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PRESIDENT'S COLUMN

Can Principles of Therapeutic Change Replace the Need for Manuals?

Larry E. Beutler



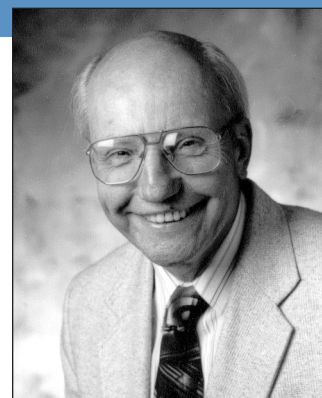
I have been warned that if I have anything of note to say to the membership of the Society of Clinical Psychology, I should say it in the first Presidential Column, since this may be the only one that people read. Taking that advice to heart, I must choose my topic carefully, selecting among several things that I think are very important both for our society and the Society: (1) implementing a research-informed response to crisis management (a topic that is timely as I write this, in the wake of the September 11th aerial terrorism); (2) the challenge posed to clinical psychology by the National Association of School Psychology (NASP); and (3) addressing the perennially broken bridge between science and practice. I have chosen to focus on the latter topic.

Now, wait before you frown and skip on to other things, telling yourself that this is an over worn and tired topic on which there can be nothing new—one that leads to a lot of rhetoric but little action. I elected this topic over the first because by the time this column is printed (March, 2002), events will be very different than they are at the time of this writing (September, 2001) and I fear that whatever I say will be eclipsed by what transpires between now and then. I elect to address the third topic over the second because my thoughts about the role of clinical psychologists in schools are not yet formed to a point that I have much to offer other than simply the expression of concern over the efforts of NASP to keep clinical psychologists out of the schools (a later column will address this issue). Thus, I want to talk about the science-practice disparity because this is an enduring issue, which is not likely to be resolved over the next four months, and it is one for which I have a plan. The results of my proposal may actually move us along the road to developing a profession that is both research-informed and flexibly responsive to clinical judgment, at least as pertains to the practice of psychotherapy.

As of this writing, Louis G. Castonguay and I have organized a new Task Force that is co-sponsored by the Society of Clinical Psychology and the North American Society for Psychotherapy Research. The purpose of this task force is to craft a set of basic principles of effective treatment that cut across theoretical frameworks and that can supplement current clinical practices with sound empirically derived knowledge.

As psychologists, our code of ethics binds us to finding and applying the best possible treatments for a given person's problems. That is, we should try to identify what treatments work and then we are obliged to learn them and apply them. The problem has always been with deciding what treatments work. The Society of Clinical Psychology, Division 12, has been very prominent in the effort to define effective treatment. In fact, it was a Division 12 Presidential initiative, under David Barlow, that began the process of identifying "Empirically Supported Treatments"

(continued on page 3)



Larry Beutler, Ph.D.
*Professor of Psychology
University of California*



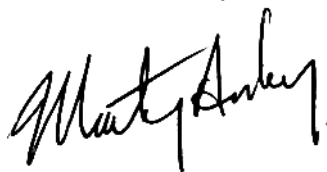
It is with great pleasure that I assume the role of Editor for *The Clinical Psychologist*, for 2002 through 2005, effective with this issue. I want to thank my predecessor, Paul Rokke, for the great job he has done over the past four years, and for helping to orient me to the position. Many of the innovations that he and previous editors brought to TCP will remain during my tenure. First and foremost,

TCP will continue to provide readers with important news and information about the activities of the Society of Clinical Psychology. As before, each issue will feature a President's column, as well as various announcements about awards and fellowships, and other information about Division-related issues.

I also hope to introduce a number of changes over the coming years. Starting with this issue, TCP has undergone a complete design overhaul. In addition to these cosmetic changes, you will also notice an editorial shift in the content of the newsletter. In keeping with the newsletter format of TCP, it is my intention to publish a larger number of brief pieces in each issue, rather than a single feature article. These shorter papers will include some invited articles, as well as submitted arti-

cles that have undergone a thorough peer review. I intend to increase the number of book reviews published in TCP, as well as the frequency with which articles on student related matters are included. I will also do my best to include articles that address controversial topics in clinical psychology, and letters to the editor will be welcomed. TCP will publish articles on a broad range of topics that are of interest to professionals and students in clinical psychology, including research oriented articles and articles about professional practice issues, ethical and legal issues, and matters concerning education and training. As always, TCP will be committed to the principles of evidence-based practice and education.

I welcome your feedback!



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(ESTs), altogether. The reports of the EST task force are extremely controversial. They have been seen as favoring behavioral and cognitive-behavioral theories over others, as being insensitive to the importance of therapist creativity and judgment, and as non-responsive to non-diagnostic characteristics of the patient. Some of these criticisms have resulted in a more recent effort, a Presidential Initiative by Division 29 (Psychotherapy), under John Norcross, that is devoted to defining the nature of "Empirically Supported Relationships".

Unfortunately, the Division 12 and Division 29 initiatives have been seen as anything but complementary to one another, and in fact, they are metaphors for the schism that exists in the field and do little to heal it. There remains a division between those who primarily emphasize the roles of techniques (ESTers) and those who mainly emphasize interpersonal processes (relationship'ers) as relational ingredients of change.

"The Society of Clinical Psychology, Division 12, has been very prominent in the effort to define effective treatment."

Typically, these two positions are represented by different people with very different values and beliefs about psychotherapy.

On one hand, the ESTers are very focused on techniques, theoretical models, and discrete procedures.

They believe in manuals and

in the axiom that the best method for ensuring optimization of practice is to train therapists to use treatment models that have been shown to work for patients who represent a particular diagnosis. Thus, this position encourages practitioners to learn a variety of manuals that will allow them to treat a range of patients and to periodically check their own performance to ensure continuing compliance. But, while use of the manuals advocated as being ESTs have been found to produce results that are better than no treatment or placebo treatment, it is less clear that manualized treatments produce any better results than non-manualized ones. In addition, head-to-head comparisons of the effects of different treatment manuals indicate that most seem to produce similar outcomes. To the degree that there are differences among them, the best estimates indicate that these differences account for no more than 10% of the observed changes. Moreover, there is an ever expanding list of empirically supported treatments, leading some to doubt either that distinctions of this type are very discriminating or that the difficulty of applying them in real settings is justified by their limited value. There are now over 150 different manuals and

models of treatment that have passed one or another criteria for being "empirically supported treatments." This number far exceeds the learning capabilities and time of even the most diligent practitioner.

Together, the evidence of only minor differences in effectiveness among treatments and the burgeoning number of different conditions for which a different manual and method is needed, have raised doubts for many about whether the benefits to be realized by learning and practicing research supported treatments are either practical or cost effective. Many scholars and practitioners have concluded that therapist, patient, and relationship factors, rather than therapy models and procedures, are the most important contributors to effective therapeutic work. These scholars, many of whom are "relationship'ers", think that effective treatments can better be identified by how patients and therapists interact with one another, and the level of their working alliance, than by the specific procedures used. While research supports the value of the therapeutic relationship, so far it indicates that relationship and caring accounts for no more of the treatment outcomes than that attributed to various specific treatments—about 10%.

I believe that it is time to find a common ground between these two perspectives, one that will take us beyond the point of arguing over what causes a mere 10% of the change. I believe that we must find a way to guide practice that is helpful to both scientists and practitioners, and that informs our practices without limiting us to a certain theory or a certain menu of treatment techniques. We must quit thinking of psychotherapy as a process whose effects are bifurcated between "techniques" and "relationships". I think that we will be better served by a psychology that defines basic foundation principles of psychotherapeutic change, principles that are not tied to any specific theory, technique, or treatment model. Effective principles would identify the conditions, therapist behaviors, and classes of intervention that are associated with change under identified circumstances and for particular kinds of patients. Principles are not theories—they are descriptions of observed relationships. They are more general than techniques and they are more specific than theories. They are the "if...then" relationships that tell us when to do and what to do, and who to do it to. I believe that stepping outside of the box that is defined by our theories, in this way, may allow us to begin to better understand and help a wider range of patients.

The Task Force on "Defining the Principles of Effective Therapeutic Change" will work during the remainder of this year and through my presidential

term (2002). They will first review the work of both the prior Division 12 reports on ESTs and the Division 29 report on the empirically supported relationship. They will then review some of the extant treatment manuals that have been identified by the Division 12 Task Force (now the Committee on Research and Practice) as well as some of the treatment descriptions used to define factors that enhance healing through relationships. From this review, they will be asked to extract cross-cutting principles of therapeutic change.

Task Force members will be organized into subgroups, each of which will address one of four different problem areas (Dysphoric Disorders, Anxiety

"We must quit thinking of psychotherapy as a process whose effects are bifurcated between "techniques" and "relationships"."

Based Disorders, Personality Disorders, and Habit Disorders). The subgroups will be comprised in such a way as to ensure that three perspectives are represented and then these three perspectives will be integrated into a final list of treatment principles. The three per-

spectives include: (1) Participant characteristics (patient and therapist factors), (2) Relationship factors, and (3) Treatment Procedures. These three perspectives then will be consolidated into an integrated formulation of treatment by a secondary group comprised of members of each of the other working groups.

Think of the product of this task force as a book that is separated into four sections, each of which addresses a separate problem area (Dysphoria, Anxiety, etc.). Within each of these sections, think of four chapters. The first chapter in each section will extract principles that relate participant factors to outcomes, across treatment models. The second chapter will extract principles that define ways to build effective relationships, across treatment models. The third chapter will extract principles that define the effective use of different subclasses of techniques. The final chapter in each section will be an integrative chapter that extracts from the other three chapters, the most relevant and robust principles of change, each framed in a way that is usable by those from a variety of theoretical perspectives and that both allows and fosters therapist judgment and skill in selecting and developing the particular techniques that are used to implement these principles.

I sincerely believe that this integrative and consolidating work can be an important step toward unifying practice and research and even in reducing the impairing effects of the boundaries that so often separate and induce conflict among those who find value in different theoretical models. I hope that this effort also will revise the way that we view the relationship between science and practice. We live in a time when healing rifts and identifying similarities in our collective therapeutic efforts is necessary for our collective growth. □

UPDATE ON CLINICAL PSYCHOLOGY IN THE SCHOOLS

After the announcement of a possible Interest Group on the subject of Clinical Psychology in the Schools, the Division 12 Board of Directors has discussed the considerable number of psychologists who responded favorably to the idea, and the importance of clinical psychology to diverse service contexts. The Board of Directors has endorsed moving forward, with the immediate tasks being to assess the possibility of instituting a Section (as opposed to an Interest Group) and having the scope be expanded to clinical psychology in diverse settings (as opposed to just schools), which will include schools.

The tentative plan is to submit a proposal by the summer meeting and to take formal action, if appropriate, at the fall meeting of the Board of Directors. Robert Woody, Ph.D., J.D., will chair an ad hoc committee, involving Robert Kelpac, Ph.D., Larry Siegel, Ph.D., and Danny Wedding, Ph.D.

Comments and suggestions on the matter will be welcomed, preferably by e-mail. Please contact Robert Woody at psychlegal@aol.com.

Division 12 Elections Candidate Statements

Elections for several Division 12 positions will occur this Spring. Ballots will be mailed to members in the middle of April, 2002, and must be returned no later than June 1, 2002.

PRESIDENT ELECT

Sheila Eyberg, Ph.D.

Sheila Eyberg obtained her Ph.D. in Clinical Psychology from the University of Oregon and completed clinical internship and postdoctoral fellowship in pediatric psychology at the Oregon Health Sciences University. She is currently Professor of Clinical and Health Psychology at the University of Florida where she trains graduate students and clinical interns in clinical research and treatment with young children. She has developed and tested behavioral assessment instruments for measuring treatment change and an evidence-based treatment for young children with disruptive behavior. Dr. Eyberg has published over 100 articles and chapters on child assessment and treatment, has served as associate editor of the *Journal of Clinical Child Psychology and Behavior Therapy*, serves on the editorial boards of seven journals, and has been a member of the NIMH Child Psychopathology and Treatment review committee. She is a past president of the Society of Pediatric Psychology (Division 54, formerly Section 5 of Division 12), the Society of Clinical Child and Adolescent Psychology (Division 53, formerly Section 1), the Division of Child, Youth, and Family Services (Division 37) and the Southeastern Psychological Association. Within Division 12, she has presented Post-Doctoral Institutes at APA and has served on the program committee for a number of years. She has served on the board as a representative from Sections 1 and 5, and has been a member of the Publications Committee, and Chair of the Finance Committee, the Program Committee, and the task force that developed the *Clinical Psychology Brochure*.

I have always had a deep sense of loyalty to Division 12, and I would welcome the opportunity to build on the accomplishments of the division and the board. As the primary clinical division of APA that brings together issues of science and practice, I would strongly support the continuing work of the Committee on Science and Practice in identifying effective treatments and disseminating information about treatment approaches and principles that are supported by sound research. I believe it is important that we continue to support the development and dissemination of effective assessment procedures and intervention procedures across the life span and that we work to establish guidelines for effective practice from within Clinical

Psychology. As a clinical child psychologist, I would also strongly support the direction of the board in collaborating with APA's directorates and policy offices to expand clinical psychology services in the schools and to attain mental health coverage for all children. Finally, I am committed to the future of clinical psychology and would promote the division's relationship with APAGS, to encourage student membership and involvement in the activities of the division, and with the new Committee on Young Professionals, to foster early professional identification with the issues facing clinical psychology as a science and practice. □

PRESIDENT ELECT

Nadine J. Kaslow, Ph.D., ABPP

I would be honored to serve as the President of Division 12, as my primary professional

identity is as a clinical psychologist. I have a long-standing affinity for Division 12, given that my undergraduate and graduate school mentors, Marty Seligman, Ph.D., and Lynn Rehm, Ph.D., have served as presidents of the division.

After receiving my doctorate in clinical psychology from the University of Houston, and completing my internship and postdoctoral fellowship training at the University of Wisconsin School of Medicine, I was an assistant professor at Yale University in the Department of Psychiatry and the Child Study Center. In 1990, I joined the faculty at Emory School of Medicine, where I am Professor and Chief Psychologist in the Department of Psychiatry and Behavioral Sciences, with joint appointments in the Departments of Psychology, Pediatrics, and the Rollins School of Public Health. Board certified in clinical psychology, I am the recipient of the Krasner Award for Distinguished Early Career Contributions to Psychotherapy and the Division 43 Award for Outstanding Contributions to Family Psychology. In 2000, I was a Primary Care Public Policy Fellow through the Department of Health and Human Services. I have authored over 120 publications on the assessment and treatment of depression in children, pediatric psychology, the link between intimate partner violence and suicidal behavior in women, and family violence. A member of the NIMH Interventions Study

Section, I have two grants from the Centers for Disease Control and Prevention, one on the link between intimate partner violence and child maltreatment in African American families and the other on the effectiveness of a group intervention for abused, suicidal African American women.

I would bring to the leadership of this division considerable experience within APA. In terms of Division 12, I served as the Chair of the Postdoctoral Institutes, the major continuing professional education program sponsored by the division. For the past five years, I have chaired the division's governance committee, and am pleased that we have successfully supported the nominations of many Division 12 members to APA Boards and Committees. I have been a board member of both Division 29 (Psychotherapy) and Division 43 (Family Psychology), and currently serve as the President of Division 43. I am in my final year on the APA Board of Educational Affairs. Further, I am in my final year as member and Chair of the Association of Psychology and Postdoctoral Internship Centers (APPIC) and the Chair of the Council of Chairs of Training Councils.

If selected as president, I would look forward to collaborating with my Division 12 colleagues on three major areas. First, I would hope to continue the division's efforts to increase the dialogue between scientists and practitioners to ensure the conduct of clinically meaningful research that is both informed by real-world practice and useful to practitioners. Second, I would like for our division to be more active in advocacy and legislative efforts regarding the training, practice, and science of clinical psychology at the state and federal level. Third, I firmly believe that our division would be strengthened if we increase our attention to the broad of diversity issues and enhance the diversity of our membership.

I would be happy to discuss my platform in more detail and can be reached at nkaslow@emory.edu. □

PRESIDENT ELECT

Lawrence J. Siegel, Ph.D., ABPP

Larry Siegel is Dean and Professor at Ferkauf Graduate School of

Psychology of Yeshiva University. He received his Ph.D. from Case Western Reserve University in 1975. Previously he has been on the Clinical Psychology faculty at the University of Missouri and the University of Florida, and was Director of the Division of Pediatric Psychology at the University of Texas Medical Branch.

He is a Fellow of Divisions 12, 37, 38, 53, and 54 of APA and he is a Diplomate of the American Board of Clinical Psychology. Dr. Siegel is also a Fellow of the American Psychological Society. From 1981-1982 he was a Congressional Science Fellow from the American Psychological Association. He was appointed to the President's Council on Children and Youth by President Carter. He has published more than 100 research articles and chapters in the areas of both clinical child and pediatric psychology, and he is the author or co-author of five books in the field. In addition, he has obtained numerous research and training grants in these areas. He serves on the Editorial Boards of a number of journals in clinical and child psychology.

For more than a decade Dr. Siegel has provided active service to Division 12. He served as President of the Society of Pediatric Psychology (Section V) and was the Editor of the Newsletter Progress Notes for the Section. In addition, he has been the Editor of Division 12's *The Clinical Psychologist*. More recently, he served as chair of the Publications Committee and is currently serving as Chair for the Membership Committee of the Division and Division representative to CAPP. Finally, he has served as Chair of the Program Committee for Division 12 for the APA convention.

As one of the largest Divisions of APA, Division 12 must work to establish a greater presence within the organization to influence its policies and agenda. Our Division has considerable potential to play a major role in helping APA respond to the major challenges facing our profession as service providers, researchers, and educators. Division 12 represents all of these diverse interests and it is important that our membership feel that these areas are being addressed through our activities and initiatives if we are to retain and attract new members. I am a strong advocate for *both* the science and practice sides of our profession, as I have demonstrated throughout my career, and believe that a unique emphasis of Division 12 is its focus on their integration and reciprocity. I am also committed to ensuring that the governance and committee structure of Division 12 reflects the diversity of our membership. If Division 12 is to remain a strong advocate for the model of integrating science and practice both within APA and at the national level it is imperative that we enhance our activities which appeal to young scientists and practitioners who are the future of our profession. I would be honored to serve as President of Division 12 and I am deeply committed to promoting an agenda that furthers the basic mission of our Division. □

PRESIDENT ELECT

Samuel M. Turner, Ph.D.

Samuel M. Turner received his Ph.D. from the University of Georgia in 1975 and completed his clinical internship at the University of Mississippi Medical Center. He has held faculty positions at the University of Pittsburgh, the Medical University of South Carolina, and currently is Professor of Psychology and Director of Clinical Training at the University of Maryland, College Park.

Dr. Turner has served the interests of Division members within and outside of the APA. He has served on the Board of Educational Affairs, Board of Scientific Affairs, Committee on Ethnic Minority Human Resources, the Council of Representatives, the Task Force on Test User Qualifications (Co-chair), the College of Professional Psychology, and as editor of *The Clinical Psychologist*. He is a diplomate in both clinical and behavioral psychology, fellow in Divisions 1, 12, 25, and 45, and the 1997 recipient of APA's award for Distinguished Contributions to Professional Knowledge, and the Association of Medical School Psychologists' award for Distinguished Contributions to Medical Research.

I would be honored to serve as the President of Division 12 and to help address some of the issues confronting clinical psychologists and the Division. These include ensuring the membership and active involvement of younger clinicians in the division, increasing the diversity of membership and participation in the governance structured, improving the quality of CE programs, and fostering of the integration of science and practice in a fashion that will lead to a better science and better practice. □

COUNCIL REPRESENTATIVE

Janet R. Matthews, Ph.D., ABPP

Janet R. Matthews received her Ph.D. in clinical psychology from the University of Mississippi in 1976. She is a tenured Professor at Loyola University New Orleans, is a consultant to the predoctoral internship at the New Orleans VAMC, and has a part-time private practice. She has been active in both Division 12 and APA governance. Among her Division 12 service is program chair and secretary-treasurer of the former Section 2; membership chair, secretary, and president of Section 4; three years on the Fellows Committee; three years as Secretary; and currently serves on the Finance Committee as well as completing her first term as APA

Council representative. Within APA she has been chair of the Assembly of Scientist Practitioner Psychologists; member of both the Education and Training Board and Board of Convention Affairs; chair of the Committee on Undergraduate Education, Policy and Planning Board, and Board of Professional Affairs; and served a term on the APA Board of Directors. She served for three years as Board of Directors liaison to the Association of State and Provincial Psychology Boards. Currently she serves on the APA Membership Committee.

"I respectfully ask for your vote to be your representative on the APA Council of Representatives. I believe I bring a combination of experience with both Division 12 and APA governance which will allow me to be a strong representative of the interests of Division 12. My combination of academic and practice employment exposes me on a regular basis to a range of issues facing our discipline today. As APA selects a new CEO and new directions are developed for the association, I believe it is important to have Division 12 Council representatives who have a solid understanding of both Division 12's positions and APA governance processes. I am currently completing my first term as your representative and would very much like to serve a second term during these times of change." □

COUNCIL REPRESENTATIVE

Jerome H. Resnick, Ph.D.

Jerome Resnick, Professor of Psychology at Temple University, has served for a decade as Director of the Department's Psychological Services Center and also as Director of Graduate Studies of the Department's five doctoral programs.

He is the 1999 recipient of the Society's Award for Distinguished Professional Contributions to Clinical Psychology. In 1991 he served as President of Division 12 and has previously worked for the Division as its representative to the APA Council. For 10 years he served as editor of the Division's bulletin, *The Clinical Psychologist*.

Within APA, he is past-Chair of the Board of Professional Affairs, and of its Committee of the Structure and Function of Council. He held office as a member of APA's Finance Committee, and served two terms of APA's Policy and Planning Board. He is a Fellow in six APA Divisions and holds the ABPP in Clinical Psychology.

He was President of the Pennsylvania Psychological Association and was a member of his

state's Licensing Board. He was an invited participant at the 1990 National Conference on Scientist-Practitioner Education, and the 1994 National Conference on Post-Doctoral Education. For seven years he served as Eastern Regional Vice-President of Psi Chi.

Division 12, representing the *field* of Clinical Psychology, is pivotal in *two* ways: First, as representing science *and* practice as a mutually reinforcing entity. Second, as representing the *range* of arenas in which our field functions. This range includes both the life-span and the myriad of activities and sites in which we find ourselves operating. We need to work to broaden our base while keeping our standards for membership high.

With a record of involvement in these various aspects of our field *and* in the corridors of policy-making now extending for over three decades, if elected with your help, I believe I can continue to be an effective leader for our interests. □

COUNCIL REPRESENTATIVE

**John D. Robinson,
Ed.D., MPH, ABPP**

Having served as a member of the Membership Committee for the Society

for nine years (five as chair), and currently as Chair of the Fellows Committee, I have shown my dedication to the Society. In addition, I have been the Society's liaison to the American Psychological Association for Graduate Students (APAGS) for 10 years. My major goal has been to increase the diversity of the division in terms of gender, race, disability, sexual orientation, and ethnicity. The Society of Clinical Psychology is now well represented by a very diverse number of psychologists who may otherwise feel disenfranchised in our profession. I have increased the number of students and "new" psychologists as members of the Society and developed innovative ways to recruit and retain members. After receiving undergraduate and graduate degrees from the University of Texas at Austin, I received my EdD from the University of Massachusetts at Amherst, an MPH in Psychiatric Epidemiology from Harvard University School of Public Health, and a Doctor of Humane Letters, *Honoris causa*, from the Massachusetts School of Professional Psychology (MSPP). Currently, I am a professor of psychiatry and surgery at the Howard University College of Medicine and a clinical professor of psychiatry at Georgetown University School of Medicine. I hold ABPP board certification in both Clinical and Clinical Health Psychology and am president of the American Board of Clinical Psychology. Having served on a number of committees and task forces of APA, I am very familiar

with the governance structure of the organization. I hope to continue to represent the diversity and interests of the Society by being a member of the APA Council of Representatives. □

TREASURER

**Robert K. Klepac,
Ph.D.**

I received my doctorate in from Kent State University. I have served

on the faculties of Western Washington University; North Dakota State University, where I chaired the Department of Psychology; and Florida State University, where I served as Director of Clinical Training. My current position is Director of Psychology Training at Wilford Hall Medical Center, directing a large scientist-practitioner internship program and overseeing a postdoctoral program in clinical health psychology. I also serve as National Coordinator of Air Force Psychology Training. My research interests lie in behavioral health, and include studies of pain and of the reduction of fear of intrusive medical and dental procedures. I maintained a small private practice for many years as well. These varied positions have provided me with a broad scope of clinical psychology and education in our discipline.

I have served on several boards and committees for professional associations, including service as chair of the board of directors of the Association of Psychology Postdoctoral and Internship Centers (APPIC), and as a member of the APA Committee on Accreditation, among others. My involvement in Division 12 governance covers a period of more than 10 years. I have served as liaison to the Division 12 board from APPIC, as President of section III (SSCP the Society for a Science of Clinical Psychology), as a member of the publications committee, and as a member the Division's board of directors as SSCP representative.

I have had direct responsibility for budget management throughout my career, including budgets for large research grants, an academic department, and a doctoral program in a major university. I have also been involved in budgetary issues as a member of the boards of directors of APPIC and Division 12, and as an officer in SSCP. I would welcome the opportunity to serve as Treasurer of the Society. □

TREASURER

**Robert H. Woody,
Ph.D., Sc.D., J.D.**

As the current Treasurer of Division 12, I would be honored to be re-elected

for another term. The tasks have been challenging and educational, allowing me to develop advanced budget planning and management skills. With the help and support of the Finance Committee and Board of Directors, I have worked to reduce spending, achieve prudent expenditures, maximize investments, and create new income streams.

The Treasurer must go beyond budgetary matters, and provide leadership in confronting critical issues and resolving problems that impact on clinical psychology. I support the scientist-practitioner model, and structuring the Division to serve and unite members with diverse interests. I am gravely concerned about governmental and managed care sources lessening the status of clinical psychologists, and will work for a proper balance of professional and public interests (e.g., to help clinical psychology command the standards for practices). In representing clinical psychology, I strive to be scholarly, rational, assertive, and persuasive. Pursuing benefits for clinical psychology is pursuing benefits for society. Being trained in both psychology and the law, I can offer unique strategies for improving clinical psychology. I will appreciate your support for my being Treasurer of Division 12.

Robert H. Woody is Professor of Psychology (and former Dean for Graduate Studies and Research) at the University of Nebraska at Omaha. He is a Fellow of the Division of Clinical Psychology, and holds Diplomates in Clinical and Forensic Psychology, ABPP. He is admitted to the Florida, Michigan, Nebraska, and Tennessee Bars, and is a Licensed Psychologist in Florida and Michigan. He has authored/edited thirty books, and approximately two hundred articles. He has served on the APA Ethics Committee, and is presently on the Board of Directors and Treasurer for Division 12. In 2001, he was President of the Florida Psychological Association; and in 2002, he begins as the Florida Representative on the APA Council of Representatives. □

TREASURER

**Sheila R. Woody,
Ph.D.**

I am on the faculty in the Psychology Department at University of British

Columbia in Vancouver. I earned my Ph.D. in 1992 from American University and began my first academic position at Yale University in 1994. My work truly represents the scientist-practitioner, as I conduct research on anxiety disorders, provide training to graduate students and professionals, and maintain a small private practice. I have also collaborated with community-based practitioners on clinical training, workshop development, and outcome research. In furtherance of my commitment to a dialogue between scientists and practitioners, last year I published a book (with Peter McLean) that combines an accessible discussion of recent treatment research in anxiety disorders with detailed instruction in how to conduct these interventions.

I have been a member of Division 12 since graduate school, and in more recent years I have been active in leadership roles within the Division. From 1998 to 2001, I chaired the Dissemination Subcommittee of the Committee on Science and Practice (and I still serve on that committee). Under my leadership, the subcommittee developed a page for the Division website that provides information for the public about empirically supported treatments. I serve on the editorial board of the Society's journal *Clinical Psychology: Science and Practice*, and I was honored to receive the 2000 David Shakow Early Career Award from the Division. In the past, I also served on the Board as Representative from Section III. As a member of the Board, I was active in constructing and supporting bridges between the applied and research branches of our field.

I would bring 10 years experience in managing academic budgets and strong organizational skills to the Board. I believe I can offer a fresh perspective and make a unique contribution as Treasurer of the Division, and I ask for your support. □

Division 12 Professional Development Institutes

The Society will present 14 CE workshops in Chicago, IL in 2002, just prior to the APA Convention. CE credit given will range from 4-7 hours, depending on the length of workshop chosen. Topics will include Psychopharmacology for Non-Prescribers, Anxiety Assessment, Ethics and Legal Issues, Empirically supported treatments in Clinical Care, Principles of CBT, ADHD, Child Anger Management, Positive Psychology, Neuroimaging for Non-Radiologists, Dialectical Behavior Therapy, and a workshop directly focused toward students on establishing a private practice.

Please contact the Central Office to be placed on the brochure mailing list or for more detailed information. See ad on page 20 for more details.

Applying for Fellow Status in Division 12

Fellows Applicants:

For those individuals who would like to apply to Division 12 as "new" Fellows (those who are not yet a Fellow in any other Division) should submit their application to the Division Central Office by December 1st of any given year. Notification will be in February of the following year.

Ratification of the Fellows Committee's choices, however, must be done by APA's Membership Committee when they meet in August at the Convention. The Fellow status will begin the following January 1st.

For those who are already Fellows in another Division, but who would like to apply for this status in Division 12, applications should be sent to the Division Central Office by February 15th of any given year. Notification of outcome will be in April, with ratification by APA's Membership Committee in August.

Send all applications to:

*Fellowship Committee Chair
Div 12 Central Office
P.O. Box 1082
Niwot, CO 80544-1082*

To request applications:

*Tel: 303-652-3126
Fax: 303-652-2723
email: div12apa@attbi.com*

Division 12 Establishes Affiliate Membership Category

At the Board of Director's meeting in October, 2001, the Board ratified the member vote to establish an Affiliate Membership in the Society of Clinical Psychology. This action broadened the Affiliate status from to include psychologists who have an interest in clinical psychology, even if they are not members of APA. In the past, this designation of Affiliate has been reserved for those who lived outside of North America. The new classification includes those who reside in North America and Canada who may not wish to belong to APA.

Affiliate Members will receive the journal, *Clinical Psychology: Science and Practice* and *The Clinical Psychologist*.

Join a Division 12 Section.

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

Clinical Geropsychology (Section 2)

Society for a Science of Clinical Psychology (Section 3)

Clinical Psychology of Women (Section 4)

Clinical Psychology of Ethnic Minorities (Section 6)

Section on Clinical Emergencies and Crises (Section 7)

Section of the Association of Medical School Psychologists (Section 8)

Section on Assessment (Section 9)

Science-Based Responses to Terrorism

Melissa A. Polusny
Minneapolis VA Medical Center

Sonja V. Batten
*National Center for PTSD,
VA Boston Healthcare System
and Boston University School of Medicine*

Edna B. Foa
University of Pennsylvania

Richard Gist
*Kansas City, Missouri Fire Department and University
of Missouri-Kansas City*

Robin H. Gurwitch
University of Oklahoma Health Sciences Center

Steven C. Hayes
University of Nevada, Reno

Dean G. Kilpatrick
*National Crime Victims Research and Treatment
Center, Medical University of South Carolina*

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Behavior Therapists Discuss Terrorism

Following the terrorist attacks of September 11, 2001, on the United States, psychologists and social scientists across the country were called upon by the media and public to provide psychological explanations for these human acts of violence, to describe potential mental health effects of terrorism, and to offer interventions needed by victims and their families. Furthermore, psychotherapists, many of whom have not previously specialized in providing trauma therapy, have been faced with the task of addressing trauma-related issues in the context of their clinical practices, even when their practices are geographically distant from the sites of the events (Schuster et al., 2001).

In order to address a number of issues raised by the September 11 attacks, the Disaster and Trauma Special Interest Group of the Association for the

Advancement of Behavior Therapy (AABT) assembled a panel of nationally known experts to present a special symposium, *In the Wake of Terror: Science-Based Guidelines for Mental Health Professionals*, at the November 2001 convention in Philadelphia, PA (Batten & Polusny, 2001). The discussant for the symposium was Dr. Richard Gist, Principal Assistant to the Director of the Kansas City, Missouri Fire Department. Dr. Gist commented on the presentations and encouraged mental health providers to assist victims of the recent terrorist attacks to utilize natural resources in the environment rather than focusing exclusively on the use of mental health services. Highlights of the presentations by Robin Gurwitch, Edna Foa, Dean Kilpatrick, and Steven Hayes are summarized below.

How Terrorism Impacts Children

Dr. Robin Gurwitch of the Child Study Center in the Department of Pediatrics at the University of Oklahoma Health Sciences Center has conducted research investigating the effects of the bombing of the Alfred P. Murrah Federal Building in Oklahoma City. Based on studies conducted by Dr. Gurwitch and her colleagues in Oklahoma City, as well as a review of the current literature, she provided an overview of the wide range of reactions that are common in children following exposure to large-scale traumatic events. In her presentation, *The Impact of Trauma and Disasters on Children*, (see Gurwitch, Sullivan & Long, 1998, and Gurwitch, Silovsky, Schultz, Kees, & Burlingame, 2001, for further discussion of these issues), Dr. Gurwitch noted that such reactions may include significant worries and fears, concerns about personal safety and security, nightmares (either resembling or seemingly unrelated to the traumatic events), separation anxiety, and somatic complaints. In addition, children may experience changes in sleep and appetite, and school performance may be adversely impacted due to difficulties with concentration, attention, and increased activity levels. Other reactions common in children include an increased sensitivity to sounds such as sirens, increased startle response, and a decreased interest in once pleasurable activities. As they attempt to cope with and process traumatic events, younger children may engage in post-traumatic play and ask questions or tell about the event multiple times. Among older children, concerns about safety and security may extend to a sense of a foreshortened future. In addition, adolescents may demonstrate problems with withdrawal, substance abuse, and risk-taking behaviors, as well as a fascination with death and suicide. Finally, extensive viewing of media coverage appears to negatively affect children of all ages. Interventions with children must consider the

distinct differences between adult and child responses.

Unraveling the Psychological Debriefing Controversy

Dr. Edna Foa, Professor of Clinical Psychology in Psychiatry at the University of Pennsylvania and an expert on posttraumatic stress disorder, presented a review of the literature on Psychological Debriefing and other early interventions conducted following traumatic events. In her presentation, *Early Interventions for Trauma: Possibilities and Pitfalls*, Dr. Foa concluded that, at best, Psychological Debriefing does not help to lessen PTSD symptoms among those exposed to traumatic events. At worst, debriefing interventions may

“...at best, Psychological Debriefing does not help to lessen PTSD symptoms among those exposed to traumatic events. At worst, debriefing interventions may actually impede the natural recovery of trauma victims.”

actually impede the natural recovery of trauma victims (for a review of research in this area, see Bisson, McFarlane, & Rose, 2000).

Research comparing a single session of Psychological Debriefing to no intervention in samples of motor vehicle accident survivors and women who had experienced miscarriage has shown no differences

between debriefed subjects and controls. However, two studies, one with burn victims and the other with motor vehicle accident survivors, have shown that victims who received Psychological Debriefing remained more distressed than those who did not receive intervention. On the other hand, Dr. Foa noted that her research with female assault victims has demonstrated that four sessions of Cognitive-Behavioral Therapy (CBT) can accelerate the recovery process. Women who met symptom criteria for PTSD and received CBT showed earlier improvements on PTSD symptoms than controls. These results were replicated by Richard Bryant who adopted Foa's early CBT intervention to men and women who had Acute Stress Disorder (ASD) after a variety of traumas. Rather than delivering one-session Psychological Debriefing interventions immediately following trauma exposure, Dr. Foa cautioned that mental health professionals should offer 4-5 sessions of CBT to those who are at highest risk for developing PTSD as determined by severe PTSD symptoms

(or ASD) shortly after the trauma (for additional guidelines for mental health professionals' responses to potentially traumatic events, see Foa, Hembree, Riggs, Rauch & Franklin, 2001).

Lessons from Lockerbie

Dr. Dean Kilpatrick, Professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, gave a presentation entitled, *Lessons from Lockerbie: Service Utilization and Victim Satisfaction after the Pan Am 103 Terrorist Bombing*. The *Lockerbie bombing*, which marked the largest mass murder in Scotland history, killed 259 passengers on board the flight as well as 11 individuals on the ground. Following this event, Dr. Kilpatrick and his colleagues at the National Crime Victims Research and Treatment Center were commissioned by the Office of Crime Victims to evaluate a treatment program designed for family members impacted by the terrorist bombing.

Services that were evaluated included an international toll-free telephone number and informational hotline, secure internet web page to provide updates about the trial, funding for mental health services, travel funds to attend the trial, assistance with travel arrangements, and a Lockerbie trial handbook. The most frequently used resources included the trial handbook and web page. These innovative services allowed accurate information to be disseminated to large numbers of people.

Although the death of family members was identified as a cause of major disruption in people's lives, and approximately half of the individuals contacted reported that they had emotional or behavioral problems serious enough to consider seeking therapy, only about one-third used mental health services. Reasons for low mental health care utilization included beliefs that they could handle their difficulties on their own with support of friends, family, and clergy, stigma around obtaining services, and lack of funds. However, 90% of victims who did use services evaluated them positively.

Terrorism, Prejudice, and the War Within

Moving from the understanding of reactions to terrorism and potential resources and interventions needed by such trauma survivors, the hope for prevention of such acts also prompts us to work to understand how such events can occur. Dr. Steven Hayes, Foundation Professor of Psychology at the University of Nevada and expert in behavioral formulations of language and cognition, provided a framework for understanding the violent acts of September 11 in his presentation entitled *Prejudice, Terror, and Acceptance: Problems and Solutions*

Science-Based Responses to Terrorism (cont.)

Presented by Human Language and Cognition. Dr. Hayes called for clinical scientists to work to understand human acts of terrorism, how to prevent them, and how to change the destructive behavioral processes that lead to such acts. Based on Relational Frame Theory, a new approach to human cognition (Hayes, Barnes-Holmes, & Roche, 2001), Dr. Hayes discussed the process by which prejudice and the objectification and dehumanization of others is built into human language. Dr. Hayes identified prejudice as a kind of cognitive entanglement that is shockingly common and difficult to deal with. He argued for clinical scientists to work towards developing and testing methods for reducing human prejudice and offered acceptance-based therapies as one method of treating or preventing these cognitive processes.

In Conclusion

While more questions remain unanswered than answered with respect to the identification and treatment of psychological problems related to terrorism, we believe that behavioral scientists can and should play a significant role in these areas. It is hoped that with a concerted, science-based effort, of which this panel is a first step, we can make progress toward the prevention of terrorism and the amelioration of its aftereffects. □

Audiotapes of this special session are available from Audio Archives International at 1-800-747-8069.

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The Society of Clinical Psychology Welcomes Section 9, Assessment Psychology

Division 12 is very proud to announce the formation of its newest section, Section 9, Assessment Psychology. Led by recently elected Officers Charles Golden, Robert Archer, Irving Weiner, Robert Heaton and Alan Raphael, the Section is accepting members whose professional interests emphasize the development, use and interpretation of tests based on psychological theory, knowledge and principles. The Assessment Psychology Section member may be involved in test use, development and interpretation in such diverse areas as personality, neuropsychology, intelligence, achievement, aptitude and other areas within psychology which are amenable to quantitative or qualitative methods. Such techniques may be objective or projective and may involve any population seen by psychologists in general.

For more information, please view the website at www.assessmentpsychologyboard.org

Call for Nominations for Division 12 Awards

Call for Nominations:

Two Awards for Distinguished Contributions in Clinical Psychology

Distinguished Scientific Contribution Award:

Honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology.

Florence Halpern Award for Distinguished Professional Contributions:

Honors psychologists who have made distinguished theoretical or empirical advances in psychology leading to the understanding or amelioration of important practical problems.

To nominate someone for these awards, send nominee's name, recent vita, and a concise (1-2 page) typewritten summary of his/her achievements and contributions to:

Larry E. Beutler, Ph.D., Chair
2003 Awards Committee, c/o Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082

Deadline: October 30, 2002

The award will be presented at the 2003 APA Convention in Toronto, Ontario, Canada

Call for Nominations

2003 David Shakow Award for Early Career Contributions

The "David Shakow Early Career Award" shall be given for contributions to the science and practice of Clinical Psychology. The awardee will be a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to the science and to the practice of Clinical Psychology.

Letters of nomination should include the nominee's vita and a summary of his/her contributions.

Larry E. Beutler, Ph.D., Chair
2003 Awards Committee, c/o Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082

Deadline: October 30, 2002

The award will be presented at the 2003 APA Convention in Toronto, Ontario, Canada

Call for Nominations

2003 Theodore Blau Award

The "Theodore H. Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology" will be given by the Division of Clinical Psychology to a Clinical Psychologist who has made an outstanding contribution to the profession of Clinical Psychology. Outstanding contributions are broadly conceived as promoting the practice of Clinical Psychology through professional service, innovation in service delivery, novel application of applied research methodologies to professional practice, positive impact on health delivery systems, development of creative educational programs for practice, or other novel or creative activities advancing the profession. Given the difficulty of making such contributions very early in one's career, the award will be given to a person who is within the first 10 years of receiving his or her doctorate. This award is made possible through the sponsorship of Psychological Assessment Resources, Inc.

Larry E. Beutler, Ph.D., Chair
2003 Awards Committee, c/o Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082

Deadline: October 30, 2002

The award will be presented at the 2003 APA Convention in Toronto, Ontario, Canada.

Congratulations to the 2002 Award Winners!

Dr. Mark Sobell will receive the Award for Distinguished Scientific Contributions to Clinical Psychology

Dr. George Stricker will receive the Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

Dr. Louis Castonguay will receive the David Shakow Early Career Award

Dr. Michael Goldberg will receive the Theodore H. Blau Early Career Award

These 2002 awards will be presented at the 2002 APA Convention in Chicago, IL.

Psychology and Long-Term Mental Illness

Ronald F. Levant,
Nova Southeastern University
APA Recording Secretary

Address correspondence to the author at Center for Psychological Studies, Nova Southeastern University, 3301 College Ave., Ft. Lauderdale, FL 33314, or by electronic mail at RLevant@aol.com.



Psychology is not currently a major player in the public sector care and treatment of patients suffering from serious mental illness, such as schizophrenia, bipolar disorders and major depression. This is somewhat ironic because at one time clinical psychology had defined its purview as serious psychopathology. It is also very short-sighted because in this era of cost-containment and shrinking opportuni-

“...the deinstitutionalization movement succeeded in emptying the beds of the state mental hospitals and filling the streets and jails with chronic mental patients.”

ties for the practice of psychology, the care of such patients represents a potential growth area, one based on an expanded scope of practice.

The Center for Mental Health Services (CMHS; 1996) estimates that 5.4 million adults (2.7% of the population) have a "severe and persistent" mental illness,

and that more than 3 million children and adolescents have a serious emotional disturbance that undermines their present functioning and endangers their future.

This large and very vulnerable population receives substandard care, as we all know. Deinstitutionalization, which was conceived in the humanitarianism and the idealism of the Community Mental Health Movement, has been a stark failure overall (although there have been some success stories here and there). With the clarity of 20/20 hindsight, we can see that there was insufficient investment in community-based care and psychological rehabilitation to make it work. There was also an over-reliance on psychoactive medications, which (again in retrospect) was terribly short sighted given the lack of adequate care sys-

tems designed to prevent relapses due to non-compliance. In the end, the deinstitutionalization movement succeeded in emptying the beds of the state mental hospitals and filling the streets and jails with chronic mental patients. Indeed, an article in the New York Times described the jail as the "new mental hospital" (Butterfield, 1998).

Having worked with this population off and on over many years I have found that many such consumers have very complex comorbidities, including (in addition to their serious mental illness) substance abuse, brain injury, PTSD (particularly among the women, many of whom have been victims of rape), and Axis II characterological problems (to name some of the more common diagnoses). Also, due to the harsh lifestyle of the street that many such consumers lead, there are often untreated medical problems as well. A population this vulnerable and disabled deserves much better care than our society now offers.

Psychologists could play a very significant role in the care of this population. Although some advocates promote the idea that serious mental illness is a "brain disease" and therefore treatable only by biological interventions (e.g., medications), psychiatrists have virtually abandoned this population. Furthermore, the outcome research literature strongly indicates that while psychoactive medications can suppress the symptoms of serious mental illness, psychological rehabilitation actually holds out hope for recovery (Anthony, 1993; Coursey, Alford, & Safarian, 1997).

The concept of recovery is really quite an important notion in that it confronts the stigmatizing stereotypes that view serious mental illness as essentially hopeless. Too often such long-term conditions as schizophrenia and bipolar disorder (to name just two) are viewed extremely pessimistically, as incurable conditions. But evidence has been accumulating that indicates that some people diagnosed with serious mental illness do recover through a combination of psychotherapy, psychosocial rehabilitation, consumer-run self-help programs, and medications (Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Harding, Zubin & Strauss, 1992; Falloon, Roncone, Malm, & Coverdale, 1998). The concept of "recovery" in this work involves a shift in perspective from a medical to a rehabilitative model.

We must continue to work to change public policies and social attitudes that regard these illnesses as hopeless and thereby allow the disgraceful neglect of people who suffer from them to continue. The American Psychological Association (APA) has begun this process with the passage of the Resolution on Stigma and Serious Mental Illness by the APA Council

of Representatives in February 1999.

Hence, I think that we have a lot to offer in the care and treatment of the seriously mentally ill (SMI) patient. First of all, there is no profession better qualified than psychology to conduct the careful diagnostic assessments that would tease out the complex comorbidities that many of these individuals suffer from. Second, since psychologists have taken the lead in developing and evaluating psychological rehabilitation and recovery methods, we can surely lay claim to the role of designing, implementing and training staff members to carry out psychological rehabilitation. Third, we can provide empirically validated therapies for persons with serious mental illness. Fourth, practitioners can team up with researchers and develop the next generation of psychological interventions that might have even greater effectiveness (Bellack, Mueser, Gingerich, & Agresta, 1997; Dixon & Lehman, 1995; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991)

Fifth, we can play a larger role in medications. Ultimately, of course, we could prescribe after the successful passage of prescription privilege legislation. Right now psychologists with the appropriate knowledge can function as consultative psychopharmacologists, who, working in conjunction with primary care doctors or in some states even advanced practice nurses, can provide the full spectrum of care for the SMI patient. Our role as consultative psychopharmacologists for the SMI population has been delineated by an APA Board of Educational Affairs task force on Level II psychopharmacology. Although this role has been challenged recently in several jurisdictions (e.g., MA, FL, and Washington, DC) as well as by some psychologists (e.g., Robiner et al., in press), the Board of Psychology in all three instances has upheld this role as part of psychologists' scope of practice.

Finally, such an enhanced role in the care of the SMI would go a long way toward furthering our aim of becoming the premier primary behavioral health care profession. By reaching out and responding effectively to a public health problem of this size and scope we would surely establish our credibility. Furthermore, such an expanded role is consistent with other efforts to expand the scope of practice of psychology in areas such as health care, brain injury, and the courts.

The critical factor is going to be the develop-

ment of new pathways to practice. In the care for the SMI, new pathways to practice are clearly needed, based on an expanded scope of practice as outlined above. Some universities are now offering training in this area (e.g., Nova Southeastern University, Boston University, University of Maryland) but much more needs to be done. We need postdoctoral retraining programs that include training in psychological rehabilitation and level II psychopharmacology, legislation to change archaic civil service staffing patterns where they still exist, and entrepreneurship to develop psychological delivery systems in those states that outsource mental health care.

Psychology would also be well advised to work to develop partnerships with recovered consumers. There is a growing cadre of people who have recovered from serious mental illness who can serve as invaluable allies in the recovery process because of their ability to relate to the consumer's experience. Such consumers, also known as "survivors of psychiatric treatment" and "ex-mental patients" are interested in collaborating with psychologists, and deeply believe from their own experiences that psychotherapy and psychosocial rehabilitation can be very beneficial. But to develop such a coalition, consumers state clearly that psychologists must understand the perspectives of

consumers on such matters as participating in their own recovery, the integration of self-help with professional services, living with a diagnosis of serious mental illness, forced treatment and its alternatives, and on the abuses that many have experienced in the mental health system (Bassman, 1997; Freese & Davis, 1997). □

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New committee formed to evaluate changes in the APA Convention

Norman Abeles is chairing a committee appointed by Norine Johnson, the 2001 President of APA. The committee's charge is to evaluate the changes in the APA convention.

*If you have suggestions or comments, please contact Norman Abeles:
email: abeles@pilot.msu.edu
Department of Psychology
Michigan State University,
East Lansing, MI 48824*

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::
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Fax (303) 652-2723
Email: div12apa@attbi.com***

Book Review

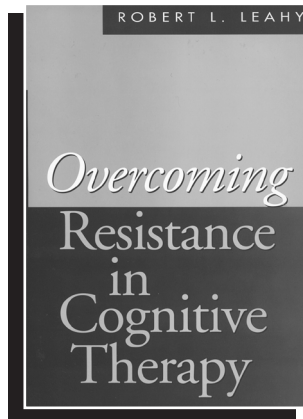
Leahy, R. L. (2001).


Overcoming Resistance in Cognitive Therapy

New York, NY: Guilford.

Reviewed by Peter J. Bieling, Ph.D.

Department of Psychiatry and Behavioural Neuroscience,
McMaster University, and St. Joseph's Healthcare, Hamilton



 Robert Leahy's new volume on resistance in cognitive therapy starts with the premise that cognitive behavior therapy (CBT) is an efficacious and effective form of treatment that brings benefits to the majority of those who are treated. However, his book aims to help therapists with that significant minority of patients who progress slowly, have setbacks, or with whom we otherwise get

"stuck." Leahy's vast clinical experience and broad scholarly interests are much in evidence here. He applies ideas and principles that range from eastern meditative practices to modern microeconomics and theories of investment, and then translates these into ideas and actions to help motivate, understand, and help patients move forward. At the heart of Leahy's book are two sets of concepts related to resistance. One set is patient-based resistance, consisting of seven different types of resistance encountered in therapy. The second set includes therapist-based, countertransference factors that impede treatment. To reflect these different areas, the book is divided into three parts, an introduction and overview, a review of the seven types of resistance, and an examination of the countertransference issues.

Probably the initial "hook" for most readers looking at the jacket and table of contents of this book are the seven different types of resistance. There is a strong temptation to flip open the book and see what these types of resistance are, perhaps with one's toughest cases in mind. However, readers who do this are not doing themselves a favor. One of the most interesting aspects of the book is Leahy's description of the history of the concept of resistance in different schools of psychotherapy. This discussion highlights the fact that CBT therapists are hardly the first to encounter resistance and try to overcome it. Indeed, much of what has been learned in other schools of therapy can and is used by Leahy as building blocks for his strategies. Certainly, those with a more academic interest in ideas

related to resistance will get a lot from this introductory section of the book.

Leahy also takes the time to examine resistance to the procedures of CBT, which many readers will find very helpful. In fact, when most clinicians think of resistance, it is probably resistance to therapy processes and roles that they have in mind (e.g., not doing homework). For Leahy, this type of resistance is not the most interesting, though he acknowledges that it arises frequently and must be resolved. This section will probably be very helpful for students learning CBT, as these kinds of problems are encountered to a greater or lesser extent with almost every patient at some point in therapy. Those who supervise students in CBT may also get some ideas about how to help their trainees with individuals who are not cooperative with the therapy process.

The second part of the book tackles the seven different kinds of resistance. Here, the breadth of the book begins to grow, both in terms of scholarship and diversity of clinical issues. Leahy broadens the simple definition of resistance (i.e., a patient actively interfering with therapy) to include individuals who are difficult to treat, potentially chronic, interpersonally complex, or amotivated. This broadens the utility of the book, and at various points I envisaged different, albeit less catchy, titles like "Overcoming difficulties in cognitive therapy" or "Obstacles in cognitive therapy." In each subsequent chapter, Leahy first defines the specific type of resistance, providing examples, and then makes suggestions for how to overcome that particular issue, again using many examples and sample dialogues.

Taking each of the types of resistance in turn, Leahy relates validation resistance partly to philosophical perspective that highlights the need to express suffering and clinical approaches that focus on validating the person's experience as a central ingredient of therapy (e.g., Greenberg's EFT; Greenberg & Paivio, 1997). However, Leahy argues that the need for validation can be too much of a good thing. It may place therapist and patient at odds, with the therapist using strategies for change while the patient is busy looking for validation, and only validation. One of the interventions that is first introduced here and then repeated throughout this book is to first "lean into the problem." In other words, begin by pointing out to the patient that the need for validation is important, describe what works and doesn't work about validation, and slowly bring the patient around to want to also explore more active problem solving strategies.

The next chapter introduces self-consistency as a form of resistance. This concept is based on tried and tested social-psychological principles that have to do with the value of consistency within the self, even if that consistency might be maladaptive to an outside observer. Examples include staying in a bad relationship with dim prospects because a person has already invested time and emotion. In such situations the patient perceives the benefits of consistency as having more value than the benefits of change. Here, Leahy effectively uses analogies and metaphors from economics to help illustrate to the patient that there is more to be gained from change than from consistency, and he provides many questions to help lead the patient to this new conclusion.

The chapter on schematic resistance will seem familiar to readers of Jeffrey Young's (1999) work, and focuses particularly on schematic processes that "harden" or intensify maladaptive beliefs. In effect, the techniques Leahy describes are intended to first slow and then reverse the vicious cycles that usually lead to schema compensation and schema validation. One area that was not so clearly addressed in this chapter is how one differentiates normal schema work, which is probably part of treatment for nearly all individuals, from schema work in resistant individuals or in more challenging cases. Nonetheless, the chapter is one of the more comprehensive reviews of schema work that is currently available.

Leahy next describes two kinds of resistance related to moral reasoning. The first kind is related to excessive responsibility, an important component of obsessive-compulsive disorder (Rachman, 1993). In these cases, Leahy suggests that the moral world view of therapist and patient are not just different, but potential pitted against one another. Leahy explicitly differentiates between "good" and "bad" "shoulds", and suggests that it is important for therapists to respect and carefully consider the moral set of each patient. The second kind of resistance related to moral reasoning is victim resistance. Here, the patient is motivated by wanting to justify his or her victimhood, and may maintain negative emotions and behaviors as a way to repeatedly demonstrate the injustice he or she has suffered. An active CBT therapist might then be seen as trying to undo the victimhood, thus invalidating the patient, or taking up sides against the notion that the person has suffered an egregious injury.

The subsequent chapters on risk aversion and self-handicapping draw heavily on Leahy's recent work incorporating microeconomic models and theories of investment. The general idea here is that, for a variety

of reasons, patients develop a system of thinking about their world that does not result in extracting maximum reinforcement (or utility for those who recall Economics 101). Of course, using a model from one discipline (in this case economics) to understand issues in another discipline (psychopathology) tends to suggest that the "new" model has some advantages. However Leahy never convincingly makes the case that using economic models results in a different understanding of cognitive processes in depression. Nonetheless, this discussion has real value because it provides a new, rich vocabulary and easy to understand economic metaphors for working with patients. Using a combination of acknowledgement and validation, gentle questioning about the underlying logic of these pessimistic emotional-investment models, and gradual testing of alternative models, Leahy describes numerous ways to help patients overcome risk aversion and self-handicapping.

The final section of the book concerns countertransference issues, which to this point have not been well considered in the CBT literature. Certainly, other texts on CBT ask therapists to track and evaluate their own automatic thoughts about their patients and the therapy process. However, Leahy takes this many steps further by describing a taxonomy of countertransference, and then steps to modify these potential obstacles to an effective alliance. This section follows Leahy's own advice by first validating that certain kinds of countertransferences are common, understandable, and unavoidable, and then focusing on how these can be defused to put therapy back on track.

Overall, this book will be extremely useful for clinicians, students, and for those who train cognitive therapists. It is written in an engaging style, with many patient-therapist dialogues, and numerous examples that most therapists will relate to easily. Even after an initial reading, it will make a valuable reference, a book to be plucked from the shelf after a particularly difficult session or when one is left with a sense of being stuck with a particular case. Of course, as one of the first books in the area of resistance in CBT, there are unresolved issues, and plenty of new questions can be raised. For example, the notion of seven kinds of resistance has not been validated with research, and one is left wondering whether some of these dimensions of resistance are independent or inter-related. For example, validation resistance and victim resistance could be describing two different aspects of the same construct, and are at times are difficult to differentiate. Similarly, self-handicapping and risk aversion seem to have similar processes and outcomes for patients. Also, the author

makes only limited attempts identify certain diagnoses or diagnostic groups that may be more difficult, even though it seems likely that excessive responsibility would more commonly be associated with obsessive-compulsive disorder while self-handicapping and risk aversion seem, at their core, to be depression related processes. Despite these limitations, Leahy's work will be a much valued and practical addition to the bookshelf of CBT practitioners, and should be applauded for helping to establish resistance as an important area of inquiry on the CBT landscape. □

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Professional Development Institutes
DIVISION 12 SPONSORED CONTINUING EDUCATION WORKSHOPS
will be offered this year in Chicago, IL, Convention Center Room tba, August 20-21, 2002, just prior to the APA Convention. Chair: Stephen S. Ilardi, Ph.D.

Half-day Workshops

Tuesday, August 20: 4 CE Credits

- A. Advanced Competence: Ethics, Professional and Legal Issues for ABPP Preparation**
Norman Abeles, Ph.D.
- B. Family Therapy: Ethical and Legal Issues**
Robert Woody, Ph.D.
- C. Principles of Psychopharmacology for Psychologists**
Sheldon Whitten-Vile, M.D.
- D. Avoiding Malpractice Complaints**
Robert Woody, Ph.D.

Full-day Workshops

Tuesday, August 20: 7 CECredits

- E. Cognitive Behavioral Therapy for Generalized Anxiety Disorder**
Thomas D. Borkovec, Ph.D.
- F. Principles of Neuropsychological Assessment**
Paul F. Malloy, Ph.D.

Full-day Workshops

Wednesday, August 21: 7 CE Credits

- G. Making ESTs Fit the Demands of Clinical Care**
Lawrence E. Beutler, Ph.D.
- H. Principles of CBT**
Jacqueline B. Persons, Ph.D.
- I. Multi-modal Treatments of ADHD**
William E. Pelham, Jr., Ph.D.
- J. Positive Psychology in Clinical Practice**
C. R. (Rick) Snyder, Ph.D.
- K. Child and Adolescent Anger Management**
Eva L. Feindler, Ph.D.
- L. Neuroimaging for Non-Radiologists**
Paul F. Malloy, Ph.D.
- M. American Psychological Association of Graduate Students—Establishing a Private Practice**

SATURDAY HALF-DAY WORKSHOP, AUGUST 24

1:30pm-5:30pm

4 CE Credits

***Location tba**

Cost \$95

- N. Dialectical Behavior Therapy for Borderline Personality Disorder**, Marsha Linehan, Ph.D.

Members:

\$170 full day, \$85 half day

Non-members

\$190 full day, \$95 half day

Student Members:

\$95 full day, \$50 half day

Student Non-members:

\$115 full day \$60 half day

Limit of 10 Student Spaces Per Workshop

INFORMATION:

Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082.

Tel. (303) 652-3126 Fax (303) 652-2723 Email: div12apa@attbi.com

Prevention of Recurrent Depression with Mindfulness-Based Cognitive Therapy

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University of Toronto

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Unipolar Depression—A Chronic, Recurrent Condition

Depression was once thought to be a self-limiting and discrete disorder. The view was taken that once a person recovered from their depression, there was little chance they would become depressed again. Understandably, this led to an emphasis on treatments designed to alleviate the symptoms associated with the acute episode. As further evidence has accumulated, however, the picture of the course taken by this disorder has started to change. For example, recent data indicate that close to 50% of patients who recover from an initial episode of depression will have at least one subsequent depressive episode (Paykel et al., 1995), and that those patients with a history of two or more past episodes will have a 70 to 80% likelihood of recurrence in their lifetimes (Judd, 1997). Depression, therefore, is better viewed as a disorder with a high likelihood of returning to people's lives, rather than being eliminated at first contact.

Since the clinical management of depressed patients had emphasized symptom reduction within the episode as its primary goal, little attention has been paid to strategies for reducing the risk of recurrence post-recovery, or towards measures capable of signalling that risk in recovered patients. Such knowledge may help to shorten the span of depression, which is potentially lifelong, and help to reduce the social and familial costs of depression, which have been estimated as comparable to or worse than major chronic medical conditions (Wells, Sturm, Sherbourne & Meredith, 1997).

Cognitive Vulnerability to Depressive Relapse

Many women and men think in an unduly self-critical and pessimistic fashion when they are in an episode of depression but no longer do so once their depression lifts. There is now good evidence to suggest that these patterns of negative thinking can be 'reactivated' in certain circumstances and that when this occurs recovered depressed patients are at increased risk for relapse.

The work of Teasdale and others has shown that a general lowering of mood can be a powerful trigger in reactivating these depressive thinking styles (the differential activation hypothesis—Teasdale, 1983). Using methods developed by cognitive psychologists to study the reciprocal relationship between cognition and emotion, Teasdale found that sad moods were likely to re-activate thinking styles that had been associated with previous sad moods. He also noted that these thinking styles would differ from one individual to another, depending on an individual's past experiences. Whereas most people might be able to ignore the occasional sad mood, in those who have been previously depressed just a little lowering of mood might bring about a large and potentially devastating influx of negative thought patterns. What is especially damaging is that these thoughts patterns often involve global, negative judgments about the self such as "I am worthless" and "I am stupid".

Once reactivated, these thinking patterns, which often involve ruminatively dwelling on current and past difficulties, can be an important factor making the person more depressed. The person may then spiral down into a process which, if not detected and 'caught' early on, can lead to relapse to a full blown clinical depression. Drawing on this research, and on methods for training mindful awareness that have been in use for more than two thousand years, we developed a psychological intervention aimed at preventing depressive relapse. This treatment helps patients learn skills to detect when their thoughts and feelings are

About the Author

Zindel Segal holds the Morgan Firestone Chair in Psychotherapy at the University of Toronto. He is Head of the Cognitive Behaviour Therapy Unit at the Centre for Addiction and Mental Health and a Professor of Psychiatry and Psychology in the Department of Psychiatry at the University of Toronto. He is also the Head of the Psychotherapy Program for the Department of Psychiatry. Dr. Segal is a Founding Fellow of the Academy of Cognitive Therapy. *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* was published by Guilford Books in 2002 and is co-authored by Mark Williams and John Teasdale.

becoming more negative and to take action to 'nip in the bud' the spirals of negative thinking that may lead on to relapse.

Mindfulness-Based Cognitive Therapy (MBCT)

Mindfulness-Based Cognitive Therapy is a preventative intervention that I and my colleagues, Mark Williams and John Teasdale, developed to address recovered depressed patients' heightened risk for relapse. The treatment is based on an integration of aspects of cognitive therapy for depression (CT) (Beck et al., 1979) with components of the mindfulness-based stress reduction program (MBSR) developed by Kabat-Zinn and colleagues (Kabat-Zinn, 1990). Unlike CT, there is little emphasis in MBCT on changing the *content* of thoughts; rather, the emphasis is on changing *awareness* of and *relationship* to thoughts, feelings and bodily sensations. Aspects of CBT included in MBCT are primarily those designed to facilitate "decentered" views such

"A core feature of the program involves facilitation of an aware mode of being, characterized by freedom and choice"

as "Thoughts are not facts" and "I am not my thoughts." Unlike MBSR, which is a generic program applicable to a wide range of problems, MBCT is specifically designed to achieve a particular goal for patients with a specific clinical problem; the prevention of future episodes

of depression in recurrently depressed patients currently in recovery. This degree of specificity allows MBCT, like CBT, to customize aspects of the program towards the details of a particular clinical problem. For example, decentering can be facilitated specifically for negative depressive thoughts by providing participants, as a group, with a list of the most frequently observed negative automatic thoughts, and allowing them to recognize that their own personal "top ten" negative thoughts are actually very similar to those of other group members and to the findings reported by systematic research.

MBCT is designed to teach patients in remission from recurrent major depression to become more aware of, and to relate differently to, their thoughts, feelings, and bodily sensations, e.g., relating to thoughts and feelings as passing events in the mind, rather than identifying with them or treating them as necessarily accurate read-outs on reality. The program teaches skills that allow individuals to disengage from habitual ("automatic") dysfunctional cognitive routines, in particular depression-related ruminative

thought patterns, as a way to reduce future risk of relapse and recurrence of depression.

Because, unlike CBT, there is little explicit emphasis in MBCT on changing the content or specific meanings of negative automatic thoughts, in MBCT training can occur in the remitted state, using everyday experience as the object of training.

The MBCT Program

MBCT is a manualized group skills training program (Segal, Williams & Teasdale, 2002) that draws heavily on the MBSR program developed by Kabat-Zinn and colleagues (Kabat-Zinn, 1990), and integrates it with compatible elements of CT for depression (Beck et al., 1979). After an initial individual orientation session, the MBCT program is delivered by an instructor in eight weekly two-hour group training sessions involving up to 12 recovered recurrently depressed patients. During that period, the program includes daily homework exercises. Homework invariably includes some form of guided (taped) or unguided awareness exercises, directed at increasing moment-by-moment non-judgmental awareness of bodily sensations, thoughts and feelings, together with exercises designed to integrate application of awareness skills into daily life. Key themes of the program include empowerment of participants and a focus on awareness of experience in the moment. Participants are helped to cultivate an open and acceptant mode of response, in which they intentionally face and move in to difficulties and discomfort, and to develop a "decentered" perspective on thoughts and feelings, in which these are viewed as passing events in the mind.

A core feature of the program involves facilitation of an aware mode of being, characterized by freedom and choice, in contrast to a mode dominated by habitual, overlearned "automatic" patterns of cognitive affective processing. For patients, this distinction is often illustrated by reference to the common experience, when driving on a familiar route, of suddenly realizing that one has been driving for miles "on automatic pilot," unaware of the road or other vehicles, preoccupied with planning future activities or ruminating on a current concern. By contrast "mindful" driving is associated with being fully present in each moment, consciously aware of sights, sounds, thoughts and body sensations as they arise. When mindful, the mind responds afresh to the unique pattern of experience in each moment, rather than reacting "mindlessly" to fragments of a total experience with old, relatively stereotyped, habitual patterns of mind. Increased mindfulness allows early detection of relapse-related

patterns of negative thinking, feelings, and body sensations, so allowing them to be "nipped in the bud" at a stage when this may be much easier than if such warning signs are not noticed or are ignored. Further, entering a mindful mode of processing at such times allows disengagement from the relatively "automatic" ruminative thought patterns that would otherwise fuel the relapse process. Formulation of specific relapse/recurrence prevention strategies (such as involving family members in an "early warning" system, keeping written suggestions to engage in activities that are helpful in interrupting relapse-engendering processes, or to look out for habitual negative thoughts) are also included in the later stages of the initial seven week phase.

Following the initial phase of eight weekly group meetings, follow-up meetings are scheduled at intervals of one, two, three and four months.

"Increased mindfulness allows early detection of relapse-related patterns of negative thinking, feelings, and body sensations..."

episodes (who made up 77% of the total sample), MBCT significantly reduced relapse compared to treatment as usual. Of these patients, those who simply continued with the treatment that they would normally receive showed a 66% relapse rate over the total 60 week study period, whereas those who received MBCT showed a relapse rate of 37%. In patients with only two past episodes (who made up 23% of the total sample), there was no difference in relapse rates between patients receiving MBCT and treatment as usual. In other words, the beneficial effects of MBCT were shown only in the patients with more extensive histories of depression.

To our knowledge, the results of our trial provide the first demonstration that a group-based psychological intervention, initially administered in the recovered state, can significantly reduce risk of future relapse/recurrence in patients with recurrent major depression. This adds to the work of Fava and colleagues (Fava, Grandi, & Zielezny, 1996) who have demonstrated the efficacy of a form of individual cog-

Evaluation

In order to evaluate this intervention we conducted a 3-center clinical trial in which 145 formerly depressed patients received either MBCT or Treatment as Usual and were followed longitudinally for a one year period. Our findings indicated that in patients with three or more past depressive

nitive therapy for depression they have developed that focuses on enhancing well-being rather than targeting negative aspects of experience. It is administered to recovered patients as their antidepressant medication is gradually withdrawn. Their results show that it can also substantially reduce future risk of relapse and recurrence. Findings such as these suggest a role for sequencing the administration of treatments to the different phases of depression. For example, what are the efficacy and cost implications of allowing pharmacological treatment for the acute episode to take its course, with the later introduction of psychological interventions designed to prevent relapse? I would hope that questions such as these and others will dominate this area in the coming years. □

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Call for Nominations for Awards of Year 2002

The Society for General Psychology, Division One of the American Psychological Association, announces its Year 2002 awards competition.

The William James Book Award is for a recent book that serves to integrate material across psychological subfields or to provide coherence to the diverse subject matter of psychology. Other award programs include the competition to deliver the Year 2002 Arthur W. Staats Lecture for Unifying Psychology, the Ernest R. Hilgard Award for a Career Contribution to General Psychology, and the George A. Miller Award for an Outstanding Recent Article in General Psychology. The awardees will receive a certificate and a cash prize of \$1000 for each Award. For each of these awards, the focus is on the quality of the contribution and the linkages made between the diverse fields of psychological theory and research.

The Society for General Psychology encourages the integration of knowledge across the subfields of psychology and the incorporation of contributions from other disciplines. The Society is looking for creative syntheses, the building of novel conceptual approaches, and a reach for new, integrated wholes. A match between the goals of the Society and the nominated work or person will be an important evaluation criterion.

The Staats Award has a unification theme, recognizing significant contributions of any kind that go beyond mere efforts at coherence and serve to develop psychology as a unified science. The Staats Lecture will deal with how the awardee's work serves to unify psychology. There are no restrictions on nominees, and self-nominations as well as nominations by others are encouraged for these awards.

Winners will be announced at the Fall convention of the American Psychological Association the year of submission.

Winners will be expected to give an invited address at the subsequent APA convention and also to provide a copy of the award address for inclusion in the newsletter of the Society.

For the Hilgard Award and the Staats Award, nominators are asked to submit the candidate's vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award and supporting letters from others who endorse the nomination.

For the Miller Award, nominations should include: vitae of the author(s), four copies of the article being considered (which can be of any length but must be in print and have a post-1996 publication date), and a statement detailing the strength of the candidate article as an outstanding contribution to General Psychology.

Nominations for the William James Award should include three copies of the book (dated post-1996 and available in print); the vitae of the author(s) and a one-page statement that explains the strengths of the submission as an integrative work and how it meets criteria established by the Society. Text books, analytic reviews, biographies, and examples of applications are generally discouraged.

All nominations and supporting materials for each award must be received on or before April 15, 2002.

Nominations and materials for all awards and requests for further information should be directed to:

General Psychology Awards

c/o Lynn Hasher
Department of Psychology
University of Toronto
Toronto, ON M5S 3G3
Canada.
Phone: 416-978-7620
Fax: 416-978-4811
E-mail: hasher@psych.utoronto.ca

ABBREVIATED MINUTES: SOCIETY OF CLINICAL PSYCHOLOGY BOARD OF DIRECTORS MEETING OCT 6-7, 2001, SAVANNAH, GEORGIA



President Karen Calhoun called the meeting to order at 8:30AM, 10/6/01.

Board meetings for 2002:

Larry Beutler announced the following schedule:

1. Coconut Grove, Miami, Florida, on January 3-5, 2002, with joint sessions (half day) and Saturday night dinner with Divisions 53 and 54.
2. Atlanta, Georgia on June 7-9, (with intention to end on Saturday night)
3. Seattle, Washington, Mayflower Hotel, on October 19-20. (This was later changed to St. Louis, Missouri). The issue of cost savings by reducing meeting days and finding less expensive locales and accommodations prompted changes.

Presidential Appointments:

Larry Beutler announced his list of appointments for 2002:

Program committee—Tim Anderson, Chair.
PDI—Stephen Ilardi, Chair.
Finance Committee—Charles Spielberger, Chair.
Awards—Karen Calhoun, Chair.
Nominations & Elections—Karen Calhoun, Chair.
Publications—Tom Ollendick, Chair.
Governance—Nadine Kaslow, Chair.
Science/Practice—John Weisz, Chair.
Fellows—John Robinson, Chair.
Membership—Larry Siegel, Chair.

Program:

Two tracks are being developed for our 5 division cluster. 1 = trauma, 2 = empirically supported treatments. Tim Anderson is the cluster chair for our group of divisions. The board commended Tim Anderson for his excellent work.

Publication Committee:

Because the contract with Oxford, the publisher of *Clinical Psychology: Science and Practice* is up in 2005 Division 12 is considering alternatives. David Barlow finishes his term as editor of CPSP in 2003 so the Division needs to identify a new editor by June, 2002.

Motion: Approve and support the search committee of Steve Ilardi, Michelle Cooley-Quille, Phillippe Cunningham, Larry Beutler and Karen Calhoun. **Passed.**

The Clinical Psychologist (TCP):

Paul Rokke reports that the Journal is hooked into Highwire and can look at other journals. It is on Medline and has an electronic table of contents with abstracts. Paul was given an ovation for his work on TCP. The division's web site received 12,000 hits in a year.

Motion: that Steve Ilardi investigate and report to the board on new products related to website and videotapes, and that the division be able to draw on reserves for such product investments. **Passed.**

Section Reports:

The Section Caucus had some concerns about planning their convention programs without knowing the allotment of hours that may be reduced due to the Division's reduction in hours allotted for the shorter convention time in Chicago.

Motion: that a section on Assessment Psychology be added to the Division and numbered Section 9. **Passed.**

In response to Section 3 requests regarding support of their seven recommendations on prescription privileges for psychologists, the Board asked Bob Klepac and Larry Beutler for more data.

New membership category:

Larry Beutler presented a by-law change so that Division 12 members who are not APA members can join as affiliates.

Motion: There will be two ways to be an affiliate member (international and non-APA members). **Passed.**

Budget Requests Approved for 2001:

TCP: \$1000. COS membership, \$150. Budget requests Approved for 2002: \$5000 for Science & Practice Committee. \$1000 for presidential initiatives. \$1000 for Multicultural Conference. Budget deficit is \$24,000 at this point.

Respectfully submitted,
Annette M. Brodsky, Ph.D.,
Secretary-Elect

EARLY CAREER AWARD FOR OUTSTANDING CONTRIBUTIONS TO PRACTICE IN THE FIELD OF CHILD MALTREATMENT

The Section on Child Maltreatment of Division 37 (Child, Youth, and Family Services) of the American Psychological Association is proud to announce the establishment of an Early Career Award program.

This year, nominations are sought for an Early Career Award for Practice. The award will be made in 2002. Self-nominations are welcome.

ELIGIBILITY

Nominees should be investigators who have made substantial contributions to practice relevant to child maltreatment within eight years of receiving a terminal degree (e.g., Ph.D., J.D., D.S.W., or M.S.W.) and who have demonstrated the potential to continue such contributions. Nominees need not be current Section on Child Maltreatment members.

TO NOMINATE

Send 4 copies of:

- 1) A cover letter outlining the nominee's accomplishments to date and anticipated future contributions. This letter should describe the nominee's major accomplishments related to the field of child maltreatment and how the nominee's work has had an impact on the field;
- 2) The nominee's current curriculum vitae;
- 3) One letter of support; and
- 4) If possible, other relevant supporting material, as appropriate (e.g., no more than two articles authored by the nominee).

NOMINATION DEADLINE

Postmarked by March 15, 2002.

SEND NOMINATIONS OR DIRECT QUESTIONS TO:

Gail S. Goodman
Department of Psychology
University of California
One Shields Avenue
Davis, CA 95616
(530) 752-6981
ggoodman@ucdavis.edu

THE SECTION ON CHILD MALTREATMENT'S 2002 DISSERTATION AWARD

The Section on Child Maltreatment (Section 1 of Division 37, APA) announces its third annual dissertation award. A \$400 prize will be awarded to one successful graduate student applicant to assist with expenses in conducting dissertation research on the topic of child maltreatment.

Applicants are requested to submit:

- 1) a letter of interest, indicating how the applicant would use the award funds toward the completion of the dissertation research,
- 2) a 100 word abstract, and
- 3) a five page proposal summarizing the research to be conducted.

Please submit applications by April 1, 2002, to:

Dr. Patricia Hashima
Institute on Family and Neighborhood Life
Clemson University
158 Poole Agricultural Center
Clemson, SC 29634-0132
(864) 656-6711 or 656-6271

Applicants will be notified of the decision in mid-June.

The award will be presented at the annual meeting of the American Psychological Association in Chicago, Illinois, August 22-25, 2002.

POSITION OPENING

Postdoctoral Position Available in Rural, Northeastern Utah

The Ashley Family Clinic (AFC)—a private mental health clinic with a broad referral base, located in Vernal, Utah—and the Northeastern Counseling Center (NCC)—the Mental Health and Substance Abuse Local Authority for Uintah, Duchesne, and Daggett counties—are co-recruiting for a psychologist. This psychologist will share time between the two settings. The base salary will be approximately \$40,000 per year plus health insurance. Private practice work is likely to generate additional income. We are looking for a clinical psychologist experienced in working with children, adolescents, and families, and capable of performing psychological assessment as well as treatment. This position might be ideal for a postdoctoral resident. Supervision and training will be provided. Training will focus on performing psychological evaluation with a variety of populations, including forensic evaluations for the District Court. The majority of our patients are children, adolescents, and families. Training will also focus on individual and family psychotherapy with this population. We make use of (and are reimbursed for) both short term and long-term treatments. Vernal is in Uintah County, which is a Health Professional Shortage Area, and qualifies for the National Health Service Corps loan repayment program as well as State rural health provider funding programs. This is a beautiful area in which to live. Vernal is located just below the High Uintahs mountain range, 20 minutes from Dinosaur National Monument and 45 minutes from Flaming Gorge National Recreation Area. Recreational activities include cross-country skiing in the winter, and backpacking, kayaking, and mountain biking during the warmer months.

If interested please call Dan Goodkind, Ph.D., at (435) 781-2524 or email Dr. Goodkind at dgkind@yahoo.com

INSTRUCTIONS FOR ADVERTISING

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).

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Instructions to Authors



The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Division 12 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, clinical practice, training, and public policy. Also included will be material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. Examples of submissions include: position papers, conceptual papers, data-based surveys, and letters to the editor. 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 Fifth Edition of the Publication Manual of the American Psychological Association (2001). It is preferred that a single electronic copy of a submission be sent as an attachment to e-mail. Alternatively, send four copies of manuscripts along with document file on computer disk for review. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. The Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries may be made to the editor:

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