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PRESIDENT'S COLUMN

The Case for Prescription Privileges

Diane J. Willis

In the Winter 2003 issue of *The Clinical Psychologist* (TCP) my Presidential Column focused on the over-medication of young children and how, as psychologists, we have treatments that are effective in remedying many behavioral and social-emotional problems (Willis, 2003). Hopefully, psychologists would not be guilty of resorting to medication as a first approach, while considering behavioral or other treatments second. I also mentioned that as a postdoctoral fellow I was permitted to prescribe for my patients. Given the current debate about prescription privileges among some of our members in Division 12, I want to review the some of the pertinent issues and the historical context regarding prescription privileges.

The debate about whether psychologists should be allowed to prescribe is intense, with strong feelings on both sides. While the debate will likely continue for some time, it is my hope that we can disagree in a constructive, respectful manner rather than a negative, destructive manner. In my own practice as a consultant at a rural Indian Health Service clinic, I have been frustrated at times with the inability to obtain medications that, in my opinion, were absolutely necessary for a my patients. These circumstances have been fueled by the scarcity of psychiatrists, the long wait for services, and the rationing of services so that only the most severe or emergent cases get seen for medication. In my experience, after finally finding a physician who was willing to do his own evaluation of the patients and prescribe medication, the behavioral changes in many of my patients have been dramatic. Thus, the importance of access to mental health professionals who can prescribe appropriately is clear. On the other hand, I have also seen numerous patients who have been prescribed medications for depression, but for whom depression was related to their distress over conditions of poverty, domestic violence, and concerns about being evicted or not having food for their children. When I helped these patients get into a shelter, or provided assistance in getting food stamps and housing subsidies, their depression lifted. Was medication the answer for these patients? In my experience it was not, but it was probably the most expedient course of action for the psychiatrist. In these cases, I have to question whether a psychologist, who hopefully would examine all aspects of a patient's situation, might make a better choice of treatment.

Psychologists have been working on the issue of prescription privileges for years, and we have all had opportunities to disagree, approve, modify, or otherwise provide input on the final document proposed by APA Council. The issue has been widely publicized and discussed, and no efforts have ever been made to be less than open. The identifiable beginning of psychology's pursuit of prescriptive authority is Senator Daniel Inouye's 1984 address to the Hawaii

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Psychological Association. In that address, Senator Inouye challenged psychology to obtain prescriptive authority as a way to improve access to comprehensive mental health care—particularly for underserved populations. Following Senator Inouye's challenge, debates began in the profession about whether psychology should pursue prescriptive authority and, if so, the nature and extent of the training needed to ensure that psychologists would be safe and effective prescribers.

The first opportunity for psychology to explore the nature and extensiveness of training needed for psychologists to become safe and effective prescribers was the Department of Defense Psychopharmacology Demonstration Project (DoD PDP). In 1989, Congress asked the Department of Defense to begin a demonstration project to determine whether licensed, practicing psychologists could be trained to prescribe safely and effectively. Coinciding with the DoD PDP in the late 1980s, there was growing interest in the role of psychotropic medications for childhood disorders, such as Attention Deficit Hyperactivity Disorder. At that time, Dr. Russell Barkley was appointed to chair an interdivisional Task Force on the appropriate role of clinical child psychologists in the prescribing of psychoactive medication for children. The Task Force report provided a scholarly review of this issue, and was published as a special supplement of the Journal of Clinical Child Psychology (JCCP; Barkley, et al., 1990) to facilitate wide dissemination. In March 1990, I provided testimony before the Committee on Interior and Insular Affairs on the subject of prevention of child abuse on Indian reservations. Given that psychologists within the Indian Health Service (IHS) were already prescribing, I concluded my testimony with the statement that psychologists need to be able to prescribe. In a 1991 JCCP article, DeLeon, Folen, Jennings, Willis, and Wright made a case for prescription privileges as a logical evolution of professional practice. Also in 1991, the DoD PDP began training military psychologists to prescribe psychotropic medications. By the time the demonstration project was brought to a close, it was clear that psychologists could be trained to prescribe safely and effectively while maintaining their identity primarily as psychologists. The PDP curricula were modified repeatedly as the demonstration project sought to focus in on the particular knowledge and training that psychologists would need (Newman, 2001). As a result of their experience, the graduates of the

PDP have been actively involved with APA to develop the three levels of model psychopharmacology training, as well as the College of Professional Psychology's Psychopharmacology Examination for Psychologists (PEP). The unique training and experience of these graduates has informed the development of APA's recommendations and structures to guide psychology towards safe and effective prescribing.

From the late 1980s until its adoption by APA Council as policy of the association in 1995, prescriptive authority for psychologists was explored by several groups within APA. The first group to consider the issue was the Board of Professional Affairs (BPA). As a result of their 1989 retreat to consider the issue, BPA asked the Board of Directors to establish a task force for further exploration of the potential for psychology to pursue prescriptive authority. The Board of Directors then turned to Council of Representatives, asking that Council support and fund such a task force. The Ad Hoc Task Force on Psychopharmacology was established in 1990 and this group made their report to Council in 1993. The Ad Hoc Task Force, comprised of psychologists from the science, education, and practice communities, concluded that psychologists with the ability to utilize psychopharmacological interventions had the potential to dramatically improve patient care. Also included in the report were outlines for three levels of psychopharmacology education for psychologists. The Board of Educational Affairs, at the direction of Council, created task forces to develop curricula for Level 1 and Level 2 training in psychopharmacology.

The Committee for the Advancement of Professional Practice (CAPP) formed a task force to develop model prescriptive authority legislation as well as recommendations for Level 3 psychopharmacology education (at the independent practice level) to make certain that the psychologists who sought prescriptive authority would be safe and effective prescribers. The CAPP Task Force on Prescription Privileges, including a graduate of the DoD PDP, drew from the experience of the PDP, as well as the curriculum developed by the California Blue Ribbon Panel (this Blue Ribbon Panel was composed of nationally recognized health professionals and scientists with expertise in medicine, psychiatry, nursing, pharmacy, neuroscience, psychology and public policy) to create an outline of a curriculum for psychologists pursuing prescriptive authority. The goal of this outline was to ensure that psychopharmacology training programs would provide psychologists with the core content knowledge areas necessary for safe and effective prescribing, while allowing the programs the flexibility to develop as the field changes.

The year 1995 was pivotal within APA regarding the issue of prescription privileges. At the August meeting, the Council of Representatives voted to adopt prescriptive authority for appropriately trained psychologists as a policy of the APA (APA Council of Representatives, 1995). At the direction of the Council, a task force was formed with representatives from APA's Board of Scientific Affairs, Board of Educational Affairs, and the Committee for the Advancement of Professional Practice to develop model legislation and a model curriculum for independent practice. This task force, working from the drafts created by the CAPP Task Force, created the "Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges" and the "Model Legislation for Prescriptive Authority," which were adopted by the Council of Representatives in 1996.

Since then, a number of programs have developed to train psychologists in psychopharmacology, using the Recommended Training as a basis for their curricula. The Recommended Training requires a minimum of 300 contact hours of instruction in five core content areas: (1) neurosciences; (2) pharmacol-

APA Apportionment!

APA sent out their apportionment letter out October 15th.
Your vote is vital to the Division. We urge you to return your apportionment ballot this year with a strong vote for Division 12 representation. The Society advocates practice, education, and research. Please assist us to increase our proactive impact. In order to allow the Division to be maximally effective, please allocate as many of your 10 votes to Division 12 as you can.

Above all, remember to return your ballot.

ogy and psychopharmacology; (3) physiology and pathophysiology; (4) physical and laboratory assessment; and (5) clinical pharmacotherapeutics. This classroom work is one part of the required training. Clinical psychologists seeking prescription privileges are also required to have direct clinical responsibility for at least 100 patients under the supervision of a qualified practitioner as part of their clinical requirements. Many of these training programs have continued APA's tradition of tapping into the unique resources provided by the graduates of the DoD Psychopharmacology Demonstration Project. The psychologists trained to prescribe in the military have acted as curriculum developers, advisors, faculty, and guest lecturers.

In summary, the case for prescription privileges has an almost 20-year history whereby input has been obtained from scientists, practitioners, professors, and others within the leadership (e.g., Boards, Committees, Council of Representatives) of APA. While some of our members are opposed to psychologists having prescription privileges, most of us are supportive of this right. Given that our differences of opinion, at times, seem complex, there is the need for us to be imaginative, receptive to new ideas and new ways for our graduates to practice in a more comprehensive manner, and to have a willingness to examine issues on their merit. If our minds are immersed in ideology or dogma, there is a risk that we become resistant to fact and reason. This can lead to confusion, misjudgment, and simply maintaining the status quo. As a senior psychologist, I will not likely prescribe for my patients, but it is a privilege I would want for the next generation.□

References

APA Council of Representatives. (1995). Recommended postdoctoral training in psychopharmacology for prescription privileges. *Council Agenda Book*. Washington, DC: American Psychological Association.

Barkley, R.A., Barclay, A., Conners, C.K., Gadow, K., Gittelman, R., Sprague, R., & Swanson, J. (1990). Task force report: The appropriate role of clinical child psychologists in the prescribing of psychoactive medication for children. *Journal of Clinical Child Psychology, 17*, 14-24.

DeLeon, P.H., Folen, R.A., Jennings, F.L., Willis, D.J., & Wright, R.H. (1991). The case for prescription privileges: A logical evolution of professional practice. *Journal of Clinical Child Psychology, 20*, 254-267.

Newman, R. (February, 2001). Testimony in support of proposed Senate Bill 584, An Act Concerning Prescriptive Authority for Psychologists. Connecticut General Assembly, Public Health Committee, Hartford, CT.

Willis, D.J. (Summer, 2003). The drugging of young children: Why is psychology mute? *The Clinical Psychologist, 56(3)*, 1-3.

Division 12 Awards Presented at APA

Drs. Lauren Alloy (left) and Lyn Abramson (not in photo) receive the Award for Distinguished Scientific Contributions to Clinical Psychology (presented by Dr. Nadine Kaslow at the APA Convention in Toronto)

Dr. Gerald Koocher (left) is presented with the Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology (presented by Dr. Diane J. Willis at the APA Convention in Toronto)

Dr. Michael Addis (left) is presented with the David Shakow Award for Early Career Contributions (presented by Dr. Diane J. Willis at the APA Convention in Toronto)

Dr. Julia Kasl-Godley (left) receives the Theodore H. Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology (presented by Dr. Nadine Kaslow at the APA Convention in Toronto)

Dr. Stanley Sue received the first Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology.

Technology Meets Psychology: Integrating Virtual Reality Into Clinical Practice

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Anxiety disorders are characterized by excessive worry, fear and nervousness, and are associated with avoidance of the emotions or stimuli that trigger the anxiety and fear. Exposure therapy, which encourages patients to confront their feared memories and situations in a therapeutic manner, has been used with great success for many years to treat a variety of disorders, including phobias, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (Barlow, 2002). Typically, exposure is conducted in vivo (i.e., exposure to feared objects or situations, in real life), although exposure may also be to feared imagery, or to anxiety provoking physical sensations, such as sweating or a racing heart.

In the mid 1990s, a new modality for conducting exposure therapy was introduced. Virtual reality (VR) offers a human-computer interaction paradigm in which users are no longer simply external observers of images on a computer screen, but are active participants within a computer-generated three-dimensional virtual world. The user experiences multisensory stimuli (e.g., visual, auditory, kinesthetic) by wearing a helmet-like head-mounted display consisting of display screens for each eye, earphones, and a head-tracking device. The head-tracking device provides head location and/or orientation information to a computer graphics workstation that computes visual images on the display screen consistent with the direction in which the user is looking within the virtual environment.

VR technology has revolutionized exposure therapy because of its immersive properties, which give the user a sense of presence or immersion in the virtual environment. In the case of use with persons with anxiety disorders, this is achieved through the integration of real-time 3-dimensional animation and video, body tracking devices, visual displays, and other sensory input devices to create an environment that elicits common physical sensations associated with fear and anxiety, including sweating, "butterflies," and "weak knees" (Hodges et al., 1995). Other techniques used to enhance immersive properties include manipulation and control of movement through a hand-held puck, similar to a joystick. This feature has been incorporated into the Virtual Vietnam environment to move forward and backward and navigate around the virtual clearing. In the Virtual Heights environment, the puck opens and closes elevator doors and allows the user to ascend and descend floors. The puck is also used to scroll forward or backward through a speech text presented on a virtual podium in front of a Virtual Audience. Evoking a sense of presence in a virtual situation is one of the essential ingredients of the success of conducting VR exposure therapy.

Another revolutionary aspect of VR is the control given to the therapist in delivering the treatment. Because exposure therapy uses a hierarchical framework, VR programs are designed with the capacity to increase difficulty as the client feels ready to confront the situation. This includes such features as experiencing an airplane taxiing before taking off, flying in good weather before flying in turbulence, hearing jungle noises in a Virtual Vietnam simulation before hearing combat sounds, presenting to an interested audience before presenting to one that is bored, and visiting a lower floor in a building before the top floor.

Research Outcomes Using VR

Early research on VR exposure therapy was mainly in the form of case studies in which VR was used to treat a variety of anxiety disorders, including claustrophobia (Botella et al., 1998), fear of spiders (Carlin, Hoffman, & Weghorst, 1997), acrophobia (Choi, Jang, Ku, Shin, & Kim, 2001; Rothbaum et al., 1995a), flying phobia (Rothbaum, Hodges, Watson, Kessler, & Opdyke, 1996; Smith, Rothbaum, & Hodges, 1999) and social anxiety (Anderson,

Rothbaum, & Hodges, in press). Another case study treated a Vietnam veteran with PTSD with a virtual Vietnam environment (Rothbaum et al., 1999). Most recently, VR exposure was effective in reducing PTSD symptoms in a survivor of the 9/11 World Trade Center attacks (Difede & Hoffman, 2002). In each of these reports, brief and focused treatment was deemed successful based on decreased self-report of anxiety and greater ease of confronting a previously fearful object or situation.

Several case studies have demonstrated the benefit of VR as a distracter for pain management. One research group found that VR was somewhat successful in relieving children's anxiety associated with chemotherapy (Schneider & Workman, 1999). A second case study compared VR distraction with a video game in three adolescent burn patients during wound care procedures (Hoffman, Doctor, Peterson, Carrougher & Furness, 2000). The third case study involved a pediatric oncology patient followed over four consecutive appointments for medical procedures (Gershon, Zimand, Lemos, Rothbaum, & Hodges, 2003). VR was also shown to distract from painful dental procedures for two adult patients with periodontitis (Hoffman, Garcia-Palacios, Patterson, Jensen, Furness, & Ammons, 2001). These case studies demonstrated that patients reported less pain and lower anxiety ratings during VR distraction and Hoffman et al., (2000) found that the patients needed less pain medication.

These case studies were followed by open clinical trials without comparison groups for combat-related PTSD (Rothbaum, Hodges, Ready, Graap, & Alarcon, 2001), social anxiety (Anderson, Rothbaum, Hodges, & Zimand, 2003), body image dissatisfaction (Riva, Bacchetta, Baruffi, Cirillo, & Molinari, 2000), acrophobia (Emmelkamp, Bruynzeel, Drost, & van der Mast, 2001), and most recently, post-earthquake traumatic stress (Basoglu, Livanou, & Salcioglu, 2003). In the Rothbaum et al., (2001) study, ten Vietnam veterans completed a course of VR exposure therapy using two VR war environments: a virtual clearing surrounded by jungle and a virtual Huey helicopter, in which the therapist controlled various visual and auditory effects (e.g., rockets, explosions, day/night, yelling). After an average of 13, 90-minute exposure therapy sessions delivered over five to seven weeks, there was a significant reduction in PTSD and related symptoms. In another open clinical trial for individuals meeting criteria for social anxiety with a prominent fear of public speaking, Anderson et al. (2003) treated ten individuals who received eight therapy sessions, including four sessions of anxiety management training and four sessions of exposure therapy, according to a standardized treatment manual. During VR exposure therapy, participants were presented first with a small, and then a large group virtual audience, consisting of video of actual people embedded within a virtual auditorium environment (see Figure 1). Results indicated that treatment was successful as measured by decreases on self-report measures of public speaking anxiety from pre- to post-treatment,

Figure 1: Photographic image of the Virtual Audience environment.

decreases on ratings of anxiety, and increases on ratings of performance from the pre- to post-treatment on a behavioral avoidance test. Three-month follow-up data showed that treatment gains were maintained. These preliminary findings suggest that VR may be a promising component for exposure therapy within a comprehensive treatment.

Although these results are positive, case studies are vulnerable to threats to internal validity (Cook & Campbell, 1979), and uncontrolled clinical trials have limited generalizability. As such, in order to make any claims of success regarding this procedure, larger randomized clinical trials are needed, with controlled comparison groups and long-term follow-up data.

The first published controlled study used VR exposure therapy compared to wait list control for the treatment of acrophobia (Rothbaum et al., 1995b). The treatment group received seven weekly individual treatment sessions consisting of exposure to virtual footbridges, virtual balconies, and a virtual elevator (see Figure 2) presented according to each participant's self-rated fear hierarchy. Participants were allowed to progress at their own pace, but were encouraged to spend as much time in each situation as needed for their anxiety to decrease. Results indi-

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Figure 2: Photographic image of the Virtual Heights environment.

cated significant decreases in anxiety, avoidance, and distress from pre- to post-treatment assessment for the VR exposure group only. Furthermore, the VR exposure group reported more positive attitudes towards heights than did the control group. Without being instructed to do so, seven of the ten VR treatment completers faced real-life heights situations by the end of treatment. This controlled study provided the first evidence that, not only could VR lead to decreased reported fear and avoidance compared to a wait list, but also could lead to changed behavior in the real world.

An independent replication also compared VR exposure with in-vivo exposure therapy for acrophobia (Emmelkamp, Krijn, Hulsbosch, de Vries, Schuemie, & van der Mast, 2002). Ten participants with acrophobia received two sessions of VR therapy followed by two sessions of in-vivo exposure. VR exposure was found to be as effective as in-vivo exposure for reducing anxiety and avoidance. In fact, following only two sessions of VR, participants were found to have reached a ceiling, having successfully overcome their fear, thereby diminishing the potential effect of the in vivo-exposure. These positive results support previous research and suggest that brief exposure using VR can be an effective tool for overcoming a phobia.

Recent controlled studies have shown the effectiveness of VR in treating body image disturbance in obesity (Riva, Bacchetta, Baruffi, & Molinari, 2001) and public speaking anxiety (Harris, Kemmerling, & North, 2002). It is important to note that the findings from the body image study are preliminary, as follow-up data were not collected. The success of the public speaking study is limited by the small sample of 14 participants.

As standard in-vivo exposure therapy for fear of flying is inconvenient and cumbersome for therapists, and extremely expensive for patients, researchers developed and tested a virtual airplane to treat aerophobia. More recently, in the post 9/11 era, security measures taken at airports prohibit access by therapists to airplanes and flying stimuli at airports in order to conduct standard exposure. As such, research to determine the efficacy of VR exposure therapy for fear of flying is even more imperative for treating this disorder.

Several large, controlled clinical trials have been conducted in which fearful fliers were randomly assigned to receive either standard in-vivo exposure therapy or VR exposure therapy (Maltby, Kirsch, Mayers, & Allen, 2002; Muehlberger, Herrmann, Wiedemann, Ellring, & Pauli, 2001; Rothbaum, Hodges, Smith, Lee, & Price, 2000; Wiederhold, Gervitz, & Spira, 2001). The Rothbaum et al, (2000) study assigned participants to one of three conditions: wait list (WL), standard exposure (SE) therapy, and virtual reality exposure (VRE) therapy. Treatment consisted of eight individual therapy ses-

Division 12 Election Results

The Division is proud to announce the winners of this year's election process. Dr. Linda Sobell was elected President-Elect Designate and will begin her term as President-Elect January 1, 2004. Dr. Charles Spielberger will serve a three year term as Representative to APA Council for Division 12, also beginning January 1, 2004.

Congratulations to Drs. Sobell and Spielberger

Linda Sobell, Ph.D

Charles Spielberger, Ph.D

sions conducted over a six-week study period. The first four sessions of both VRE and SE consisted of training in anxiety management using breathing retraining, cognitive restructuring for irrational beliefs, thought stopping, and hyperventilation exposure. These were followed by four exposure sessions, either in VR or to an actual airplane at the airport (SE). VR sessions were conducted twice weekly in the therapist's office using such stimuli as sitting in the virtual airplane, taxiing, taking off, landing, and flying in both calm and turbulent weather (see Figure 3). For SE sessions, patients were exposed to pre-flight stimuli (e.g., ticketing, waiting area) and to a stationary airplane. Immediately following the treatment or WL period, all patients were asked to participate in a behavioral avoidance test consisting of an actual commercial round-trip flight.

Results indicated that both types of treatment were equally effective, and superior to the WL condition. Participants receiving VRE or SE showed substantial improvement, as measured by self-report questionnaires, willingness to participate in the graduation flight, self-report levels of anxiety on the flight, and self-ratings of improvement. There were no differences between the VRE and SE treatments

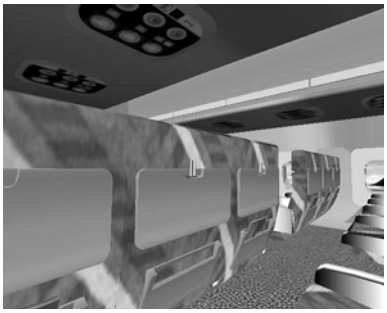

Figure 3: Photographic image of the Virtual Airplane environment.

on any measures of improvement. WL participants demonstrated no significant differences between pre- and post-treatment self-report measures of anxiety and avoidance, and only one of the 15 WL participants agreed to fly.

Follow-up data gathered six months and one year post-treatment indicated that treated participants maintained their treatment gains and 93% had continued flying since completing treatment (Rothbaum et al., 2002). A recent replication has supported these results with a larger sample (Rothbaum, Hodges, Anderson, Zimand, & Wilson, 2003).

These studies represent initial attempts to compare the use of VR in the treatment of several different disorders to the current standard of care (e.g., imaginal or in-vivo exposure). Results from these studies suggest that VR therapy has positive outcomes with at least equivalent treatment effects, and long-term maintenance of treatment gains. Future research will benefit from larger, longitudinal controlled studies addressing these and other important clinical areas.

Current Limiting Factors in VR Development

Based on the successful case studies and clinical trial research demonstrating the efficacy of VR as a modality for exposure therapy, one might wonder why all disorders that respond to exposure therapy and distraction cannot be treated with VR. Furthermore, the interest generated for VR by clinicians, researchers and the public might lead one to believe that VR treatments could revolutionize the world of psychotherapy. In some ways they have. But there remain practical matters that must be considered in the process of creating new virtual environments and the process of applying this technique to a broader range of disorders. Some of the questions that have been asked to date in developing current environments include: (1) What types of exposure are difficult to conduct in-vivo? and (2) What types of exposures are difficult to control, repeat, or conduct for extended periods of time (prolonged and repeated exposure is known to maximize the effectiveness of this treatment)?

However, more difficult issues will need to be addressed to facilitate future developments. Some of these are discussed below.

Availability of Equipment

Currently, the virtual environments developed at Virtually Better require a head-mounted display with tracking and Virtually Better's software loaded on an up-to-date computer. High quality head-mounted displays used in technology research are too costly for routine individual use. But, because the mass market for head-mounted displays is limited, it is difficult for companies designing and building this equipment to remain in business while also upgrading to meet new advances in technology and keep the equipment affordable. Thus, it may be necessary to revise the delivery system of VR in order to make it more widely available for clinicians' use.

Generalizability of the Virtual Environment

An important factor in the efficacy of VR exposure therapy is the degree to which elements in the virtu-

al environment simulate the relevant triggers for the patient's fear. If exposure to the virtual environment does not activate the appropriate "fear structures" stored in the patient's memory (Foa & Kozak, 1986), the effects of VR exposure may not generalize to the actual feared situation, and the patient may not respond to treatment. For example, acrophobics afraid of curvy mountain roads and the edges of mountainous chasms may not become anxious in an indoor glass elevator and catwalk, even though the height feature is present. Furthermore, exposure environments that are fairly easy to find in the real world may not be practical to create in VR. For example, individuals with contamination obsessions and rituals, who avoid public bathrooms, can easily be exposed to these stimuli with in-vivo exposures. Therefore, a practical component to creating new environments is the extent to which the environment meets the needs of a range of people with a variety of fears without losing specificity.

"...VR therapy has positive outcomes with at least equivalent treatment effects, and long-term maintenance of treatment gains."

Cost in Creating Environments

VR environments require the building of 3-D animated models, video taping and editing, and sound engineering that are programmed to be rendered in a head-mounted display. Personnel needed to create these environments include highly trained and skilled 3-D animators, videographers, and programmers whose time is solely dedicated to this endeavor. Presently, the market to cost ratio is high, limiting the pace of developing new environments to be used by clinicians for therapy.

Overall Evaluation and Future Directions for VR Applications

There are a number of advantages to using VR in treatment, particularly for anxiety disorders. First, recreating a situation or environment for a patient is sometimes difficult or impossible in the real world. Second, with VR, a therapist has the ability to control variables and participate with the patient in a virtual scene. Additionally, the therapist can control the variables that might facilitate behavioral exposure for some patients. Third, in-vivo exposure therapies often require time consuming and expensive efforts such as planning, scheduling, and visiting locations outside the office. With VR, therapists do not have to leave the office at all, but instead can bring the 3-D world into their offices, thereby alleviating the need to travel, the loss of control, and the risks to client confidentiality.

Of course, there are also some disadvantages of using VRE. Computer glitches can occur during exposure sessions. As described above, with some patients, the VR may not elicit the fear, particularly when the environment does not adequately match the feared situation. The cost of the equipment and software may make the availability of such treatments prohibitive for some therapists. However, as the price of hardware continues to decline, VR should become increasingly affordable.

Outcome research conducted to date using VR in behavioral treatment of anxiety disorders supports its effectiveness as a powerful research and clinical tool. In the area of specific phobias, data clearly indicate that specially designed virtual environments are effective tools for exposure therapy. Early indications of VR exposure efficacy in social phobia, PTSD and body image disturbance warrant further research in controlled clinical studies. Also, pain distraction applications may improve the quality of patients' experiences during some medical procedures. Additional advantages for the use of VR in treatment for anxiety disorders include greater control of situations, increased safety, less travel, and improved patient confidentiality. Finally, there is some indication that patients prefer the virtual world when given the choice. People appear more willing to try things in VR that they might avoid completely in the real world. As costs of equipment and programming are reduced, more specially designed environments can be created. This will allow for broader VR usage in treatment and research. □

For more information about clinical and research programs offered by Virtually Better, the reader is referred to www.virtuallybetter.com.

References

Anderson, P., Rothbaum, B.O., & Hodges, L.F. (in press). Virtual reality in the treatment of social anxiety: Two case reports. *Cognitive and Behavioral Practice*.

Anderson, P., Rothbaum, B.O., Hodges, L.F. & Zimand, E. (2003). *Treating social anxiety using virtual reality exposure: An open clinical trial.*

Manuscript submitted for publication.

Barlow, D.H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic, second edition*. New York: Guilford Press.

Basoglu, M., Livanou, M., & Salcioglu, E. (2003). A single session with an earthquake simulator for traumatic stress in earthquake survivors. *American Journal of Psychiatry, 160*, 788-790.

Botella, C., Banos, R.M., Perpina, C., Villa, H., Alcaniz, M., & Rey, A. (1998). Virtual reality treatment of claustrophobia: A case report. *Behaviour Research & Therapy, 36*, 239-246.

Carlin, A.S., Hoffman, H.G., & Weghorst, S. (1997). Virtual reality and tactile augmentation in the treatment of spider phobia: A case study. *Behaviour Research and Therapy, 35*, 153-158.

Choi, Y.H., Jang, D.P., Ku, J.H., Shin, M.B., & Kim, S.I. (2001). Short-term treatment of acrophobia with virtual reality therapy (VRT): A case report. *Cyberpsychology & Behavior, 4*, 349-354.

Cook, T.D., & Campbell, D.T. (1979). *Quasi-experimentation: Design and analysis issues for field settings*. Chicago: Rand McNally.

Difede, J. & Hoffman, H.G. (2002). Virtual reality exposure therapy for world trade center post-traumatic stress disorder: A case report. *Cyberpsychology & Behavior, 5*, 529-536.

Emmelkamp, P.M.G., Bruynzeel, M., Drost, L., & van der Mast, C.A.P.G. (2001). Virtual reality treatment in acrophobia: A comparison with exposure in vivo. *Cyberpsychology & Behavior, 4*, 335-345.

Emmelkamp, P.M.G., Krijn, M., Hulsbosch, L., de Vries, S., Schuemie, M. J., & van der Mast, C.A.P.G. (2002). Virtual reality treatment versus exposure in vivo: A comparative evaluation in acrophobia. *Behaviour Research & Therapy, 40*, 25-32.

Foa, E.B. & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.

Gershon J., Zimand E., Lemos, R., Rothbaum B.O., & Hodges L. (2003). *Use of virtual reality as a distracter for painful procedures with pediatric cancer: A case study*. Manuscript submitted for publication.

Giuseppe, R., Baccheta, M., Baruffi, M., & Molinari, E. (2001). Virtual reality-based multidimensional therapy for the treatment of body image disturbances in obesity: A controlled study. *Cyberpsychology & Behavior, 4*, 511-521.

Giuseppe, R., Baccheta, M., Baruffi, M., Cirillo, G., & Molinari, E. (2000). Virtual reality environment for body image modification: A multidimensional therapy for the treatment of body image in obesity and related pathologies. *Cyberpsychology & Behavior, 3*, 421-431.

Harris, S.R., Kemmerling, R.L., & North, M.M. (2002). Brief virtual reality therapy for public speaking anxiety. *Cyberpsychology & Behavior, 5*, 543-550.

Hodges, L.F., Kooper, R., Meyer, T.C., Rothbaum, B.O., Opdyke, D., de Graff, J.J., et al. (1995) Virtual environments for treating the fear of heights. *IEEE, 27-33*.

Hoffman H.G., Doctor J.N., Peterson D.R., Carrougher G.J., & Furness T.A. (2000). Virtual reality as an adjunctive pain control during burn wound care in adolescent patients. *Pain, 85*, 305-309.

Hoffman, H.G., Garcia-Palacios, A., Patterson, D.R., Jensen, M., Furness, T., & Ammons, W.F. (2001). The effectiveness of virtual reality for dental pain control: A case study. *Cyberpsychology & Behavior, 4*, 527-533.

Jacobson, E. (1938). *Progressive relaxation*. Chicago, IL: University of Chicago Press.

Maltby, N., Kirsch, I., Mayers, M., & Allen, G.J. (2002). Exposure therapy for the treatment of fear of flying: A controlled investigation. *Journal of Consulting and Clinical Psychology, 70*, 1112-1118.

Muehlberger, A., Herrmann, M.J., Wiedemann, G., Ellring, H., & Pauli, P. (2001). Repeated exposure of flight phobics to flights in virtual reality. *Behaviour Research & Therapy, 39*, 1033-1050.

Rothbaum, B. O., Hodges, L. F., Alarcon, R., Ready, D., Shahar, F., Graap, K., et al. (1999). Virtual reality exposure therapy for PTSD Vietnam veterans: A case study. *Journal of Traumatic Stress, 12*, 263-270.

Rothbaum, B.O., Hodges, L.F., Anderson, P., Zimand, E., & Wilson, J. (2003). Virtual reality exposure therapy and in vivo exposure therapy in the treatment for the fear of flying. Manuscript submitted for publication.

Rothbaum, B.O., Hodges, L.F., Kooper, R., Opdyke, D., Williford, J. and North, M.M. (1995b). Effectiveness of virtual reality graded exposure in the treatment of acrophobia. *American Journal of Psychiatry, 152*, 626-628.

Rothbaum B.O., Hodges L.F., Kooper R., Opdyke D., Williford J.S., & North M. (1995a). Virtual reality graded exposure in the treatment of acrophobia: A case report. *Behavior Therapy, 26*, 547-554.

Rothbaum, B.O., Hodges, L., Ready, D., Graap, K., & Alarcon, R. (2001). Virtual reality exposure therapy for Vietnam veterans with posttraumatic stress disorder. *Journal of Clinical Psychiatry 68*, 617-622.

Rothbaum, B.O., Hodges, L.F., Smith, S., Lee, J. H., & Price, L. (2000). A controlled study of virtual reality exposure therapy for the fear of flying. *Journal of Consulting and Clinical Psychology, 68*, 1020-1026.

Rothbaum, B.O., Hodges, L., Watson, B.A., Kessler, G.D., & Opdyke, D. (1996). Virtual reality exposure therapy in the treatment of fear of flying: A case report. *Behaviour Research and Therapy, 34*, 477-481.

Schneider S. & Workman M. (1999). Effects of virtual reality on symptom distress in children receiving chemotherapy. *Cyberpsychology & Behavior, 2*, 125-134.

Smith, S., Rothbaum, B. O., & Hodges, L. F. (1999). Treatment of fear of flying using virtual reality exposure therapy: A single case study. *the Behavior Therapist, 22*, 154-158.

Wiederhold, B. K., Gervitz, R.N., & Spira, J.L. (2001). Virtual reality exposure therapy vs. imagery desensitization therapy in the treatment of flying phobia. In G. Riva & C. Galimerti (Eds.), *Towards cyberpsychology: Mind, cognition and society in the internet age* (pp. 253-272). Amsterdam: IOS Press.

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Training in Psychotherapy: Why Supervision Does Not Work

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Introduction

Contemporary research supports three fundamental and somewhat startling conclusions about the nature of the training of psychotherapists: 1) Traditional training and supervision is not a very powerful means for increasing the effectiveness of psychotherapists (Beutler, Machado, & Neufeldt, 1994; Stein & Lambert, 1995; Holloway & Neufeldt, 1995). 2) Training therapists to comply with specific treatment manuals may be related to psychotherapy benefit, regardless of the specific model of psychotherapy represented by the manuals (Beutler, et al., 1994; Dobson & Shaw, 1998). This suggests that it is the structure and consistency of psychotherapy training may be more important than what is trained, at least insofar as what is translated to patient outcomes. 3) However, manualized training tends to reduce the level of therapist empathy and sensitivity and minimizes the importance of therapist judgment (Henry, Strupp, Butler, Schacht, & Binder, 1993). This suggests that the structure of training with manuals may have some negative consequences for patient change.

These conclusions raise serious concerns about the nature of contemporary training in psychotherapy. One may conclude from such data that the usual ways of training psychotherapists do not work. Less extremely, one can suggest that it is inefficient and needs to be improved. With a hope of facilitating the needed changes to psychotherapy training, we will inspect here some of the obstacles to effective training and potential solutions.

Trainees are subjected to four kinds of experience, in varying amounts, in order to learn how to deal with dangerous and destructive patients. Each of these types of experience possesses some serious limitations.

1. Lectures about psychotherapy technique and processes are adequate for conveying information and cognitive knowledge to students, but are not efficient methods for training the complex technical skills that are needed for assessment/diagnosis and treatment.

2. The addition of role playing exercises to lectures can address the problem of training complex technical skills, but role play exercises assume that the various actors who play the part of patients can adequately, fairly, consistently, and believably portray the problems of actual clinical "patients." Unfortunately, the fledgling actors who are enrolled to enact "patients" usually are other students. It is unlikely that naive student volunteers can accurately portray such high risk patients or that student trainees can make the generalization from role playing exercises to actual clinical practice. The resulting portrayals are likely to be, at best, of inconsistent quality and to have poor ecological validity. Moreover, by confounding the skill of the "actor" with the performance of the clinician-trainee, it is unlikely that ratings of clinician readiness to face the real world of complex patients are accurate and true. Thus, the exercise often fails to inspire roles that are likely to be either believable or accurate.

3. Case studies of difficult patients provide interesting reading for students, but are usually far from typical. Case studies are usually devoted to illustrating a particular difficulty and although this is sometimes important, they are accurate representations of most problems that face the clinician. Moreover, case reports don't allow one to draw causal conclusions about what works, and they don't provide an opportunity to practice the clinical skills that are illustrated.

4. The procedure on which supervisors rely the most heavily in training clinical skills is clinical supervision--closely monitored practice. However, the best evidence available suggests that supervision is a relatively feeble way of influencing patient behavior. Beutler, Machado, and Neufeldt (1994) were able to find fewer than a half dozen studies that had even addressed the question of whether supervision of therapists improved patient outcomes, and these studies found either nonsignificant or negative correlations between amount of supervision and patient improvement.

Not only is the influence of the supervisor both indirect and expensive (i.e., time intensive), but

it is also always late. Supervisors of psychotherapy are always dealing with the last problem presented or session discussed. Thus, trainees are provided with suggestions for addressing crises and major problems from days to weeks late, reducing the ability of supervision to directly benefit the patient. Add to these problems, the concern that most supervision is poorly focused and provides for few means to assess improvement, and one can see why the supervisory process has produced so little evidence that it improves the therapist's ability to induce patient benefit (Beutler, Machado, & Neufeldt, 1994).

The list of Empirically Validated Treatments (EVTs) (Chambless, et al. 1996) offered by a Division 12 (APA) task force has resulted in increasing emphasis being placed on replacing the usual methods with manual-guided training (Maki & Syman, 1997). Training therapists to follow treatment manuals possesses the advantages of providing structure and focus to training, identifying skills in advance of practice, and providing a structured means for receiving feedback and correction. Because of these advantages, the movement to identify empirically validated interventions will invariably continue under pressure from managed health care organizations, licensing boards, and those who establish public policy. One can expect to see the introduction of more structured and goal-directed educational procedures in our continuing education and graduate education programs.

But, training via manuals is not likely to solve many problems facing the student who seeks to acquire psychotherapy skills. Manuals are almost all confined to training in how to treat a specific type of patient (i.e., diagnosis) within the framework of a specific type of theoretical model. Unfortunately, there are over 150 different manuals in existence and they address only one-fourth of the diagnostic conditions of the DSM (Chambless & Ollendick, 2000). And, it is doubtful that manuals, even those that derive from the same theoretical model, are interchangeable (Malik, Beutler, Gallagher-Thompson, Thompson, & Alimohamed, 2003). Training in even a small number of manualized approaches is an extremely unwieldy task.

Moreover, while manualized training is rapidly becoming a standard practice for helping students acquire therapeutic skills (e.g., Maki & Symon, 1997), the benefits of such training may also be offset by the rigidity and lack of appeal of using manuals, to many practicing therapists. Anderson and Strupp (1996) interviewed 59 patients who were treated either before or after the 16 therapists who treated them received manualized training in short-term dynamic therapy. Outcomes were more dependent on the therapist than on the training; relatively large differences were present from therapist-to-therapist, both before and after training. Therapists who obtained particularly good outcomes after training were also the ones who were likely to depart from the training guidelines and to follow their own judgments.

Strupp and Anderson (1997) suggest that manuals do not allow sufficient opportunity for the therapist to adapt the treatment to states of the patient and to use their own intuitive judgments. Their use will require more flexibility than is currently offered in order to address some inconsistencies between manualized approaches and current practice (Luborsky & DeRubeis, 1984). At least two basic inconsistencies are of note. First, the single-theory orientation of manuals does not correspond with the eclectic and integrative orientation of most therapists (Beutler & Baker, 1996; Lambert & Ogles, 1988). Second, even when a sample of therapists all follow the same manual, there continue to be wide variations in effectiveness from therapist-to-therapist (Crits-Christoph et. al., 1991), suggesting that manuals do not adequately address some important issues in therapist effectiveness. These limitations in research-based manuals translate to limitations in the evolution of training that utilizes structured procedures based on manuals.

Prescriptive, integrative, and eclectic models of psychotherapy, based on Aptitude Treatment Interaction (ATI) research, have been designed to respond to the lack of fit between the single-theory orientation of the manualized treatments used in most research and the eclectic orientation of those treatments used in clinical practice (Beutler, 1991), one aspect of current manual inflexibility. Manualized descriptions of these integrative models have been introduced widely and are currently generating some interesting and productive research (e.g., Beutler & Harwood, 2000; Beutler et al., 2003).

This research is designed to identify patient dimensions, largely separate from diagnostic labels, as indicators for implementing treatment strategies that are also separate from brand name labels and that are both specific to the patient indicators and flexible enough to be implemented by those who ally themselves with different theoretical models. These

developments have profound and cross-cutting implications for training.

Prescriptive and Eclectic Psychotherapies: Roles for Training Structures and Outcomes

Research on training in the tradition of prescriptive and eclectic psychotherapy has two major objectives: 1) to identify the patient characteristics that can empirically be identified as moderating the effects of different therapies or interventions and 2) to learn ways to teach both experienced and fledgling therapists how to competently apply those therapies and interventions in an effective way, independently of the theories that spawned them. There is a vital need to integrate training with the objectives of this research, and further, to integrate the resulting course work with practice. The nature of integrative theory emphasizes the close link between empirically based clinical assessment and demonstrably effective clinical interventions, all within a framework that allows effective practice in fieldwork courses. Unlike the conventional training methods that separate courses in theory (e.g., social psychology, psychotherapy theories, etc.) from courses in practice (practica and internship), integrated and prescriptive approaches to treatment see a very close link among such courses.

"...new perspectives on the roles of both psychological assessment and intervention are required."

For example, traditional training tends to separate assessment courses either into divisions or domains—intellectual assessment, personality assessment, projective assessment—or into those that address specific instrument—WAIS, Rorschach, Projective Assessment, etc. This is not an ideal way to introduce assessment procedures if one desires to imbue in the student an appreciation for the integral relationship between assessment and resulting treatment plans. It instills within the student, from the outset, a set that focuses on instruments rather than on the functions that the instruments play in the process of developing a comprehensive treatment program. Moreover, such a plan fails to address the importance of therapist judgment and creativity, thus, perpetuating the myth that treatment can proceed independently of assessment. Unfortunately, this fiction has been adopted by most managed health care and insurance programs, and has tended to fragment psychotherapy training. The consequence, as we have seen, is that the first service to be eliminated from third-party mental health coverage is almost always a comprehensive program of psychological assessment.

Similarly, to the degree that training programs are wedded to teaching intervention courses that are organized around specific models (psychodynamic therapy, cognitive therapy, family therapy, etc.), students are denied necessary training in how to extract the important characteristics of treatment and to tailor the interventions to the particular needs of the patient. In the tradition of training in ESTs, a student is implicitly taught that the patient is equated with their diagnosis and effective treatment is equated with a manual. This is a short-sighted view and ignores the weaknesses of the diagnostic system (e.g., Beutler & Malik, 2002) as well as the extensive body of research done on common treatment processes and integrated applications (Norcross & Goldfried, 1992).

In order to correct these problems, new perspectives on the roles of both psychological assessment and intervention are required. Psychological assessment would emphasize the use of focused instruments that have the very specific ability of predicting prognosis and differential treatment response, rather than on omnibus measures; The central psychometric processes emphasized would be predictive validity rather than construct validity; and it would stress fitting patient needs to treatment demand characteristics--capitalizing on interaction effects—rather than on only main effects.

For example, such a training program would concentrate on teaching assessment courses that were focused on assessing different patient indicators (e.g., level of impairment, strengths and resources, and social networks) rather than different instruments or artificially defined domains of intelligence and personality. Within these courses, the instructor would address empirically-based indicators and treatment demand characteristics that would allow students to make several distinctions among patients: 1) between those clients needing mental health treatment and those that don't, 2) between those who need medication and those who don't, 3) among those clients needing long-term and those needing brief or time-limited treatment, 4) among those clients requiring inpatient, outpatient, partial care, and other variations of settings, 5) among the probable benefits to be achieved by different, prospective therapists, 6) among those who will benefit from

family, individual, and group therapies, 7) between those who are and are not likely to respond to different treatment models, and 8) among the therapists' styles and preferred strategies that are expected to be maximally effective.

Intervention courses would also have to be redirected and restructured to incorporate these same types of decisions, eschewing the concept of a single model that will address all problems. Methods for bridging interventions across theoretical models would be given equal status with courses that focus on specific theories or theoretically-based approaches.

A final issue, of course, is that the resulting practices must be carried over into clinical settings and programs, and procedures must be implemented for ensuring that they do not erode over time. The extant system for continuing education ultimately must be replaced by a system that monitors clinical practice and tracks therapist breadth. Such a system would identify areas of weakness and lack of experience, replacing the current CE system that fails to ensure that the content of post-graduate education is based on scientifically valid findings. As noted, the usual methods of supervision, role playing, and lecture, are relatively ineffective for training novice psychotherapists. The same conclusion is probably equally warranted for maintaining the skills of the established practitioner. For example, Strupp and Binder (in press) report that in the Vanderbilt I and II projects, even extensive and structured efforts to train psychotherapeutic skill through lecture, role playing, and supervision, were unsuccessful in teaching highly experienced therapists how to deal with patient resistance and anger. The relative lack of evidence that conventional training methods enhance patient outcomes is one of the factors that has led some (e.g. Christensen & Jacobson, 1994) to advocate abandoning advanced therapist training altogether. While training may alter trainee attitudes and enhance their abilities to develop a therapeutic alliance, these changes only indirectly alter patient condition, if at all (Stein & Lambert, 1995).

There are many patient behaviors that are likely to leave the therapist angry and anxious and that are difficult to portray in lectures and role plays. Suicide gestures, patient requests for personal information about the therapist, chemical intoxication, threats of violence, and a host of other situations all are likely to increase therapist anxiety and in doing so, may reduce needed flexibility and effectiveness. The effects of practice would be enhanced by using an environment that is, at once, both realistic for the therapist and safe for the patient (i.e., the therapist's acts do not induce or exaggerate level of risk). Thus, computer-intensive technologies, including virtual environments, offer an opportunity to create the realistic cues and stimuli that will engage the trainees in effective learning while preserving the level of safety and reliability in the "patient's" response that are advantageous in training and research.

Conclusion

Training procedures that include lectures, role playing, case studies, and closely monitored supervised practice have serious limitations that need to be addressed effectively and immediately in order to ensure the future of the field. It has been prescribed that prescriptive and eclectic psychotherapy training that focuses on multiple patient dimensions, therapist dimensions, and therapy attributes must be incorporated into single analyses to assess the interchange among variables and their complex interactions in disposing patients to change and changing major sources of contention that state supervision cannot and does not work in our field.

The application of ATI models of treatment planning and the concomitant use of evolving technologies can be brought to bear in order to enhance the therapists' acquisition of the ability to recognize patient generated cues that signal the use of specific procedures, while at the same time reducing therapist negative response to patient defense, and improving skill development. Applications of contemporary technology would provide a means to train and re-train therapists in a cost-efficient manner for work in managed health care environments would be adaptable to training therapists to work in a variety of specialized health care settings that are not easily accessible to the usual training procedures for research purposes. Unlike the supervision process that relies on backward learning (i.e., the cue and reinforcement precedes the "corrected" behavior), emersion and other computer intensive procedures enhance the availability of forward contingencies and for reducing lag time by immediately replaying the same scenario several times. Alternative patient cultural variables, expressions, and demographic qualities can be inserted to ensure that therapist/trainees gain an appreciation for diversity and culture.

Still, it is important to keep in mind that even contemporary technology and evolving training

models are quite simplistic, relying as they do on an analysis of individual therapy and patient dimensions. Future research must develop methods for increasing the complexity and individuality of treatment. □

References

Anderson, T. & Strupp, H.H. (1996). The ecology of psychotherapy research. *Journal of Consulting and Clinical Psychology, 64*, 776-782.

Beutler, L.E. (1991). Have all won and must all have prizes? Revisiting Luborsky, et. al.'s verdict. *Journal of Consulting and Clinical Psychology, 59*, 226-232.

Beutler, L.E., & Baker, M. (1996, March). *The movement toward empirical validation: At what level should we analyze and who are the consumers?* Paper presented at annual Banff Conference on Behavioral Science, Banff, Canada.

Beutler, L. E., & Harwood, T. M. (2000). *Prescriptive psychotherapy: The treatment of co-morbid depression and substance abuse*. New York: Guilford Press.

Beutler, L.E., Kim, E.J., Davison, E., Karno, M. & Fisher, D. (1996). Research contributions to improving mental health care outcomes. *Psychotherapy, 33*, 197-206.

Beutler, L.E., Machado, P.P., & Neufeldt, S. (1994). Therapist variables. In S.L. Garfield & A.E. Bergin (Eds.). *Handbook of psychotherapy and behavior change* (4th ed) (pp.259-269). New York: Wiley.

Beutler, L. E., & Malik, M. (Eds.) (2002). *Rethinking the DSM: Psychological perspectives.* Washington, DC: American Psychological Association.

Beutler, L. E., Moleiro, C., Malik, M., Harwood, T.M., Romanelli, R., Gallagher-Thompson, D., & Thompson, L. (2003). A comparison of the Dodo, EST, and ATI indicators Among Co-Morbid Stimulant Dependent, Depressed Patients. *Clinical Psychology & Psychotherapy, 10,* 69-85.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685-716.

Chambless, D., Sanderson, W.C., Shoham, V., Johnson, S.B., Pope, K.S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S.R., Sue, S., Beutler, L.E., Williams, D.A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*(2), 5-14.

Christensen, A., & Jacobson, N. S. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*, 8–14.

Crits-Christoph, P., Baranackie, K., Durcias, J. S., Beck, A. T., Carroll, K., Perry, K., Luborsky, L., McLellan, A. T., Woody, G. E., Thompson, L., Gallagher, D., & Zitrin, C. (1991). Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research, 1*, 81–91.

Dobson, K.S., & Shaw, B.F. (1988). Training issues in behavior therapy. *Journal of Consulting and Clinical Psychology, 56*, 673-680.

Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61*, 434–440.

Holloway, E.L., & Neufeldt, S.A. (1995). Supervision: Its contributions to treatment efficacy. *Journal of Consulting and Clinical Psychology, 63*, 207-213.

Lambert, M.J., & Ogles, B.M. (1988). Treatment manuals: Problems and promise. *Journal of Integrative and Eclectic Psychotherapy, 7*, 187-204.

Luborsky, L., & DeRubeis, R.J. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research. *Clinical Psychology Review, 4*, 5-14.

Maki, R.H., & Syman, F.M. (1997). Teaching of controversial and empirically validated treatments in APA-accredited clinical and counseling psychology programs. *Psychotherapy, 34*, 44-57.

Malik, M. L., Beutler, L. E., Gallagher-Thompson, D., Thompson, L., & Alimohamed, S. (2003). Are all cognitive therapies alike? A comparison of cognitive and non-cognitive therapy process and implications for the application of empirically supported treatments (ESTs). *Journal of Consulting and Clinical Psychology, 71*, 150-158.

Norcross, J. C., & Goldfried, M. R. (Eds) (1992). *Handbook of psychotherapy integration*. New York: Basic Books.

Stein, D.M., & Lambert, J.J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology, 63*, 182-196.

Strupp, H. H., & Anderson, T. (1997). On the limitations of therapy manuals. *Clinical Psychology: Science and Practice, 4*, 76-82.

Strupp, H. H., & Binder, J. (in press). Therapist inner processes in the Vanderbilt project, and conclusions for future training. In F. Caspar (Ed.), *The inner processes of psychotherapists: Innovations in clinical training*. New York: Oxford University Press.

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Applying the APA Cultural Competency Guidelines: A Cultural and Cognitive Flex Perspective

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Ask psychotherapists to define cultural competency and they generally speak in abstract terms about cultural or racial differences and cultural sensitivity. What is usually missing from such philosophical and academic responses are specifics about how they would modify their style of therapy or theoretical orientation when working with clients who are culturally or racially different. Part of the problem of the lack of a precise definition of cultural competency can be attributed to the wording of the American Psychological Association's (APA, 2003) Cultural Competency Guidelines - they are somewhat obtuse and general, and thus removed from the real world of working with clients in the therapeutic process. Furthermore, the recommendations can be overwhelming—particularly with respect to the many racial and ethnic groups in the United States and the diversity that exists within each group. In this short paper we do not purport to answer all of the complex questions related to cultural competency in therapy, but we hope to provide a conceptual framework from which effective treatment of culturally and racially diverse clients can begin to be understood. Our focus will be multicultural competency as carried out by mental health practitioners (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000);

> (a) awareness and knowledge of how age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status are crucial dimensions of an informed professional understanding of human behavior, and
> (b) clinical skills necessary to work effectively and ethically with culturally diverse individuals and communities (p. 653).

In this endeavor we will address the three major goals of cultural competency—awareness, knowledge/sensitivity, and skills, by focusing on the three guidelines that are most directly related to psychotherapy, guidelines #1, 2, and 5. Many of our recommendations are based on the Cultural and Cognitive Flex Model of therapy developed by the senior author and his colleagues (Ramirez, 1999; Ramirez & Casta_eda, 1974; Ramirez, Cox, Garza, & Casta_eda, 1978).

The Cultural and Cognitive Flex Model of Multicultural Psychotherapy

The model is based on two principal concepts—values (cultural styles) and modes of cognition (cognitive styles). Values are conceptualized (Casta_eda, 1977) as falling into one of two comprehensive belief systems or worldviews with respect to sense of identity, social organization, and creation of the universe. These two worldviews have been referred to by Nisbet (1970) and Inkeles (1975) as traditional (belief in creationism, a community identity, and preference for a hierarchical organization style) and modern (preference for a rational explanation of the origins of the universe, individual identity, and egalitarian organizations). A bicultural orientation to life is one that combines elements of both belief systems. Styles of cognition are classified with respect to a field sensitive-field independent continuum comprising variability in incentive preferences, preferences with regard to modes of relating and communicating with others, and modes of learning and teaching/psychotherapy. A field sensitive style is characterized by a global-relational learning/teaching style, preference for social rewards, and personalized communication styles. A field independent style is expressed as a parts specific-analytical learning/teaching style, preference for nonsocial rewards, and a more impersonal and formal communication style. The ability to combine both styles is referred to as bicognitive (cognitive flex). The two sets of concepts are interrelated because values (cul-

tural styles) moderate socialization practices and types of life experiences, which in turn mediate the development of preferred cultural and cognitive style.

This conceptual framework in mind, the model involves four basic steps of multicultural therapy: 1) therapist self-evaluation and evaluation of the client with respect to preferred cultural and cognitive styles, 2) matching the preferred cultural and cognitive styles of the client, 3) when appropriate, mismatching the client's preferred styles through a match approach to encourage development of bicultural and bicognitive flexibility, and 4) continuing match and mismatch to reinforce flex. The four states or steps of cultural and cognitive flex therapy reflect the recommendations of Guidelines #1, 2, and 5—therapist self-assessment, multicultural knowledge/sensitivity, and culture-matching treatment skills.

Awareness Through Self-Assessment

Guideline #1: Psychologists are encouraged to recognize that as cultural beings they may hold attitudes and beliefs that can detrimentally influence their perception of and interactions with individuals who are ethnically and racially different from themselves.

Identifying preferred cultural style. One of the greatest challenges posed by the cultural competency guidelines is that of therapist self-assessment. In clinical and counseling training programs we are urged to know ourselves before working in helping relationships with clients, but this recommendation is often ill defined. In complying with the cultural competency guidelines, self-knowledge must be relegated to a center-stage role. Guideline #1 urges us to become aware of our own values and attitudes. This process can be initiated by doing our own life histories. There are a variety of different approaches to journaling in the literature but we recommend one that is focused on our past and present experiences with diversity, both within our own sociocultural group and with peoples of other races and cultures.

We view cultural diversity as present both in the culture in which we participate most of the time as well as in cultures and races that differ from it. For example, we recommend the examination of experiences with respect to the influence of role models, friendships, intimate relationships, our home communities/neighborhoods, and schools attended. An outline for doing a self life history focused on cultural diversity experiences can be found in the senior author's book Multicultural psychotherapy (Ramirez, 1999). We also encourage that the therapist respond to the items of two instruments provided in the Appendix of the aforementioned book — the Family Attitudes Scale (FAS) and Traditionalism-Modernism (TMI) Inventory. The therapist can interpret the findings with respect to his or her identification with traditional, modern, or bicultural values as identified in the Cultural and Cognitive Flex model.

Assessing preferred cognitive style. Preferred cognitive style can be identified by responding to the items of the Bicognitive Orientation to Life Scale (BOLS), which can also be found in the book by Ramirez (1999). In addition, the cognitive style(s) that is most reflected in the individual treatment style can be assessed by using the Therapist's Cognitive Style Observation Checklist while in the process of interacting with clients.

Assessment of extent of experience with diversity. Also critical to therapist self-knowledge is identifying one's degree of experience with cultural and racial diversity in society. The Multicultural Experience Inventory (MEI), also provided in Ramirez (1999), examines diversity experience achieved through friendships in elementary, middle school, high school, and college, as well as in current relationships. In addition, the inventory asks questions regarding the frequency with which we currently participate in celebrations and functions that are part of the traditions of other ethnic/racial groups.

Stage of racial identity. While not a component of the flex model of therapy, we encourage therapists to evaluate themselves with respect to their stage of racial identity development as part of the process of self-awareness. We agree with Helms (cited in Ponterotto & Casas, 1991) that the stage of racial identity of the therapist can have a significant impact on the quality of therapeutic alliance with clients who are culturally or racially diverse. Identifying one's stage of racial identity development is of importance both for therapists who are members of ethnic/racial minority groups as well as for those who are Anglo. The therapist's stage of racial identity and the process by which it was achieved (as assessed through the self life history) can be related to the willingness of the helping professional to address issues of racism when doing treatment with minority clients. Furthermore, it is important for the therapist

to know how his or her racial identity is related to feelings about the "other," since identification as white, nonwhite, or both is related to the black-white skin color dichotomy which is at the root of racism in American society. A scale of African American identity (which with minor changes can be made applicable to members of other minority ethnic and racial groups) developed by Helms and her colleagues (Cross, Parham, & Helms, 1991; cited in Ponterotto & Casas, 1991) can be used to determine stage of racial identity by therapists who are members of minority ethnic or racial groups. Anglo health care providers, in turn, can evaluate themselves relative to the stages of White racial identity proposed by Helms (cited in Ponterotto & Casas, 1991).

Self-Awareness and Range of Therapeutic Flex

Information obtained through the self-evaluation gives the therapist an idea of her or his range of therapeutic flex. As therapists we have an effectiveness-comfort range that determines how well we can match clients who are culturally or racially different and still feel effective, comfortable, and genuine as health service providers. In illustration, in the following section we will examine range of flex relative to a specific case:

> A Japanese American woman presents for therapy in great distress. The client is married and in her late twenties. She reports that she immigrated to this country three years ago, shortly after she married an Anglo man who was living in Japan at the time. She informs the therapist that her family did not approve of her marriage or of her move to the United States. She has been in crisis since she and her husband received a phone call from her parents in which they informed her spouse that they wished to buy their daughter so that she might rejoin the family. The client reports that she is seeking therapy because she feels torn between the guilt she feels for the unhappiness of her parents and the love she feels for her husband.

For the therapist who is consulted by the patient described above the major questions relative to the results of self assessment are as follows:

- Do the findings of the self life history, the FAS and TMI, the MEI and the examination of racial identity development indicate that the therapist can understand the traditional-modern values conflicts being experienced by the client? During the course of her/his life, has the therapist had experience with the biculturation stress related to the push and pull the client is feeling between the traditional values of her parents and the modern values of the culture in which she is now living?
- Does the therapist's preferred cognitive style, as indicated by the BOLS and the Therapist's Cognitive Style Observation Checklist, indicate that she or he can match the style of the client? (Procedures for evaluating the client's preferred style are described in the Knowledge section below)
- Will the therapist's racial identity, as indicated by the Helms instrument (1990) and the self life history facilitate or interfere with the development of the therapeutic alliance and with the likely need to discuss the client's experiences with racial discrimination in Japan and in the United States?

The information obtained from self-assessment is also crucial to addressing the other two goals of culturally competent therapy—multicultural knowledge/sensitivity and culturally appropriate therapeutic skills, which are discussed in further detail in the following sections.

Client Assessment: Multicultural Knowledge/ Sensitivity

Guideline #2:Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge and understanding about ethnically and racially different individuals.

In the context of treatment, Guideline #2 is centrally concerned with accurate, culturally, and racially sensitive assessment of the client. Research on the outcome of psychotherapy has consistently shown that inaccurate or incomplete assessment of clients is one of the most common causes of treatment failure (Beutler, 1989; Kazdin, 1995). For the mental health professional working with clients who are culturally or racially different, assessment is doubly crucial and challenging.

In the previous discussion of Guideline #1 we posited the importance of self- assessment for the purpose of identifying degree of therapeutic flex with respect to matching clients. Guideline #2 is concerned with the converse, knowledge and experience concerning the client and the group(s) with which she or he is identified with, and the identification of therapist range of competency in this regard.

Some critical issues and suggestions with respect to knowledge building are:

1. Reading the multicultural literature, travel, learning the language(s), and engaging in cultural

immersion through diversity challenges (Ramirez, 1999) can serve to acquaint the therapist with the values, common practices, communication styles (Hall, 1977), family dynamics, and typically preferred cultural and cognitive styles of the ethnic/racial groups from which her or his clients are likely to originate. The knowledge achieved can make the information obtained from life histories with prospective clients more meaningful, thus, helping the therapist to view the client as an evolving social being in a diverse society—a product of her or his past and present experiences. In addition, symptoms with which the client presents can subsequently be interpreted in a cultural or racial context. For example, an understanding of the tendency of traditional Latino clients to internalize negative feelings to maintain harmony in family and personal relationships and then to express their feelings through physical symptoms (Diaz-Guerrero, 1955) can provide useful food for thought during the assessment of a Latino client's presenting problems.

"For the mental health professional working with clients who are culturally or racially different, assessment is doubly crucial and challenging."

2. Multicultural knowledge can form a knowledge base from which a therapist can ask culturally educated questions (Rodriguez & Wells, 2000) in the initial session(s)—a sine-qua-non for establishing a good therapeutic alliance. For example, Torrey (1973) refers to knowing the "magic of the right word" as essential to establishing a therapeutic bond (p.16).
3. Being knowledgeable about diversity also helps in de-pathologizing culturally or racially unique behaviors. An example would be that some Native American clients prefer to interact with therapists in a manner in which eye-to-eye or face-to-face contact is minimized (Trimble, 1981).
4. Multicultural knowledge is also relevant to the use of appropriate treatment behaviors. For instance, in working with traditional Asian American clients it is important to know that a common cultural practice is gift giving in trusting relationships. Thus, a therapist would know to provide some concrete advice, such as the teaching of relaxation exercises, as a "gift" to the client upon termination of the initial session (Sue & Zane, 1987).
5. Information about a client's racial and cultural identity is also central to an accurate and complete assessment. The client's specific stage of racial identity or her/his cultural identity type could provide important information about individual dynamics and lifestyles. For instance, understanding multicultural identity development processes is centrally important to working with multiracial and multicultural clients (Root, 1992).

In general, knowledge building contributes to the eradication of cultural and racial stereotypes, and is important to viewing the client as a unique person so that the therapy plans and goals can be properly individualized. The following case illustrates the utility of multicultural and multiracial knowledge for treatment planning:

> Raul is a multiracial and multicultural (Latino, African American, and Native American) middle-aged man who was reared largely in an urban community in Texas. At various times in his youth he also spent time with relatives on a Native American Reservation and in a rural U.S.-Mexico border community in South Texas. He presents for therapy with identity confusion and with the concern that he has not succeeded in forming lasting relationships with the women he has dated.

- The initial session indicated evidence of somatization, with attempts to ameliorate symptoms with alcohol and marijuana.
- There was also evidence of obsession and disappointment with blue-eyed Anglo women, "They never seem to love me as much as I love them."
- The life history revealed that his attempts to form a multiracial or multicultural identity had been marked by conflict and pain throughout his life, which entailed discrimination by Anglos and rejection by the ethnic and racial groups in which he was socialized. To become better acquainted with multicultural and multiracial identity development processes, the therapist read the book by Root (1992).
- The life history also revealed that the client closely identified with the perspective on spirituality he had learned from his Native American uncle (a possible therapy resource), a medicine man on the reservation he had often visited as a child.
- A preliminary assessment with respect to racial identity development indicated Raul was presently

between the pre-encounter and encounter stages. It also appeared that his obsession with the stereotypical Anglo woman was related to an internalized racism. "I want Whites to see us and think, "Look at that colored guy with that beautiful blond."

- Assessment with the observation instruments for preferred cultural and cognitive styles indicated that Raul was multicultural—predominantly traditional with respect to spirituality, family relationships, and sense of community, but predominantly modern with respect to gender relationships.

Knowledge of the client contributes to the identification of therapy goals and also informs the therapist as to the skills she or he will need to develop and implement a successful treatment plan.

Culture-Matching Treatment Skills

Guideline #5: Psychologists should strive to apply culturally appropriate skills in clinical and other applied psychological practices.

The most significant challenge posed by the Cultural Competency Guidelines is to modify preferred theoretical orientations and treatment styles when working with clients who are ethnically/racially diverse as well as those who are different with respect to sexual orientation, disability, socioeconomic status, and/or national origin. This challenge is even more significant to the field of Psychology because most of the major theoretical orientations and approaches to therapy taught in graduate programs and practicum and internship settings are either Eurocentric or based on North American world views. The theories most reflective of Western cultural beliefs (modern cultural styles) usually involve the use of strategies and procedures of treatment emanating from an etic perspective. The impact of etic approaches, which are based largely on the medical model regarding the lifestyles and belief systems of the "different," is enculturation to Western European-North American cultural styles. Thus from our point of view the principal objective of Guideline #5 is to encourage therapists to question and discard the cultural superiority notions that may be embedded in preferred theories and approaches to treatment. To meet the requirement of using culturally appropriate skills, we need to use models of therapy that are more heterogeneous and synergistic, incorporating both humanistic and Western perspectives and strategies—a multidimensional understanding of psychotherapy (Woolfolk, 1998; Polkinghorne, 1999).

In contrast, an emic orientation to psychotherapy incorporates traditional cultural styles and worldviews in three major dimensions with respect to culturally or racially-appropriate approaches to treatment:

- A more holistic view of health—mind-body unity.
- A humanistic belief system emphasizing discovery of the meaning of life and focusing on the quality of social relationships (within one's ethnic/racial group, in the community, and with family and friends).
- A spiritual dimension focused on the nature of the relationship of the client to a higher power or to forces in life that cannot be explained by a Western scientific perspective.

The incorporation of emic approaches and strategies can aid in matching the worldview of a culturally or racially different client. Such strategies include the following:

1. Using milieu therapy, as recommended by Fanon (as cited in Bulhan, 1985), focusing on the benefits of the broad therapeutic community rather than exclusively on the dynamics of the client and therapist. Similarly, employing treatment approaches used by healers in African, Asian, Latino and Native American communities. Specific examples include Attneave's (1969) retribalization approaches and Szapocznick and colleagues' (1984) use of family systems therapy to focus on intergenerational conflict in Cuban American families.
2. The use of story telling approaches such as Cuento Therapy (Costantino, Malgady, & Rogler, 1986) or historical information that is part of the oral history of a group, such as Haley's book (1976) Roots, which documented how African Americans emerged from the shackles of slavery.
3. Working with folk and spiritual healers as consultants and co-therapists (Kreisman, 1975), as mentioned in the above discussion of the treatment of Raul.

These examples are merely a few of the myriad methods that can be used to match the worldviews and preferred cultural and cognitive styles of clients. More generally, with proper modifications, emic and etic approaches can be combined effectively in constructing therapy plans. The case below is a good example of this synergistic model of treatment:

A Latina who is single and in her early 20s presents with severe symptoms of social phobia. Her therapist, after completing an evaluation similar to the one done with Raul and the self evaluation recommended for therapists, devised the following therapy plan.

- She began treatment using a cognitive-behavioral approach to attack the client's symptoms of social phobia.
- As the client's therapy progressed, the focus of treatment shifted to the client's conflicting familial and personal goals. The therapist began to use the cultural and cognitive flex model of therapy, becoming less directive in her approach. (The client's assessment had indicated a bicultural with traditional cultural style preference and a bicognitive with field-sensitive cognitive orientation).
- The therapist matched the client's preferred traditional cultural style by helping her to examine the guilt she was experiencing over her desire to be "the obedient daughter." She felt obligated to sacrifice for her younger sister, despite the fact that her sister seemed financially irresponsible at a cost to her personal life goal (i.e., attending a graduate program).
- The therapist also matched the client's preferred cultural style by using a family-centered worldview to analyze the bicultural conflict she was experiencing, discussing with her the historical context of emphasis on parental authority and family loyalty. The therapist also used a global approach in analyzing the problem, matching the client's preferred field-sensitive orientation.
- The final stage of therapy involved gradually mismatching the client. The "big picture" was addressed by discussing possible alienation from her family. In addition, a more field-independent style was introduced by asking the client to focus on the details of a possible approach to decision-making—listing and then discussing the pros and cons of the different options available to her. The process of flex development was thus initiated.

As Hansen, Pepitone-Arreola-Rockwell & Greene (2000) have so aptly stated in their paper on cultural competency, striving for the goal of being culturally competent as a therapist should be viewed as an on-going process requiring continuing diversity challenges, keeping up with the literature, consulting with colleagues who have expertise, and focusing case consultation group discussions around issues of individual, cultural, and racial differences. Still another valuable recommendation made by the authors was encouraging therapists to use the Cultural Competency Inventory (La Framboise, Coleman, & Hernandez, 1991).

Conclusions

Development of culturally and racially-appropriate treatment plans should include the combination of the etic and emic perspectives as well as humanistic and empirically validated approaches. A synergistic theory and set of strategies will help the therapist to become more culturally and cognitively flexible in order to expand her or his range of therapeutic flex, as described earlier in this paper.

In the early 1900s, W.E.B. DuBois observed that the greatest challenge facing the twentieth century was the problem of the color line (as cited in Lewis, 1993). The major challenge of the twenty-first century is broader—it is one of racial, cultural, and individual differences. Those of us who are mental health practitioners and social scientists have been charged by the Cultural Competency Guidelines to meet this new challenge. What we do will determine how we will be judged by history. □

References

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402.

Attneave, C. L. (1969). Therapy in tribal settings and urban network intervention. *Family Process, 8*, 192-210.

Bulhan, H.A. (1985). *Frantz Fanon and the psychology of oppression*. New York: Plenum Publishing.

Beutler, L.E., Consoli, A.J., & Williams, R.E. (1995). Integrative and eclectic therapies in practice. In Bongar, B., & Beutler, L.E. (Eds.). *Comprehensive textbook of psychotherapy: Theory and practice*. New York: Oxford University Press.

Casta_eda, A. (1977). Traditionalism, modernism, and ethnicity. In J.L. Martinez (Ed.). *Chicano psychology* (1st ed.). (pp. 355-360). Orlando, FL: Academic Press.

Costantino, G., Malgady, R., & Rogler, L. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting & Clinical Psychology, 54*, 639-645.

Cross, W. E., Parham, T. A, & Helms, J. E. (1991). The stages of Black identity development: Nigrescence models. In R.L. Jones (Ed). *Black psychology* (3rd ed.). (pp. 319-338). Berkeley, CA: Cobb & Henry Publishers.

Diaz-Guerrero, R. (1955). Neurosis and the Mexican Family Structure. *American Journal of Psychiatry, 112*, 411-417.

Haley, A. (1976). *Roots: The saga of an American family*. New York: Doubleday.

Hall, E.T. (1977). *Beyond Culture*. Garden City, NY: Anchor.

Hansen, N. D., Pepitone-Arreola-Rockwell, F., & Greene, A. F. (2000). Multicultural competence: Criteria and case examples. *Professional Psychology: Research & Practice, 31*, 652-660.

Helms, J. E. (1990). *Black and White racial identity: Theory, research, and practice*. New York: Greenwood Press.

Inkeles, A. (1975). Becoming modern: Individual change in developing countries. *Ethos*, 323-342.

Kazdin, A.E. (1995). Methods of psychotherapy research. In Bongar, B., & Beutler, L.E. (Eds.). *Comprehensive textbook of psychotherapy: Theory and practice.* (pp. 405-433). New York: Oxford University Press.

Kreisman, J.J. (1975). The Curandero's apprentice: A therapeutic integration of folk and medical healing. *American Journal of Psychiatry, 132*, 81-83.

La Framboise, T.D., Coleman, H.L.K., & Hernandez, A. (1991). Development and factor structure of the cross-cultural counseling inventory-revised. *Professional Psychology: Research and Practice, 22*, 380-388.

Lewis, D.L. (1993). *W.E.B. DuBois: Biography of a race, 1868-1919*. New York: Henry Holt and Company.

Nisbet, R.A. (1970). *Tradition and revolt*. New York: Vintage.

Polkinghorne, D. E. (1999). Two views of the cure of souls. *Contemporary Psychology, 44*, 237-238.

Ponterotto, J.G. & Casas, J.M. (1991). *Handbook of Racial/Ethnic Minority Counseling Research*. Springfield, IL: Charles C. Thomas.

Ramirez, M. (1999). *Multicultural psychotherapy: An approach to individual and cultural Differences.* (2nd ed.). Needham Heights, MA: Allyn and Bacon.

Ramirez, M. & Casta_eda, A. (1974). *Cultural democracy, bicognitive development and education*. New York: Academic Press.

Ramirez, M., Cox, B.G., Garza, R.T., & Casta_eda, A. (1978). *Dimensions of biculturalism in Mexican American college students*. Unpublished technical report. Office of Naval Research, Arlington, VA.

Rodriguez, R.R., & Wells, N.E. (2000). Culturally educated questioning. Toward a skills-based approach in multicultural counselor training. *Applied & Preventive Psychology, 9*, 89-99.

Root, M.P.P. (1992). *Racially mixed people in America*. Newbury Park, CA: Sage.

Sue, S. & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42*, 37-45.

Szapocznick, J., Santisteban, D., Kurtines, W.M., Perez-Vidal, A., & Hervis, O. (1984). Bicultural effectiveness training: A treatment intervention for enhancing intercultural adjustment in Cuban American families. *Hispanic Journal of Behavioral Sciences, 6*, 317-344.

Torrey, E.F. (1973). *The mind game: Witchdoctors and psychiatrists*. New York: Bantam Books.

Trimble, J.E. (1981). Value differentials and their importance in counseling Indians. In P.B. Pedersen, J.G. Dragnus, W.J. Lonner, & J.E. Trimble (Eds.). *Counseling across cultures*. Honolulu: University Press of Hawaii.

Woolfolk, R. L. (1998). *The cure of souls: Science, values, and psychotherapy*. San Francisco: Josey-Bass.

The Internship Match Hazing Process: A Survival Guide

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Among the stream of scholastic and professional hurdles that clinical psychology graduate students encounter, the internship process is perhaps one of the most daunting. Intern "veterans" impart their Match process war stories in a manner comparable to that of a great grandfather reminiscing about walking 80 miles barefoot through 25 feet of snow to school each day. Novices currently going through the application process quiver in trepidation as they contend with "automatic thoughts" (or substitute the equivalent term here depending on your theoretical proclivity) propagated by those brave souls who have gone before them: "The interviewers will see right through me and realize I never should have been admitted into graduate school in the first place." "My vita looks rather bare – I am sure everyone else had at least 40 publications last year alone." "I think I should have used 'that' instead of 'which' on the third sentence of essay number 4 —now I will never get matched!"

Of course, an advantage to the matching process is that it permits a unique opportunity to practice your finely tuned clinical skills on yourself (or on each other). The most therapeutic self-statement I have acquired is that, similar to other hurdles, the internship process is part of the psychology student hazing ritual. I could somehow take solace by envisioning professional psychologists laughing maniacally at the anxiety they invoke in potential recruits during internship matching. By thinking of the internship application process in this way, the steps necessary to successfully negotiate the Match seemed more manageable.

The purpose of this paper is to convey some bits of wisdom that may be helpful to you in navigating the internship Match hazing. I have no special expertise in obtaining an internship to say the least, save for having successfully endured the process myself about one year ago to date. Thus, permit me to make a disclaimer: The advice in this paper is for your consideration only and the author cannot be held liable in court for damages caused by taking this advice wholesale. If anything, the intent of this paper is to catalyze your thinking about ways to ease the burden of the internship Match so that you can bear the process with a smile (or at least a poker face).

By the time this article is published, you will have presumably already registered for the Match with National Matching Services (www.natmatch.com/psychint) and submitted applications to your sites of choice. As such, this paper will primarily focus on interviewing, ranking, and matching. Space limitations preclude a comprehensive discussion of these issues, and as such I have provided additional references and resources I found helpful in Table 1. Before proceeding with a discussion of the Match hazing, however, I begin by placing the internship process in context.

Clinical Psychology Internship in Context

The process of internship matching from start to finish makes it easy to lose sight of the forest through the trees. For over 50 years, the purpose of internship training has remained a critical pedagogical tool: It is a means of acquiring additional and more intensive clinical experience in areas where your practicum training to date may have been

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TABLE 1

RESOURCE	COST	COMMENTS
Listservs: APPIC Distribution Lists and APAGS Internship Distribution List	FREE	APPIC match list: Send a blank e-mail to "subscribe-match-news@lyris.appic.org" Internship issues list: Send a blank e-mail to "subscribe-intern-network@lyris.appic.org" APAGS list: Send an e-mail to Listserv@lists.apa.org with "Subscribe APAGSINTERNSHIP Your Name"
http://www.apa.org/ed/intern.html	FREE	List of APA-accredited internship sites
http://www.appic.org/training	FREE	List of links to sites that are of interest to interns (e.g., licensure resources, travel discounts, etc.)
http://www.psychzone.com	FREE	A site for prospective interns containing various material (e.g., where you should be at in each stage of the process, typical interview questions, etc.)
http://www.orbitz.com http://www.priceline.com http://www.sidestep.com	FREE	Discount travel sites (see the APPIC site for additional travel resources)
APAGS Workbook (available at amazon.com for a discount rate)	$24.95 (retail)	Brand new book containing information and sample materials for internship applicants (see reference list)
The Clinical Psychology Internship Guide (available at www.psychzone.com)	$13.00 (+ s/h)	Routinely updated book containing useful information about the Match process tailored to current internship applicants

insufficient or unavailable (see Dosier, 2000). The internship year is often the final opportunity to obtain and polish the broad-based skills necessary to perform professionally as a doctoral level clinical psychologist. This is why we get paid the big bucks as interns. As you move through the process of selecting and ranking your sites, remind yourself that the internship year can have a large influence over your competencies as a professional psychologist. Instead of seeking a site that largely rehashes the skills you believe you already possess, consider a site that can furnish you with additional aptitudes fundamental to the professional practice of clinical psychology.

Students also often lose sight of the purpose of internship by becoming obsessed with the inherent competition. Worrying about whether to use 4th or 5th edition APA style (American Psychological Association [APA], 1994, 2001) when answering an essay question on your research interests, or whether to use references in the essay at all, is probably a misguided source of anxiety. Moreover, would you really want to be at an internship site that refuses students because they referenced an essay question incorrectly? This is not to understate the competitiveness of the internship process. Last year, nearly one in five participating applicants were unmatched (Keilin, 2003). The number of unmatched applicants increased by 101 from the year previous, whereas the number of unfilled positions decreased by 54 (Keilin, 2003a). From my advanced knowledge of undergraduate economics, this appears to be a problem of supply and demand that has been an issue in clinical psychology internships for several years (see Lopez, Oehlert, & Wettersten, 1997; Oehlert & Lopez, 1998; Thorn & Dixon, 1997). Scarcity drives competition, and thus it is prudent to solicit information as to how to be successful in the internship Match game. What I am trying to emphasize, however, is that solely focusing on the competitive aspect of the Match (e.g., how to make yourself appear better for the express purpose of gaining an internship spot) seems to negate the ultimate purpose of attaining that internship spot in the first place. Advice given by a number of training directors has continued to be, "to thine self be true" (Kerns, 2003).

Scheduling Interviews

After submitting applications, the next step is to wait in eager anticipation for interview offers. There is no universally correct way of doing this, but I found biting my nails and pulling out my hair to be especially helpful. Debate continues as to the merits of a universal deadline for interview notification, but this has not yet been implemented. Consequently, sites will notify you in a manner analogous to a time-lagged research design. This can be especially distressing, particularly when sites may contact your colleagues before you, even if you applied to the same sites! Rest assured that like most time-lagged designs, the length of the time lag is largely arbitrary and says nothing about your status as a candidate.

Your mission in the first part of the interview process, should you choose to accept it, is to prioritize sites such that interview conflicts among your current top choices are kept to a minimum. Many internship sites post their interview dates for the upcoming internship year in the Association of Psychology Postdoctoral and Internship Centers (APPIC) on-line directory (http://www.appic.org/directory). Thus, a good strategy is to assume you will get interview offers from everywhere you applied (this is especially effective if you have a streak of narcissism) and to determine how you would negotiate that situation well in advance. At the very least, ensure that you can arrange your schedule to visit your top few sites. If you hear from sites lower on your list prior to hearing from sites higher on your list (and you will!), you can generally buy yourself some time by informing the site representative that you are very excited about their interview offer, but that you have to check on flight and/or hotel availability before formally agreeing on an interview date and time. Although many sites offer phone interviews as an option, this should generally be used as a last resort given the wealth of information you can obtain from an on-site visit versus a telephone call. Moreover, some suspect that there may be a selection bias favoring those who attend interviews in person, although I am not aware of research on this to date. A final interview option used by some sites is an "open house interview," in which applicants visit the internship site as part of an "open house." Attendance at the open house interview is not mandatory and does not necessarily increase your chances of being selected (Prinstein, 2003).

> ***"...the statistics from last year indicate that 70% of matched applicants were matched to one of their top three sites..."***

Another important issue with respect to scheduling interviews is to allow ample time between interviews. Although there is no universally recommended number of sites at which to interview, the statistics from last year indicate that 70% of matched applicants were matched to one of their top three sites (Keilin, 2003a). Generally, students have an idea of their top few sites even before visiting the site during the interview day. Thus, scheduling 12 interviews in 12 days is perhaps not the most healthy of ideas and probably will not result in better odds of getting matched. Many students who arrange a large number of interviews typically have to schedule them over several consecutive days and, not surprisingly, report getting burned out after the first several have been completed. The consequence is that they can no longer effectively represent themselves at subsequent interviews nor be in an appropriate state of mind to solicit information needed to make an informed decision as to the merits of each site. This does a tremendous disservice to you, in that interviewing can actually be an enjoyable process that allows you to meet colleagues and visit sites with which you may collaborate at some point in the future. Scheduling several consecutive interviews close together for sites that are geographically proximal is acceptable, as this approach is cost-efficient (an important word in the graduate student lexicon). However, in general, allow yourself at least a day between interviews, if not more. This is important not only to give you some opportunity to recuperate between interviews, but also to give you additional time to see the area. Geography is a major consideration for most students during internship matching. It thus behooves you to allow some time when visiting the site to gather information about the community so that you can determine if you (and perhaps a significant other) would be willing to live there for at least a year, if not more. This was actually a factor in my ranking of sites—with plenty of input from my spouse!

Another important issue with respect to scheduling interviews is cost. I personally had the brilliant insight of scheduling a wedding and honeymoon in the middle of internship interviews and in all likelihood will be paying off internship debt until I retire (and perhaps beyond). However, I did make a

Herculean effort to limit costs where possible. Table 2 offers some suggestions for limiting interview costs.

Doing the Interview

Should you happen to successfully survive the interview scheduling part of the Match hazing, the next step is braving the interview itself. Materials you should bring with you when interviewing include: a copy of the site materials for the sites at which you are doing the interview (to refresh yourself on the merits and potential drawbacks of the site), a copy of your completed internship application and essays (to refresh yourself on what you said about the site in your application), copies of your CV, appropriate attire (generally a suit for men and a dress or suit for women), brief refreshers or abstracts of the research of faculty with whom you may be working during the internship year (for research-oriented sites), and enthusiasm (as cheesy as that sounds, enthusiasm is infectious and conveys to the site your interest in ultimately matching there) (Prinstein, 2003).

Sites typically schedule you for two or more interviews with faculty they have selected based on your common interests, although you may have some say in the matter when you schedule your interview date. Your mission in this stage of the hazing, should you choose to accept it, is to appear sufficiently professional and congenial that the interviewer would feel comfortable having you as a colleague. In addition, it is important to show enthusiasm for the site and to convey how the training at that site matches well with your professional (and personal) interests and goals (if it does). You have in all likelihood already been bombarded with sentiments regarding how to be successful in an internship interview. However, the bottom line remains: Interviewers are not so much interested in the content of what you are saying, but in the way that you present yourself. Sites already have a vast array of information on you from your internship application materials and obviously have already liked what they have seen. The interview is essentially a means of the

TABLE 2

NUMBER	MEANS OF REDUCING COSTS
1	Use internet services (and/or APPIC travel discounts) to book your flights, hotels, and car reservations
2	Keep the number of interview sites to a reasonably manageable number.
3	Try to arrange carpools with other applicants. Pitching in on a compact car rental is often cheaper and easier than getting individual taxis, unless of course you are all squeamish at the thought of driving in certain places (e.g., New York City).
4	Cash in your frequent flyer miles, if you have any.
5	Reduce stress and potential cost by booking your arrangements as soon as possible after hearing from all sites at which you wish to interview.
6	Get a hotel that has a free shuttle service to the airport.
7	If you rent a car, do not get the extra insurance or upgrade unless you have no confidence in your driving ability whatsoever. You are typically covered at a base level under your own policy.
8	Book low-cost rooms. You will not be spending much time in the room, so requesting a suite in the Ritz Carlton may be a tad excessive.
9	Consider getting a credit card with an introductory 0% finance charge and putting all your internship expenses on it. This has the added benefit of keeping records of your internship costs all in one place, which is important (see point 10!).
10	Keep receipts of everything. You can claim interview expenses against your (whopping) internship income when filing taxes the following year.

site giving you the information you need to assemble a rank list and giving the site information as to whether they would feel confident in their decision to have you on staff. Staying true to yourself is as important during the interview as anywhere else in the Match hazing process, provided you have no glaring psychopathology about which the interviewer would be concerned. If the latter is true, temporarily conceal it as best as possible!

Based on that prelude, obsessing over which questions the interviewer will ask is again a source of misplaced anxiety. However, generally you should be extremely comfortable concisely discussing your dissertation, research interests, at least one clinical case, and perhaps an ethical dilemma, with the balance among these depending on whether you are interviewing at a largely academic or clinical site. Some additional common interview questions include: Why did you apply to our program? What are your goals for the internship year? What sorts of clinical experience would you like to have during the internship? Tell me about an ethical problem you have faced and how you handled it. What kinds of clinical/assessment/research experience have you had? What is your experience in working with underserved populations? What are your interests outside of psychology? What are your personal/clinical/professional strengths and weaknesses? What is your primary theoretical orientation and why? (see Prinstein, 2003, for additional common questions).

"...an extremely useful resource for gathering information about a training site on interview day is past interns."

As with any hazing, the interviewer may ask you a question that completely consternates you. The best solution in this case is to fail with poise: "That is a great question that I really have not considered. I would really like to think on that for a minute—would that be okay?" Or, "What a great question, and you know, I am not sure what the answer would be. But I would really like to know—can you tell me how you would answer that?" Obviously you can change the wording to suit your needs; the phrases are not patented (yet). The point is that again, interviewers are often more interested in how you answer the questions than what you say in response to them. Being honest about not knowing an answer, or asking for more time, is taken more as a reflection of good character than of low intelligence.

Interviewers also appreciate you asking them questions, as it reflects your interest in the site Examples of questions to ask interviewers include: What is a typical day like for an intern at this site? What do you think the main strengths and weaknesses are of this internship? Are there opportunities to stay here after the internship year? What kinds of clinical opportunities are available on the rotations here, and do interns typically get their first choice of clinical rotation? How does supervision typically work at this site? What research collaborations are possible for the internship year? What kind of didactics/professional seminars are available to interns during the internship year? (see Prinstein, 2003, for additional questions). Having a set of canned questions for each site at which you interview is fine, but a better approach would be to use these questions as a last resort (if you are struggling for things to ask) and instead focus your questions on the specific site. What would you want to know about this particular training site that would make the difference between ranking this site toward the top or bottom of your rank list? Alternatively, what would you want to know about this training site that would make you feel more or less confident that upon graduating from the internship, you could effectively function as a professional doctoral level clinical psychologist?

One final point before continuing is that an extremely useful resource for gathering information about a training site on interview day is past interns. Typically interns are less biased about the information they provide and can provide unique information not available from an interview with a faculty member. For example, interns are generally very forthcoming as to the number of hours they work in a week, and you may not feel comfortable asking an interviewer about the typical workload. The internship training year is intended to be intensive, but working at a site with an average work week of 40 hours versus 75 hours may be important information for prospective interns (especially those with family obligations). Thus, take advantage of speaking with (or e-mailing) current or past interns at the training sites at which you interview.

The Ranking

Ranking can be extremely stressful if you have several sites that are comparable. Your mission in ranking is to review all of the information you have gathered

throughout the Match hazing to date and to assemble and electronically submit an ordinal list based on which sites are the best overall match to the considerations most important to you. You should rank all the sites that you are seriously considering. Asking yourself questions that clarify your goals for the internship year can help you to rank sites based on how well the sites match your responses to those questions. If you have a spouse or family, their input can also be very helpful as you prepare your rank list. Geographic location and job opportunities for a spouse are important to weigh; ranking does not have to be exclusively based on research or clinical "match." Similarly, sites do not necessarily exclusively base their rank list on your research or clinical skills.

Debating about the relative merits of sites will eventually allow you to meet the diagnostic criteria for Primary Insomnia. There is no easy fix for this. The best you can do is to arrange your list based on your true perception of which sites would be the best match for your clinical, research, and personal interests. You will continue to hear the following ad nauseum throughout the Match process, but the point bears repeating: Do not base your list on your perception of which sites may rank you higher. The computer algorithm that ultimately performs the Match (it is comforting to know that at the end of the day the Match hazing is ultimately in the "hands" of a computer) functions based on the assumption that you submit your list based on your true ordinal preference. Thus, it is to no advantage to attempt to guess how sites will rank you among fellow candidates (in fact, you will be worse off).

"Do not base your list on your perception of which sites may rank you higher."

As a final point regarding the rank list, you are permitted to continue to revise your list on-line until the deadline date, which is typically two weeks following the opening of the on-line rank system. Submitting a first draft of your rank list to the ROLIC (Rank Order List Input and Confirmation) system through National Matching Services (www.natmatch.com/psychint) therefore does not doom you to whatever fate may befall you from submitting that particular rank list. The advantage to this is that you can freely update your rank list based on any new incoming information that may bear an influence on how you rank a site. The disadvantage is that you will continue to obsess about the rank list until the deadline date has passed.

Match Day

Once you have submitted your rank list of training sites, attempt to master the wisdom inherent in the Serenity Prayer: "Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference" (Niebuhr, 1950, pp. 6-7). In this case, accept that there is no longer anything you can alter. After the rank deadline, there is nothing to do but wait. However, I strongly advise you to take that time as an opportunity to plan Match Day festivities for all who are participating that year (and for any others who want to attend). After all, no hazing ritual would be complete without culminating in a party.

The Match process takes place in two stages. During the first stage, typically on a Friday in late February, applicants find out whether they are matched at all. This can be a sensitive time, in that some of your colleagues (or perhaps you) may not get matched. If someone does not get matched, the weekend is generally spent reorganizing application materials in preparation for sending them out to sites listed in the "Clearinghouse" on Monday morning. This is a grueling ordeal and it is extremely unfortunate that some strong candidates are not getting matched to sites at which they wish to train. Nevertheless, unmatched applicants often are able to secure a position at an excellent training site through the Clearinghouse (Draper & Lopez, 1997). The APPIC Web site (www.appic.org) has extensive information on the operation of the Clearinghouse (Keilin, 2003b). The alternative is to spend another year at the respective graduate school or to find an internship on your own. In either case, trust that the "mismatch" occurred for a reason (i.e., that the sites made a huge mistake in not realizing what an incredible candidate you are) and decide what course of action would be best to attain your personal and professional goals at that point.

During the second stage of the Match, typically the Monday following initial Match results, applicants find out to which specific training site they got matched. Match results are distributed on the internet (www.natmatch.com) and via e-mail to Clinical Directors and applicants early in the morning of that Monday (as early as 6 a.m. CST for those who wish to know, although the ROLIC website suggests 9

a.m. as the release time). Conceivably, you may not get one of your top choices. If this is the case, cognitive dissonance works well: simply maintain your belief structure about your personal competencies while altering your belief about the attractiveness of the site. In seriousness, if you do not get your top choice, do not obsess about why that might be the case. Rather, trust that you were matched to the best site for you (and go out and enjoy the Match party!).

Conclusions

Surviving the internship Match hazing can be taxing. Hopefully the suggestions and resources provided in this article will give you an upper hand in navigating the process. Matching to an internship site will by no means be the final haze in your route to becoming a successful professional psychologist. However, the useful ability to reframe similarly stressful experiences as simply par for the course (albeit, perhaps a par 6 course) is a tool that will remain with you through your remaining hazing experiences in psychology (and elsewhere). You will then have the opportunity to impart your knowledge to those brave souls who come after you…perhaps even to the ones you haze yourself. □

"…simply maintain your belief structure about your personal competencies while altering your belief about the attractiveness of the site."

References

American Psychological Association (2001). *Publication manual of the American Psychological Association: Fifth edition.* Washington, DC: Author.

American Psychological Association (1994). *Publication manual of the American Psychological Association: Fourth edition.* Washington, DC: Author.

Dosier, C. (2000). Report of roundtable on internship and training of clinical psychologists. *Journal of Clinical Psychology, 56*, 319-325.

Draper, K., & Lopez, S.J. (1997, August). APAGS *APA APPIC Survey of unplaced students: What happens after UND?* Poster presented at the 105th Annual Convention of the American Psychological Association, Chicago, IL.

Keilin, G. (2003a). 2003 APPIC match report. *APPIC Newsletter, 27(3)*, 8. Retrieved July 29th, 2003, from http://www.appic.org/news/Newsletter/March2003/APPICMarchNewsletter.pdf

Keilin, G. (2003b). The match. In C. Williams-Nickelson & M. J. Prinstein (Eds.), *Internships in psychology: The APAGS workbook for writing successful applications and finding the right match* (pp.80-81). Washington, DC: American Psychological Association.

Kerns, R. (2003). *Advice for applicants from internship faculty and training directors*. Retrieved July 28th, 2003, from http://www.psychzone.com/Question.htm

Lopez, S.J., Oehlert, M.E., & Wettersten, K. (1997). Trends in the supply of and competition for APA-accredited internships: 1988–1997. *Association of Psychology Postdoctoral and Internship Centers Newsletter, 22*, 6.

Niebuhr, R. (1950). *The Alcoholics Anonymous Grapevine*. New York: AA Grapevine, Inc.

Oehlert, M.E., & Lopez, S.J. (1998). APA-accredited internships: An examination of the supply and demand issue. *Professional Psychology: Research and Practice, 29*, 189–194.

Prinstein, M. J. (2003). The interview. In C. Williams-Nickelson & M. J. Prinstein (Eds.), *Internships in psychology: The APAGS workbook for writing successful applications and finding the right match* (pp.80-81). Washington, DC: American Psychological Association.

Thorn, B., & Dixon, K. (1997, August). *Internship supply and demand: A tempest or a teapot?* Poster presented at the 105th Annual Convention of the American Psychological Association, Chicago, IL.

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