do harm, using clinical integration inappropriately also could do harm. Nelson and Wilson (1984) propose that clinical integration is ethical when the following criteria have been met: (1) when the client is not psychotic or otherwise inappropriate, (2) when timing is appropriate, (e.g., the client is not in crisis), (3) when the therapist works within the client's existing value system, and (4) when the client has agreed to religious or spiritual discussion and intervention during the informed consent process. These criteria provide a framework for using clinical integration so as to promote nonmaleficence.

Although beneficence and nonmaleficence may be important reasons for clinical integration with religious clients, concerns about respecting the autonomy of clients raise questions about the ethicality of this approach. The therapist's approach to clinical integration appears to be the most important consideration in examining this issue (see below for detailed recommendations). In general, therapists honoring autonomy must vigilantly avoid incorporating religion without informed consent, making judgments about the client's religious belief system, or imposing their religious views.

How does the field of psychology address the ethics of integrating religion and psychotherapy? As drafted by the American Psychological Association (APA) (1992), the "Ethical Principles of Psychologists and Code of Conduct" specifically mentions religion in four places (Hawkins & Bullock, 1995). First, religion is named in conjunction with the goal of respecting people's rights and dignity. This statement recommends that psychologists be aware of "cultural, individual, and role differences, including those due to age, gender, race... and religion," (p. 1599).

Religion is also specifically mentioned in ethical standards regarding Human Differences (Section 1.08: requires psychologists to obtain training and supervision that ensures competence in treating religious clients), Nondiscrimination (Section 1.10: prohibits psychologists from discriminating on the basis of religion), and Other Harassment (Section 1.12: prohibits psychologists from knowingly harassing or demeaning clients on the basis of religion). Lastly, Section 1.09 (Respecting Others) requires psychologists to allow clients the freedom to hold values that differ from their own. Although not stated explicitly, this standard could easily be interpreted to include religious values (Hawkins & Bullock, 1995). The APA Code of

Ethics makes it clear that, at a minimum, psychologists should be aware of clients' religious values, respect religious diversity, and increase their competence in dealing with religious issues.

Toward Ethical Guidelines for Clinical Integration

Careful examination of the ethical concerns surrounding a clinical issue allows for more careful, proactive, and well-informed decision-making. Employing both the consequentialist and deontological ethical perspectives, scholars have outlined a number of recommendations for the ethical practice of clinical integration.

Hawkins and Bullock (1995) state that although many psychologists are careful to respect diversity deriving from racial or cultural factors, they may be much less likely to acknowledge religious diversity. This failure to acknowledge religious beliefs may stem from a lack of emphasis on religious diversity in training programs or from our generally secular academic and professional culture. Under many circumstances, discussing religious beliefs or values is seen as somewhat taboo.

The authors assert that psychologists are ethically bound to increase competence in treating issues with spiritual or religious dimensions (Hawkins & Bullock, 1995). Hall and Hall (1997) argue that therapists should at least be aware of different world religions, of their own religious beliefs and value systems, and of how religious beliefs and values affect therapy. Awareness of these issues can help the therapist to confront issues such as how a client's beliefs about sin affect his or her understanding of maladaptive behavior, how the church serves as a source of social support for a client, and how the client's religion informs his or her ideas about meaning in life (Hall and Hall, 1997).

If a therapist is uncomfortable working with religious clients or feels ill-prepared to do so, appropriate referrals should be made (Hopkins, 1995). Therapists should not practice outside their area of competence with any client type, including religious clients. For clinical integration to be conducted ethically and optimally, new models of training and supervision are needed. Schultz-Ross and Gutheil (1997) found that only 5% of psychologists in one survey reported receiving any training in spiritual issues. Interestingly, one-third of a random sample of clinical psychologists in Division 12 (Clinical Psychology) of the APA felt competent in dealing with religious or spiritual issues in therapy (Shafranske & Malony, 1990). These data suggest that it was their personal experience with religion and affiliation with religious organizations that contributed to the feelings of increased competence, rather than any specific education, training, or supervision.

Given the diversity of religious systems and the array of clinical and ethical issues that clinical integration can raise, more than personal experience with religion may be needed before addressing religion in therapy. Therapists interested in formal training in clinical integration may be frustrated by the scarcity of training sites. Hall and Hall (1997) recommend gaining competence by becoming familiar with the growing body of literature, consulting with colleagues who use clinical integration, and consulting with religious professionals.

In addition to increasing professional competence, therapists may choose to communicate the spiritual or religious system from which they derive their values at the outset of therapy, preferably through the informed consent process (Hall & Hall, 1997; Hawkins & Bullock, 1995). Basic elements of proper informed consent, such as discussing therapist qualifications, therapy goals, and treatment alternatives, could apply directly to clinical integration (Hawkins & Bullock, 1995). Addressing these issues in the informed consent process answers questions such as: Does my therapist feel comfortable with or have experience discussing religious issues? Will my therapist incorporate biblical scriptures or prayer into therapy? Does my therapist think it would be wise for me to consult with a minister in addition to (or instead of) therapy? Clients who are well-informed about their therapists' values can make better decisions about entering therapy and have a better sense of what to expect from the process.

Several researchers argue that regardless of whether a therapist plans to integrate religion into therapy, he or she should take a religious history during the initial intake process (Koenig, Matthews, & Larson, 1996; Shultz-Ross & Gutheil, 1997). This discussion gives the therapist important information about the client's developmental history, worldview, and preferred coping strategies. When taking a religious history, therapists should inquire about the clients' present and past religious beliefs and behavior, religious educations, spiritual beliefs outside the stated religion (e.g., astrology, new age beliefs, etc.), current religious practices, images of and relationships to a higher power, and views of the importance of religion in therapy (Shultz-Ross & Gutheil, 1997).

Investigators also have made process-level recommendations for incorporating religion in therapy. Holmes (1997) encourages therapists to frame their morals broadly in discussion with clients to allow for interpretation and modification based on individual circumstances. Holmes states, "Therapist and client need to inhabit a similar moral universe...but at the level of specific beliefs (e.g. that abortion is always wrong, or than marriage is invariably disadvantageous to women) the therapist's values, if they intrude, may hinder rather than

foster progress," (1997, p. 336). When integrating religion and therapy therapists should vigilantly avoid arguing over religious doctrine, using religion to avoid painful material (praying defensively, for example), or using religious interventions exclusively when traditional therapy techniques or pharmacotherapy is indicated (Hall and Hall, 1997). In general, it appears that clinical integration can be conducted ethically if therapists honor these guidelines.

Conclusion

For graduate students trying to become proficient in various therapy techniques as well as develop a personal therapeutic style, exploring religious values in therapy may seem like an added challenge. My hope is that the data presented and issues examined herein allow beginning therapists to evaluate and perhaps incorporate religious integration in their clinical work. Whether religious or secular, the data demonstrate that values are inherent in therapy, and the values convergence literature suggests that explicit discussion of values may actually facilitate symptom reduction and personal change. For religious clients, several treatment outcome studies already have demonstrated greater efficacy for interventions that incorporate religious values as compared to secular interventions.

Furthermore, researchers have shown that religious values are strongly held by the majority of people in this country, suggesting that many of our clients are likely to be "religious" and might wish to integrate those beliefs in therapy. Finally, preliminary research suggests that religious clients, in particular those who have a sustaining, guiding faith or whose religious beliefs include themes of spiritual connectedness and meaning in life, appear to have better mental *and* physical health outcomes. As a result, therapists who choose to integrate religion into psychotherapy with such religious clients may be delivering treatment that is both more relevant and more beneficial.

Despite these potential benefits, concerns about clinical integration are valid and the incorporation of religion in therapy must be done carefully, competently, and with informed consent. When these criteria are met, however, therapy incorporating religious issues and values can be done ethically. And, in fact, given therapists' obligation to be aware of clients' religious values and increase competence in dealing with religious issues (as outlined in the APA Code of Ethics), one could argue that it would be unethical to ignore religious values in therapy. In sum, encouraging therapists to acknowledge their values and helping clients clarify their belief systems and strengthen religious coping strategies has the potential to be profoundly healing for clinician and client alike. ■

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Reclaiming Mental Health Services

Commentary on ethical and professional considerations

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From the vantage point of being an attorney serving mental health professionals, I am aware and increasingly concerned that psychology is being assailed, and sometimes controlled too much, by commercial interests, political correctness, and governmental regulation. In this article, I wish to offer my personal observations and opinions about the problems, and urge psychologists to be more assertive in their dealings with external (nonpsychological) sources. Also, I will offer eight suggestions intended to help the psychologist exercise effective counter-measures to assure high-quality professional practices.

From the outset of academic training, the psychologist is guided to an unrelenting commitment to professionalism. Today, professional psychology faces barriers that, if allowed to prevail, portend to diminish professionalism. Certain governmental and managed care sources profess mightily that they are the guardians of society when they are, in fact, serving less than honorable purposes. As a result, these influential sources have, to the disadvantage of society, stripped control of mental health services away from the profession of psychology.

Perhaps more than ever, the professionalism now requires that the psychologist maintain a firm resolve to counter inappropriate actions from external (nonpsychological) sources. Regrettably, some psychologists have rather passively allowed external sources, with motives that are not necessarily aligned with quality care for consumers, to redefine the concept of "professionalism."

By definition, professionalism comes about when society purposefully relinquishes control of a particular set of public services to persons trained and experienced adequately to deserve the status of "expert." Thus, the term "professionalism" means that the members of the profession decide how to define services,

roles, standards, and delivery systems. Today, three sources, which harbor motives outside of mental health professionalism, have come to control certain decision-making and practices that should be accomplished solely by mental health professionals. These external problem sources are: commercial interests; political correctness; and government regulation.

"I am aware and increasingly concerned that psychology is being assailed, and sometimes controlled too much, by commercial interests, political correctness, and governmental regulation."

Commercial Interests

Mental health services have been reduced and the skeletal remains are being deprofessionalized and subjected to financial attack, such as by reducing the number of treatment sessions, types of services, and amounts for reimbursement. To evidence this assertion, consider the following indisputable facts. First, since about 1970, publicly-funded mental health services have declined. Second, fiscal controls imposed by managed care organizations determine treatment standards and lessen the availability of mental health care, for example, by conditioning reimbursement on a preferred treatment modality (e.g., cognitive-behavioral), not paying for certain services (e.g., psychological testing), and disallowing extended services (e.g., requests for long-term treatment).

Scholarly analyses reveal that the fiscal wrenching of mental health services from the professions con-

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stitute a potentially destructive societal fiasco. Not only is there a decline in the availability and quality of mental health services, fiscal interests lead to a disregard, such as by managed care organizations, for the ethical standards (Appelbaum, 1993; Acuff, Bennett, Bricklin, Canter, Knapp, Moldawsky, & Phelps, 1999).

Political Correctness

Since health care reform, predicated on fiscal interests, has great favor with governmental sources, the frightening concept of “political correctness” has infiltrated the profession of psychology. That is, certain priorities or standards evolve for political purposes, rather than having scholarly bases reflect objective analyses and, indeed, public welfare and legal rights for all concerned. For example, it is not unusual for a licensing board to require for licensing renewal proof of continuing education in politically correct areas, such as HIV and domestic abuse. Certainly some of the politically correct areas deserve attention, but by unjustly elevating their importance, other critical areas receive too little attention.

Political correctness also breeds emotionalized interest by decision makers. For example, placing exaggerated importance on ferreting out wrongdoers is connected to political correctness, whereas cultivating positive professional conduct (that is, being educative rather than punitive), which might produce the best long-term effects, lacks political pizzazz.

Political correctness is contradictory to professionalism. It allows pious bias to be cloaked in undeserved honor.

Government Regulation

Diminished professionalism and political correctness lead to excessive power now resting with government regulators, which include the members of the licensing boards, as well as the prosecuting attorneys who advise the licensing boards. Consequently, the members of the licensing boards often abandon their allegiance to the professional values and adopt those values advocated by politicians and their prosecutorial minions.

Too often, the term “protecting the public” is distorted to promote politically correct notions or nefarious needs within the government. One prosecutor told me recently that it troubled her greatly that the chair of the psychology board stated openly that “any psychologist who has a complaint filed against him or her should be disciplined, just to teach the psychologist to avoid complaints!” Another board member said publicly, “I don’t care what the APA code of ethics states; as long as I am on the board, I will determine the standards.”

Finally, one regulatory group admitted in private that it applied more strict standards to males involved in certain types of complaint cases than to females.

A critical feature of government regulation is that professionalism becomes secondary to political motives, such as creating an impression with the public that licensing boards are hard on practitioners. Numerous members of licensing boards have told me personally that they recognize that, upon joining the licensing board or ethics committee, they adopt a prosecutorial mindset.

The prosecutorial mindset often means that licensing boards and ethics committees consider a psychologist facing a complaint to be “guilty until proven innocent,” and that the procedural process itself creates an “uneven playing field.” With regret, I report to you that I, too, have witnessed these negative features when I have worked with licensing boards and ethics committees. Evidence of these negative conditions also comes from the numerous psychologists who, after having served on a licensing board or ethics committee, have become disenchanted with the regulatory process and speak ill of the board or committee upon which they served previously.

Proposed Solutions

I do not condemn the people who give untold hours of service to licensing boards and ethics committees. On the contrary, I applaud all who serve in these roles, but I hasten to say that all psychologists must guard against external sources’ stripping away professionalism from mental health services. Let me offer eight suggestions.

First, I believe that all psychologists, particularly those on regulatory boards, should recognize that the United States Constitution affords equal protection and due process to all citizens. Whenever there is an indication of questionable objectivity or unfairness impacting on professional issues, regardless of the source of the problem, this message needs to be transmitted. Finding an excuse to trod on a Constitutional right is unacceptable. For example, even if a committee within a professional association is not legally bound to maintain due process, professionalism alone requires that fair play and objectivity must rule.

Second, in service to fairness and objectivity, there should be no primary allegiance to prosecution. Protecting the public does not require adopting a prosecutorial mindset; it requires the mindset represented by an impartial judge or a jury. Therefore, there must be a level procedural playing field, with no preordained assumptions based on political or personal motives, or the characteristics of either the complainant or the respondent.

Third, as members of a profession, each of us must adhere to behavioral science and research for determining the standards and criteria that are applied to judgments. To renounce a code of ethics in favor of personal preferences is contrary to professionalism, public policy, and the law.

Fourth, there must be a commitment to collegiality. This does not mean that sins need go unpunished. It means that, in keeping with professionalism, there should be a positive, open-minded approach to dealing with a psychologist who may have breached the prevailing minimum standard for the profession. Promoting collegiality is not self-serving, it is furthering what society expects and requires of any profession.

Fifth, we need to guard against the modern-day argumentative culture that permeates our society (Tannen, 1998). Mills (1997) states: "Meanness today is a state of mind, the product of a culture of spite and cruelty that has had an enormous impact on us" (p. 2). With regret, I assert that psychologists are often drawn into the argument culture, which is more aligned with the entertainment media than with professionalism.

With chagrin, I have witnessed innumerable psychologists who, clearly for unhealthy characterologic reasons, view other psychologists as being inferior. This type of watchdog psychologist makes assertions of incompetence and wrongdoing against other psychologists, reflecting the narcissistic belief that he or she has been ordained for the role of guardian of society. When encountering a watchdog psychologist, I think of Freud's defense mechanism of reaction formation, which has, more than once, been borne out when the watchdog psychologist encounters a licensing or ethics complaint.

Sixth, certain ethics within the APA code (1992) merit special attention. For example, consider: Standard 8.02, which states: "When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved" (APA, 1992, p. 1599). Also, consider Standard 8.07, which reads: "Psychologists do not file or encourage the filing of ethics complaints that are frivolous and are intended to harm the respondent rather than to protect the public" (p. 1611). Many formal complaints could be avoided by collegial efforts.

Incidentally, there seems to be a near epidemic of complaints that reflect differing views among psychologists about child custody and neurological evaluations. In part, these two trouble spots may be because the psychologists are function-

ing within the adversarial legal system. Working in forensic psychology does not provide an exemption from the ethics pertaining to collegiality, informal resolution of complaints, and improper complaints.

Seventh, self-monitoring is essential. Psychologists should monitor the frequency of their: negative comments about another practitioner; respectful, constructive interactions with peers; and communications to the public designed to enhance professional services. Every psychologist should emphasize speaking words of support or praise about colleagues (especially competitors) and judiciously make statements that convey or imply negativism toward the profession or other psychologists.

Eighth, the psychologist must hold professionalism aloft for all external sources to see. If there is a challenge to acceptable professionalism by an external source, the psychologist should adopt the position that "if you [the external source] want me to lessen professionalism to accommodate a motive that is not devoted to high-quality health care for consumers, I shall not participate with you."

Understandably but regrettably, I have encountered some psychologists who accepted nonprofessional dictates for reduced professionalism. Their explanation or rationalization commonly highlights the financial penalty that would occur if the psychologist asserted higher professional standards (e.g., "if I don't take clients according to the managed care company, I won't be able to earn a living"). In other words, the psychologist is putting personal financial gain before client welfare and professional integrity. Fortunately, many psychologists firmly adopt the honorable stance (e.g., "I will not practice in a manner that I do not believe is adequate for the health needs of my clients, and the policies and procedures imposed on me have to be within professional limits or I will do another kind of work"). The conduct of the psychologist must not reinforce conditions for service delivery that are not adequately supportive of health-care benefits for consumers and compatible with the standards prevailing in the profession. This is an era that necessitates every psychologist exercise a special vigilance against potentially detrimental influences from external sources.

Conclusion

If psychology is to regain control of mental health services, there must be a commitment to true and complete professionalism. More than ever, psychologists need to band together in a supportive fashion. Increased peer support and interaction can actually foster ethical conduct and high standards for service. The outcome will assure quality care for the

public, as well as risk management and legal safeguards for the practitioner. By promoting positive professional relationships, the psychologist can counter the negative effects from financial influences, political correctness, and government regulators. In the end, however, the solution rests with the individual psychologist. Every psychologist should be: watchful for potentially detrimental influences from external sources; and resistant to accommodating policies, procedures, or expectations that will subvert acceptable professional standards and practices. ■

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Call for Papers: Women, Therapy & Exercise/Sport

We are both pleased and excited to announce that volume 24 (no 3 or 4) of *Women & Therapy* will be devoted to the use of exercise and sport as an adjunct to therapy. This edition, entitled "Constructing Exercise and Sport as Therapeutic Modalities," will explore the healing use of sport and exercise from several therapeutic orientations within a feminist context. The introduction will describe ways in which feminist orientations challenge the "mind/body" dichotomy and will cite the benefits of integrating physical activity, exercise, and sport into therapy. The introductory material will also include an invited paper on the relationship of physical activity and sport to psychopharmacology, the traditional biological intervention. Major sections to follow will address fundamental orientations in psychotherapy: psychoanalytic, cognitive-behavioral, constructivist and organismic/systems. Each section will include an invited paper to be accompanied by two to three refereed papers. Refereed papers will focus on how therapists use the principles and techniques of their orientation to introduce and maintain exercise/sport as a therapeutic component. The papers must also address how the therapist's and client's class, race/ethnicity, and sexual orientation serve as barriers to or facilitators of treatment.

Papers are to be no more than 20 pages in length (includes figures, graphics and references): Please use 12 point Times Roman font and APA style. Include three copies of your paper and a copy of your paper on a disc formatted for IBM PCs. Include your name, address, phone number, fax number and email address and your preferred means of being contacted by us. Your paper must not have been published elsewhere.

Deadline: Submissions are due on or before January 1, 2001.

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Is There a Baby Boomer in Your Future?

A Report and Update from Section II (Clinical Geropsychology)

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As a budding geropsychologist in my mid-twenties I tried to imagine what it would be like to get older. My grandmothers had been models of what has been called “successful aging” — mentally and physically robust older people who enjoyed active and challenging lives well into their 80’s. When I was a teenager, however, my mother provided a glimpse into the problems some older adults confront when she brought back stories from the local nursing home where she volunteered to cut the hair of its indigent older residents. I learned that, in contrast to my own grandmothers, some older people lost their mental abilities, suffered from depression, and were challenged by multiple health problems. Graduate school brought an academic understanding of the physical, social, and financial challenges that often accompany late life. But I knew that growing older was something that could be best understood through its direct experience.

Waiting for My Invitation to AARP

Now, almost fifty years old, I wait for an invitation to join the American Association of Retired Persons (AARP). Even as a geropsychologist I find the prospect of AARP membership at age 50 amusing. Yet, for the first time in my life, I think seriously about the financial and social implications of retirement (Have I put enough money into the 401K? Where might I live in fifteen years? At what age would it be financially optimal to get a long-term care insurance policy?) Like clockwork, at age 40, my vision changed and I now cannot read without glasses. In a recent family football game I was struck by how much less physical stamina I had compared to younger family members. My mother, now 81, needs help from my siblings and me and, on a recent visit home, she walked me through the financial and legal papers that I will need to access at her death. And yet I feel more content than at any other time in my life.

Many people enter clinical psychology with hopes that their work will be personally relevant and meaningful. I think that being a clinical geropsychologist has the added advantage of helping one to gain a

broader and deeper understanding of what life will be like in the later stages of one’s own life span. One interesting phenomenon that I and others have observed is that some psychologists who have had no prior professional interest in aging develop it as they themselves begin to age. The fact is that for many clinical psychologists — especially those in recent age cohorts — clinical work with older adults is highly likely.

The Pig in the Python

Although the average age of U.S. population is growing older, persons of my generation constitute a demographic bulge that is moving into their later years. At the baby boomer demographic peak, at least one-fifth of the United States will be 65 years and older. If you’ve traveled to elder-dense Florida you’ll have a sense of what the future will look like. (I’m sure the AARP mailroom will be mighty busy in coming years sending out those invitations for membership.). Because of World War II and lingering financial constraints from the Great Depression, many people delayed having families. And then they had lots of children between 1946 and 1964. Demographers call us baby boomers the “pig in the python” phenomenon — conjuring up an image of a ball of baby boomers moving through the demographic pipeline creating all sorts of problems along the way. There were not enough schools for baby boomers when we were younger and not enough houses when we were young adults. Is it any coincidence that the seemingly drab issues of social security and Medicare solvency are front-and-center in this year’s presidential campaign? A critical question now raised as the baby boomer ball moves through the python is, of course: Will there be enough money to support us in our old age?

Silver Haired Baby Boomers at Your Therapeutic Door

Within 11 years the first wave of baby boomers will be hitting the historically denoted beginning of late life, age 65. Many psychologists will have silver

haired baby boomers knocking on their therapeutic doors. Generationally, baby boomers are psychotherapy-inclined and will be much more likely to bring their personal and social concerns to a psychologist than generations before them. For the field of psychology, an emerging issue is whether there will be enough psychologists well enough trained to provide clinical services to older adults. This issue has gained the increasing attention of APA. Do you remember that Norman Abeles' Presidential theme in 1997 was psychology and aging?

Although hard figures are difficult to come by, there will likely be dearth of geropsychology specialists when my generation most needs them. I believe the reality is that clinical psychology generalists will be called upon to deliver services to many older adults. How well prepared are psychologists to see older adults in clinical practice? Historically, they have been very well prepared at all. Despite 15-20 years of nagging by geropsychologists, most graduate programs in applied psychology do not have a course in adult development and aging. From the perspective of many graduate programs, development ends at age 21. However, recent work by my colleagues and I has documented that among psychology externs and interns, there is a large reservoir of favorable attitudes toward older adults and a recognition and willingness to provide clinical services to them in the future (Hinrichsen, 2000). In today's increasingly competitive health care arena, psychologists-to-be have a sharp eye on the future and many realize that the future will encompass the concerns of the elderly. Other work suggests that there are substantive doctoral internship training opportunities across the country that will, at the least, prepare generalists to provide competent clinical services to the aged (Hinrichsen, Meyers, Stewart, 2000).

The Future is Upon Us

The need for more psychologists formally trained to work with older adults is already evident, particularly in nursing home settings. The prevalence of mental health problems in nursing homes is markedly high. At least half of older residents of nursing homes have one or more mental health problems. Until recent years, those problems were not addressed adequately by mental health care providers. In the past, an important reason why psychologists were rarely mental health care providers in nursing homes is because we were not paid to provide services within them. In the late 1980's psychologists became recognized providers under Medicare (the national health insurance program for the aged and disabled) to which the vast majority of older adults subscribe. With this change, providing clinical services to older adults in nursing homes (and in the larger community) became financially viable for psychologists. In recent years, as managed care has ratcheted down fees, Medicare fees for psychotherapeutic

services have actually increased. However, outpatient mental health services are only reimbursed at 50% under Medicare (in contrast to 80% for medical conditions). There are also continuing problems with restrictions placed by some local Medicare "carriers" on the provision of psychotherapy service to nursing home residents, especially those with cognitive impairment. Another issue is the reluctance of many states to use Medicaid funds to pay that part of the fee not covered by Medicare for indigent elderly.

Given the large unmet mental health needs in nursing homes, it was predictable that psychologists began to look to their residents as potential clients. This has been a two-edged sword. Many more older nursing home residents in need of psychological services now receive them. Some (many? most?) psychologists providing services in nursing homes have had little if any formal training in geropsychology. This situation is further complicated by other issues. Older adults in nursing homes are one of the most therapeutically challenging populations for geropsychologists to treat. They often have multiple physical problems, frequently have cognitive deficits, and reside in nursing home environments that a prominent gerontologist has characterized as "neither providing nursing care nor are homes." Although a solid literature in geropsychology now documents the utility of psychotherapy for older adults, little of it has been conducted with nursing home residents.

I hasten to add that increasing numbers of psychologists new to nursing home work are showing up at geropsychology continuing education programs to acquire needed knowledge. A few for-profit nursing home groups (enterprises that hire psychologists to provide services to nursing home clients) provide continuing education to their employees without geropsychology training. Yet, among geropsychologists, there is controversy about whether for-profit nursing home groups or solo practitioners can provide the best quality services in nursing homes.

Professional Developments in Geropsychology

Questions about what constitutes appropriate training in geropsychology have been on the professional agenda for years. In 1981 the first conference on professional training in geropsychology was held in Boulder (dubbed the "Older Boulder" conference). From the conference emerged a wide range of well thought-out recommendations. I believe that there was little follow-through from the conference chiefly because psychologists were not reimbursed for psychological services until the end of that decade. In 1992 another training conference was held, following which emerged a number of notable professional developments.

I believe the most substantive development was the creation of Section II (Clinical Geropsychology) within Division 12. (But more about that later.) After the 1992 training conference, Division 20 (Adult Development and Aging) and Section II formed a Task Force on Qualifications for Practice in Clinical and Applied Geropsychology to craft a statement of what clinical geropsychologists do and what they need to know. The Task Force includes a broadly based group of psychologists with expertise in diverse areas. A report from the Task Force is currently under consideration by the APA Council of Representatives. (A copy of the draft report can be found on the Section II website: bama.ua.edu/~appgero/apa12_2) From the ranks of the Task Force membership and through efforts of Division 20 and Section II emerged a petition for recognition of clinical geropsychology as a proficiency area, which was granted by APA in recent years.

Under current consideration by the College of Professional Psychology is a petition to develop a mechanism for the credentialing of geropsychologists. In an effort to bolster the argument that there is a need for such a credential, Division 20 and Section II conducted a survey of the geropsychology continuing education interests and needs of practicing psychologists. However, all of this comes at a time when the pros and cons of further credentialing in applied psychology are being debated. Within the Task Force there has been ongoing discussion of the need to set the guidelines bar high enough so that substantive and ethical services are provided to older adults but not so high as to discourage applied psychologists from obtaining education and training. Another important development has been the creation of the Committee on Aging within the APA's Public Interest Directorate. The Committee is the focus of academic, applied, and public service initiatives with APA.

Another Home Within APA

Ever since I can remember, psychologists with applied interests in geropsychology joined APA's Division 20 (Adult Development and Aging). Although the preponderance of membership of Division 20 was persons in academic and research positions, applied psychologists were welcomed and active within Division 20. Historically, geropsychologists have also been active within other divisions and formed formal and informal interests groups in them. With the increasing growth of geropsychologists it seemed wise to establish another home — within Division 12 — since most geropsychologists were clinical psychologists by training. George Niederehe, well known within geropsychology circles, circulated a petition for establishment of Section II and in 1993 the Section was off and running.

Over the past seven years there has been a steady growth of membership with over 375 individuals currently on the Section's roster. There have been an impressive array of nationally prominent individuals who have assumed Section offices. As the Section addresses more and more issues relevant to geropsychology, the number of Section committees and task forces has increased. The Section has continuously published a thrice yearly newsletter, has a website and listserv, offers a variety of offerings at APA meetings, and maintains liaison with divisions within APA and with organizations outside of APA. Its officers and members have played key roles in the definition of clinical geropsychology and have been strong voices at national and state discussions of mental health policy for the elderly.

What's Happening Now in Section II

As noted earlier, Section II members continue to play an important role in trying to establish a credential in geropsychology through the APA College of Professional Psychology as well as to steward the report of the APA Interdivisional Task Force on Qualifications Report through the Council of Representatives. Jiska Cohen-Mansfield represents the Section on the Coalition on Mental Health and Aging. The Coalition works toward improving the availability and quality of mental health prevention and treatment to older adults and their families. Dr. Cohen-Mansfield also represented the Section at a recent conference on mental health care in nursing homes, which will be followed by specific steps to improve mental health services in these settings.

Last year the Section established a joint task force with the American Association for Geriatric Psychiatry of which Dolores Gallagher, William Haley, and Sara Qualls are the Section representatives. At a time when psychology's interests are sometimes pitted against those of psychiatry, these two groups are actively working to promote access to quality mental health services for older adults. Recently, Forest Scogin, Margy Gatz, and Susan McCurry were appointed Section Representatives to Division 12's Treatment Guidelines Task Force. As noted, there is a growing research literature on the utility of several psychotherapies in the treatment of late life mental health problems. The Section's Public Policy Committee headed by Margaret Norris has worked to disseminate information about managed mental health care and older adults. At the recent APA convention, Section member Steve Rapp gathered together representatives of a number of APA divisions with interest in aging to develop a common agenda of concerns that can be brought to APA.

Merla Arnold, who is in the Counseling Psychology Program at Teachers College-Columbia University and an intern at

the Northport Veteran's Administration Hospital, has played an active role as Student Liaison to the Section. Recently she and I updated Section II's 1997 *Directory of Doctoral Internships with Clinical Geropsychology Training Opportunities and Postdoctoral Geropsychology Fellowships*. The 2000 Directory can now be found in the Section's website: bama.ua.edu/~appgero/apa12_2. Students seeking doctoral and post-doctoral training in geropsychology should find the directory useful in identifying training programs.

Please Consider Joining Us

If you have interest in clinical geropsychology please consider joining the Section. Dues are \$15 and for students they are \$5. Membership includes a subscription to the Section Newsletter, access to the Section listserve, a chance to participate in Section activities, a membership directory, and opportunities to work with a group of committed and congenial colleagues. For information about membership contact the Section II membership chair, Michele Karel. E-mail: karel@boston.va.gov; Phone: 508-583-4500, x3725; Address: Brockton/West Roxbury VA Medical Center, 940 Belmont, Brockton, MA 022301. ■

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Recommended Readings in Clinical Geropsychology

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- Qualls, S.H., & Abeles, N. (Eds.) (2000). *Psychology and the aging revolution: How we adapt to longer life*. Washington, D.C.: American Psychological Association.
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*The American Psychological Association Public Policy Fellowship and Internship Programs
Seek Applicants for the 2001-2002 Program Year*

APA Congressional and Science Policy Fellowship Programs

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

APA Congressional Fellowship Program

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

William A. Bailey AIDS Policy Congressional Fellowship

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

APA Science Policy Fellowship

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

Applications

Applicants for the APA Policy Fellowship Programs must be members of APA (or applicants for membership) and must have completed a doctorate in psychology or a related field at the time of application. Applicants must submit a current vita, personal statement of interest, and three letters of recommendation to: APA Policy Fellowship Programs, Public Policy Office, American Psychological Association, 750 First Street, N.E., Washington, DC 20002-4242. The deadline for applications is December 15, 2000. Annual stipends range from \$48,500 to \$61,200, depending upon years of postdoctoral experience and the specific Fellowship sought. More detailed information about the application process can be found at: <http://www.apa.org/ppo/fellow.html>. Further inquiries can be directed to the APA Public Policy Office at (202) 336-6062 or ppo@apa.org.

Graduate Student Public Interest Policy Internship

The APA Public Policy Internship provides graduate students with an opportunity to gain first-hand knowledge of how psychological research can inform public policy, and the roles psychologists can play in its formulation and implementation. The intern works in the Public Policy Office of APA's Central Office in Washington, D.C., on public interest policy issues pertaining to: children, women, ethnic minorities, HIV/AIDS, disabilities, aging, lesbian/gay/bisexual concerns, media, and/or violence. The Public Policy Office helps to formulate and implement APA positions on major federal policy initiatives of importance to psychology in the areas of public interest, education, and science.

Applicants must be doctoral students in psychology or a related field in at least the third year of graduate training. APA policy interns work 20 hours per week at a rate of \$14.50 per hour. Application materials comprised of a current vita, a personal statement, and two letters of reference should be sent by March 15, 2001, to: American Psychological Association, Public Policy Office/ Internship Program, 750 First Street, N.E., Washington, DC 20002-4242. More detailed information about the application process can be found at: <http://www.apa.org/ppo/fellow.html>. Further inquiries may be directed to the APA Public Policy Office at (202) 336-6062 or ppo@apa.org.

Ellen G. Garrison, PhD
Director of Public Interest Policy
American Psychological Association
750 First Street, N.E.
Washington, DC 20002-4242
(202) 336-6066 phone
(202) 336-6063 fax
egarrison@apa.org

Society News

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

John D. Robinson Honored

John D. Robinson, EdD, MPH; Professor of Psychiatry and Surgery at Howard University College of Medicine, was awarded the Doctor of Humane Letters—*Honoris causa*, by the Massachusetts School of Professional Psychology (MSPP) in Boston on June 10, 2000. This honorary degree was awarded to Dr. Robinson for his over 20 years of distinguished service in promoting ethnic minority issues in psychology. MSPP established a scholarship fund named for him in 1982 with the stipulation that the scholarship can be awarded to any student at MSPP who is interested in research and/or clinical practice in the area of ethnic minority issues. John served on the Board of Trustees of MSPP 1978-1982 while he was on the faculty of the Harvard University School of Medicine.

Also this year, John was the recipient of the first American Board of Professional Psychology (ABPP) Distinguished Service and Contributions to the American Board of Professional Psychology award. It was given to him because of his service to ABPP in recruiting ethnic minorities and military candidates and successfully mentoring them through the examination process. In 1998, he received the APA 1998 Raymond Fowler Award given by the American Psychological Association for Graduate Students (APAGS) for outstanding work as a mentor.

John was chair of Membership in Division 12 for four years (1995-97, 1999) and a member of the membership committee for nine years. He is serving a three-year term as treasurer of Section VI (1998-2001). He is a Fellow of Division 12, and president-elect of the American Board of Clinical Psychology (ABClinP) of the ABPP.

Call for Editor

The Publications Committee of the Society of Clinical Psychology, Division 12 of the American Psychological Association, is currently seeking applications for the position of Editor of *The Clinical Psychologist*.

The *Clinical Psychologist* is the primary communication vehicle of the Society. Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Society. It serves to inform the membership about elections, Board decisions and initiatives, convention affairs, and events within APA which concern all of us. As such, it serves as an archival document for the Society. It also publishes original, scholarly articles of current interest to the field.

The Editorial appointment will be made for a four year term, starting in January 2002. The Editor is responsible for all content and for managing the production of the newsletter. The Editor reports to the Publications Committee of the Society, and is a non-voting board member of the Society.

Individuals interested in applying for the position should arrange to have a letter of application, vita, and three letters of recommendation sent to the address below by March 1, 2001.

Chair, Publications Committee
c/o Lynn Peterson, Administrative Officer
Society of Clinical Psychology
PO Box 1082
Niwot, CO 80544-1082

Inquiries and nominations can be addressed to: Paul Rokke, Editor, Paul_Rokke@ndsu.nodak.edu, or Larry Siegel, Chair, Publications Committee, lsiegel@aecom.yu.edu.

Correction

The following individuals should have been listed as candidates for Fellows in *The Clinical Psychologist* 53(3) Summer 2000 issue:

Robert F. Bornstein, PhD
Leonard Handler, PhD
Michael T. Hynan, PhD

Phillip M. Kleespies, PhD
Thomas G. Plante, PhD
Anthony Spirito, PhD

Nominations Sought for Sarason Award

Nominations are sought for the Seymour B. Sarason Award for Community Research and Action. The award winner will present an address at the annual convention of the American Psychological Association in San Francisco, August 2001. The \$1000 award recognizes those working in the conceptually demanding, creative and groundbreaking tradition of Seymour B. Sarason. This tradition includes: 1) novel and critical re-thinking of basic assumptions and approaches in the human services, education, and other areas of community research and action; 2) major books or other scholarship that reflects these approaches; and 3) action-research and other action efforts. People may nominate themselves or others. Along with the name of the nominee, please send a detailed paragraph of support for the nominated individual and, if possible, a copy of the person's curriculum vita by December 15, 2000 to: Professor Murray Levine, Department of Psychology, SUNY at Buffalo, Buffalo, NY 14260.

Ronald F. Levant Won Re-election

Ronald F. Levant, Dean and Professor of the Center for Psychological Studies, Nova Southeastern University, Ft. Lauderdale, FL, has just won re-election as Recording Secretary of the American Psychological Association. He will finish his current three-year term on 12/31/00 and begin his next term on 1/1/01. This will be his third term of the APA Board of Directors, having also served as a member-at-large of the Board of Directors.

Dr. Levant has been active in state and national psychological associations for over twenty years. He has served as a two-term member of APA's Council of Representatives, a two-term member and two-term chair of the APA Committee for the Advancement of Professional Practice, President of the Massachusetts Psychological Association and of Division 43 (Family Psychology) of APA, Editor of the APA Journal of Family Psychology, and co-founder and first President of Division 51 of APA—the Society for the Psychological Study of Men and Masculinity.

Dr. Levant stated "I have a vision for psychology's future in which science and practice are integrated and play expanded and primary roles of knowledge generation and service delivery to address society's most pressing problems".

Dr. Levant's goals for his next term of office are to:

- ♦ Strongly advocate for the continuation of a prominent place for psychologists in the health care marketplace.

- ♦ Expand the scope of practice of professional psychology by furthering such agenda items as obtaining prescriptive authority, redefining psychology as a primary health care profession, and expanding the involvement of psychologists in areas of great public need.
- ♦ Support collaborative efforts to reexamine and change, as needed, the education, training and licensure sequence for professional psychologists, with sensitivity to the complex issues of implementation.
- ♦ Enhance the public awareness of, and support for the scientific core of psychology and its many applications.
- ♦ Foster the growing collaboration between science, practice, public interest and education constituencies.
- ♦ Enhance the Association's approach to diversity and multiculturalism.
- ♦ Obtain the representation of all state psychological associations while supporting collaborative efforts with all constituencies within psychology.

The American Psychological Association, based in Washington, D.C., with 159,000 members and affiliates, is the world's largest association of psychologists.

Call for Graduate Student Manuscripts

The Student Forum is a section of *The Clinical Psychologist* dedicated to graduate student readership. The mission of this section is two-fold. First, it is an arena in which students are invited to voice opinions about issues related to graduate education in clinical psychology and the state of the field as a whole. Second, it is intended to feature research, theory, and literature review papers written by graduate students about virtually any topic falling under the broad rubric of clinical psychology. We are currently calling for submissions that fit into either of these two categories.

Authors should submit two copies of their manuscripts to David B. Feldman (Student Forum Editor), Department of Psychology, Fraser Hall, University of Kansas, Lawrence, Kansas 66045. All papers should be formatted according to guidelines contained in the *Publication Manual of the American Psychological Association* (4th ed.). Articles not prepared according to these guidelines will not be reviewed. Submissions will be reviewed by the Student Forum editor and at least one member of a graduate student review board. Any additional inquiries should be directed by e-mail to David Feldman at davef200@aol.com.

Editor Sought

The Publications Committee of Division 49 of APA, Group Psychology and Group Psychotherapy, seeks nominations for the editorship of the journal, *Group Dynamics: Theory, Research, and Practice*, for the years 2002-2007. Donelson R. Forsyth, PhD is the incumbent editor.

Candidates should be members of APA and Division 49 and should be available to start receiving manuscripts January 1, 2001, in order to prepare for issues to be published in 2002. The duties associated with the position are described in detail at the journal's web page, <http://www.vcu.edu/hasweb/group/gd.html>. Please note that the Committee encourages participation by members of underrepresented groups in the publication process, and would particularly welcome such nominees. Self-nominations are also encouraged.

To nominate candidates, send a statement of one page or less in support of the candidate to the chair of the search committee: Richard Moreland, PhD, 423 Langley Hall, Psychology Department, University of Pittsburgh, Pittsburgh, PA 15206.

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

Division 12 Net

This is an e-mail net available to Division 12 Members only.

To subscribe, write to listserv@listserv.nodak.edu.

In the text of your message (not the subject line) write:

Subscribe Div12 [First name & Last name]

Free Book Offer for Members of D-12

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

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

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

*American Psychological Foundation
Randy Gerson Memorial Grant*

The American Psychological Foundation (APF) announces the Randy Gerson Memorial Grant to be given in 2001. For the 2001 cycle of the grant, graduate students engaged in doctoral studies are invited to apply. The grant has been created to advance the systemic understanding of family and/or couple dynamics and/or multi-generational processes. Work that advances theory, assessment, or clinical practice in these areas shall be considered eligible for grants through the fund.

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

Who is eligible:

Applicants from a variety of professional or educational settings are encouraged to apply. Awards will be given in alternate years to students and professionals. The 2001 grant will go to a graduate student.

Applications must include:

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

Applicants must submit seven (7) copies of their entire application packets. Send application packets by February 1, 2001, to the APF Awards Coordinator (address below)

Amount of Grant: \$5,000.00

Deadline: February 1, 2001

For additional information:

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

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

Full-page TherapyWorks Ad here

Position Openings

NEUROPSYCHOLOGY AND PSYCHOLOGY DIRECTOR. The Neuropsychiatric Institute of UCLA (a multidisciplinary research institute), in conjunction with the Department of Psychiatry & Biobehavioral Sciences, seeks applicants for a full-time senior faculty position as Director of Neuropsychology and Psychology to lead integrated research and clinical training programs. The Director, a neuropsychologist, will oversee collaborative ventures with UCLA's Brain Research Institute, Brain Mapping, Neurosurgery, Neurology, MRI facilities and other units in the School of Medicine. The Director will be responsible for: overseeing the internship and post-doctoral training programs for clinical psychologists and the faculty of psychologists and neuropsychologists; participating with Division Chiefs in faculty recruitment and, as a member of the Executive Committee, representing Psychology to the Executive Chair. Applicants should be psychologists and have a well-established research program; demonstrated ability to obtain extramural funding; a significant publication record; a national/international reputation for scholarship and must qualify for academic appointment at UCLA, preferably at the level of full professor. Experience as a researcher/clinician/educator, a strong background in mentoring faculty and fellows, and the ability to work constructively within a multidisciplinary context essential. Questions may be addressed to Mary Jane Rotheram, PhD, Search Committee Chair, via e-mail (rotheram@ucla.edu) or c/o UCLA, 10920 Wilshire Blvd., Suite 350, Los Angeles, CA 90024. Send curriculum vitae, statement of research interests, & names & complete addresses of three references to: Cynthia Brooks, Neuropsychology/Psychology Director Search Coordinator, Psychiatry Academic Personnel Office, UCLA, 760 Westwood Plaza, Los Angeles, CA 90024-1759. UCLA is an EOE.

TENURE TRACK FACULTY POSITION in Clinical Health Psychology with Specialty in Cancer Research. The Department of Psychology, University of Missouri-Kansas City (UMKC) and St. Luke's Hospital Department of Oncology announce a jointly sponsored position in behavioral oncology. We are seeking a PhD level, tenure-track Assistant Professor candidate who has specialized in Clinical Health Psychology to begin August 2001 or earlier. This position is modeled after a successful program in behavioral cardiology sponsored by UMKC and St. Luke's Mid America Heart Institute. The individual selected for this unique position will devote their time to graduate and undergraduate education and doctoral student research training in Clinical Health Psychology at UMKC as well as developing a behavioral oncology research and clinical program for St. Luke's Oncology Department. St. Luke's oncology program provides comprehensive cancer treatment programs and includes a state-of-the-art bone marrow transplant unit. Current faculty in the Department of Psychology at

UMKC have active research programs and extramural funding in cardiovascular research, HIV/AIDS, health promotion, obesity and eating disorders, tobacco control, and mood disorders. Required duties will include conducting behavioral oncology research at St. Luke's Hospital, teaching courses in behavioral oncology and health psychology at UMKC, and supervising students in clinical or research practica. Individuals whose research areas include cancer prevention and control, screening/early detection, adherence to treatment, or psychosocial aspects of cancer treatment/survivorship will be most competitive for the position. The Department of Psychology offers doctoral programs in Clinical Health Psychology (through the UMKC Interdisciplinary PhD Program), Community Psychology, and participates in an APA-approved program in Counseling Psychology. Candidates with a strong record of scholarly achievement are preferred. The position will include generous start-up funds, a funded behavioral oncology research assistant for three years (in addition to regular department graduate assistants), and research and clinical space in the oncology department at St. Luke's Hospital and at UMKC. Send letter of application describing research and teaching interests, vita, selected reprints/preprints, and three letters of recommendation to: James Collins, PhD, Chair, Department of Psychology, University of Missouri-Kansas City, 5100 Rockhill Road, Kansas City, MO 64110. Screening will begin immediately and continue until position is filled. Women and members of under-represented groups are especially urged to apply. UMKC is an equal opportunity employer.

UNIVERSITY OF OTTAWA: PSYCHOLOGY. Subject to budgetary approval, the School of Psychology of the University of Ottawa anticipates filling two tenure-track positions effective July 1, 2001, at the Assistant Professor level. Priority will go to applicants in the areas of 1) clinical psychology and 2) quantitative methods in psychology. Applicants should meet the following minimum requirements: Doctorate in Psychology and research competence. Fluency in French and English is essential. The salary (minimum: \$48,000) is competitive and is adjusted as a function of experience. Start-up funds are also available. Applications should be received before December 1, 2000. Submit a letter of application, curriculum vitae, names and addresses of three individuals who will be sending letters of reference, and reprints of two recent publications in refereed journals or other visible evidence of scholarly publication to: Dr. Pierre Mercier, Assistant Director, School of Psychology, Lamoureaux Hall, University of Ottawa, Ottawa, Ontario, Canada, K1N 6N5. In accordance with Canadian immigration requirements, this advertisement is directed to Canadian citizens and permanent residents. Equity is a University policy, and as such, the University strongly encourages applications from women.

Instructions for Placing Position 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: kapaun@aol.net, 3810 South Rivershore Drive, Moorhead, MN 56560-5621.

Instructions to Authors

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