



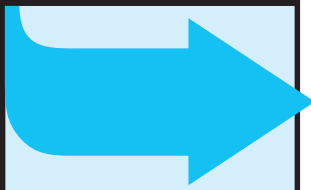
The Clinical Psychologist

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- Paul D. Rokke, PhD, Editor*
Department of Psychology
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Paul_Rokke@ndsu.nodak.edu
(701) 231-8626
- Wanda A. Kapaun, MS*
Editorial Assistant
wandakapaun@att.net
(701) 238-9072

Current Activities

At its recent meeting in Alexandria, Virginia, the Society's Board of Directors took up a full agenda of issues and business items. Representatives from each of APA's Directorates attended part of the meeting. They gave us updated information on their many and varied activities. We, in turn, had the opportunity to make known our interests and willingness to work with them on issues important to Society members. The following are a few examples.

The Education Directorate plans an Educational Leadership Conference later this year, to which the Society will send a representative. Two issues related to continuing education should be of interest. Plans have been developed for electronically crediting attendance at selected sessions at APA conventions. Also, the Continuing Education Committee has developed a draft statement on offering continuing education credits for training in "nontraditional therapies", and is requesting comments. The draft can be obtained through their website or by contacting the Office of Continuing Education.

The Public Interest Directorate has developed a public service campaign on violence prevention aimed at parents and teachers. They also groups working on workplace violence and on advertising to children. Their Office on Aging is working on medicare reimbursement for services to persons with dementia.

The Board has an ongoing interest in seeing that Clinical Psychologists who wish to provide services in the schools are able to do so without restriction. To this end, we invited the Director of APA's Office of Policy and Advocacy in the Schools, Ron Palomares, to our meeting. We agreed to work together in the interest of keeping exclusionary guidelines from taking effect, and to keep the independent practice of psychology at the doctoral level. The Society is exploring member interest in developing a section on clinical psychology in the schools. Robert Woody has a list of members who expressed interest and will continue working on the issue.

Congratulations are in order to the newly elected officers of the Society. For 2002 the President-elect will be Diane Willis, the Secretary will be Annette Brodsky, and Norm Abeles and Lynn Rehm were both re-elected to the Council of Representatives.

For the APA Convention in San Francisco, the Society will be well represented with a number of exciting program contributions. It should be a great program in a great city. I hope to see all of you there.



Karen S. Calhoun, PhD
Professor of Psychology
University of Georgia

President's Column

Full-page AAPB Ad

Mental Health Service Provision in Rural Communities

A Challenging Opportunity for Growth in Our Profession

Alexander L. Chapman
Idaho State University

Abstract

Providing psychological services to persons in rural communities is a challenging and potentially fulfilling endeavor. Low population, combined with a generally poor mental health resource base, poor knowledge of mental health resources, and potentially differing value orientations can hinder rural psychological practice. Further, professional isolation and ethical dilemmas regarding competency and multiple relationships are common in rural settings. Within this paper, key barriers to clinical practice in rural settings are outlined, and the unique resources in rural communities that can facilitate service provision are described. In so doing, it is demonstrated that barriers to rural practice might actually serve as the impetus for the growth of our profession.

The purpose of this paper is to orient students and psychologists to the ways in which barriers to clinical service provision in rural communities can form the impetus for the growth of our profession. It is important for students to be aware of the unique challenges and opportunities present in a variety of practice settings as they decide upon a direction for their professional careers. Psychology service provision in rural communities can be a rewarding and challenging endeavor, requiring creativity, flexibility, and strong generalist graduate training. Those students considering such a career should challenge themselves to think critically about the key personal, attitudinal, and logistical issues unique to rural practice so as to positively impact service provision in a markedly underserved population.

Rural communities, consisting of towns and open land areas of less than 2,500 persons (Wagenfeld, 2001), offer diverse and challenging opportunities for mental health service providers. Persons residing in rural areas constitute approximately 20% of the United States population (Wagenfeld, 2001). Mistakenly viewed as homogeneous panaceas of health and adjustment, rural communities are ethnically and economically diverse, with strong mental health needs (Keller & Murray, 1982; Wagenfeld, 1982). Compared

to urban areas, rural settings suffer more socioeconomic pressures and poverty, as well as a dearth of mental health resources (Hargrove & Breazeale, 1993; Miller & Ostendorf, 1982;). Recent data from the U.S. Department of Agriculture's National Agricultural Library (USDA, 1999) suggests that, compared to urban areas, rural communities have higher unemployment and poverty rates as well as lower incomes, less insurance coverage, larger proportions of elderly persons, and smaller proportions of minority persons. In addition, researchers stress that mental health difficulties are as prevalent, if not more so, in rural settings as in urban areas (Hargrove & Breazeale, 1993; Wagenfeld, 1982). Since graduate training often perpetuates mental-health service models developed primarily for work in urban centers, it is important for new professionals to learn how to modify their approach to maximize efficacy in rural settings (Murray & Keller, 1986). Several specific characteristics of rural settings can provide challenges for service provision, including (a) lack of available resources, (b) geographical, knowledge, and financial barriers, and (c) values and attitudinal factors. Through the use of unique resources available in rural communities, these factors can form the impetus for new, flexible approaches to service delivery.

Lack of Resources

Poor federal funding for rural mental health services combined with the tendency of providers to remain in urban centers (where they were trained) contribute to a lack of mental health services in rural communities (Keller & Murray, 1982). Compared with urban areas, rural settings have fewer community mental

Correspondence concerning this article should be addressed to Alex Chapman, Department of Psychology, Idaho State University, Pocatello, ID 83209-8112. Electronic mail may be sent via Internet to chapalex@isu.edu.

health facilities with fewer staff (Keller & Murray, 1982; 1991), less well-trained providers, and less diversity in their mental health resources (Wagenfield, 2001). Although Wagenfield (2001) points out that federally assisted community health resources have increased in numbers recently, the lack of resources in rural settings continues to impact mental health service provision on several levels.

First, mental health professionals may be dissuaded from practicing in areas that lack resources necessary for promoting successful practice. In particular, a lack of referral sources and a limited pool of potential employees may further hinder the arduous and expensive task of establishing a private practice. Second, providers in rural settings may suffer professional and intellectual isolation. Hargrove (1982a) pointed out that mental health professionals often hold post-baccalaureate degrees, and therefore may experience intellectual isolation from the often lesser educated rural citizens. Practitioners living in smaller rural settings may also be isolated from their professional colleagues who work at mental health centers located in larger towns. This may be a particularly salient issue for postdoctoral clinicians who are used to practicing in high intensity learning environments with a variety of like-minded professionals. Such isolation can lead to (a) a lack of social and professional support, (b) the unavailability of mental health services to combat "occupational burnout" and other emotional difficulties, and (c) a lack of continuing education and consultation opportunities. In addition, rural areas are frequently without adequate library and research resources. Professionals must be willing to utilize Internet resources and to travel to conferences in order to keep up on new research and clinical innovations. One particularly useful Internet resource is the electronic article database offered by the American Psychological Association (APA) to paid APA journal subscribers. Persons who are interested in learning more about this resource should visit www.apa.org.

...the lack of resources in rural communities often requires psychologists to be generalists, and to assume numerous roles for which they may not have specific training.

Third, the lack of resources in rural communities often requires psychologists to be generalists, and to assume numerous roles for which they may not have specific training. While psychologists from scientist-practitioner programs may be well trained as generalists, they may sometimes overstep their boundaries of competence due to a lack of available referral sources (Hargrove, 1986). The ethical issues regarding competency become particularly difficult to resolve when refusal to provide a service beyond the practitioner's domain of competence leaves the client with no alternative providers. In addition, psychologists are often required to be administrators in rural community mental health centers. While psychologists may be quite capable of assuming such roles, the absence of administrative support professionals, such as accountants, financial experts, etc. (Keller & Murray, 1982), may hinder effective administration. Graduate students considering work in a rural setting should pursue training in program evaluation and implementation as well as practica experiences in rural mental health centers (if available) in order to increase their awareness of key administrative concerns.

Geographical, Knowledge, and Financial Barriers

Despite the mental health risks posed by low education and high poverty levels, service utilization is markedly lower in rural than in urban settings (Murray & Kupinsky, 1982). This is particularly true for members of ethnic minorities, for whom culturally based mental health resources are sparse (Markstrom, Stamm, Stamm, Berthold, & Running Wolf, 2001). Several factors that may lower service utilization include (a) lack of financial/insurance resources, (b) geographic isolation and large travel distances, (c) lack of available mental health resources, and (d) low awareness of mental health issues (Keller & Murray, 1982). In addition, social isolation, loneliness, and a lack of economic resources may decrease peoples' willingness and ability to seek available mental health resources (Murray & Keller, 1991).

Rural populations are often diffusely distributed. Thus, providing services to large numbers of people is expensive and time-intensive, often requiring frequent travel. In addition, a single community mental health center's catchment area is physically much larger than for urban communities. Complicating this issue is the fact that many rural residents cannot afford the insurance or transportation resources that would facilitate such travel. Public transportation is often less efficient and more expensive in rural than in urban settings (Keller & Murray, 1982). In addition, despite current innovations in communication technology, rural residents may remain under-informed about mental health issues. Keller and Murray (1982) noted that a lack of information about mental health might contribute to the reluctance of rural citizens to seek services.

The innovative use of communication technology is a promising strategy for removing barriers related to transportation and information access. There is a growing literature on the use of *telemedicine* in rural service provision (Stamm, 1998). Telemedicine is defined broadly as "...the use of electronic communications and information technology to provide or support clinical care at a distance" (Stamm, 1998, p. 536). Perhaps the most common mode of telemedicine is the use of telephone contact and conference calling when face-to-face contact is non-viable. Computer-based communications, involving the storage and forwarding (Stamm, 1998) of information (psychological tests, educational information, etc.) via email and Internet, require minimal computer literacy and have great potential for the dissemination of mental health information and possibly for on-line psychological testing and feedback. A more expensive and sophisticated tool for circumventing geographical barriers is video teleconferencing (VTC), whereby the client and service provider can have simultaneous audio and visual contact (Stamm, 1998). The key limitations of these approaches are their expense and the fledgling state of the outcome research with rural populations. As these modes of service delivery gain empirical support, however, they may be eventually be considered integral components of rural health care by the key reimbursing structures within this country (managed care and insurance).

Values and Attitudinal Factors

Some research has pointed to key value and attitudinal differences between rural and urban residents that may challenge rural service provision; however, Wagenfield, Murray, Mohat, and DeBruyn (1994) have noted that there is very little consensus as to whether or not significant rural-urban value differences actually exist. Some studies have found that, compared with their urban counterparts, rural residents hold more conservative social and political views (Keller & Murray, 1982), are more mistrustful of "outsiders", and place more importance on individualism and self-reliance (Coward, DeWeaver, Schmidt, & Jackson, 1983). In addition, rural citizens have been reported to be more religious and more strongly opposed to premarital sex, the use of contraceptives among teenagers, and divorce (Keller & Murray, 1982). Others (i.e., Cordes, 1990) have suggested that the notion of rural-urban value differences is a myth, and that any differences that may have existed are becoming smaller as advances in communication and transportation decrease the isolation of rural communities (Wagenfield et al., 1994). Further, researchers on rural-urban value differences struggle with numerous empirical problems, such as: (a) defining "rural" and "urban", (b) identifying representative samples of rural and urban citizens, and (c) determining which value dimensions to examine and how to measure

these dimensions in a psychometrically sound manner. As a result, the reliability and generalizability of current findings are somewhat unclear. It is clear that research has not identified particular value orientations that are both sensitive (present across rural settings) and specific (unique to rural settings). Unfortunately, it is possible that proposed value differences may dissuade students trained in urban centers from moving to rural areas. In turn, those persons considering rural psychology practice should closely scrutinize the research on value differences, which are perhaps best seen as hypotheses to be tested in the context of clinical practice.

It is helpful to briefly consider some hypotheses regarding the interaction between proposed value differences and other barriers to clinical practice discussed earlier in this paper. For instance, strong values on self-reliance, combined with a lack of knowledge about mental health and geographical barriers, may contribute to a general reluctance to seek help. Further, rural communities are by definition small, and rural mental health centers are often in prominent, visible locations. Those persons who fear the stigma associated with mental health issues may refrain from seeking help in order to avoid being ostracized by other members of the community. Clinicians must be sensitive to this possibility and willing to help reduce stigma by facilitating mental health education in the community and encouraging the use of existing resources. In addition, rural citizens may be much more accustomed to seeking help and advice from their primary care physicians. Some research has supported this idea (e.g., Flaskerud & Kviz, 1982), suggesting that it is particularly important for psychologists to establish referral networks that include community medical professionals.

Strong religious values may lead persons to be more likely to seek help from non-psychologist sources, such as their religious leaders.

A strong value placed on religion may play a salient role in rural practice. Strong religious values may lead persons to be more likely to seek help from non-psychologist sources, such as their religious leaders. In addition, Bergin (1991) has pointed out that psychologists are generally less religious than

non-psychologists, and that religion may play a key role in the therapeutic process. Further, Taylor (2000) reviewed research suggesting that particular forms of religious coping may positively impact mental health. Therefore, it may be important for rural psychologists to be familiar with the literature on the use of religious values in therapy and to establish working relationships with community religious leaders.

In summary, it is clear that service provision in rural communities is challenging due to poor resources, geographical/financial barriers, and potential value differences. There are, however, several unique resources within rural communities that can facilitate mental health service provision. These resources are discussed within the next section

Community Networks

Heyman (1986) pointed out that while rural settings pose many challenges to service provision, an understanding of the rural social context could enhance mental health programs. According to Heyman, rural communities are comprised of several interacting systems of individuals, including (a) formal networks, (b) informal networks, and (c) "doers", or natural helpers, like volunteers. Formal networks consist of community officials with power over the provision of funding and the creation of public policy. Through communication with formal networks, mental health professionals can garner necessary financial/political support. Formal networks can also help by orienting service providers to the social/political structure, geographical characteristics, economics, resources, culture, and needs of rural communities (Higgins, 1982).

Informal networks, consisting of family, friends, and colleagues, offer unique opportunities for providers to impact the natural social context in which their clients live. Systems and contextual theorists often emphasize the need for therapeutic efforts to modify the contexts supporting client difficulties. Being known to the community in multiple roles (e.g., school board volunteer, spouse of business owner, etc.) may speed acceptance by the community and increase service utilization. In addition, persons in small communities know who is suffering more often than do those in urban centers, and there is an explicit value on helping neighbors. It would, therefore, be deleterious to ignore the importance of existing rural social networks in promoting mental health. As Heyman (1986) has pointed out, psychologists in rural settings can act as consultants to their clients' informal social network, and thereby impact some important contextual maintaining factors for client difficulties. The need to utilize these informal networks offers psychologists opportunities to develop creative, non-traditional modes of service provision.

In order to achieve acceptance and to utilize community resources, the practitioner must often become a visible member of the community and establish multiple relationships with residents, a factor that brings up the ethical concern regarding multiple relationships (Hargrove, 1986; Schank & Skovolt, 1997). They must also accept the community and have an open attitude toward differing values. Hollister (1982) pointed out that rural service providers must be willing to (a) make personal acquaintances with community officials, (b) act as a "humble student" who desires to understand the community, and (c) decrease stigma associated with mental illness by initially avoiding the use of technical or diagnostic terminology. The

The success of the rural practitioner may depend largely on his or her willingness to establish multiple relationships with potential clients through involvement in community committees, establishing informal community networks, etc.

success of the rural practitioner may depend largely on his or her willingness to establish multiple relationships with potential clients through involvement in community committees, establishing informal community networks, etc. Further, the necessities of everyday life, wherein the practitioner's banker or hairdresser may also be his or her client, may also require clinicians to manage multiple relationships to the benefit of their clients. While the American Psychological Association's (1994) Code of Ethics allows for the necessity to establish dual relationships with clients in some settings, there is very little guidance on how to manage these issues and avoid client harm. Further, students do not often receive training in community networking and education and would benefit from seeking practica and internship opportunities that necessitate an exploration of pertinent ethical and practice issues.

Cooperative Extension Service

Along with community networks, another resource in rural communities that could facilitate mental health service pro-

vision is the Cooperative Extension Service (CES) (Coward, VanHorn, & Jackson, 1986). Originating as a vehicle for disseminating agricultural research data produced at state universities, the CES is a federal/state-funded organization of paid workers/volunteers who disseminate knowledge about agriculture, family life, and community development to rural communities. Coward et al. (1986) have depicted the CES as a unique vehicle for the provision of rural primary prevention services. Through its connection with state universities, the CES has access to the professional knowledge, skills, and federal/state funding needed to facilitate primary prevention. Furthermore, through its vantage point as a respected community institution, the CES can create an interface between new service providers and existing community networks, thereby helping providers utilize natural social resources.

Conclusion and Future Directions

Although rural communities have many characteristics that may challenge or hinder mental health service provision, professionals who creatively utilize existing community resources and innovative approaches to clinical care may find rural practice stimulating and rewarding. Unfortunately, traditional training in mental health service provision has grown out of urban models of care and many not prepare professionals to capitalize on the existing strengths of rural communities. Rural mental health service providers who utilize natural social and financial resources such as community networks and the CES are likely to find stimulating, challenging, and fulfilling opportunities for practice.

In order to address the unique needs of rural communities, psychologists must be willing to expand their theories and practices beyond those that are most functional in urban contexts. Although difficult due to small sample sizes, poor funding, and geographical barriers, research on mental health and quality of life issues in rural communities is needed (Murray & Keller, 1991). Further, the somewhat unconventional practices that are likely to find success in rural settings necessitate new training components that address issues of coping with professional isolation, working in multidisciplinary settings, culturally competent practice, building and evaluating clinical service programs, and promoting the education of citizens on mental health issues. Training that specifically addresses the practical and ethical issues regarding use of communication technology in service provision would be particularly helpful. Along these lines, rural practice requires sophisticated and flexible thinking on how to apply ethical standards and values, particularly regarding multiple relationship and competency issues. It is my opinion that such training would be beneficial even for students who never intend to practice in rural set-

tings, as it would encourage flexibility in thinking about how contextual factors influence service provision.

The University of Florida has tackled such training goals by creating a rural psychology track at the pre-doctoral internship level within their Department of Clinical and Health Psychology (Sears, Evans, & Perry, 1998). This interdisciplinary training program operates in conjunction with the Cooperative Extension Service and the North Florida Area Health Education Center (AHEC) to train competent rural service providers. Training focuses include increasing knowledge of issues and barriers specific to rural practice, developing skills in program implementation and evaluation, disaster preparedness, community networking and education, and interdisciplinary collaboration (Sears et al., 1998). It is my hope that efforts to prepare psychologists for work in non-traditional settings and with diverse populations will become more widespread and thereby promote the growth of our profession.

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2001 APA CONVENTION

SAN FRANCISCO, CALIFORNIA

DIVISION 12 PROGRAM SUMMARY

Friday, August 24

8:00 AM-8:50 AM

Symposium:

Depression, Achievement, and Self-Esteem in Native Americans – Science, Culture, and Spirituality

Daniel, W. McNeil, PhD

Michael J. Zvolensky, MA

Chebon A. Porter, PhD

Moscone Center South Building

Rooms 228 & 230

8:00 AM-8:50 AM

Paper Session:

New Developments in Psychotherapy

Outcome Research

Timothy Anderson, PhD

Moscone Center South Building

Rooms 252/254/256

9:00 AM-9:50 AM

Presidential Address

Moscone Center South Building

Room 310

10:00 AM-10:50 AM

Presidential Address

Philip M. Kleespies, PhD

Moscone Center South Building

Room 238

10:00 AM-10:50 AM

Business Meeting

Moscone Center South Building

Rooms 258/260

11:00 AM-11:50 AM

Presidential Address

San Francisco Marriott Hotel

Golden Gate Salon C1

11:00 AM-12:50 PM

Symposium:

Broadening Cognitive–Behavioral Models of Emotional Disorders with Flexibility and Mindfulness

David M. Fresco, PhD

Moscone Center South Building

Room 309

11:00 AM-12:50 PM

Symposium:

Dynamic Assessment–Purpose and Promise

Julian G. Elliott, PhD

Moscone Center South Building

Room 310

12:00 PM-12:50 PM

Conversation Hour:

Issues and Strategies for Applying to Clinical Psychology Internship

John D. Otis, MA

Donna B. Pincus, PhD

San Francisco Marriott Hotel

Golden Gate Salon B2

12:00 PM-12:50 PM

Business Meeting

San Francisco Marriott Hotel

Golden Gate Salon C1

1:00 PM-1:50 PM

Invited Address: [Davison]
Moscone Center South Building
Room 309

1 PM-2:50 PM

Symposium:
*Primary Care Psychology –
Opportunities for Practice and Education*
James Bray, PhD
San Francisco Marriott Hotel
Golden Gate Salon C1

2:00 PM-2:50 PM

Invited Address:
[Distinguished Scientist Award]
San Francisco Marriott Hotel
Golden Gate Salon B2

2:00 PM-3:50 PM

Symposium:
*Psychopathology–Toward a Psychometrically
Informed Classification System*
Robert F. Krueger, PhD
Moscone Center South Building
Room 100

3:00 PM-3:50 PM

Symposium:
*Behavioral Emergencies in the
Community–Mental Health
and Police Perspectives*
San Francisco Marriott Hotel
Golden Gate Salon A3

3:00 PM-3:50 PM

Invited Address:
[D'Esposito]
Moscone Center South Building
Room 236

4:00PM-4:50 PM

Presidential Address
Division 12, Section 3
San Francisco Marriot Hotel
Golden Gate Salon A2

Saturday, August 25

8:00 AM-8:50 AM

Paper Session:
*Social Anxiety and Depression - Cognitive,
Attentional, and Affective Correlates*
Norman S. Endler, PhD
Moscone Center South Building
Rooms 202/204/206

8:00 AM-8:50 AM

Paper Session:
*Trauma and Grief -
Psychopathology and Treatment*
Amy L. Ai, PhD
Moscone Center South Building
Rooms 252/254/256

9:00AM-10:50AM

Symposium:
*Family Intervention in
Geriatric Health Care Decisions*
Sara H. Qualls, PhD
Moscone Center South Building
Room 236

10:00AM-10:50AM

Invited Address:
Distinguished Scientist Address
Karen S. Calhoun, PhD
Moscone Center South Building
Room 302

10:00AM-11:50AM

Poster Session:
Psychopathology and Personality
Moscone Center South Building
Exhibit Hall C

12:00 PM-12:50PM

Symposium:
*Emergency Psychological Assessment
and Intervention with Victims of Violence*
Dale E. McNeil, PhD
Moscone Center South Building
Room 305

12:00PM-1:50PM

Symposium:

Fringe Psychotherapies -

What Lessons Can We Learn?

Scott O. Lilienfeld, PhD

Moscone Center South Building

Room 303

1:00PM-1:50PM

Invited Address: [*Goldfried*]

Moscone Center South Building

Room 308

2:00PM-3:50PM

Discussion:

Conducting Rigorous and Clinically

Relevant Research - Why and How

Thomas D. Borkovec, PhD

Moscone Center South Building

Room 303

3:00PM-3:50PM

Presidential Address:

Business Meeting

Lenore Walker, EdD

Moscone Center South Building

Rooms 202/204/206

4:00PM-4:50PM

Conversation Hour:

NIMH Translational Research Program –

Opportunities for Basic and Clinical Scientists

Robert S. Heinssen, PhD

Bruce N. Cuthbert, PhD

Moscone Center South Building

Rooms 228 and 230

4:00PM-4:50PM

Award Ceremony:

The Palace Hotel

Sea Cliff Room

5:00PM-5:50PM

Social Hour:

The Palace Hotel

Rose Room

Sunday, August 26

8:00AM-8:50AM

Paper Session:

Partner and Domestic Violence - New Findings

Diane M. Ackard, PhD

Moscone Center South Building

Room 224

8:00AM-8:50AM

Paper Session:

*Marital Therapy - New Conceptualizations
and Research Developments*

Andrew Christiansen, PhD

Moscone Center South Building

Room 309

9:00AM-9:50AM

Business Meeting:

Moscone Center South Building

Room 272

9:00AM-9:50AM

Presidential Address:

Diane J. Willis, PhD

Moscone Center South Building

Room 270

10:00AM-10:50AM

Business Meeting:

Sarah Miyahira, PhD

Moscone Center South Building

Room 270

10:00AM-11:50AM

Poster Session:

Psychotherapy and Clinical Assessment

Moscone Center South Building

Exhibit Hall C

11:00AM-12:50PM

Symposium:

Emotion and Psychopathology

Denise M. Sloan, PhD

Moscone Center South Building

Room 309

1:00PM-1:50PM

Conversation Hour:
*NIMH Adherence and Behavior
Change Research Program*
Robert K. Heinszen, PhD
Peter R. Muehrer, PhD
Moscone Center South Building
Room 236

1:00PM-1:50PM

Invited Address: [Monahan]
Dale E. McNiel, PhD
Moscone Center South Building
Room 305

2:00PM-3:50PM

Symposium:
*Assessing Child and Adolescent
Anxiety in Multiethnic Populations*
Michele Cooley-Quille, PhD
Moscone Center South Building
Room 309

Monday, August 27

8:00AM-8:50AM

Paper Session:
*New Approaches to Preventing
Depression Onset and Relapse*
Terry M. Bush PhD
Moscone Center South Building
Rooms 202/204/206

9:00AM-9:50 AM

Executive Committee Meeting
Sarah Miyhira, PhD
San Francisco Marriot Hotel
Sierra Conference Suite K

9:00AM-10:50AM

Symposium:
*Geropsychology for Clinical Graduate
Students - Models of Training*
Helen M. DeVries, PhD
Moscone Center South Building
Room 306

9:00AM-10:50AM

Symposium:
*Maternal Mental Distress - Effects,
Correlates, and Treatment*
Carol T. Mowbray, PhD
Moscone Center South Building
Room 309

10:00AM-11:50 AM

Symposium:
*Trainee Impairment - A Review of
the Literature and Proposed Solutions*
Steven K. Huprich, PhD
Moscone Center South Building
Room 303

10:00AM-11:50AM

Symposium:
*Recipe For Success - Strategies for
Ethnic-Minority, Female Graduate Students*
Hilda F. Besner, PhD
Lynissa L.S. Stokes, MA
Moscone Center South Building
Room 101

11:00AM-12:50PM

Symposium:
*New Research on Sexual Boundary
Violations and Experts' Responses*
Gary R. Schroener, BA
Moscone Center South Building
Room 300

11:00AM-12:50PM

Symposium:
*Marital Therapy - What Helps,
How Much, and For Whom?*
Brian D. Doss, BA
Moscone Center South Building
Room 305

1:00PM-2:50PM

Symposium:
*Medications, Psychological Interventions,
 and Prescription Privileges - Where
 Is Psychology Headed?*
 Garland Y. DeNelsky, PhD
 Moscone Center South Building
 Room 302

1:00PM-2:50PM

Symposium:
*Prevention and Treatment Effectiveness
 Research - Lessons From the Trenches*
 Louis G. Castonguay, PhD
 Moscone Center South Building
 Room 300

3:00PM-3:50PM

Workshop:
*Assessing Executive Functioning
 in Clinical Practice*
 Moscone Center South Building
 Rooms 252/254/256

3:00PM-4:50PM

Symposium:
*Dementia Caregiving Interventions - The
 Impact of Gender, Ethnicity, and Sexuality*
 Dolores Gallagher-Thompson, PhD
 Moscone Center South Building
 Room 300

Tuesday, August 28**9:00AM-10:50AM**

Symposium:
Inpatient Staffing and Ward Effectiveness
 Gordon L. Paul, PhD
 Moscone Center South Building
 Room 300

9:00AM-10:50AM

Workshop:
*Fundamentals of Exposure-Based
 Treatments for Anxiety Disorders*
 Joan Davidson, PhD
 Moscone Center South Building
 Room 302

10:00Am-11:50AM

Symposium:
*Lives of Girls and Women:
 Interpersonal Context and Well-Being*
 Valerie E. Whiffen, PhD
 Moscone Center South Building
 Room 301

11:00AM-11:50AM

Invited Address: *[Burgio]*
 Moscone Center South Building
 Room 202/204/206

11:00AM-12:50PM

Discussion:
*The Clinical Psychologist and Physician
 Training in Academic Health Centers*
 Michael Lechner, PhD
 Moscone Center South Building
 Room 238

12:00PM-1:50PM

Symposium:
*Efficacy of Short-Term Psychotherapies
 and Pharmacotherapies - An Empirical
 Reappraisal*
 Drew Weston, PhD
 Moscone Center South Building
 Room 301

1:00PM-2:50PM

Workshop:
Application of DBT With Triply Diagnosed Clients
 Elizabeth E. Wagner, PhD
 Moscone Center South Building
 Rooms 228 and 230



Society News

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

Thank You Reviewers for the 2001 APA Convention

Scott Lilienfeld, PhD, 2001 Division 12 Program Chair, wishes to thank the following individuals who served as reviewers for the 2001 APA Convention. A number of these reviewers went well above and beyond the call of duty by reviewing 8 or more submissions on very short notice, and I am grateful to all of these reviewers for performing a valuable and valued service under intense time pressure. Division 12 is deeply indebted to all of the individuals listed below.

Norman Abeles
Frank Andrasik
Michael Andrykowski
Michael Bagby
Alan Barclay
J. Gayle Beck
Jeffrey Berman
Larry Beutler
Ronald Blount
Steve Boggs
Robert Bornstein
Elisa Brontman
Timothy Brown
Jonathan Brush
Simon Budman
Laurie Chassin
Andrew Christensen
Eddie Clark
Gerald Conners
Raymond Costello
Kenneth Craig
Florence Denmark
Keith Dobson
Ronald Drabman

Dennis Drotar
Barry Edelstein
Sheila Eyberg
Albert Farrel
Jane Fisher
John Foreyt
Gary Foster
Sharon Foster
Cyril Franks
Violet Franks
Sol Garfield
William Garrison
Donna Gelfand
Ian Gotlib
Peggy Greco
Stephen Hinshaw
Stefan Hofmann
Grayson Holmbeck
William Iacono
Rick Ingram
Joan Jackson
Alan Kazdin
Terence Keane

Peter Keller
Phil Kendall
Candace Konnert
Gerald Koocher
Mary Koss
Mary Jo Kupsi
Richard Lanyon
Kenneth Leonard
John Linton
John Lochman
Jeffrey Lohr
Janet Mathews
Richard McNally
Cheryl McNeil
Gary Mesibon
Andrew Meyers
Catherine Murray
Debra Murphy
Peter Nathan
Arthur Nezu
Michael O'Hara
Thomas Ollendick
Sara Qualls

Lynn Rehm
Jeffrey Ring
Paul Rokke
Zindel Segal
Kenneth Sher
Lawrence Siegel
Timothy Smith
Tony Spirito
Annette Stanton
Wendy Stone
Catherine Stoney
George Stricker
Ken Tarnowski
Frank Treiber
Leon Vandecreek
Thomas Wadden
C. Eugene Walker
Joel Weinberger
Thomas Widiger
Deborah Wiebe
Diane Willis
Theodore Zahn
Antonette Zeiss
Robert Zeiss

Interested in applying for Initial APA Fellow Status?

Because of changes made by the APA Membership Committee, deadlines for initial applicants are now earlier than in the past. The deadline for initial Fellow applications for 2003 will be December 1, 2001. For persons who are already APA Fellows through other Divisions, the deadlines will continue to be February 15, 2002. Applications and information can be obtained from the Division 12 Central Office.

Clinical Psychology Brochure

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

Call for Nominations to the Committee on Women in Psychology

The American Psychological Association's Committee on Women in Psychology (CWP) is seeking nominations for two new members to begin terms in January 2002. The committee functions as a catalyst by interacting with and making recommendations to the various parts of the APA's governing structure, the APA's membership, and the Society for the Psychology of Women, as well as to other relevant groups. Additionally, the committee collects information and documentation concerning the status of women and develops the means by which the participation of women in roles and functions of the profession could be increased.

Committee members plan, develop, and coordinate various activities regarding the status of women. CWP's present strategic initiatives include translating research in women's health to practice, women and work, and women in psychology careers. The committee is interested in persons with demonstrated interest and experience in women's issues to serve a three-year term beginning in January 2002 and ending in December 2004. For this term, CWP seeks at least one member actively involved in research. To fulfill the committee's commitment to full diversity in representation, one of the slates should be filled by an openly identified lesbian psychologist. Letters of nomination should clearly describe the candidate's specific qualifications relative to these criteria.

Selected candidates will be required to attend two committee meetings a year in Washington, DC, with expenses reimbursed by the APA. Members also work on CWP priorities between meetings. If possible, members attend a CWP meeting at their own expense held during the APA Convention.

Nomination materials should include the nominee's qualifications, a letter from the nominee indicating willingness to serve on CWP and a current curriculum vita. Self-nominations are also encouraged. APA nominations are open to members who are retired or employed less than full time. Nominations and supporting materials should be sent by September 1, 2001, to Stephanie Olmstead-Dean of the APA Women's Programs Office, 750 First Street, N.E., Washington, DC, 20002-4242.

Position Opening

Postdoctoral Fellowships in Alcohol Etiology and Treatment. The Research Institute on Addictions (RIA), a research component of the University at Buffalo, The State University of New York, has multiple openings for NIAAA-funded postdoctoral fellows in alcohol etiology and treatment. The program provides specialized postdoctoral training for individuals seeking to pursue a career in alcohol research. The interdisciplinary training program emphasizes two primary areas: (1) etiology and course of alcohol use and misuse and (2) treatment for alcohol use disorders. Fellows develop and pursue research interests under the supervision of faculty preceptors. Seminars on alcohol use disorders, current alcohol research, grant writing, and professional issues and career development are an integral part of the training program. Start dates are negotiable. Estab-

lished in 1970, RIA has a staff of over 175 persons working on over 30 separate research projects. RIA occupies a five-story building, and offers outstanding resources in support of its research endeavors. Visit the RIA website at <http://www.ria.buffalo.edu>. Inquiries can be made to either Gerard J. Connors (connors@ria.buffalo.edu) or R. Lorraine Collins (collins@ria.buffalo.edu), Co-Training Directors. Applicants should forward a vita, representative reprints, letters of reference, and a cover letter describing research interests and training goals to: Alcohol Research Postdoctoral Training Committee, Attn: G. Connors and R. L. Collins, Research Institute on Addictions, 1021 Main Street, Buffalo, NY 14203. Applications from minority candidates are particularly welcome. Applicants must be citizens or noncitizen

nationals of the U.S. or must have been lawfully admitted for permanent residence. AA/EOE

INSTRUCTIONS: Want ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of *The Clinical Psychologist*. Ads will be charged at \$2 per line (approximately 40 characters).

Submission deadlines are: January 15 (March 1 edition); May 15 (July 1 edition); September 15 (November 1 edition); November 15 (January 1 edition).

Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, and advertisement to Wanda Kapaun, Editorial Assistant, wandakapaun@att.net, 3810 South Rivershore Drive, Moorhead, MN 56560-5621.

LETTERS TO THE EDITOR

FROM THE EDITOR

Though it is current policy of the Board of Directors of Division 12 to not endorse candidates for APA President-elect, we would like to aid our members in becoming more informed. As a follow up to a request made by a presidential candidate to use The Clinical Psychologist as a forum for communicating issues relevant to members of the division, other candidates for this year's election were invited to contribute similar letters. A letter from Stanley Moldawsky was printed in the last issue. Letters from all the other candidates appear below.

FROM THE DESK OF

JAMES H. BRAY, PH.D.

As your president I will work tirelessly to enhance the profession of psychology through expanding opportunities in practice, education, and science for all psychologists. Although we have made great strides, we face tremendous challenges at all levels of our profession.

TOP PRIORITIES AS APA PRESIDENT

Expand practice opportunities for psychology. Psychological practice in the 21st century requires that we change our traditional ways of education, practice and research to take advantage of the new possibilities available in the evolving healthcare arena. We are in the process of broadening our definition and focus from psychology as a mental health profession to psychology as a health profession that will enable us to be full partners in the healthcare arena. The vast majority (over 70%) of mental health problems are treated by medical providers without the assistance of psychologists or any other mental health providers. Primary care physicians often function as the de facto mental health system for the majority of patients, frequently due to the impact of managed care policies. Research indicates that over 50% of major health problems (diabetes, heart disease, HIV/AIDS) are due to psychosocial and lifestyle problems, yet these issues are not effectively addressed by the medical profession. Minority and underserved patients suffer even more from these systems of care. Psychologists are often not involved in the prevention and treatment of these problems because we are not seen as an integral part of the healthcare team. **This must change.**

As president, I will lead our expansion of psychology as a health profession to become a full partner in the healthcare arena. We need to develop stron-

ger alliances with primary care providers and professional organizations. As a faculty member in a Family Medicine Department, I have learned that primary care providers prefer to work with psychologists and develop collaborative approaches to the treatment of patients. As president, I will help APA develop new relationships with our primary healthcare colleagues, working together to solve the pressing healthcare problems of our nation.

Redefining psychology as a health profession in federal and state regulations provides us access to federal, state and private resources that are not currently available to psychologists. We must increase our advocacy efforts for inclusion of psychology in federal healthcare programs, such as HRSA Title VII programs and to gain prescriptive authority in the States and Provinces. We have made a major step in this direction with the inclusion of psychology in Graduate Medical Education funding. The APA Rural Health Committee (which I chaired) and the Board of Educational Affairs (of which I was a member) lobbied extensively for this change. With the help of APA staff and other groups, we are finally seeing the fruits of our labors.

Expand funding for psychological science and education. APA's lead in creating the Decade of Behavior sets the stage for increasing federal funding for psychological and behavioral science. Over 50% of health problems are caused by psychosocial and life-style factors, yet less than 5% of the National Institutes of Health budget is spent on research in these areas. Congress is in the process of doubling the NIH budget over the next five years. This is a propitious time for APA to join with other behavioral science groups to increase the percentage of the NIH budget for psychological science. Congress is also considering increased funding for health professions; psychologists need to be part of those programs. I have been an active advocate with the Science and Education Directorates through the Public Policy Advocacy Network. With the creation of the new companion APA Practice Organization, APA is able to spend additional funds on lobbying for all of our efforts. As president, I will strongly advocate for APA to spend the resources to take advantage of these unprecedented opportunities.

Finally, electing a president who will represent **both** practice and science interests will further enhance our collaborative atmosphere. I am an active scientist/practitioner and deal with both issues in my daily professional life. As president I can and will effectively represent the multiple points of view

within APA and foster an ongoing collaborative approach for the organization. Thank you for the honor of being nominated to serve as your president and for your support and vote.

Biographies Sketch

James H. Bray, Ph.D. is Director, Family Counseling Clinic and Associate Professor in the Department of Family and Community Medicine, Baylor College of Medicine in Houston, Texas. He received his Ph.D. in clinical psychology from the University of Houston in 1980. Dr. Bray was on the faculty at Texas Woman's University, Houston Center for 6 years. He teaches psychology students, resident physicians, and medical students, he conducts research on divorce, remarriage, adolescent substance use, applied methodology, and collaboration between physicians and psychologists. In addition to his internationally recognized research, he maintains an active clinical practice specializing in children and families, behavioral medicine, and child custody issues. He has been active in APA governance for over 12 years involved in practice, science, education, and state issues.

Effective Leader Within Psychology: Chair, APA Rural Health Committee and Task Force; APA Council of Representatives (Division 43); President, Division of Family Psychology; Chair, Board of Educational Affairs Awards Committee; Chair, Texas PSY-PAC.

Active in APA governance: Board of Educational Affairs, Primary Care Task Force; State Leadership Organizing Committee; President's Mini-Convention Program Task Forces; Board of Scientific Affairs Observer; 91 treasurer for Divisions of Child, Youth and Family Services and Family Psychology; Member at Large, Division of Psychotherapy.

Strong Advocate for All of Psychology: Federal Advocacy Coordinator Divisions of Clinical Psychology and Family Psychology and Texas; APA Public Policy Advocacy Network; Fund-raiser for Association for Advancement of Psychology; Texas Supreme Court Advisory Committee on Child Support and Child Visitation; National Leadership Coalition for Health Care Reform; National Health Policy Council, Steering Committee.

Recognized for Achievements: Elected Distinguished Practitioner-National Academies of Practice for Psychology; Karl F. Heiser APA Presidential Award for Advocacy on Behalf of Professional Psychology; Federal Advocacy Award from the APA Practice Directorate; Family Psychology and Health and Distinguished Service awards-Division of Family Psychology; Psychologist of the Year—Houston Psychological Association.

Internationally Recognized Scholar and Researcher: Over 100 publications and four National Institutes of Health grants: Developmental Issues in Step Families and A Longitudinal Study of Stepfamily Development (two ROIs from National Institute of Child Health and Human Development); Al-

cohol, Psychosocial Factors and Adolescent Development (two ROIs from National Institute of Alcoholism and Alcohol Abuse); Center for Substance Abuse Treatment contract on Alcohol and Other Drug Abuse Linkages Project with Rural Psychologists and Physicians; Consultant to National Institute of Mental Health (NIMH) Consortium on Families and HIV/AIDS research program and planning committee for annual conference, Role of Families in Preventing and Adapting to HIV/AIDS; NHMH SRCM-D Review Group and ad hoc reviewer MHAI-I Initial Review Group; National Science Foundation grant reviewer.

Recognized by the National Media: He has been featured on ABC 20/20; TODAY Show; Good Morning America; CNN News; USA Today; New York Times; Los Angeles Times; Washington Post; U.S. News and World Report; Time Magazine, National Public Radio, and many others. Author: *Stepfamilies: Love, Marriage and Parenting in the First Decade* (Broadway Books).

FROM THE DESK OF

KATHLEEN M. MCNAMARA, PH.D., ABPP
ON THE PRIMACY OF OUR DISCIPLINE

I appreciate the invitation and opportunity to address the membership of Division 12 as a candidate for APA President on an area of interest or concern for me.

The Society of Clinical Psychology's long commitment to advancing Clinical Psychology as both a science and a profession is a mission that will continue to strengthen our discipline and our practice. One of the major areas I have included among the top priorities if I am elected to the APA Presidency is promoting and securing the recognition (at a policy level) of Psychology as among the primary care health professions. The work of the members of the Society and the focus of the Society, itself, are valuable assets for promoting such an agenda. I would welcome the Society as a partner in this endeavor.

Simply stated, if Psychology remains defined by others (and especially those in policy positions) only as a mental health discipline and profession, and if mental health continues to be inappropriately separated from health care, the incredible contribution we can make to the overall health and well-being of those who could benefit from our services will be severely curtailed. Until we are recognized at a policy level as primary to health care, we will continue to do good things as individual psychologists in a limited number of circumstances - where someone is either wise enough to understand the long-term personal and economic benefits, or strong enough to risk

Kathleen M. McNamara, Ph.D., ABPP is a Staff Psychologist at the Maui VA Primary Care Clinic.

challenging convention in order to place a psychologist in a primary care role. This will continue to occur in only a small fraction of the settings where there is a potential for using our services. The funding for research in the area of behavioral health, for program development in the application of psychological knowledge to general health problems, and for the development of new service delivery models and outcome measures will remain a fraction of the budget allocated for biomedical research. The funds for training of our interns and postdoctoral fellows in these areas will barely be noticeable. Until we are included in legislation, regulations, agency planning documents, health care initiative documents, and the business plans of health care administrators, our good work will continue, but we will not begin to meet our responsibility to provide for the enhancement of human welfare.

We, as psychologists, already know that those psychologists working in primary care settings make substantial contributions to the assessment and treatment of patients in broadly-defined health care problems. Yet, in funding and resource allocation models relating to primary care there typically is not an assigned position for a psychologist. Psychological services for primary care settings are rarely discussed in planning for service delivery by those in the business of health care nor by those establishing public policy. This situation exists despite the existing data.

A recent briefing paper by the Government Relations Office of the APA Practice Directorate (February, 2001) highlighted some of that data in a variety of areas. For example, on cost savings, the paper cited the well-known study showing the 40% reduction in Medicaid utilization when psychological services were provided. Also noted was a 27% reduction in hospital admissions and bed days when psychologists are included in primary care clinics, and data from the most recent study showing the savings in direct treatment costs for breast cancer of two to five times the amount spent for psychological services.

The situation in which psychologists are not routinely considered remains despite the common knowledge that the majority of the leading causes of death have primary behavioral factors associated with them, or that a significant percentage of visits to primary care physicians (75% by some accounts, 20-80% by a number of historical accounts) are due to psychosocial problems, presenting as primary medical complaints. Even looking at the diagnoses by primary care physicians, the majority have a behavioral component. We know the substantial literature generated by psychologists on compliance issues with medical treatments (e.g. for diabetic, cystic fibrosis, and other chronic health conditions); on effective treatments for headaches, hypertension, incontinence, and managing chronic pain; on reducing post surgical bed days and medication utilization with pre-surgical psychological interventions; on prevention efforts for smoking and obesity - high risk factors in cardiovascular disease and cancer; and the

list of primary health-related disorders about which our journals are replete with successful interventions. Yet, the evening news program on national television does not cite our premier journals on a weekly basis as a regular news feature, and actually rarely even in the top stories of the day!

One need only look to the Society's own web page to see the successes we have had. Addressed there are the treatments for a number of significant health problems with empirically-supported psychological interventions. Your President and the candidates for your various offices repeatedly and eloquently have spoken of the continuing need to support the work of the clinician in practice with research conducted by scientist-practitioners. They have addressed effectiveness research, as well as efficacy research, the need to broaden the scientific base for clinical practice, not deny clinical experiences, and make clinical research increasingly relevant to clinical practice. Primary care is without a doubt an area ripe for a partnership between the clinician whose expertise is in the practice arena and the scientist-practitioner with knowledge and skills to apply so that Psychology excels in addressing the very core of our discipline - behavior!

The Committee for the Advancement of Professional Practice (CAPP) has set as one of its priorities increasing the opportunities for collaboration between psychologists and primary care providers, and the broader participation in health care interventions in general.

With an overall strategic plan and our collective wisdom, we can make a difference. We can be identified as primary to the health care of this nation. I look forward to participating in our success, and in carrying out responsibility.

As we say in Hawai'i, mahalo nui loa (thank you very much) for allowing me this opportunity to share my ideas about our future.

FROM THE DESK OF STEPHEN A. RAGUSEA, PSYD, ABPP

Clinical psychologists must broaden their perspective and learn to tackle the more difficult and complex psychological issues of modern life. Researchers must conduct relevant and scientifically rigorous research and practitioners must move their interventions out of comfortable consultation rooms, into the rapidly changing, technological world of the modern family.

The American Psychological Association should encourage clinical psychologists to publish and practice the kind of psychology for which our world is yearning. Psychology's many journals are packed with solid psychological research which has, in the past century, established Psychology as the

Stephen A. Ragusea is a clinical psychologist at the Child, Adult and Family Psychological Center at State College, PA

society's needs. As Pat Deleon is fond of saying, "Psychologists spend too much time talking to themselves." We clinical psychologists need to converse with our culture.

What can we do to fix this problem? Let's start by looking at our criminal justice system. Make no mistake about it, America has won the World Wide Incarceration Derby. We in the United States have demonstrated that we have the will and financial resources to put more of our citizens behind bars than any other nation. Indeed, throughout most of the past decade, America has incarcerated a higher percentage of its population than any other country in the world. And, according to a recent report by ABC News, 25% of the entire world's prison population is in U.S. prisons.

Prisons, as we know them, are really a modern invention. For most of human history, jails were a place to keep prisoners for a short time — until they were punished by techniques such as being placed in the stocks or whipped. Over the last hundred years, America has embraced a model which involves incarcerating people in prison for very long periods of time. Time in prison has itself become the punishment. Commonly, people are sentenced to jail terms of 18-24 months or 5 years or 25 years. There are lots of problems with this technique. First, it's expensive. It costs approximately \$25,000 to keep one prisoner in jail for one year and that doesn't include the cost of building the prison itself! What's worse, all that money doesn't buy much of a solution. The recidivism rate commonly approaches 40-50%.

I think we can all agree that some people need to be behind bars. There are some folks out there that are so disturbed and/or dangerous, that they need to be kept where they can't hurt other people. That number is relatively small.

However, the number we choose to imprison is not small. As of February of 2001, we have slightly more than 2 million U.S. citizens behind bars. That equals the entire population of the three states of N. Dakota, S. Dakota and Delaware, at an annual cost of approximately 50 billion dollars. Who are those people behind bars? Some of them are violent, dangerous people. Approximately half are in jail for drug and/or alcohol related offenses.

And, according to a 1998 survey done by the federal Bureau of Justice Statistics, 238,000 prisoners are known to be mentally ill, a population approximately equal to that of the cities of St. Petersburg, Florida or Akron, Ohio.

How did this happen to our mentally ill? We all know the history of deinstitutionalization. Nationally, state mental hospital populations peaked in 1955 at 559,000 people. By contrast, today's public hospital population is approximately 70,000 and 25,000 of these are for forensic evaluation! So, what we

have experienced is nothing short of a mass migration from mental hospitals to prisons.

Again a small percentage of prisoners will need to be incarcerated for extended periods. None of us wants John Wayne Gacy living next-door to our children. But, we need to start trying a different approach to crime and punishment.

A new movement is gathering strength. It's called Restorative Justice. It's an approach that combines justice with mercy and common sense. Restorative Justice is based upon a re-definition of crime as injury to the victim and the community rather than a challenge to the power of the government. Victims help define the harm of the crime and identify how the harm might be repaired. The essence of the punishment is to fix that which has been damaged. This model of crime resolution has proven very successful and costs much less money too!

It is psychology which should lead the way in prison reform. What other profession has our expertise in human behavior? Using our research methodologies, psychologists could explore a range of new alternatives to our existing criminal justice system. All we lack is the will. The APA's Task Force on Envisioning, Identifying, and Accessing New Professional Roles (Levant et.al.) recently reflected that "Approximately 1% of the population is currently in prison, on probation, or on parole. Many billions of dollars are spent annually to support this massive incarceration effort. Psychologists have not effectively contributed to the resolution of this massive societal problem. Psychologists must become involved at the center of what is fundamentally a psychological problem of learning and behavior. "

Unfortunately, psychologists, like most folks, would rather not think of our failures. Prisoners are society's failures and many are psychotherapy failures. We all want to forget about the people who live inside that gray, cold, cement and steel world of American's prisons. We are willing to think about crime and punishment, only when it invades our world, our neighborhood, and our family. We must do better.

Prison reform is one of my particular interests, but there many challenges for us to tackle. Clinical psychologists in research and practice must be willing to address society's major problems if we expect society to respect and fund our work. Briefly, here are three ways we can help:

#1 -- The American family is in crisis. The divorce rate now stands at 50%. What can psychologists do to predict successful marriages by premarital screening of couples? What can psychologists do to improve the success rate of marriages? Where is the research to guide family psychologists?

#2 — How many clinical psychologists are preparing for the technology revolution and telehealth? How many researchers are investigating diagnosis and treatment facilitated by television and computer?

#3 — The Human Genome Project is unlocking the human genetic code. If not already in progress, we will soon commence human cloning. But this is minor compared to the reality that we will soon be making conscious decisions about how to adjust the human chromosome. As we complete the genetic map and learn how to change design elements, we will begin changing the genes that impact height, weight, intelligence, assertiveness, creativity, memory, athletic skill, etc. Anybody think that the human race is currently prepared to face the challenge of making these decisions? Psychology should be leading the way by investigating: (a) the psychological factors which contribute to the making of such decisions, (b) the impact of such decisions on individuals and families, and (c) how we can best work with physicians, ethicists, and social planners to enhance the likelihood that this genetically enhanced chapter of humanity's book of life will be a rich and joyous one, not a horror story.

Psychology must become actively involved in with our social reality, and the American Psychological Association should lead that involvement. If we psychologists take care of society, society will take care of us. We can do better and, with strong leadership at APA, we will!

EDUCATION: Stephen A. Ragusea, PsyD, ABPP, received his doctorate from the APA approved program in clinical psychology at Baylor University.

PRACTICE: Since 1980, Ragusea has worked in a large group practice as a clinical psychologist at the Child, Adult and Family Psychological Center in State College, Pennsylvania. Experience was also gained at community mental health centers, state and community hospitals. He was founding CEO and Clinical Director of a 92 bed private psychiatric hospital.

Research: Since 1995, Ragusea has served as founding chair of Pennsylvania's Practice-Research Network, a unique and effective model which unites practitioners and research psychologists to conduct clinically relevant and scientifically rigorous psychological research. See: The Pennsylvania Practice Research Network *Clinical Psychology: Science and Practice*, (In Press, 2001.)

Public Service: Dr. Ragusea was appointed to the Pennsylvania Board of Psychology by Governor Tom Ridge in 2001.

Teaching: Ragusea has taught at Penn State University, Harvard Medical School, and presented numerous workshops across North America on topics such as family therapy, forensic psychology, medical psychology, the need for prison reform and the importance of developing practice-research networks.

Publications: He has written more than 30 articles and book chapters related to professional psychology and served as occasional editorial reviewer for *Professional Psychology: Research and Practice*.

Broadcasting: Ragusea has appeared as a psychologist on many television and radio shows broadcast throughout the Northeast.

Pennsylvania Psychological Association: Ragusea is a Fellow of PPA and has served as PPA's President, Clinical Division President, Hospital Practice Committee Chair, PennPsyPAC Board Member, and founding chair of PPA's Practice Research Network. He has also served on numerous PPA task forces and working groups.

American Psychological Association: Ragusea is a Fellow of APA and served on the Council of Representatives for over 6 years where he also functioned as Chair of the State and Provincial Caucus. He has also served on numerous APA task forces and working groups including the presidential task force on Envisioning and Accessing New Professional Roles. See: *Professional Psychology: Research and Practice*, 32, 79-87.

Certifications: ABPP Diplomate in Family Psychology, ABPN Diplomate in Neuropsychology, ACFP Certificate in Forensic Psychology, American Red Cross Certificate in Disaster Mental Health Services.

Honors: Award for Distinguished Service to Psychology, conferred by the Pennsylvania Psychological Association.

FROM THE DESK OF ROBERT J. STERNBERG, PH.D.

THE GOALS OF CLINICAL PSYCHOLOGISTS SHOULD BE THE GOALS OF ALL PSYCHOLOGISTS

Introduction

Psychologists are great classifiers and labelers. So it came to be that we, as a group, created labels to distinguish clinical psychologists from other kinds of psychologists. Yet, increasingly, these labels have become counterproductive as psychologists of all kinds have used common ideas and constructs in their work, and sought to reach common goals. For example, psychologists in all fields need to understand cognition, emotion, motivation, and their roles in behavior. We thus need to think in terms of a unified psychology in which, instead of concentrating upon often empty distinctions among fields, we focus on the phenomena and goals of common interest to all us, which attracted us to study psychology in the first place. We also need to recognize that the scientist-practitioner dichotomy is largely misguided. Just as many practitioners see

Robert J. Sternberg, Ph.D., is an IBM Professor of Psychology and Education at Yale University.

themselves as scientist-practitioners who infuse scientific thinking into their practice, so should many scientists view themselves as practitioner-scientists who are cognizant of and receptive to the potential practical applications their work may have. As APA President, I would seek to unify psychology.

About My Platform

1. Decisions regarding length and type of psychotherapeutic treatment received. I believe that psychologists, not bureaucrats, should make decisions regarding length and type of treatment. The role of managed care, unfortunately, has been largely negative. Underinformed and in many cases underqualified or even unqualified people are making important health-care decisions. These decisions should be made by the people in the best place to make them—the mental health-care professionals. I doubt that, as APA President, I could change the health-care system. I think I could effectively work, however, to change the way decisions about treatment are made within this system.

2. Removal of stigma associated by some with mental health care. Unfortunately, for many people, there is a stigma associated with seeking out mental health care. A priority for APA should be to remove this stigma from everyone's mind. Indeed, people should be rewarded for taking responsibility for dealing with their mental-health issues, in the same way that they would be rewarded for doing so with physical-health issues. Thus, seeking help when it is needed, whatever the kind of help, should be valued by society. Psychologists need to take responsibility for disseminating to the general public the data that show that psychotherapy can be and is successful in promoting wellness and in improving both subjective and objective measures of well-being.

3. Training for Practice. Mental-health care places a great responsibility on the caregiver. The caregiver should be intensively and extensively trained in order to be able to assume this responsibility. Thus I believe that mental health care is most appropriately given by practitioners with doctoral, not just masters level, training.

4. Parity in reimbursements. If there is one thing that research on health psychology has shown, it is the extent to which mental and physical health are interconnected. It makes no sense, therefore, to have separate reimbursement structures for the two kinds of practitioners, because essentially all practitioners are in the same business of curing or at least alleviating symptoms of disorders and promoting wellness. I thus believe in parity of reimbursement structures. Reimbursements should reflect actual costs of caring for individuals, regardless of whether the disorder is psychological, physical, or some combination of the two.

5. Prescription privileges for practicing psychologists. I fully realize what a controversial issue this is. I support prescription privileges for psychologists with APA-approved

postdoctoral training. There are several reasons why I have taken this position. First, as I stated, mental and physical health are interrelated, and I believe that sometimes medication is appropriate in addition to psychotherapy. I do not believe, however, that medication without psychotherapy is appropriate for treating psychological disorders. Second, I believe that all psychotherapists should have available to them the full armamentarium of treatments with which they wish to be equipped. Some psychologists might not even wish to have prescription privileges; others might. The choice should be theirs, not legislators'. Third, there are now good data from the military showing that prescription privileges for psychologists can work successfully. Fourth, all practitioners of any kind need to recognize when they need to consult with specialists. Psychologists will consult with others as necessary, just as they always have done. Fifth, I believe that the long-term economic well-being of psychologists as a profession depends in part upon their being able to provide the broadest range of mental health-care services that are feasible.

6. Jobs. The advent of managed care has hurt employment prospects (as well as decreased income) for many professionals. APA needs to take an active role in doing what it can to repair this situation. Indeed, we need to improve living and working conditions for *all* psychologists.

I believe that clinical psychology is key to other initiatives I would undertake if elected to the APA Presidency. Among these initiatives are support of psychological research, development of action plans, and action toward solving important world problems—reducing violence in schools and society; reducing worldwide poverty, hunger, and conflict; fighting all forms of exploitation of children; removing all forms of discrimination in society; and promoting worldwide appreciation of ethnic, cultural, and religious differences. I also will actively promote psychological science and funding for it, at both the university and governmental levels, as well as work to improve teaching of psychology at all levels. None of these or any other initiatives can succeed without clinical perspectives, and that is why it is so important to unify psychology.

About Me

I am IBM Professor of Psychology and Education at Yale and a former Acting Chair and Director of Graduate Studies in Psychology. I also am Director of the Yale Center for the Psychology of Abilities, Competencies, and Expertise (PACE Center). Our new Center currently has a research and development wing and is now initiating a practice wing. Hence, practice is very much of a concern to us. Some of us are clinically trained, others are not, but in our Center, we all are scientist-practitioners and practitioner-scientists. And we all work as a united and cohesive team, which is the kind of atmosphere I would seek further to develop in APA.

My main interests are in intelligence, creativity, wisdom, thinking styles, love, and hate. I have published widely (over

800 books and articles) and also have done much research (currently over \$7 million in grants and contracts) in these and related areas. My triangular theory of love and my theory of love as a story (and the scales associated with them) have been used in psychotherapy, and some clinical psychologists have found my triarchic theory of (successful) intelligence (and the scale associated with it) useful to them in thinking broadly about intelligence. I have been president of four APA divisions and editor of two APA journals. I am a Fellow in 12 APA divisions and also a Fellow of the American Academy of Arts and Sciences and the American Association for the Advancement of Science. I have won numerous awards from APA and many other organizations. My doctorate is from Stanford (1975) and I also have four honorary doctorates.

1/4 page On Good Authority Ad

Instructions to Authors

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

Material to be submitted should conform to the format described in the *Publication Manual* of the American Psychological Association. It is preferred that a single electronic copy of a submission be sent as an attachment to e-mail. Alternatively, submit four copies of manuscripts along with document file on computer disk for review. Manuscripts should not exceed 20 pages including references and tables. The Editor must transmit the material to the publisher approximately three months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time. Inquiries may be made to:

Paul D. Rokke, PhD, *TCP* Editor
Department of Psychology
North Dakota State University
Fargo, North Dakota 58105-5075
Paul_Rokke@ndsu.nodak.edu
(701) 231-8626 (voice)
(701) 231-8426 (fax)



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Society of Clinical Psychology (12)
American Psychological Association
P.O. Box 1082
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