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An Interesting Year

My term as your president is drawing to a close and I am reminded of the ancient curse, "May you live in interesting times". We are all living in times that are more interesting and challenging than most of us would have imagined at the beginning of the year. In one way or another, clinical psychologists are having to deal with the consequences of national disaster. We can take great pride in the way that so many of our members have risen to this challenge, individually and collectively. Individuals have donated time, money, blood, and expertise. Our Section VII: Emergencies and Crises has been active in sharing information and expertise to assist APA in its response efforts. We have our own heroes who were near ground zero and, like our Membership Committee Chair, Larry Siegel, have volunteered help in numerous ways. Other members are designing research projects to study psychological effects and preventive interventions.

The fall Board meeting in early October was impacted somewhat in that several board members were not able to attend. However, thanks to everyone's cooperation, we carried on fairly normally and had a very productive meeting. We approved a new section on assessment: Section IX. Join me in welcoming them, and please contact the Society's Central Office if you are interested in becoming a member of our newest section. Another important development was the approval of a member ballot on a bylaws change that would create an Affiliate member category. If approved it will allow those who can't or don't wish to be full members, but who have an interest in clinical psychology, to join the Society. The board continued its ongoing struggle against deficit spending, with several good ideas generated for cost-cutting as well as for increasing future revenues. The Publication Committee met in conjunction with the board and they too had a very productive meeting. They are beginning the search for the next editor of the Society journal, *Clinical Psychology: Science and Practice*. It is extremely important that we continue the tradition of outstanding leadership of our journal, which in many ways is the public face of the Society. I encourage your participation in the search effort.

Please remember to return your apportionment ballot, and give your votes to Division 12, so that the Society will have a strong voice in the APA Council. And I urge you to send in your nomination ballot so that we will have a strong slate of candidates for division offices.

This year has been a wonderful, if challenging, experience for me. It has given me a whole new appreciation for the Society and the work done by our profession. I have had tremendous support from the Board, the Administrative Officer, the Sections, and the Committees. I owe them all my thanks. I leave office with confidence that the Society is in good hands. And I leave each of you with my very best wishes.

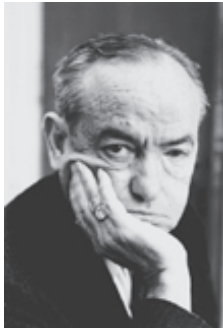


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President's Column

The Developmental Approach to Adult Psychopathology

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Edward Zigler

In Zigler's research, principles from classical developmental theory have been applied to investigations of adult psychopathology, self-image, and mental retardation. The developmental approach to adult psychopathology has yielded an integrated body of findings relating premorbid competence, symptomatology, diagnosis, and many facets of outcome to underlying developmental level. The developmental research on self-image has yielded consistent findings concerning both normative and atypical development in children and adults. Research with psychiatric inpatients with mental retardation integrates Zigler's developmental approaches to psychopathology and mental retardation. This paper presents the developmental principles underlying the research and summarizes the findings.

The field of developmental psychopathology has expanded rapidly. Principles from classical developmental theory are applied to the investigation of psychopathology and other clinical phenomena. Through this integration of developmental and clinical psychology, knowledge about normal development informs issues in psychopathology, and discoveries in the fields of psychopathology and atypical development enhance understanding of normative developmental processes.

In research that has been ongoing for over 40 years, Zigler and his colleagues have applied principles from classical developmental theory to the investigation of adult psychopathology, self-image, and mental retardation. In this article, the research on psychopathology and self-image is reviewed along with two studies that integrate the developmental approaches to psychopathology and mental retardation.

The Developmental Formulation

Although influenced by many developmental theorists (e.g., Lewin, 1946; Piaget, 1951; Rapaport, 1951), the developmental approach to adult psychopathology owes the greatest theoretical debt to Werner's organismic-developmental theory (Werner, 1948; Werner & Kaplan, 1963). Among the major developmental theorists, Werner was the most concerned with extending developmental theory beyond child development to fields such as adult psychopathology.

The developmental approach to adult psychopathology assumes that even in adulthood individuals can be viewed as functioning at different levels along an underlying developmental continuum. The person's underlying developmental level is presumed to broadly influence social and emotional as well as cognitive functioning. A second premise is that the person's underlying developmental level continues to influence behavior after the onset of disorder just as it did in the premorbid period. People are not presumed to change characterological modes of responding with the onset of psychopathology by regressing to an earlier level. Instead, patients are presumed to maintain their premorbid developmental characteristics even after the emergence of psychopathology. Manifestations of psychopathology as well as premorbid behavior should reflect the person's same broad underlying developmental characteristics.

Three fundamental principles in developmental theory underlie this approach to psychopathology. The first principle, elaborated most fully by Werner (1957), is that development "proceeds from a state of relative globality and lack of differentiation to a state of increasing differentiation, articulation, and hierarchic integration" (p. 126). Of particular relevance to psychopathology are the implications of this orthogenetic principle for understanding the self in relation to external reality and other people. At earlier developmental levels, subjective experience and external events tend to be undifferentiated. Neither the boundaries nor the point of view of the self can be adequately distinguished from the boundaries and point of view of the other. In psychodynamic terms, this condition is described as the relative lack of boundary articulation and reality testing. With increasing development, not only are the

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self and the external world differentiated, they are also reintegrated in complex and relatively stable ways. Apprehension of the self and the external world as differentiated entities, each organized in its own right and interrelated with the other, allows for greater planning and active control over both external events and internal need states. Gratification can be delayed, goals can be envisioned, and it becomes possible to employ substitutive means and alternative ends in order to achieve these goals (Werner & Kaplan, 1963). Adaptive capacities and coping, therefore, increase as a function of the structural changes that define development.

The second principle is that developmentally early behavior is marked by immediate and unmodulated responses to external stimuli and internal need states whereas developmentally higher functioning is characterized by indirect, ideational and symbolic or verbal responding (Piaget, 1951; Werner, 1948). In the developmental approach to psychopathology, this principle has been applied most extensively to the categorization of symptoms.

The third principle is that development entails the capacity to incorporate increasingly complex social demands and values. If they are not adhered to, the greater internalized demands can lead to increased guilt. This developmental principle underlies the research on role orientation in symptomatology and is also central to the work on self-image.

The application of developmental principles to adult psychopathology has considerable theoretical and practical significance both for research and ultimately for treatment programs. First, it allows the various forms of psychopathology to be considered in relation to each other. Despite differences in particular forms of behavioral expression, underlying similarities can be discerned. Second, it permits a classification system based on a coherent, theoretically derived, interrelated set of principles. Third, by viewing psychopathology within the context of normal maturation, it allows for an emphasis on the adaptive potential of the individual and provides a framework whereby the movement between pathological and nonpathological states can be understood. Finally, implicit in the developmental formulation is the view that different treatments will be required for individuals who are themselves at different developmental levels.

Developmental Differences in Adult Psychopathology

Based on developmental theory, psychiatric patients who function at developmentally higher levels, compared to those at lower levels, should display: (1) greater differentiation and hierarchic integration leading to greater coping effectiveness, (2) more frequent expression in thought and verbal behavior rather than action, and (3) a greater internalization of societal

demands and possible guilt. These broad developmental characteristics have been found to relate to each of the following major variables in psychopathology: premorbid social competence, symptomatology, major diagnostic categories, paranoid-nonparanoid status in schizophrenia, outcome, age at first hospitalization, and self-image (see Glick, 1997; Zigler & Glick, 1986).

Premorbid social competence. When Zigler and Phillips (1960, 1961c) began research on the developmental approach to psychopathology, an issue was how to measure developmental level in adults when the concept was broadly conceptualized as including social, emotional, motivational, and cognitive components. Research by Loevinger and Vaillant (e.g., Loevinger & Wessler, 1970; Vaillant, 1977) have provided measures of developmental status appropriate to adulthood, but these were not available when Zigler and Phillips began their work. Zigler and Phillips (1960) believed that the developmental construct was too broad and contained too many facets to permit a practical single measure. Given the inherent relationship between developmental level and coping effectiveness, they chose instead to measure the individual's premorbid social competence. Scoring has been found to be highly reliable (e.g., Glick, Zigler, & Zigler, 1985; Zigler & Levine, 1981b). The construct validity of the social competence measure has been supported by findings that premorbid social competence scores correlate positively with Rorschach developmental level, maturity in moral reasoning, and level of ego development (Glick, 1997; Lerner, 1968; Quinlan, Rogers, & Kegan, 1980).

The construct of premorbid adjustment had been applied previously to patients with schizophrenia in order to designate process (poorer prognosis) versus reactive (better prognosis) subtypes (see Zigler & Glick, 1986 for a review of this research). In contrast to this interpretation, Zigler and Phillips construed premorbid social competence as a developmental indicator. Thus they assumed that the measure could be applied to patients in many diagnostic groups and would be related to many major variables in psychopathology in addition to outcome. The many relationships discovered between premorbid social competence and other major variables in psychopathology for patients in many diagnostic groups support the developmental interpretation.

Symptomatology. The research on the developmental approach to adult psychopathology has utilized three modes of categorizing symptoms developmentally. The first mode of symptom categorization, along an action-thought continuum, is based on the fundamental premise in development theory that expression in direct action reflects developmentally lower functioning than expression in thought or verbal behavior.

Consistent with this premise, a predominance of symptoms involving thought or verbal expression (e. g., suicidal ideas, obsessions) rather than action (e.g., suicidal attempt, assaultive) has been found to be related to higher social competence in patients with many psychiatric diagnoses (Glick et al., 1985; Phillips & Zigler, 1961).

The second categorization uses three symptom clusters that Phillips and Rabinovitch (1958) conceptualized as reflecting three patterns of role orientation: self-deprivation and turning against the self, self-indulgence and turning against others, and avoidance of others. Inasmuch as turning against the self implies the internalization of societal values with possible consequent guilt, this role orientation was conceptualized as reflecting developmentally higher functioning than the other two. Examples of symptoms in each role orientation are (1) turning against the self: depressed, suicidal attempt; (2) turning against others: assaultive, irresponsible behavior; (3) avoidance of others: delusions, hallucinations, withdrawn. The developmentally higher status of the role orientation of turning against the self has been supported by many findings that patients with a predominance of symptoms in the turning against the self category display higher premorbid social competence than patients whose role orientations reflect either turning against others or avoidance of others (Glick et al., 1985; Mylet Styfco, & Zigler, 1979; Zigler & Phillips, 1960, 1962). These results have been obtained for patients with nonschizophrenic diagnoses (e.g., affective disorder, personality disorder) as well as for patients with schizophrenia.

The third ordering, which is applicable only to psychotic patients, is based upon a developmental interpretation of hallucinations and delusions. Conceptual and ideational modes of organization are presumed to reflect developmentally higher functioning than perceptual modes of organization (Freud, 1933; Werner, 1948). Based on this developmental principle, Zigler and Levine (1983) posited that delusions (false beliefs) without accompanying hallucinations (false perceptions) would reflect developmentally higher functioning. Hallucinations without accompanying delusions were conceptualized as reflecting developmentally lower functioning, while the presence of both symptoms was presumed to reflect an intermediate developmental position between the two single symptom groups. This formulation has been supported in research with patients with schizophrenia and affective psychoses. Within both diagnostic groups, patients who displayed delusions but not hallucinations obtained the highest premorbid competence scores. Patients with hallucinations but not delusions obtained the lowest premorbid competence scores, and patients who displayed both symptoms had competence scores intermediate between those obtained by patients in the two single symp-

tom groups (Glick, Acunzo, & Zigler, 1993; Zigler & Levine, 1983).

Major diagnostic categories. Although the action-thought and role orientation categories relate to diagnosis, these relationships have been found to be modest (Zigler & Phillips, 1961b). Diagnosis and developmental symptom categories thus retain a considerable degree of independence. The results of many studies indicate that patients with affective disorder diagnoses obtain higher developmental scores on measures of premorbid competence and of level of ego development whereas patients with schizophrenia, antisocial personality disorder, and other diagnoses involving impulsive or aggressive behavior obtain lower developmental scores on these measures (see Glick, 1997; Zigler & Glick, 1986). In a sample of treatment-seeking cocaine abusers a similar relationship appeared in regard to comorbid diagnoses. Cocaine abusers with comorbid diagnoses of depression had higher premorbid competence scores than did abusers with a comorbid diagnosis of antisocial personality disorder (Luthar, Glick, Zigler, & Rounsaville, 1993).

Paranoid-nonparanoid status in schizophrenia. Patients with paranoid schizophrenia obtain higher premorbid competence scores than patients with nonparanoid schizophrenia (e.g., Zigler & Levine, 1973; Zigler, Levine, & Zigler, 1976; 1977). Paranoid and nonparanoid schizophrenic patients also differ on a variety of cognitive and perceptual functioning measures and in age at onset of disorder (see Zigler & Glick, 1984). Research has also disclosed many similarities between paranoid schizophrenia and the affective disorders. In reviewing these many findings, Zigler and Glick (1984, 1988) advanced the hypothesis that paranoid schizophrenia or at least some forms of this disorder may, like mania, represent a defense against depression.

Outcome. Developmental theory asserts that the increased differentiation and integration that accompany development inherently provide the means for greater adaptability and coping effectiveness. With greater adaptive resources at their disposal, individuals who function at higher developmental levels should be able to cope more effectively with the problems related to their disorders and thus display better outcomes. The relationship between premorbid competence or premorbid adjustment and outcome in schizophrenia has been demonstrated in many studies conducted over many years (see Kendler, Gruenberg, & Tsuang, 1984 for one review of this research). Much of this research on schizophrenia has been based on the assumption that premorbid adjustment designates subtypes (good vs. poor prognosis) that are specific to schizophrenic disorder and thus that measures of premorbid adjustment pertain only to patients with schizophrenia. By

contrast the developmental formulation assumes that premorbid competence reflects underlying developmental level. As an indicator of developmental level, the premorbid competence construct should be applicable not only to schizophrenia but should be related to outcome for patients in many psychiatric diagnostic groups. Consistent with this developmental interpretation, premorbid competence and outcome have been found to be related for patients with diagnoses of affective, personality, and neurotic disorders as well as for patients with schizophrenia. Within all these diagnostic groups, patients with higher premorbid competence have been found to have shorter initial hospitalizations, fewer rehospitalizations, shorter rehospitalizations, and better early response to neuroleptic treatment (e.g., Glick, Mazure, Bowers, & Zigler, 1993; Glick & Zigler, 1986; 1990; Zigler, Glick, & Marsh, 1979; Zigler & Phillips, 1961c). Developmental differences have also been related to prognosis in alcoholism. The essential-reactive distinction in alcoholism designates individuals with poorer (essential) versus better (reactive) prognoses (e.g., Rudie & McGaughan, 1961). A highly significant relationship appeared between this essential-reactive distinction and social competence, and scores on the Zigler-Phillips Social Competence index were found to be related to outcome as well as measures of developmental level in humor responses (Finney & Moos, 1979; Levine & Zigler, 1973; 1976; Sugerman, Reilly, & Albahary, 1965).

Age at first hospitalization. In addition to displaying better outcomes after hospitalization, the developmental formulation generates the expectation that individuals at higher developmental levels will be less likely to succumb to psychiatric disorders. If they do, such individuals would be expected to be older at the time the disorders become manifest than patients who function at lower developmental levels. Consistent with this developmental formulation, higher social competence has been found to be related to an older age at first hospitalization for patients with schizophrenia and for those with affective, personality, and neurotic disorders (Glick et al., 1985; Zigler & Levine, 1981a). As a group, hospitalized psychiatric patients display lower social competence than the general population (Zigler & Phillips, 1961a).

Summary. The relationships between developmental level and many major variables in psychopathology are summarized in Table 1. These relationships to developmental level have appeared for patients in many diagnostic groups. This body of work demonstrates that developmental principles can provide a framework wherein a broad range of phenomena in adult psychopathology can be conceptually organized and integrated. The findings point to developmental level and coping effectiveness as central variables in psychopathology. A major implication is that prevention and treatment programs should

Table 1
Developmental differences in adult psychopathology

Variable	Lower	Higher
Premorbid social competence	Lower	Higher
<u>Symptomatology</u>		
(1) Action-thought orientation	Action	Thought
(2) Role orientation	Turning against others	Turning against self
	Avoidance of others	
(3) Hallucinations-delusions	Hallucinations	Delusions
Diagnosis	Schizophrenia, anti-social personality disorder	Affective disorder, neurosis
Schizophrenia subtype	Nonparanoid	Paranoid
<u>Outcome</u>		
(1) Initial hospitalization	Longer	Shorter
(2) Rehospitalization	More and longer	Fewer and shorter
(3) Early neuroleptic response	Poorer	Better
(4) Posthospital social and work functioning	Poorer	Better
Age at first hospitalization	Younger	Older
Self-image disparity	Less	More

emphasize and foster these positive characteristics that may be equally or more predictive of outcome than the patient's symptoms and disordered functioning.

The Cognitive-Developmental Interpretation of Self-Image

The majority of variables investigated in the developmental approach to psychopathology pertain specifically to disordered functioning in adulthood. By contrast, self-image is relevant to both normal and disordered development and to the functioning of both children and adults. Consequently, Zigler and his colleagues have investigated self-image with adult psychiatric patients, in normative child development, and in children with mild mental retardation and those with emotional disorders. Although the research has considered diverse populations, the findings have advanced a single developmental formulation.

This research particularly illustrates the integrative value of developmental psychopathology whereby knowledge about normal development informs issues in psychopathology, and the investigation of atypical populations enhances knowledge about normal development. Cognitive-developmental differences in self-image were first examined in adult patients (Achenbach & Zigler, 1963). The formulation was then extended to normative child development (e.g., Katz & Zigler, 1967). The influences of experiential as well as cognitive-developmental variables were then examined in research with children and adolescents with emotional disturbance and those with mild mental retardation (e.g., Katz, Zigler, & Zalk, 1975; Zigler, Balla, & Watson, 1972). These findings concerning experiential variables were then applied to adult patients (Mylet, Styfco, & Zigler, 1979).

The cognitive-developmental formulation. Achenbach and Zigler (1963) first advanced the cognitive-developmental interpretation of self-image disparity. They posited that increased disparity between the real self-image (one's current view of self) and the ideal self-image (the ideal person that one would like to be) was not an indicator of maladjustment but a natural concomitant of normal growth and development. This formulation was based on two developmental principles. The first is that higher levels of development entail greater cognitive differentiation (Piaget, 1951; Werner, 1948). Inasmuch as self-images are symbolic conceptual constructions, greater differentiation or disparity between aspects of the self-image (the real and ideal self-images) should appear at higher developmental levels. Secondly with development, individuals incorporate increasingly complex social demands and expectations (Zigler & Phillips, 1960). The greater self-demands at higher developmental levels and the guilt that may accompany them should also result in greater disparity between the real and ideal self-images. Research by Bybee and Zigler (1991) has

corroborated this hypothesized relationship between self-image disparity and guilt in children and young adults.

This developmental formulation contrasts markedly with the more traditional view of self-image disparity (e.g., Rogers & Dymond, 1954; Higgins, Klein, & Strauman, 1985). Whereas the traditional view interprets greater real-ideal self-image disparity as an indicator of a lack of positive self-regard and thus of maladjustment, the developmental formulation interprets this disparity as reflecting higher developmental functioning.

Cognitive-developmental differences in self-image. Consistent with the developmental formulation, Achenbach and Zigler (1963) found that adult psychiatric and medical patients with higher developmental functioning as indicated by social competence displayed greater real-ideal self-image disparity and also greater differentiation in other aspects of the self-image than did lower competence patients. Contrary to the traditional view that self-image disparity indicates maladjustment, psychiatric and medical patients did not differ in real-ideal self-image disparity. Mylet et al. (1979) similarly found greater real-ideal self-image disparity and more differentiation in other aspects of the self-image for high as compared with low competence psychiatric and medical patients.

The cognitive-developmental interpretation of real-ideal self-image disparity has received consistent support in many studies of children and adolescents, both those exhibiting typical development and those with emotional disturbance or mild mental retardation (Katz & Zigler, 1967; Katz et al., 1975; Leahy, 1981; Leahy, Balla, & Zigler, 1982; Luthar, Zigler, & Goldstein, 1992; D. Phillips & Zigler, 1980; Zigler et al., 1972). In this research, greater real-ideal self-image disparity has been found to relate to higher developmental functioning as indicated by each of the following variables:

1. Older chronological age in children with typical development, in children with emotional disturbance, and in children with mild mental retardation.
2. Superior rather than average cognitive ability.
3. Average cognitive ability rather than mild mental retardation.
4. The presence of thought (internalizing) rather than action (externalizing) symptoms in children with emotional disturbance. As in the research with adults, thought symptoms are presumed to reflect higher developmental functioning (Piaget, 1951; Werner, 1948).
5. Evidence of nonegocentric thought in a role-taking task and greater maturity in moral reasoning.

All these studies also revealed that a higher ideal self-image was associated with higher developmental functioning

as indicated by all of the variables just listed. In middle-class children and adolescents, Bybee (1986) furthermore found that a higher ideal (but not a higher real) self-image was related to better adjustment. Research has also examined children's spontaneous descriptions of their real and ideal self-images (Bybee, Glick, & Zigler, 1990).

Experiential influences. A variety of experiential variables that affect how others respond to the individual in everyday social-psychological interactions have been found to have important moderating influences on the self-image. The influence of experiential variables has primarily been uncovered in research with atypical populations. Lower (less positive) real self-images have been found in: (1) children (with or without mental retardation) who live in institutions rather than home settings, (2) emotionally disturbed children especially those with symptom expression in action rather than thought, (3) children with mental retardation compared with children of average intelligence of the same mental age (MA), and (4) adult psychiatric compared to medical patients (Katz et al., 1975; Leahy et al., 1982; Mylet et al., 1979; Zigler et al., 1972).

In addition to lower real self-images, children in institutions and those with externalizing behavior problems displayed lower ideal self-images and less self-image disparity than children in home settings or without emotional disturbance. These children appear both to think poorly of themselves and to show little aspiration for change.

Summary of research findings. Individuals who function at higher developmental levels consistently have been found to display greater real-ideal self-image disparity. In children and young adolescents, the greater disparity at higher developmental levels primarily reflects an increasingly higher (more positive) ideal self-image. Higher self-images have also been found to relate to good adjustment. Rather than impeding development, therefore, a higher ideal self-image may reflect higher aspirations and a positive view of life's possibilities that can motivate and guide development. Negative life experiences such as those involving stigmatization and failure have primarily been found to influence the real-self image, leading to a more negative view of self.

A possible reconciliation of the traditional and cognitive-developmental interpretations of self-image. Findings have consistently supported the cognitive-developmental interpretation of self-image disparity. Nevertheless, one can ask whether increased disparity between the real and ideal self-images is invariably adaptive. Extremely high and unrealistic aspirations could paralyze rather than facilitate adaptive functioning. Such aspirations could also represent denial and the substitution of fantasy solutions for realistic striving. Both

these situations are characterized by the absence of a perceived relationship between the ideal and the real self-images. Moreover, findings that clients in outpatient therapy display greater real-ideal disparity than control subjects and that disparity decreased over the course of successful therapy (e.g., Rogers and Dymond, 1954) support the traditional interpretation.

Developmental theory provides a possible basis for reconciling the cognitive-developmental and traditional interpretations of self-image disparity (Glick & Zigler, 1985). By applying Werner's (1948) orthogenetic principle, three levels can be distinguished in relations between the real and the ideal self-images. At the earliest level, characterized by global organization, the ideal self-image, being inseparable from the real self-image, could provide no motivation or direction for change. An intermediate level of organization can be conceptualized as involving differentiation with insufficient reintegration of real and ideal self-images. Aware of the discrepancy between the ideal and the actual, an individual at this stage of development might be motivated for change but lack a sense of appropriate direction and means for its accomplishment. At this stage, discrepancy might give rise to feelings of self-dissatisfaction and helplessness. At the highest level of organization, the ideal self-image would be expected to be conceptualized in relation to an articulated real self-image. Rather than desiring to be utterly different, individuals at this stage might be more likely to envision change as the development and modification of qualities they already perceive in themselves. Such reintegration of the real and ideal self-images would not only provide motivation for change but would allow conceptualization of appropriate directions and subgoals, thereby facilitating adaptation.

Within this conceptualization involving three levels, clients in outpatient therapy who have been found to display greater real-ideal disparity than nonclients and decreased disparity over the course of successful therapy (e.g., Rogers & Dymond, 1954) can be posited to be at the intermediate level. Consistent with this assumption, entrance into outpatient therapy is frequently self-motivated and accompanied by expressions of self-disparagement, depression, and anxiety. For individuals at this level, improvement might well entail the reintegration of real and ideal self-images with a resulting decrease in disparity. By contrast, a developmentally earlier global level of organization might be more characteristic of certain psychiatric inpatients and children with action-oriented symptoms. For these groups, diminished real-ideal self-image disparity would not be construed as a favorable sign, and treatment might be directed toward increasing disparity by raising the ideal self-image.

Adult Psychopathology in Mental Retardation

In the developmental approach to mental retardation, the principles of development that characterize nonretarded people are assumed to apply as well to individuals with nonorganic mental retardation. The majority of these individuals have mental retardation in the mild range. Individuals with nonorganic mental retardation are assumed to differ from the general population only in that development proceeds more slowly and attains a lower upper limit (e.g., Hodapp, 1997; Zigler, 1969; Zigler & Hodapp, 1986). Some evidence suggests that aspects of the developmental framework can also be applied to people with organic forms of mental retardation (e.g., Cicchetti & Pogge-Hesse, 1982; Hodapp & Zigler, 1995). Based on Zigler's developmental formulation, individuals with mental retardation are assumed to react to their life experiences just as nonretarded people do. An emphasis has been on investigating personality characteristics that arise from negative experiences that people with mental retardation frequently encounter, e.g., failure and institutionalization (see Zigler & Bennett-Gates, 1999 for a review of this work). Research cited previously on the self-images of children with mental retardation and the effects of institutionalization are examples of this extensive body of work on personality and motivational variables that influence the performance of people with mental retardation. Given the focus of this paper, only studies that pertain directly to adult psychopathology are reviewed.

Inasmuch as the developmental approaches to psychopathology and to mental retardation derive from the same underlying developmental formulation, many of the assumptions in the psychopathology research should be applicable to psychiatric patients with mental retardation. In the effort to extend the work on adult psychopathology to psychiatric patients with mental retardation and thus to integrate these two lines of investigation, Glick and Zigler applied constructs from the psychopathology research to patients with mild mental retardation.

Glick and Zigler (1995) examined whether psychiatric inpatients with and without mental retardation who were closely matched on other variables would differ in regard to the three modes of symptom categorization utilized in the developmental approach to psychopathology. Based on the developmental formulation of mental retardation, the patients with mild mental retardation were expected to evidence lower developmental functioning than those without mental retardation in regard to each of the three symptom categorizations. As hypothesized, inpatients with mild mental retardation displayed: (1) more symptoms involving expression in action rather than in thought or verbal behavior, (2) more symptoms indicative of the role orientation of turning against others and fewer symp-

toms indicative of turning against the self, and (3) more hallucinations without accompanying delusions than did inpatients without mental retardation.

Glick and Zigler (1996) used premorbid social competence to further differentiate developmental level within a sample of psychiatric patients with mild mental retardation. The Zigler-Phillips (1960) Social Competence Scale was adapted to be appropriate for people with mild mental retardation. As has been found for nonretarded patients, for patients with mild mental retardation, lower premorbid competence was associated with a predominance of action-oriented rather than thought-oriented symptoms. Furthermore both developmental variables, premorbid competence and thought-action orientation in symptomatology, were found to make independent contributions to overall variance in outcome as gauged by length of current hospitalization.

This research points to the value of integrating the developmental approaches to psychopathology and mental retardation. The integration provides a theoretical framework within which symptoms and other aspects of psychopathology in people with mild mental retardation can be organized and understood in relation to the broad body of knowledge about psychopathology in people without mental retardation. Constructs from the developmental approach to adult psychopathology were found to apply to psychiatric patients with mild mental retardation, and the results indicated that there is sufficient heterogeneity in the developmental level of patients with mild mental retardation to further differentiate this group using developmental principles.

Conclusion

The developmental work of Zigler and his colleagues on adult psychopathology, self-image, and mental retardation illustrate the integrative power of developmental psychopathology. Principles from classical developmental theory have allowed many major variables in psychopathology to be elucidated and understood in relation to each other as manifestations of underlying developmental level. A common underlying developmental framework has enabled the research on adult psychopathology and self-image to be extended for understanding people with mental retardation. Just as normative developmental principles have illuminated many processes in psychopathology, findings with atypical populations have extended knowledge about normal development. The moderating influences of experiential variables on the development of self-images have been revealed primarily in research on psychopathology and in studies of children and adolescents with special needs. These findings provide direction for research on normative development.

In regard to treatment, the broad predictive power of coping effectiveness suggests that efforts should particularly be directed toward uncovering and building upon attributes that contribute to competent functioning. The developmental approach to psychopathology further suggests that the effectiveness of various treatment modalities should be related to differences in developmental level. For individuals at higher developmental levels, who are presumed to be oriented toward expression in thought and to have greater resources for coping, verbal and cognitive forms of therapy would be expected to be appropriate. Being more oriented toward expression in direct action and possessing fewer resources for coping, individuals at lower developmental levels might derive greater benefit from forms of treatment that emphasize behavior (action) and concrete reinforcement and that provide training and support for the development of coping skills.

The research on self-image offers an alternative to the view that self-image disparity indicates maladjustment. As discussed previously, for individuals at lower developmental levels, treatment might well aim to increase differentiation between the real and ideal self-images by encouraging the articulation of aspirations and the exploration of various images of the self one would like to become. By contrast, individuals at higher developmental levels may experience the real and ideal self-images as differentiated but not reintegrated. For these individuals, an aim would be to interrelate real and ideal self-images so that the ideal reflects the further development and modification of qualities already perceived in the self.

The developmental research and formulations on psychopathology and self-image reviewed in this article as well as Zigler's broad body of work on mental retardation owe a primary theoretical debt to the organismic developmental theory of Werner and Kaplan (e.g., Werner, 1948; 1957; Werner & Kaplan, 1963). Zigler's work on psychopathology began as part of the efforts in the 1950s of researchers at Worcester State Hospital to extend Wernerian developmental theory to the investigation of adult psychopathology. The early work of Leslie Phillips (e.g., Phillips, 1953; Phillips & Rabinovitch, 1958) was a guiding influence as evidenced by the many subsequent collaborations of Phillips and Zigler cited in this article. The research and the formulations of the developmental approach to adult psychopathology that unfolded over the course of more than 40 years demonstrate the power of developmental theory for understanding many major variables in psychopathology. The application of developmental theory has enabled the generation and testing of hypotheses about premorbid social competence, symptomatology, diagnosis, paranoid-nonparanoid status in schizophrenia, the course of disorder and outcome, and self-images as personality vari-

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ables. This has created a broad body of data through which these diverse phenomena can be integrated and understood in relation to each other and can furthermore be applied to understanding psychopathology in people with mental retardation. With respect to psychopathology, motivational and personality variables, and other aspects of behavior, the developmental framework has allowed the functioning of people with mental retardation to be understood and integrated with the broad body of knowledge about the functioning of people without mental retardation.

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The Scientist-Practitioner Gap and Graduate Education

Integrating Perspectives and Looking Forward

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The scientist-practitioner gap has long been a debated topic in clinical psychology. In this article, we review the history of the Boulder model for graduate training and the division that has developed between researchers and clinicians. Next, we suggest possible ways of addressing the concerns of both sides. Finally, we provide recommendations for what graduate students can do now during their training to help minimize the gap in their future professional practice.

Since it was first formally proposed over 50 years ago at the Boulder conference (Raimy, 1950), the successful integration of science and practice in clinical psychology has been difficult to realize in graduate education. Those affiliated most strongly with either the “science” or “practice” camps have engaged in a heated and often acrimonious debate of the issues, which, not surprisingly, has failed to resolve the conflict (Stricker, 1997). Much has been written about what has been called the “scientist-practitioner gap” in the wake of the Boulder Conference; however, little discussion has considered the perspectives of graduate students on these issues. Understanding the diversity of thinking on this topic, we do not suggest that we speak for all graduate students. Nevertheless, we believe that our opinions may help to shed some light on potential ways to minimize the problem, starting at the graduate level.

We come from different viewpoints regarding the scientist-practitioner debate, representing both the more science-based (BG) and practice-oriented (MS) perspectives in contemporary psychology. Our goal is to understand the various perspectives on the scientist-practitioner gap and outline possible ways of bridging the gap at the time of graduate training, in an effort to constrain a division later in the professional

domain. First, however, we want to make it clear that we are approaching this topic with the underlying assumption that the scientific method is the primary “way of knowing” in clinical psychology, which may be contrary to more post-modern conceptualizations of what constitutes knowledge (e.g., intuition, personal experience, etc.). In this context, we briefly set the historical context for the division between the science and practice elements of the profession, review the compelling arguments on both sides of the issue, outline suggested remedies and approaches to integration, and provide some practical recommendations for how graduate students can succeed in meeting these goals.

The Boulder Model

On August 20, 1949 the Boulder Conference on Graduate Education in Clinical Psychology convened with the goal of articulating a model of graduate training for the field (Raimy, 1950). The education paradigm eventually endorsed by the conferees involved the training of students to be both scientists and practitioners of psychology. In other words, graduates of clinical psychology programs would be expected to obtain knowledge of the science of psychology upon which clinical application would be practiced and conduct original scientific research. However, the implementation of the model proved more difficult than was expected and problems immediately arose in the period following the committee’s recommendations. Within a decade of the conference, the content of graduate clinical training programs shifted to the side of science, with an emphasis on research training at the minimization or even exclusion of clinical experience and practice (Stricker, 1997).

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In reaction to this trend, the professional school movement emerged and eventually led to the Vail Conference on graduate training, establishing a new "scholar-professional" model (Korman, 1976). Professional schools of psychology attempted to fill the vacuum in training produced by the more research-based programs and began educating professionals who were interested in being practitioners only (Peterson, 1991). Therefore, after 1949, more programs began to emphasize either research or practice, each at the expense of the other training (Stricker & Trierweiler, 1995). Although an integration of science and practice was boldly called for by the Boulder model, the subsequent years have ultimately brought us separate training paradigms in the form of Ph.D. and Psy.D. programs that educate career researchers or clinicians, respectively, all too often within the confines of separate institutions and cultures.

On Practice from a Scientist Perspective

The Boulder model emphasized the application of science to the practice of clinical psychology. In its broadest sense, a scientific approach involves gathering empirical evidence in a systematic way that will either support or disconfirm *a priori* hypotheses. Furthermore, research involves designing procedures that identify the lawful relations among observations (Kazdin, 1998). Ultimately, applying the scientific method produces findings that provide confirmatory or disconfirmatory evidence for clinical insights, explains observations based on empirical evidence, and permits transmission of information between professionals (Beutler, Williams, Wakefield, & Entwistle, 1995). Without a solid scientific framework from which to practice, psychologists are much more likely to journey down blind alleys or fool themselves into believing in causal relationships that are illusory (Chapman & Chapman, 1967). Unless continuously asking questions like "What do you mean?" and "How do you know?," psychologists may find themselves being more akin to soothsayers than professional therapists (Meehl, 1993).

The wealth of clinical research over the last few decades, particularly in the area of psychotherapy outcome, has produced important information that can help direct clinical practice. Although some still argue for the so-called "dodo bird" conclusion regarding treatment efficacy by suggesting that different forms of psychotherapy appear to work equally well (Wampold et al., 1997), increasing evidence has pointed in the direction of specific interventions working better for specific problems (Chambless & Ollendick, 2001; Crits-Christoph, 1997; Herbert, 2000). For example, forms of cognitive-behavior therapy have consistently been shown to demonstrate superior efficacy over other treatments for certain anxiety disorders (Seligman, 1994). Based on this growing empirical knowledge base, the Division of Clinical Psychology of the American Psy-

chological Association created a task force in 1995 to establish guidelines for defining efficacious treatments and to provide a list of treatments meeting these criteria (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). How successful the task force's recommendations will eventually be in informing clinical practice remains to be seen.

One of the major reasons for basing assessment and treatment planning on findings from empirical research is the variety of problems associated with relying on clinical experience as the sole guide. Paul Meehl (1993) states: "It is absurd, as well as arrogant, to pretend that acquiring a Ph.D. somehow immunizes me from the errors of sampling, perception, recording, retention, retrieval, and inference to which the human mind is suspect" (p. 728). The biases and distortions that Meehl mentions are common to all clinicians and researchers, and require a constant effort to be aware of their existence and impact on day-to-day judgments. There exist numerous potential biases in clinical decision making: (1) availability heuristics limit our approaches to new problems based on past experiences of success or failure; (2) representativeness biases often result in the stereotyping of clients with certain salient disorders or symptoms (e.g., a clinician's preconceived notions about a diagnosis of Borderline Personality Disorder may unduly bias his/her perceptions of the client); (3) anchoring effects occur when certain initial information results in disregarding contradictory findings that may come later; (4) biased search strategies produce a pattern of seeking only information that will confirm our pet theories and anchored beliefs; (5) hindsight biases involve *post hoc* reasoning to explain events in order to confirm our preconceived notions; and (6) feelings of overconfidence result when some of the aforementioned cognitive heuristics and biases lead us to perceive a certainty in our decisions that is unfounded (Nezu & Nezu, 1989; Tversky & Kahneman, 1974). Unfortunately, this is only a partial list, and research indicates that simply being knowledgeable about the influence of these biases and heuristics does not necessarily prevent their influence on decision making (Arkes, 1981).

Regrettably, the minimal use of empirically supported treatments and the lack of understanding of cognitive biases can contribute to the widespread use of non-scientific approaches to clinical decision making. In an acceptance speech for the David Shakow Award for early career contributions in clinical psychology, Scott Lilienfeld chose to address the issue of pseudoscience in clinical psychology. Although noting that it is nothing new, Lilienfeld (1998) warned that pseudoscience "poses an increasingly major threat to both the welfare of the general public and the integrity and reputation of our profession" (p. 3). Lilienfeld indicates several characteristics of pseudoscience based on the work of Bunge (1994): *ad hoc*

and *post hoc* reasoning to escape falsification, overemphasis on seeking confirmatory evidence, lack of self-correction, reliance on testimonial evidence, misuse of scientific jargon, and ignorance of known scientific principles.

It must be pointed out that the issue is not only with the validity of certain questionable treatments being practiced, but also the way in which these approaches are often being marketed and promoted. For example, researchers and clinicians have questioned the practices of proponents of the newer array of treatments for Posttraumatic Stress Disorder called “power therapies,” including Eye Movement Desensitization and Reprocessing (EMDR; Herbert et al., 2000) and Thought Field Therapy (TFT; Gaudiano & Herbert, 2000). Both EMDR and TFT have been promoted as “breakthrough” treatments, initially based on the clinical experience of certain practitioners and without corresponding empirical evidence to provide probative support for the claims. Often these initial claims have failed to be supported after being tested in controlled studies. For example, a recently published meta-analysis concluded that there is no reliable evidence that the “bilateral stimulation” specific to EMDR is responsible for any significant treatment gains (Davidson & Parker, 2001). Without a scientific approach to practice that involves careful weighing of clinical insights against empirical verification and extant research findings, along with a humble respect and attention to the cognitive heuristics and biases that taint our experience, pseudoscientific practices are likely to continue unabated and keep clinical psychology from being fully respected by other fields and trusted by the public.

On Science from a Practitioner Perspective

The rigorously experimental and controlled nature of psychological research has done much to further knowledge in clinical psychology, yet many argue that it has often failed to adequately address practitioners’ needs. Rychlak (1998) attributes this occurrence to the “one-way” communication between researchers and practitioners. He notes that discovering the “truth” of psychological phenomena has traditionally been seen as the domain of the researcher. Once the discovery is made, clinicians are informed that they should passively accept the results presented from the research community. Rarely does this communication of findings work in reverse.

Nowhere is the unidirectional flow of information more evident than when considering the history of efficacy research. In deeming approaches to psychotherapy efficacious, researchers often rely on highly manualized treatments, specific measures of symptomatology, and exclusion criteria that reduce the confounding effects of comorbidity. Many have questioned how the classic efficacy study can produce information that will be readily transported to the reality of clinical practice.

For example, Howard, Moras, Brill, Martinovich, & Lutz (1996) argue that the idiographic context of therapy and the non-random nature of clinical work place serious limitations on generalizing from efficacy research.

Seligman (1995) does a concise job of explaining the problems inherent with efficacy research. First, efficacy research is of a fixed duration. This is not always true for actual clinical experience in that patients can be seen from a few weeks to even years, depending on various factors (e.g., theoretical orientation, finances, and problem severity). Second, practitioners are able to correct and change their assessment or techniques mid-therapy if needed. Most controlled studies do not allow for that kind of freedom on the part of the therapist. Third, clients seeking help on their own can actively choose the type of therapy in which they become involved. This motivation and personal interest may be beneficial in its own right and substantially add to the effectiveness of therapy. Fourth, patients seeking therapy often experience multiple diagnoses, which is reflected in the high rates of comorbidity among various Axis I and II disorders (Millon, Blaney, & Davis, 1999). Classic efficacy research usually strictly limits or excludes participants with comorbid diagnoses. Fifth, psychotherapy is concerned with the overall functioning of a client, including the person’s own perception of his/her well-being, instead of discrete aspects of functioning. Efficacy research tends to view “well-being” in terms of frequency or severity of specific symptoms.

Because of these limits of classic efficacy research, there has been a burgeoning interest in conducting and funding “effectiveness” research that examines psychotherapy outcomes in real world conditions (Norquist, Lebowitz, & Hyman, 1999). However, Jacobson and Christensen (1996) argue that questions about the effectiveness of psychotherapy can be and have been addressed by efficacy research, contrary to Seligman’s (1995) assertions. Therefore, efficacy and effectiveness research can more accurately be viewed as residing along a continuum rather than as an either-or classification. Efficacy studies that retain controlled conditions while balancing effectiveness concerns, such as external validity, may provide the best solution to using either design exclusively (Clarke, 1995).

The problems with traditional efficacy research and the subsequent questionable generalizability of results to clinical settings is not the only “pet peeve” of the clinician. It seems that a common viewpoint exists in the research community that clinical work is not adequately “scientific,” which creates tension between the groups. In addition, the emphasis of research on statistical rather than clinical significance and the practice of generalizing results to the broader population based

on calculations of the “average” research subject are important factors that explain the failure of some clinicians to apply the findings of traditional science to their practice (Barlow, Hayes, & Nelson, 1984). When applied to the scientist-practitioner debate, “science” can sometimes be too narrowly defined. Beutler, Williams, Wakefield, and Entwistle (1995) point out that case studies, usually considered to be unscientific, can be a very important aspect of the scientific process. According to these authors, case studies can facilitate the two-way communication between clinicians and researchers by raising new questions and influencing the further development of psychological research. Secondly, Elliot and Morrow-Bradley (1994) propose that case studies are the perfect medium to present the specifics of how current research can be tested and applied to practice. Finally, case studies can aid in determining the benefits of a treatment for the specific and not just the “average” client.

The previous points are included in Davison and Lazarus’s (1995) discussion of the importance of case studies in psychological science. First, case studies can cast doubt upon the usefulness of various theories by acting as disconfirming evidence, which is just as important as supporting research. Also, as previously discussed, case studies can serve as a valuable guide to future research and extend current techniques into other areas of applied psychology. Furthermore, case studies may point to specific areas of theory or research that can be problematic when implemented in practical situations. Finally, case studies can provide acceptable scientific evidence if carried out as a single-subject experimental design (Kazdin, 1998). When used in such a manner, single-subject studies are not simply interesting anecdotes with little utility, but an acceptable form of science in which clinicians can contribute to the understanding of the effectiveness of psychotherapy. In other words, even though case studies do not provide probative scientific data without further replication and extension, they can help to guide future research and provide insights into the difficulties of applying nomothetic findings ideographically.

Integrating Perspectives

It is evident when reviewing the common arguments and counter-arguments that relevant points are being made by those on both sides of the scientist-practitioner discussion. Most clinical psychologists will even agree that each side of the debate provides compelling arguments and that, ideally, the field needs to balance science and practice concerns. Controversy arises in the integration of these two apparently disparate perspectives. Often, it is argued that the task of integration is difficult, if not impossible, because science and practice concerns are based on fundamentally different paradigms. However, Stricker (1997) argues that whereas theoretical orien-

tations such as psychoanalysis and behaviorism may be incommensurable, science and practice can be viewed merely as different components of the same broad paradigm. In other words, science and practice are commensurable when paradigms are understood as not only representing shared knowledge but also as an agreed upon mode of knowing, or epistemological framework. In Stricker’s view of clinical psychology, science is a way of knowing and practice is the application of knowledge developed through scientific investigation. In this way, both science and practice are speaking the same agreed upon language, yet simply serving different functions.

Stricker and Trierweiler (1995) propose the development of the “local clinical scientist” as a model of bridging the gap between science and practice. In their model, the clinician deals with the client’s problems in the office similar to the way a scientist investigates research hypotheses in the lab. Both the clinician and the scientist share the attitudes of skepticism, curiosity, and critical thinking. Also, the clinician would draw from the appropriate empirical literature as a basis for problem solving. However, Stricker and Trierweiler argue that the clinician must solve the problem in the local context, rather than in the general and public domain of the typical scientist. For the clinician, the unique information of the client must be considered and incorporated with the extant data. Then, the clinician’s ideas can be tested through the collection of evidence that will confirm or disconfirm the original hypotheses. In this way, both nomothetic and idiographic information can be integrated in a scientific fashion.

Although we recognize that the conceptualization of the local clinical scientist has a commonsense appeal, using the model with a specific client can be difficult without further guidance. Therefore, we will present a model of clinical decision making that, in our view, provides one plausible attempt at realizing a scientific approach to clinical practice. Nezu and Nezu (1989) propose a problem-solving approach to clinical decisions in behavior therapy, with the goal of integrating nomothetic and idiographic concerns. They divide the therapeutic process into four stages: screening and problem identification, problem analysis and selection of focal target areas, treatment design, and treatment implementation and evaluation. At each stage, a general problem-solving strategy is used, providing a scientific approach that is designed to reduce the cognitive biases and heuristics of the clinician. Problem solving involves several steps: (1) problem orientation, which includes a recognition of the clinician’s worldview and assumptions brought to the process; (2) problem definition and formulation, which includes the identification of specific problem areas and goals of the problem-solving process; (3) generation of alternatives, which includes brainstorming possible solutions while deferring evaluation of their merits; (4) deci-

sion making, which includes the evaluation of alternatives by weighing their relative cost and likelihood of success (i.e., their utility), and (5) solution implementation and verification, which includes the evaluation of actual and predicted consequences of solutions. Nezu and Nezu assert that taking the aforementioned approach will serve to minimize the judgmental errors made by the clinician in the decision-making process.

Persons (1991) states that clinical case formulations of assessment and treatment, such as the problem-solving approach, can help bridge the scientist-practitioner gap. However, Herbert and Mueser (1991) assert that the notion that individualized case formulations can more accurately blend science and practice than manualized treatment is, at heart, an empirical question. Furthermore, they point out that the limited outcome research that exists investigating the difference in efficacy between individualized and standardized treatments has resulted in equivocal findings. More research in this area is necessary before summarily endorsing individualized case formulations as the most effective way to bridge the scientist-practitioner gap. However, we do see considerable merit in employing a more scientific approach to case formulation, and would strongly encourage future researchers to test this hypothesis thoroughly.

Recommendations for Graduate Students

Rice (1997) has examined the gap between professional and scholarly practices within the field of psychology. He states that we must recognize that this split has been a result of various competing social, political, and economic forces. He sees this as a trend that is extremely difficult, if not impossible, to reverse. With this we would agree; and this is why the task of reconciling the ideals of science and practice is appropriately placed on the individual in training. Programs educating clinical psychologists, while never abandoning the scientist-practitioner model, must place more emphasis on personal responsibility in this area. Students endeavoring to become practitioners must understand that their work should be guided by the scientific method and that their experiences can do much to influence the types of research that will be conducted. Similarly, students interested primarily in research should always keep in mind that there is a practical side to research and that questions of applicability to clinical work will always be asked and eventually will need to be answered.

With an emphasis on the individual, we make several practical recommendations to help students in clinical graduate programs develop a scientist-practitioner mindset. First, supplementary training may be necessary to learn information that is not part of the graduate curriculum. We recommend that students take specific courses on critical thinking and philosophy of science if offered by their universities. We also

encourage graduate programs to develop seminars or courses on critical thinking in clinical psychology¹. However, if such courses are not available, students can still read works on the topic of philosophy of science by various authors. We recommend the reading of scientific classics, such as Thomas Kuhn's (1962) *The Structure of Scientific Revolutions* and Karl Popper's (1959) *Logic of Scientific Discovery*. An excellent primer on philosophy of science is Anthony O'Hear's (1989) *An Introduction to Philosophy of Science*. We also highly recommend that every present and future psychologist read Keith Stanovich's (2001) *How to Think Straight about Psychology*, which teaches critical thinking skills in evaluating psychological claims. Finally, reading contemporary classics, including Michael Shermer's (1997) *Why People Believe Weird Things* and Carl Sagan's (1996) *The Demon-Haunted World*, will help to improve critical thinking skills and scientific reasoning for controversial topics in general.

Next, we recommend that students begin practicing the scientist-practitioner approach in their clinical experiences. One of the major criticisms of scientist-practitioner training is that it results in students acting as "scientists" in the lab and "practitioners" in the clinic, without the appropriate integration of these roles (Barlow et al., 1984). Therefore, learning and utilizing scientific case formulation methods, such as the Nezu and Nezu (1989) problem-solving approach to clinical decision making, will help students develop the skills needed to be scientific practitioners. Carefully assessing the problems of the client, utilizing the extant literature as a guide to conceptualize the case, and implementing and evaluating proposed solutions in concrete ways while monitoring potential cognitive biases are all skills that need to be developed through practice. One benefit of being in training is that students can take advantage of supervision that, if utilized properly, can help reduce personal biases and provide a different perspective to minimize any mental set when conceptualizing a problem. Concerning supervision, we encourage students who have a choice in supervisors to seek out professionals with whom they feel they can truly dialogue—i.e., supervisors who will pose challenging questions and foster critical thinking skills, rather than being so theoretically focused as to exclude other perspectives that may be relevant to the discussion. In this way, students can learn to successfully use clinical experience for hypothesis generation and testing.

Furthermore, we encourage students to experiment with single-subject designs and present their results at conferences or in publications, especially newsletters². In general, we encourage those who plan on being practitioners not only to conduct single-subject research but also to become involved in larger research projects at some level. Research training and experience will make practitioners more healthy and skeptical

consumers of research literature in the future. Conversely, those interested mostly in research should practice applying empirical findings to their individual clinical cases to grapple with the problems faced by practitioners daily. This clinical experience can also serve as a useful tool for hypothesis generation for future research projects.

Finally, it is important for graduate students interested primarily in either research or practice to read each other's literature. Beutler et al. (1995) present results from a national survey suggesting that practitioners read research literature at a higher rate than they are given credit for, but that researchers tend not to read clinical writings. To help alleviate this problem, students interested in research are encouraged to consider publishing their results in more practice-oriented journals. In addition, writing summary results of literature findings in outlets such as newsletters would be helpful to disseminate findings more quickly to practitioners. Furthermore, many journal editors are quite willing to publish single-case designs, which can be a way for practice-oriented students to introduce topics for future research. For example, the journal *Behavior Therapy* has a "Case Study and Clinical Replication Series" section in each issue³.

Conclusion

In this article, we addressed the problem of the "scientist-practitioner gap" and its relationship to clinical psychology graduate training. We reaffirm the Boulder model as the preferred approach to training in clinical psychology but acknowledge that it often has been incorrectly implemented in many graduate programs. Therefore, we shift the responsibility back to the graduate student, who represents the future of the profession. By reviewing some of the arguments by scientists and practitioners, and by following some of the recommendations in this article, we believe that students can start to develop a scientific understanding of clinical psychology and skills for successfully practicing in clinical settings. If students adopt an understanding of science and practice as two components of a single paradigm, we are hopeful that the scientist-practitioner gap can be minimized in the future.

Footnotes

1. Resources for professors interested in designing critical thinking courses in psychology can be found at www.pseudoscience.org/course-resources.htm, including sample syllabi.
2. Kazdin's (1998) *Research Design in Clinical Psychology* and Barlow et al.'s (1984) *The Scientist Practitioner* provide more information on how to conduct case study and single-subject research.

3. Readers interested in suggestions for integrated scientist-practitioner graduate training at the programmatic level are referred to Drabick and Goldfried (2000), who recommend possible content areas for course projects, clinical case conferences, and colloquia.

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Society News

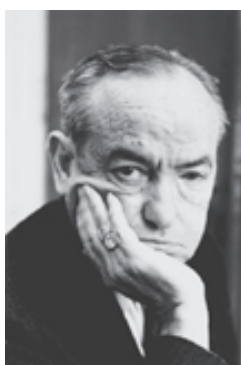
Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. Telephone (303) 652-3126. Fax (303) 652-2723.

Society Awards Citations

Edward Zigler, PhD

Award for Distinguished Professional Contributions to Clinical Psychology

The Society of Clinical Psychology is pleased to present its annual award for Distinguished Professional Contributions to Edward Zigler, Ph.D., Sterling Professor of Psychology, Yale University. Dr. Zigler clearly exemplifies and fully embodies the qualities the Award was meant to recognize. For over 40 years, Professor Zigler has made significant professional contributions to clinical psychology in the areas of teaching, research, and service. His prodigious amount of work has been innovative, important, and lasting in its impact. His influence on the development of many young professionals is without question; moreover, his impact on children and families through his professional activities has been without equal.



velopment. Known by many as the "Father of Head Start", his work has been both socially and clinically important and its impact on our discipline is evident.

Professor Zigler has achieved many awards and recognitions during his lifetime. A complete list of them would require many pages for this Award Citation and much time in the public recognition we honor him with today. Suffice it to indicate that he has served as a consultant to many governmental committees and bodies at the local, state, and federal levels, and that he has received academic and scientific awards from nearly all psychology-related professional organizations over the years. Most recently, he received the Lifetime Achievement Award from the American Association of Applied and Preventive Psychology (1998) and the Gold Medal Award for Enduring Contribution by a Psychologist in the Public Interest from the American Psychological Association (1997). The Society of Clinical Psychology is honored today to join the ranks of these associations and to recognize Professor Ed Zigler for his many professional contributions to the science and practice of clinical psychology. This is an award that is long overdue and is most fitting for someone of his professional stature and prominence. It is with great pleasure that we recognize his many accomplishments and that he receive the Society's Distinguished Professional Contribution Award today.



Marsha Linehan, PhD

Distinguished Scientific Contribution Award

To Marsha Linehan, for her seminal conceptual and empirical achievements in domains in clinical psychology that few have had the intellectual and emotional courage to enter. Her dialectical analysis of parasuicidal behavior and borderline personal disorder as well as her innovative extensions of cognitive behavior therapy into her dialectical behavior therapy have revolutionized our understanding of serious psychopathology and offered new hope for clinicians, researchers, and most of all to patients and their families. Dr. Linehan is the consummate scientist-practitioner. Clinical psychology and allied health professionals and researchers are richer for her many creative contributions.

*Martin M. Antony, PhD**David Shakow Award*

For his outstanding contributions to research in the area of anxiety and related disorders, and for advancing our knowledge about assessment procedures, interventions, and psychopathology, the Society of Clinical Psychology presents the David Shakow Award to Martin M. Antony, Ph.D. This award is dedicated to acknowledging the contributions of a deserving young scientist whose research has advanced the field of clinical psychology within seven years of graduation. It is fitting indeed that Dr. Antony receives this award.



Dr. Antony received his Ph.D. in 1994 from the University at Albany, SUNY with a dissertation entitled "Heterogeneity among specific phobia types in DSM IV". Since that time, he has published 34 important contributions in peer reviewed journals and has also found time to publish no less than 10 books or treatment manuals on such subjects as assessment and treatment planning, social anxiety, specific phobia, obsessive compulsive disorder, and perfectionism. He has also contributed over 13 chapters to other books. This is a remarkable rate of productivity in a very brief period of time. Currently, he is an Associate Professor in the Department of Psychiatry and Behavioral Neurosciences at McMaster University.

At a very young age Marty has made substantial contributions to understanding the nature of phobia, panic, and other anxiety related phenomena. He has demonstrated that the current system for categorizing phobia in DSM IV is almost certainly flawed, and this work will be influential now that the DSM V process has begun. He has put together new strategies for assessment and treatment planning that will have a wide impact on his peers struggling with these difficult issues. Perhaps most importantly, he has worked very hard to attempt to make newly developed interventions with

empirical support more available to the public through his authorship of a number of treatment manuals. He has also made important contributions to the peer review process with appointment to numerous editorial boards and his recent assumption of the editorship of *The Clinical Psychologist*.

There are few individuals who are making more notable and important contributions to the science and practice of clinical psychology than Dr. Martin Antony, and there is every reason to believe that these contributions will continue. For these reasons, the Society of Clinical Psychology is pleased to honor Dr. Martin M. Antony with the presentation of the David Shakow Award.

*2002 Randy Gerson Memorial Grant
Call for Applications*

The American Psychological Foundation (APF) is requesting proposals for the Randy Gerson Memorial Grant. The Gerson Grant provides a \$5,000 grant consistent with the goal of advancing the systemic understanding of couple and/or family 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. A strong preference will be given to projects using or contributing to the Bowen family systems theory. Priority will also be given to those applicants furthering the work of Dr. Gerson.

Eligibility: Individuals from a variety of professional or educational settings are encouraged to apply. To qualify for the 2002 cycle of the award, all applicants (including co-investigators) must have a doctoral degree (e.g. Ph.D., Psy.D., Ed.D., or M.D.).

Deadline for applications: February 1, 2002

For application procedures and additional information, contact:

APF Awards Coordinator/Gerson

750 First Street, NE

Washington, D.C. 20002-4242

202-336-5814

foundation@apa.org

Stephen S. Ilardi, PhD

Theodore Blau Early Achievement Award

For his outstanding accomplishments in all aspects of a superbly developing career, the Society of Clinical Psychology presents the Theodore Blau Early Achievement Award to Stephen S. Ilardi, Ph.D. This award recognizes outstanding contributions to the profession of Clinical Psychology within 10 years of receiving his doctorate.

His career as a scholar began at Emory University and continued at Duke University where he received his doctorate in 1995. Dr. Stephen Ilardi has held the Wright Scholar Assistant Professorship at the University of Kansas since 1997.

Dr. Ilardi is the quintessential scientist-practitioner with an orientation to doing translational science—highlighting the relevance of laboratory science for clinical applications. His research productivity reflects the active inquiring processes that see relationships and relevance.

This rising clinical psychologist attempts to unravel the mysteries of depression and its treatment. Dr. Ilardi investigates a range of related issues such as how depressed adults process information, especially emotional processing, nonspecific factors in the treatment of depression, and preventing relapse in depression after treatment.

Most recently the field has seen his contributions in clinically related cognitive neuroscience, specifically in the examination of traitlike negative bias lateralized to the right hemisphere in psychological depression (using EEG/ERP methodologies).

An interest in the systems of sociology of science in psychology led to a recent article in *Clinical Psychology: Science*



and Practice, the flagship journal for the field, examining who trains the trainers in clinical psychology programs. This article stimulated six commentaries noting its exceptional contribution of empirical analysis of professional training outcomes.

Although still early in his career, Dr. Ilardi has also demonstrated an exceptional philosophical bent as illustrated in his devotion to scientific consilience. Dr. Ilardi seeks rapprochement and enlightenment in friendly debates of rival theoretical frameworks. His passion for knowledge seeking and sharing fires his inquiry and dialogues, but he flames no one. Whether posting to the internet, debating in symposia, collaborating with colleagues, or mentoring budding psychological scientist-practitioners, Dr. Ilardi is always the consummate gentleman-scholar.

He fosters consilience through active and innovative collaborations in programmatic research informing practitioners and academics. He relates, he integrates, he links, he scores! (Oh, and he plays a strategic game of basketball, consistent with his Duke and Kansas affiliations.)

Dr. Ilardi brings intellectual energy to all activities whether discoursing on professional sports, his daughter Abby, or the theoretical and empirical underpinnings of cognitive behavioral treatments for depression.

For his outstanding contributions and achievements in a career destined to impact the science and practice of clinical psychology, the Society of Clinical Psychology is pleased to honor Dr. Stephen S. Ilardi with the presentation of the Theodore Blau Early Achievement Award.

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

Abbreviated Minutes of the Society for Clinical Psychology's Board of Directors Meeting

January 5, 2001 at El Dorado Hotel, Santa Fe, New Mexico

Dr. Calhoun, President, called the meeting to order at 8:30a.m. Introductions with announcements were made. There were no agenda changes. The Minutes of the October 14-15, 2000 meeting were approved with minor changes.

OFFICERS' REPORTS

President Calhoun provided an update on the meetings for 2001. June 1-2 meeting Alexandria will again have APA staff participate. This meeting is for members of the Board. The October 5-6 meeting will be at Savannah, GA. The locations for the meetings in 2002: January 4, June 8-9, and October 12-13 have not been determined by Dr. Beutler, President-elect. He has appointed Dr. Steve Ilardi as PDI Chair and Dr. Tim Anderson, Ohio University, as Program Chair for 2002.

Dr. Woody, Treasurer, discussed the 2000 Budget with corrections made which resulted in a deficit of \$2,150. Investments were discussed and considered to remain prudent. Motion passed to approve the amended 2001 Budget with the recommended changes by the treasurer.

COMMITTEE REPORTS

All committees reported. Of particular interest to the members are the following reports:

Nominations and Elections and Awards Committee

Dr. Calhoun indicated that the Society continues to have four APA Council Representative positions based on the apportionment balloting. There will be two vacancies to be filled. Dr. Craighead, Past-President, will be working on soliciting candidates. On another matter, Dr. Calhoun indicated that Dr. Craighead was planning a conference call to resolve the recommendations for the Awards Committee.

Membership

Dr. Seigel reported on the number of members and the concerns with student membership categories. An initiative to better track the student categories will be needed to ensure that new members are generated for the Society. Committee members provided numerous good suggestions for implementing this initiative.

Program

Dr. Lilienfeld reported that there were 200 program submissions this year, which is down from previous years. As a result, 12 convention hours were cut from the program, from 93 to 85. The division was asked to donate two hours for the

Science miniconvention, whose themes are relevant to the Society. The Hospitality Suite is available for business meetings and conversation hours.

Fellowship

Dr. Caldwell-Colbert reported that the Society has a decrease in the number of new Fellows. She plans to maintain dates for submissions and will inform the members of these.

Publication

Increasing institutional subscriptions for the *Journal* was discussed. The committee will next meet in October 2001. There is progress in the development of the website. Dr. Rokke indicated that March 31 was the closing date for selecting a new editor for *The Clinical Psychologist*.

Section Caucus Report

New section representatives will be given an orientation by the President and Lynn Petersen. Presenting the Section awards during the Society's awards session was considered a good idea.

Sections

Each section reported on its activities and progress toward increasing memberships.

New Business

Several New Business items led to the passing of motions:

Motion: Establish an adhoc committee to explore the possibility, in collaboration with other relevant divisions, of developing an interest group for clinical psychology in the schools.

Motion: To create a monthly news announcement on the listserv.

Dr. Calhoun reported that the Presidents of the three divisions met yesterday and addressed three issues: (1) Sharing the list of nominees to APA Boards and Committees, (2) Programming at the APA Convention, and (3) Having a joint social hour at the APA Convention.

The proposal for initiating an Assessment Section was discussed and supported.

The meeting adjourned on Sunday, January 7, 2001.

Respectfully submitted,

Elsie G. Lu, PhD, Secretary

Abbreviated Minutes of the Society for Clinical Psychology's Board of Directors Meeting

June 2-3, 2001 Alexandria, Virginia

The meeting was called to order at 8:05 a.m. by the President, Dr. Karen Calhoun, and all present introduced themselves.

The meeting started with presentations and dialogue with representatives from the Four Directorates of APA. Dr. Richard McCarty, Executive Director for the Science Directorate, Dr. Henry Tones, Executive Director for the Public Interest Directorate, Dr. Ron Palomares, Assistant Executive Director for the Practice Directorate, and Jo Linder-Crowe for the Education Directorate. Each provided information about the directorates and the programs and activities in which they were engaged. An area of concern to all four directorates was children of all age groups. There was an active exchange of ideas among the directorate and board members. Of interest to the members was that CE credits could be earned for attending sessions from a core of 20 presentations that would be held at the APA Convention in San Francisco. Dr. Calhoun thanked directorate representatives for their presentations and time.

OFFICERS' REPORTS

The business meeting was called to order at 11:20 a.m. The officers reported on activities completed and planned. Dr. Beutler, President-elect discussed the agenda and the three scheduled board meetings for 2002 with the January mid-winter meeting in collaboration with Divisions 52 & 53 in Miami. Dr. Craighead, as Past-President, chairs the Awards Committee and announced the following recipients for 2001:

Marsha Linehan, PhD - Distinguished Scientific Contributions to Clinical Psychology

Edward Zigler, PhD - Florence Halpern: Distinguished Professional Contribution

Martin Antony, PhD - David Shakow Early Career Award

Stephen Illardi, PhD - Theodore H. Blau Early Career Award

COMMITTEE REPORTS

Each Committee either provided a verbal or written report.

Several Motions were made and passed. These were:

1. Accept the Treasurer's report and Approved the 2001 Budget.
2. That the Awards Committee institute the requirement that the potential awardees be physically present at the time

the award is presented, that the recipients of the senior awards provide an hour talk. We recognize that there may be extraordinary conditions that might prevent a particular awardee from attending the award ceremony.

3. That newly elected Division 12 Fellows be recognized at the Awards Ceremony and that they be encouraged to attend the Division Awards Ceremony. (As part of the procedure, the Awards Committee will inform the nominees of the above requirements. Dr. Calhoun encouraged the submission of names for the 2002 awards nominations. Dr. Craighead indicated that to nominate, one should sent a letter with a copy of the curriculum and any letters of recommendations.)
4. The Board took the position that as a Board, it would not endorse any candidate for President of APA. (Passed 9 yes, 1 No, 1 Abstention, and a reminder that Sections cannot use Division resources for the endorsements of candidates nominated for Division positions.)

Each Section reported and most were quite active and gaining more members. The Board formally approved the establishment of a new Section on Assessment.

NEW BUSINESS

There were numerous "New Business" items on the agenda. Most will be discussed further at the October Board meeting in Savannah, GA.

Respectfully submitted,

Elsie Go Lu, PhD, Secretary

Membership in Section VI Encourages and Fosters Better Understanding of Ethnic Minorities and All People

This country has gone through a most frightening and depressing assault in the past week with the terrorist attacks on the USA. Now, perhaps more than ever before, people must seek to better understand and appreciate others, including those not of their own ethnic group. We must put away petty anger and jealousy and concentrate on greater caring and sharing with others for better mental health of not only others but of ourselves. This we must do if we are to survive, and what better and more knowledgeable profession to help in this effort than psychology? In particular, clinical psychologists can help others to understand what inner strengths need to be brought to bear such catastrophes and to get beyond them to "soar like an eagle".

Becoming a member in the Clinical Psychology of Ethnic Minorities enhances the goals of better understanding and helping to achieve optimum health for ethnic minorities and others because the motivation to help rather than hinder the well-being and success of all people is in the forefront. We need Section VI and so do all of our colleagues. Encourage them to join not only for their professional enhancement but also for their personal growth. There is hope that the recent tragedies will result in psychologists and others working more efficiently and meaningfully in more caring ways—ways that our cowardly enemies might never have anticipated. Pulling together, professionally and personally, we will survive! Join Section VI and urge your friends and colleagues to join too!

Carole Rayburn

Membership Chair, Section VI, Div. 12

Society for a Science of Clinical Psychology Membership Drive

The Society for a Science of Clinical Psychology (SSCP, Section III of Division 12) is embarking on a membership drive, and I wish to invite you all to join us.

Our Society is devoted to scientific inquiry and the systematic integration of scientific knowledge into the practice of clinical psychology. We are in an organization of mental health professionals (including both academics and practicing clinicians) who are deeply committed to placing clinical psychology and allied fields on firm scientific foundations and to narrowing the gap between researcher and practitioner.

Our membership drive has two goals: to encourage new members to join, and to encourage current members who have not yet renewed their membership to do so. We have discovered that our membership list is woefully outdated, and a large number of renewal notifications were recently returned with addresses unknown.

Despite this problem, SSCP is alive and well and continues to provide some very nice member benefits: very active and intellectually stimulating list serve; a new student list serve where student members discuss issues of importance to them and seek advice or help from their colleagues; APA convention events, including student posters and monetary awards; and a highly active Board which this year has been representing its members in presenting position statements on issues of major importance to the profession of clinical psychology. The latter issues have included academic freedom and the integrity of the peer-review system in APA journals, the potential possibility of accreditation of pre-doctoral "emerging substantive areas," and prescription privileges for clinical psychologists. We have also recently become more active in affiliation with APS and plan to expand our activities with that society.

The price is fairly cheap (\$35 for members; \$7.50 for students enrolled through their training directors). If you are interested in joining or renewing, you can print off an application from our web site (<http://pantheon.yale.edu/~tat22/>), or contact me by e-mail (tdb@psu.edu) and I'll send you one.

T. D. Borkovec

ASPPB Programs Facilitate Mobility for Licensed Doctoral Psychologists

Barb Van Horne, PhD*

The Association of State and Provincial Psychology Boards (ASPPB) have developed two complementary but different programs: the ASPPB's Agreement of Reciprocity and the Certificate of Professional Qualification in Psychology (CPQ) program.

Reciprocity is an agreement *between* jurisdictions in which each jurisdiction agrees to recognize licenses issued by the other jurisdictions in the agreement. The ASPPB Agreement of Reciprocity has specific requirements each participating jurisdiction must require of new applicants for licensure. Based on the comparability in current licensure standards, the participating jurisdictions agree to accept all licensees from participating jurisdictions, even if they were licensed under earlier less stringent standards. Current members of the Agreement of Reciprocity are Arkansas, Iowa, Kentucky, Manitoba, Missouri, Nevada, Oklahoma, Ontario, Mississippi and Texas. Other jurisdictions are in the process of making changes in their law or rules to enable them to join the agreement.

On the other hand, the *CPQ program* is an individually based endorsement of licensure eligibility. Potentially, it does for individuals what a reciprocity agreement does for jurisdictions. Individuals who meet established standards of training and experience can obtain the CPQ even if their jurisdiction's licensing law does not meet established standards. In endorsement, a jurisdiction agrees to recognize the CPQ as meeting most of the qualifications for licensure. Each jurisdiction decides for itself whether to recognize the CPQ.

The CPQ is a program of individual certification designed to facilitate mobility for psychologists licensed at the doctoral level in a state, province or territory in the U.S. or Canada. ASPPB issues a Certificate of Professional Qualification in Psychology (CPQ) to licensed psychologists with no history of disciplinary action and meet requirements:

- Licensed for 5 years based on doctoral degree;
- No history of disciplinary action above reprimand;
- 3000 hours supervised experience;
- Passed EPPP & Oral Examination.

ASPPB is encouraging licensing boards in the United States and Canada to accept the CPQ as evidence of eligibility for psychology licensure in their jurisdictions. Through the CPQ program, ASPPB hopes to improve the process for licensing psychologists already credentialed in one jurisdiction and ease the burdens on psychology licensing boards faced with regulating an increasingly mobile profession.

Granting of the CPQ is based on an individual psychologist demonstrating compliance with ASPPB-recommended standards for licensure. *For psychologists listed in the National*

or Canadian Registers of Health Service Providers in Psychology and who apply for the CPQ by December 31, 2001, some requirements are waived. Those who hold a diploma from the American Board of Professional Psychology will continue to have some requirements waived. For details on the options for qualifying for the CPQ, check ASPPB's web site at <http://www.asppb.org>.

A key feature of the CPQ program is its *credentials bank*, which provides a way for psychologists to store evidence of their professional education, experience, prior licensure, and exam performance, regardless of whether they are granted a CPQ. Once archived, this information can be accessed and submitted to any psychology licensing board, thereby reducing hassles associated with documenting compliance with licensure criteria, particularly long after one's training and initial licensure.

It is important to note that the CPQ does not constitute a license to practice. It is a mechanism to facilitate the granting of a license to practice in a second or subsequent jurisdiction. Once a psychology board agrees to recognize the CPQ, it has agreed to accept a CPQ holders' educational preparation, supervised experience, and examination performance for licensure. A jurisdiction may require a CPQ holder to pass local requirements such as a jurisprudence exam (e.g. local mental health law), training on abuse reporting, or a personal interview. Since a few jurisdictions limit licensure to psychologists trained as health service providers, a non-health service provider may obtain the CPQ yet not be eligible for licensure in some jurisdictions.

As of September 2001, *17 psychology regulatory bodies* in the U.S. and Canada (Alberta, California, Connecticut, District of Columbia, Kentucky, Louisiana, Mississippi, Missouri, Nevada, Ohio, Ontario, Oklahoma, Pennsylvania, Rhode Island, Vermont, Virginia, and Wisconsin) have agreed to recognize the CPQ. ASPPB is working with all U.S. and Canadian psychology boards to encourage widespread adoption. Currently, *an additional 19* (including 5 Canadian provinces added by the MRA) voted to adopt and are in the process of changing their procedures to implement this decision. ASPPB's web site features a current list of states and provinces that recognize the CPQ. As more jurisdictions move to accept the CPQ, its value in facilitating mobility will increase. And even if one seeks to relocate in a jurisdiction that does not accept the CPQ, a credentials record with ASPPB will facilitate mobility by maintaining an easily accessible record of qualifications. If you have questions, or to request an application, call 800.448.4069, or write CPQ, c/o ASPPB, P.O. Box 241245, Montgomery, AL 36124-1245, or e-mail cpq@asppb.org.

* Currently Member of the ASPPB Mobility Committee, Member of the ASPPB Board of Directors, & Chair, Wisconsin Psychology Examining Board

Second Latino Psychology Conference Comes to Rhode Island

Maria Garrido, PsyD
Adjunct Professor of Psychology
Conference Chair
"Latino Psychology 2002"
University of Rhode Island

The URI Psychology Department, in conjunction the Multicultural Center at the University of Rhode Island, will host the second national Latino Psychology Conference, to be held in Providence, October 18-20, 2002. A first, highly successful conference was held in November 2000 in San Antonio, Texas, with approximately 250 attendees and two full days of symposia and paper sessions. Its central theme was "Latino Psychology 2000: Bridging Our Diversity." As the main purpose of this conference is to bring together psychology scholars and practitioners who work with Latino populations in all areas of the U.S., we believe it to be crucial that this conference is held in various areas of the country where the diversity of the Latino experience is represented. With its renewal, vibrancy, and access to the Rhode Island Latino community, Providence is an ideal venue for this event.

We believe that Rhode Island is especially well suited to host this conference. Rhode Island has been experiencing rapid growth in its diverse Latino population. The latest U.S. Census figures for Rhode Island show that in most cities the Latino population has nearly doubled between 1990 and 2000. This population represents many Caribbean and Central and South American nationalities. The Latino presence in Rhode Island is quickly becoming well established in all areas of society as evidenced by its several educational, community and political advocacy groups. These groups and numerous other Latino health, education, and business professionals have made notable contributions not only to the Latino community but also to the broader society of the state.

Our vision for this upcoming conference is of bridging communities of service and scholarship representing child, family, community, health, mental health, and disability issues as experienced by the Latino community in the U.S. To accomplish this vision, we not only plan to have symposia, paper and poster sessions, but also a dialogue forum to bring together practitioners, scholars, and Latino community leaders representing various fields. We hope that this will enable the bridging of our professional communities and promote mutual learning. We are delighted to know that two highly regarded Latino scholars, Dr. Lillian Comas-Diaz and Dr. Steven R. Lopez, have agreed to deliver keynote addresses. Dr. Lopez was a key participant in the National Congress for Hispanic Mental Health, held in March 2000. As such, we also believe that the purposes of this conference are consistent with the tasks outlined by the Congress to address the mental health needs of the Latino community.

Please visit our website: www.uri.edu/artsci/psy/latpsy02.htm for preliminary information and feel free to spread the word! This information will be updated over the next several weeks and months. A call for programs will be issued around January 15, 2002, and proposals will be due March 15, 2002.

You can also contact Maria Garrido, Psy.D., Conference Chair, at mgarrido@etal.uri.edu for further information or if you wish to be included in future updates/mailings about the conference.

New APA Publication Features Emergency Medical Services for Children

Helping the EMS Professional: The Stress of Providing Emergency Medical Services for Children has been produced by the APA Public Interest Directorate with support from the federal Emergency Medical Services for Children (EMSC) program.

Edited by George Everly, PhD, of the International Critical Stress Foundation and April Talley of the APA PsycINFO staff, *Helping the EMS Professional: The Stress of Providing Emergency Medical Services for Children* includes a review article and a 129-item bibliography with abstracts. The publication highlights the stressful impact of providing services in pediatric medical emergencies and offers resources for further study

and consideration of ways to support professionals who do this work. The introduction by Dr. Everly reviews literature on stress among emergency services providers, describes the special context of treating childhood trauma, defines basic terminology, discusses the need for intervention services, and offers commentary on Critical Incident Stress Debriefing and Critical Incident Stress Management. The ensuing annotated bibliography is a resource for researchers, practitioners, and students who wish to pursue other information and contribute to the development of the EMSC field.

To request a single free copy, contact Luis Espinoza at (202) 336-6046, or by e-mail at LEspinoza@apa.org. Additional copies are available at \$2.00 each.

Position Openings

WASHINGTON STATE, USA: Stafford Creek Corrections Center at Aberdeen, WA (near Olympia, WA), seeks a Clinical Psychologist with prescriptive authority. (Recruitment #: SCCC-4-2001-OC-LL). Stafford Creek Corrections Center's Mental Health Unit provides a full spectrum of psychological services to 1,900-2,00 adult (18-90+ years old) male inmates and offers the opportunity to learn neuropsychological evaluating as well as the latest risk assessment techniques. The salary range is EOE plus a generous benefits package (paid vacation, medical and dental insurance, sick leave, etc.). The Washington State Department of Corrections is an EOE. Interested persons should go to the website www.wa.gov/doc to download the job application. Please send completed Washington State application to: Stafford Creek Corrections Center, Attn: Human Resource Office, 191 Constantine Way, Aberdeen, WA 98520. For additional information and job announcement you may call Angela at (360) 537-2202.

CORE FACULTY OPENING, TENURE TRACK ASSOCIATE PROFESSOR, DOCTORAL PROGRAM IN CLINICAL PSYCHOLOGY. The University of Hartford's Doctoral Program (Psy.D.) in Clinical Psychology has a core faculty opening for a tenure-track Associate Professor. It seeks a clinical psychologist with strong scholarly interests and a publication record of clinically related research to provide leadership in developing a faculty research arm for its APA-accredited, practitioner/scholar program. Year-round position to begin July or September 2002. Connecticut license or license eligibility required. This is a revision of a previous notice, based on changes in the program's needs. The search will end when an appropriate candidate is appointed. Applications from women and members of other historically marginalized groups are particularly welcome. Send letter of application, vitae and the names of three references to: David L. Singer, Ph.D., Director, Graduate Institute of Professional Psychology, Univ. of Hartford, 103 Woodland Street—4th Fl., Hartford, CT 06105. EEO/AA/M/F/D/V

NEW TCP EDITOR

INSTRUCTIONS FOR CLASSIFIED 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 Martin M. Antony, PhD, Anxiety Treatment and Research Centre, 6th Floor, Fontbonne Building, St. Joseph's Hospital, 50 Charlton Avenue East, Hamilton, Ontario L8N 4A6, Canada, E-mail: mantony@stjosham.on.ca, Tel: 905-522-1155, ext. 3048, Fax: 905-521-6120.

Call for Nominations Editor, *Clinical Psychology: Science and Practice*

The Publications Committee of the Society of Clinical Psychology (Division 12 of the American Psychological Association) invites nominations for Editor of the Society's flagship journal, *Clinical Psychology: Science and Practice*, to succeed the current editor, David H. Barlow, whose term will end in December 2003.

Clinical Psychology: Science and Practice presents cutting-edge developments in the science and practice of clinical psychology by publishing topical reviews of research, theory, and application to diverse professional issues. Oxford University Press publishes the *Journal* quarterly; details on the online version can be found at <http://clipsy.oupjournals.org>.

Nominees must be members of the Society and should be prepared to begin receiving manuscripts in January 2003 for publication in the January 2004 issue. Criteria to be considered in selecting the editor include:

- Comprehensive knowledge and broad perspective on the field of clinical psychology
- Understanding and appreciation of the many sub-disciplines and theoretical orientations within the field of clinical psychology
- Clear professional accomplishments and identity within clinical psychology, and demonstrated research, writing, reviewing, and editing skills
- Freedom to devote time and energy to accomplish the editorial duties

To nominate candidates, please provide a statement in support of the nominee. Supporting material may also be sent, including curricula vitae and brief statements by nominees of their ideas on future directions for the *Journal*. Self-nominations are encouraged, as are nominations of members of underrepresented groups in clinical psychology. Deadline for nominations is March 1, 2002.

Nominations should be sent to:

Thomas H. Ollendick
Publications Chair – Society of Clinical Psychology
Child Study Center, Department of Psychology
Virginia Tech, Blacksburg, VA 24061-0436

New TCP Editor 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.

The Society has a new editor for *The Clinical Psychologist* beginning in 2002. In light of the transition to a new editor, the January and March issues will be combined into one double Winter/Spring issue to be released in March.

Inquiries may be made to:

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