

THE CLINICAL PSYCHOLOGIST



A Publication of the Society of Clinical Psychology (Division 12, American Psychological Association)

CONTENTS

- 01 President's Column
- 04 Discussion and Debate:
Prescription Privileges
- 10 Letter to the Editor
- 13 Division 12 Program
- 19 Empirically Supported
Therapy Relationships
John C. Norcross, Ph.D.,
Clara E. Hill, Ph.D.
- 25 Evidence-Based
Clinical Assessment
John Hunsley, Ph.D.,
Rebecca Crabb, Ph.D.,
Eric J. Mash, Ph.D.
- 33 Book Review
- 34 Board Meeting Minutes

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PRESIDENT'S COLUMN

Nadine J. Kaslow, Ph.D., ABPP

I want to take this opportunity to thank all of you who have become more actively engaged in the Division during the past few months and express my appreciation to board and committee members for their active service to the Society of Clinical Psychology. I hope that my monthly listserv announcements help you feel more up to date with divisional events and happenings. In this President's Column, I have decided to focus on two topics near and dear to my heart: becoming and being an effective leader and welcoming students and new professionals, our future leaders, into Division 12.

Leadership

During the past year, I have been fortunate to have the opportunity to participate in two leadership fellowships, the Executive Leadership in Academic Medicine (ELAM) program and the Woodruff Leadership Academy (WLA). These fellowships have underscored to me that fact that leadership is a competency, with its attendant knowledge, skills, and attitudes. One of the most useful aspects of these leadership development programs is the networking they afford. Another extremely useful component of these programs is the chance to participate in a 360 degree evaluation process in which people systematically receive feedback from their boss or bosses, peers, subordinates, and self. I recommend that we each engage in such a process every five years, with self-assessment being an ongoing part of our professional and personal lives. And I believe that 360 degree evaluations should occur in graduate school, internship, and postdoctoral training programs. Receiving comprehensive input about our strengths and areas for growth facilitates our own capacity for self-reflection, helps us function more effectively in our current roles, and provides a platform for us to become stronger leaders.

I would like to share some of the key points that I have learned about leadership in the hopes that more Division 12 members will consider leadership roles, that Division 12 members who are leaders can be more effective in their roles, and that we consider teaching our students about leadership in a more systematic and coordinated fashion. It is important to remember that leadership is an action, not a position. It is a process, not a task.

Effective leaders have vision and good strategic planning abilities; they are knowledgeable about themselves, the people, the politics, and the issues; they are intelligent, creative, and have a strong work ethic; they have a high degree of emotional intelligence; and they demonstrate a sense of humor. Able to inspire, motivate, and lead others, they are attuned to new opportunities and willing to take on novel challenges. They surround themselves with smart, dedicated, and capable people and make a commitment to retaining and developing them. These interpersonally skilled, versatile, and accessible individuals hold onto their own values and high ethical standards and maintain their integrity and honesty. They demonstrate loyalty to people

(continued on page 2)

and ideas. Capable leaders manifest wisdom with regards to their ability to see and understand issues, set priorities, and act prudently and courageously. Fair, reliable, consistent, and sensitive in their dealings with others, they are tenacious, motivated, and take a lot of initiative. Competent leaders are able to on the one hand be reasoned and thoughtful, and on the other hand, display passion. These individuals model values and behaviors, focus on group and team building, develop consensus, are inclusive, share power, delegate well, and are competent at conflict management. They create relationships that generate clarity, commitment, and engagement. Effective leaders distinguish themselves as mentors; they are long-term oriented, advisory by nature, impart wisdom, care deeply about the career development of others, facilitate political navigation by their protégés, can serve as objective consultants, and celebrate and reward their protégés successes. People who are considered to be effective as leaders are good communicators and they engage in all forms of communication at every opportunity with those internal and external to the organization. They have the knack for avoiding mistakes that will haunt them forever, and when they do make mistakes they acknowledge and learn from them. Exemplary leaders challenge the process by search-

ing out opportunities and experimenting and taking risks. They fundamentally grasp the concept that the whole is greater than the sum of its parts.

There is burgeoning evidence that a collaborative approach to leadership is optimal in the majority of settings and situations. Collaborative leadership means creating a supportive and positive workplace environment, inspiring and communicating a shared vision, openly providing information, conveying the rationale for decisions (e.g., why they say yes or no), valuing and respecting others, enabling others to act, strengthening people, and sharing power and leadership. Collaborative leaders master the art and craft of empowerment. They empower their team by actively listening to others, valuing the viewpoints of others, developing people and organizational capacity, looking for ways to advance the careers of those who work with them, and putting themselves last. They encourage the heart by recognizing individual contributions and celebrating team accomplishments. They know that they gain power by giving it and that the more people feel power, the greater their satisfaction in the workplace. They build teams for the future.

Another framework that I have found useful is that of appreciative leadership. This approach, which represents a paradigm shift, is based on the

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construct of appreciative inquiry, the art and practice of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential (David Cooperrider). Appreciative leaders encourage others to tell their story. They focus on the system at its best; they see the good. They see the positive behavior they want to develop, they track the positive, and they fan it across the organization so people want to do more of it. Appreciative leaders convey hope by creating inclusive communities; searching for positive examples (best practices); and creating, validating, and spreading the message of hope (James Ludema). These individuals combine effective management and leadership skills with high emotional intelligence. In other words, they put it all together.

Institutions that value highly effective leadership frequently underscore the importance of performance management. Leaders in these settings typically espouse a well-articulated vision and associated goals and ensure that bidirectional feedback processes are in place. They provide feedback that is direct, specific, developmental, and positive and presented in an appreciative fashion. In addition, they are receptive to receiving feedback from their colleagues, subordinates, and superiors.

General Electric (GE) has a superb model of leadership (John Rice). This leadership model is based on the principle that optimal results occur when integrity and quality lay the foundation for all aspects of the organization's functioning and when the people and processes in the system facilitate the creation of high quality products. To support optimal results leaders in the system must engage in the five Es: energize, energy, edge, execution, and empathy.

The following are some of my favorite quotes about leadership.

- *Leadership is like beauty—it is hard to define but you know it when you see it.* (Warren Bennis).
- *If you are not coaching and teaching, you are not leading.* (Jack Welch)
- *There is no limit to what a (wo)man can do or where (s)he can go if (s)he doesn't mind who gets the credit.* (Robert W. Woodruff)
- *If you want to do more with less, work together.* (Lynn Epstein)
- *Imagination is more important than knowledge, for knowledge is limited to all we now know and understand, while imagination embraces the entire world, and all there will ever be to know and understand.* (Albert Einstein)
- *The best way to predict the future is to invent it.* Remember, of course, there is a kind of growth in the

leadership domains that only comes with being a leader—in your work setting, in your community, or in another context. One way that we have as a Division to acknowledge the leaders within our Division is through Fellowship status. The past 40 years has witnessed a significant decline in the percentage of fellows within our division (from 30% in 1960 to 13% in 2003) and thus I encourage everyone who meets the criterion for Fellow to submit their application this year. Materials can be obtained from Lynn Peterson at lynnadmin@comcast.net, or 303-652-3126.

Students and New Professionals

Our future leaders are our students and new professionals. How can we foster leadership in our junior colleagues? Our first step is to welcome them into the Division and it is imperative that we do so. The mean age of our members, according to a recent survey, is 53 years (S.D. 10.3, range 29-89). So, I encourage each of you to invite a student, new professional, or more junior colleague to join Division 12. How can we engage more students and new professionals into our Division? The following are some strategies that the Division leadership have put into place or plan to implement. We have instituted a committee on students that includes an equal number of division members and students (graduate students, interns, post-doctoral fellows), as well as new professionals. We have added a student onto each committee and our website features these students. At the upcoming convention in Hawaii, we have invited luminaries in our field to host conversation hours with students in the Division 12 Hospitality Suite. We are in the process of setting up a student listserv (students also are welcome on the division listserv) and of enhancing our website for students. We hope to start a student honor roll for members who sponsor students. We are putting into place a mechanism to pair students with mentors at convention and in the Division. Over time, we would like to have a fund that provides awards for students in the areas of research, service, and community action. Please email me with other suggestions about involving students and new professionals into the division or if you are a student or new professional and would like to become involved yourself (nkaslow@emory.edu).

I look forward to seeing you and talking with you at Convention. I hope you will join us for our postdoctoral institutes, divisional programming, and our special activities (e.g., awards ceremony and talks, social hour, presidential address).

Discussion and Debate: Prescription Privileges


Note from the Editor: Below is a response received from John Winston Bush to Diane Willis' President's column published in the Fall 2003 issue of *The Clinical Psychologist*. If you no longer have access to the original column, it may be viewed online at the following website: http://www.apa.org/divisions/div12/tcp_journals/tcp_fa03.pdf. Dr. Bush's comments are followed by a response from Dr. Willis.

APA's Prescription Privileges Project: Time for a Radical Overhaul

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 In the *President's Column* of this newsletter (Fall 2003), Diane Willis offers a typical version of the official APA case for drug prescribing privileges (RxP). As such, it includes statements that are demonstrably untrue, and it omits facts that I think many of us would see as putting the RxP program in quite a bad light. Specifically:

- The column portrays the RxP training proposed by APA as being adequate as it stands. Yet in the judgment of many psychologists, the training model puts ease of acquiring prescriptive authority unconscionably far ahead of patients' safety.
- It seriously distorts the history of the issue. RxP advocates' favorite poster child, the Defense Department's 1991-97 Psychopharmacology Demonstration Project, is depicted as a valid precedent for the current APA program; in fact, they are strikingly different. Moreover, the column offers a highly sanitized version of how the pursuit of RxP came to be official APA policy.
- The column describes skeptics and opponents of RxP as APA currently conceives it as "negative and destructive," "immersed in ideology or dogma," and "resistant to fact or reason." These characterizations are both false and gratuitous.

I will briefly address Willis's ad hominem comments further on. First, I would like to chase two straw men out of the barnyard:

Speaking as a fairly well-known critic of the RxP project in its current incarnation, I cannot think offhand of a single member of our profession who opposes psychologist prescribing under any and all circumstances. This simply is not an issue. Nor does anyone I know doubt that—on the whole, and allowing for exceptions in both professions—properly trained psychologists would use medications

more sparingly and judiciously than psychiatrists and other medical prescribers typically do.

Where I and like-minded colleagues dissent sharply from the official APA stance has mainly to do with (1) the amount and kind of medical training needed for safe prescribing, and (2) the way the pro-RxP faction in APA has run roughshod over the loyal opposition within its own ranks. While we have no quarrel with psychologist prescribing in principle, we do believe that APA's project is in dire need of a radical overhaul—both as to what it envisions and as to how it is handled within the profession.

Adequacy of APA Training Model

The APA curriculum—to be described below—is in my opinion much too short and much too easy. Psychoactive drugs affect every system in the body, not just the CNS. They interact with other drugs, with normal variations in individual physiology, with non-psychiatric medical conditions, and with age, gender and diet. In short, prescribing them is not a mere "logical evolution of professional [psychological] practice" as the column avers. It is an act of medical practice, with all its complexities, ambiguities and subtleties.

Prescribing psychologists would treat the same kinds of patients, for the same range of conditions, that psychiatrists spend the great bulk of their time attending to. But psychiatrists have typically had eight years of training, of which perhaps six could be considered medical in nature. Is it really credible that a single year's medical training can equip a psychologist—who typically has scant background in the biomedical sciences to begin with—to prescribe with equal safety and efficacy?

Discussion and Debate: Prescription Privileges

Distorted History

Willis says of the 1991-97 Defense Department Psychopharmacology Demonstration Project (PDP): "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." This is true if—and only if—the following facts are clearly understood:

- The DoD-trained psychologists were allowed to prescribe only for adults 65 and younger—no children, no elderly.
- Medically complex cases were also excluded from their caseloads.
- Their predominantly male patients had been pre-screened by the armed services' enlistment criteria for better than average mental and physical health.
- They trained and worked in military team practice settings where medical backup and consultation were easily and quickly available.
- Their training—unlike what the model curriculum advocated by APA allows – took place in a traditional, on-campus medical school setting and in major hospitals, chiefly Walter Reed Army Medical Center.
- They were closely monitored by the Defense Department, the American College of Neuropsychopharmacology (ACNP), and the General Accounting Office. They were the most scrutinized future prescribers in history.

In short, the 10 PDP officers performed adequately (in the judgment of their ACNP overseers) in an environment that was very different from anything that will ever be inhabited by most civilian psychologists. And in fact, five of the same ACNP monitors, interviewed last year, were lukewarm at best in their assessment of the PDP program as a training model for psychologists in civilian practice. As for APA's short-cut curriculum—well, to put it plainly, they denounced it in scathing terms.¹

More Distorted History

Willis's column carefully steps around these crucial issues:

- The PDP involved two full years of academic study and practicum experience in a traditional medical school and teaching hospital. In sharp contrast, APA's training curriculum can be completed in half that time. Moreover, it allows credit for Internet study and weekend workshops—neither

of which has a track record of any consequence in basic medical training. And finally, requirements for the clinical practicum are astonishingly vague as to duration, content and source of supervision. None of these well-known facts receives the slightest mention in Willis's column.

- Willis claims that the CAPP task force that devised the one-year APA curriculum "drew from the experience of the PDP, as well as the curriculum developed by the California Blue Ribbon Panel." The PDP, as already noted, was a two-year program. The Blue Ribbon Panel's recommendations, meanwhile, were for six to nine months of didactic instruction, plus 18 months of clinical practicum; total, 24 to 27 months.

Drew from, indeed. The data make clear that the task force turned its back on the only empirical support for RxP in existence (PDP)², and also on its own chief source of expert opinion (Blue Ribbon Panel). Perversely, APA sees fit to advertise the very precedents it knowingly disowned as a pedigree for its curriculum of convenience.

- The pursuit of RxP became an official policy of APA at the August 1995 meeting of the Council of Representatives. But Willis's column does not mention that the proposal was "fast tracked"—i.e., deliberately insulated from normal discussion and debate. This was done ostensibly as an emergency measure to help an RxP bill in California clear committee. The bill failed—yet once the putative emergency had passed, the issue was never revisited under normal parliamentary rules. No wonder many people believe RxP gained its place among APA policies with a calculated end run. It did—and APA has been sitting tight on the ball ever since.

Legal Pitfalls

Advocates of RxP assume that the kind of enabling legislation being sought in the statehouses would put psychologist prescribing on a safe legal footing (or so I judge from my inability to find any public statements to the contrary.). If so, they are ignoring the facts of malpractice litigation. It would take only a fair to middling plaintiff's lawyer to demonstrate that a defendant psychologist—despite being certified to prescribe by the state—was out of his depth medically in the case at hand and was therefore guilty of negligence. Crucial evidence: he had only one year of medical training—some of it obtained online, some

Discussion and Debate: Prescription Privileges

at the local Sheraton. And if that doesn't cook his goose to a cinder, imagine that the same psychologist, treating the same patient, was also forced to admit that he had used assessment methods or treatments with little empirical support. The coyote is out there, waiting.

Abusive Rhetoric, Spin Doctoring, Censorship

"Negative and destructive"; "immersed in ideology or dogma"; "resistant to fact or reason." These are typical of the slurs directed at psychologists who suggest that the RxP emperor may not have all his clothes on. Challenges to APA's policy and training model are not answered on the merits. Instead, they are met with silence, evasion, dissembling, irrelevant digression, arrogance ("it's policy, so we don't have to listen to you") and—as in the present instance—gratuitous insult. This hardly comports with Willis's claim that "we have all had opportunities to disagree, approve, modify, or otherwise provide input," and that "no efforts have ever been made to be less than open."

In fact, as any regular reader of the publication can verify, the pages of *Monitor on Psychology* have been all but closed for years to RxP's skeptics and opponents. *American Psychologist* does somewhat better, but even our flagship journal gives nearly twice as much ink (85% more, to be exact) to pro-RxP writers as to the other side.³ Or comb through the APA convention program of your choice. How much air time do pro-RxP presenters get, and how much is allowed to their opponents?

These biases are not accidental, nor do they result from RxP skeptics' being either apathetic or few in number. They are the product of spin management and censorship. Is this the kind of behavior we expect from people who are onto a genuinely good thing? Or

does it suggest instead a narrow, special-interest agenda that can survive only in the dark? You be the judge. □

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- American Psychological Association Division 40 (Clinical Neuropsychology) Records (1995). *Final Report of the Blue Ribbon Panel: Professional Education Task Force of the California Psychological Association and the California School of Professional Psychology—Los Angeles*. Downloaded 2003 Nov 24 from <http://www.lib.lsu.edu/special/apa/report167.htm>.

Endnotes

1. The monitors were willing to answer my questions only under promise of confidentiality. However, verbatim transcripts of their comments, with identifying material removed, are available from the author.
2. Even if APA had followed the PDP model faithfully both quantitatively and qualitatively, it would have been calling for a radical change in our professional identity based on a single, uncontrolled study among 10 painstakingly selected (i.e., atypical) subjects.
3. My analysis of AP articles on RxP from 1991 to the present revealed the following: Pages in largely or wholly pro-RxP articles, 37 (54% of 69 total pages); anti-RxP pages, 20 (29%); balanced or neutral pages, 11 (16%).

Section IV (Clinical Psychology of Women) in Honolulu!

We invite you all (and your colleagues and friends) to Section IV's program at APA in Hawai'i! Our offerings include a presidential address, an invited symposium, and a business meeting and conversation/social hour. The latter will be held on Thursday, July 29, 6-8 pm, in the South Pacific Ballroom I, Hilton Hawaiian Village Beach Resort and Spa, and will include updates and discussion of section activities as a way of welcoming new and prospective members, their guests, and anyone who is interested in meeting us and knowing more.

Our conversation hour topics include:

- preparing women for leadership in clinical settings (broadly defined), including academic and internship training, community clinics, hospitals, relevant branches of state and federal government, and APA
- the intersections of gender as defined by cultural contexts, and culture as a shaper of gender-related identity and behavior, as these may affect our clinical decision-making, especially regarding assessment.
- women as students when faculty are men: the gender gap in academic clinical training.

We hope to see you there!

Sharon Rae Jenkins, Ph.D.
President, Section IV

A Response to Bush's Commentary

Diane J. Willis, Ph.D.

Past-President, Division 12



I would urge the readers of these two columns (Bush & Willis) on prescription privileges to re-read my presidential columns in the Summer and Fall 2003 issues of *The Clinical Psychologist* (TCP) to fully understand the issue currently discussed. First, my efforts to educate our membership about the history of prescription privileges was the thrust of my Fall 2003 column. Bush is absolutely incorrect in his comments regarding how obtaining prescription privileges became APA policy. As noted in my Fall 2003 TCP Presidential

“The issue is how much actual training is functionally necessary.”

Column, the issue of prescription privileges first emerged at the Hawaiian Psychological Association (HPA) Convention in 1984. A 1990 *Journal of Clinical Child Psychology* issue reported on Task Force

findings about the appropriate role of clinical child psychologists in the prescribing of psychoactive medication for children. A review of the topic in various Divisional Newsletters indicates that the issue of prescription privileges was not “sprung” on anyone taking notice of APA governance. Granted, many of our colleagues, including Bush, have not invested themselves in APA governance, so they may not know how often this issue has been discussed. Highly competent APA member educators, scientists, and practitioners have been involved in governance and have discussed the prescription privileges issue. When the issue finally came before Council and was approved, those outside of governance may have felt that this new APA policy was forced on them. I will remind Bush that any member of APA's Council may enter new business items to re-consider any APA policy.

Secondly, Bush took personally the statement in my column that uses the words “negative and destructive.” Read my Fall 2003 column and you will

find that I described the debate on prescription privileges as “intense, with strong feelings on both sides” (p. 1), and I said that I hoped “we could disagree in a constructive, respectful manner rather than a negative, destructive manner” (p.1). I presume the reader would understand that I urged that individuals on both sides of the argument about prescription privileges handle their disagreements in a respectful and constructive manner.

Third, for psychologists to prescribe, we do need training. No one advocates prescribing without training! That is not an issue. The issue is how much actual training is functionally necessary. I think it behooves us to think outside the box on this issue. The training medical doctors receive may not be the best model for us to consider, because psychologists are already better trained than they in the psychosocial aspects of health care. Again, however, I would urge you to read my Summer 2003 Presidential Column in TCP.

I also challenge the members to read the debate between Elaine Heiby and Pat DeLeon published in *Professional Psychology: Research and Practice* (PP), which is now in press. Both psychologists offer interesting comments and do a nice job debating the issue. Additionally, I encourage readers to review the relevant psychology literature on articles pertaining to prescription privileges authored by DeLeon, Fox, D. Dunivan, R. Newman, and M. Sammons. To counteract Bush's comments in which he quotes from a few of the DoD graduates, be sure to read an article being prepared for submission to PP by four of the DoD graduates as they discuss how training in prescription privileges has modified their clinical practices. Additionally, recent graduates of the California-Alliant psychopharmacology training program will publish their article in PP describing how their additional training has already positively impacted their practices, even without a prescription privileges law in California.

In conclusion, the prescription privileges debate may continue for some time and I believe that healthy debate is always welcome. However, I will continue to advocate that we debate in a “constructive, respectful” manner and that we try to listen to all sides of the issue with an open mind. □

APA Presidential Citation

The Business of Practice Network-The Business of Practice Network (BOPN) was created by the APA Practice Directorate in 1995 and consists of a nationwide network of over 50 psychologists representing both state psychological associations and practice divisions. The BOPN representatives forge new connections in the business community through the implementation of state-based "Psychologically Healthy Workplace Award" (PHWA) programs. Through their dedicated work and successful creation of PHWA programs in their respective states, the business community is fast becoming educated about the value of psychological services. The PHWA recognizes organizations that make a commitment to workplace well-being and who strive to create a psychologically healthy work environment for employees. Awards are based on the following criteria: a) Employee Involvement, b) Family Support, c) Employee Growth and Development, and d) Health and Safety. Members of the BOPN work to strategically position psychology in a leadership role within the healthcare marketplace by developing strong collaborative relationships with organizations; and by helping practicing psychologists to better understand the changing marketplace.

In addition to the presentation of the presidential citations, the closing session features a preview of the 2005 convention in Washington, DC as well as entertainment from the Makaha Sons, and refreshments. The Makaha Sons sing traditional Hawaiian music and are known for their unique style of harmonies and their distinctive live performance. If you have any questions or require any further information or materials (e.g., photo), please feel free to contact:

Casey Ann Reeve

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CALL FOR NOMINATIONS

The American Psychological Foundation Theodore Millon Award

The American Psychological Foundation (APF) Theodore Millon, Ph.D. Award will be conferred annually (from 2004 through 2008) to an outstanding mid-career psychologist (doctoral degree received between 8 and 15 years ago), engaged in advancing the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. A scientific review panel appointed by Division 12 of the American Psychological Association will select the recipient upon approval of the APF Trustees. The winner will receive \$1,000 and a plaque, to be presented at the 2005 APA convention in Washington, DC.

Nominations should include a cover letter outlining the nominee's contributions to the science of personality psychology in one or more of the following areas: personology, personality theory, personality disorders and personality measurement. Nomination materials should include an abbreviated curriculum vitae and up to two support letters. Self-nominations are welcome. APF and Div. 12 will notify the recipient after Feb. 10, 2005.

Nominations should be sent to:

Nadine Kaslow, Ph.D.,
Chair, Division 12 Awards Committee
P.O. Box 1082 Niwot, CO 80544-1082

Deadline (for the 2005 award year): Dec 1, 2004

Congratulations to the 2004 Winner!

The 2004 American Psychological Foundation Theodore Millon, Ph.D. Award will be presented to **Drew I. Westen, Ph.D.** for outstanding contributions to diversity in the profession of Clinical Psychology.

CALL FOR NOMINATIONS

Three Awards for Distinguished Contributions in Clinical Psychology

Distinguished Scientific Contribution Award

This award honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology.

Florence Halpern Award for Distinguished Professional Contributions

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

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology

This award shall be given to a psychologist who has made remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind. Other contributions may be broadly conceived as advancing knowledge through research; developing innovative approaches to service delivery, teaching or consultation; or providing mentoring and active promotions of people of color.

Two Awards for Early Career Contributions in Clinical Psychology

David Shakow Award for Early Career Contributions

This award shall be given for contributions to the science and practice of Clinical Psychology. The awardee will be a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to the science and to the practice of Clinical Psychology.

Theodore H. Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology

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

To nominate someone for any of these five awards, send nominee's name, recent vita, and a concise (1-2 page) typewritten summary of his/her achievements and contributions to: **Nadine Kaslow, Ph.D., Chair, 2005 Awards Committee, c/o Division 12 Central Office P.O. Box 1082 Niwot, CO 80544-1082**

Deadline: October 1, 2004

The awards will be presented at the 2005 APA Convention in Washington, DC.

Congratulations to the 2004 Award Winners!

Sidney J. Blatt, Ph.D. will receive the Award for Distinguished Scientific Contributions to Clinical Psychology

Lynn P. Rehm, Ph.D. will receive the Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

A. Toy Caldwell-Colbert, Ph.D. will receive the Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology

Jonathan S. Abramowitz, Ph.D. will receive the David Shakow Early Career Award

Mitchell J. Prinstein, Ph.D. will receive the Theodore H. Blau Early Career Award


These 2004 awards will be presented at the 2004 APA Convention in Honolulu, HI.

Letter to the Editor

Confronting Terrorism: The New Challenge for Clinical Psychology

Robert Henley Woody, Ph.D.
University of Nebraska at Omaha

Correspondence regarding this letter may be sent to: Robert Henley Woody, Ph.D., Sc.D., J.D., Department of Psychology, University of Nebraska at Omaha, 347 Arts and Sciences Building, 60th at Dodge, Omaha, NE 68182; Tel: 402-496-1303; Fax: 402-496-1002; E-mail: psychlegal@aol.com

 Effective September 11, 2001, human psychology was changed profoundly and permanently. Despite countless horrible incidents in history that wrecked havoc on the mind, the current-day terrorist attacks by airplanes in the United States and other senseless violent acts (e.g., car bombings, suicide bombers, etc.) around the world have indelibly imprinted a new sense of vulnerability. Stated simply, terrorism has, in keeping with its nefarious objectives, left a residual mixture of grief, uneasiness, and outright fear that continues to build.

For the civilized person, there is a powerful awareness of the fact that there are terrorists throughout the world who are bent on assaulting personal security and national self-confidence. From a survey of Americans, Johnson (2003) reported that 80% of Americans believe that there will be another major terrorist strike and 54% believe that it will be within the "next several weeks." As Levant (2002) states: "The tragic events of September 11, 2001, have brought the problem of worldwide terrorism to the top of the radar screen for most Americans" (p. 507).

Professional sources are opining that the American culture is assimilating factors that will implant a negative sense of being (i.e., insecurity). Of course a primary objective of terrorism is to weaken and deplete the psychological strength and reduce the productivity (e.g., economically) of the person and the society.

Given terrorism's significant negative imposition on the human mind, modern clinical psychology must, as a guardian of civilized society's human resources, confront the effects of terrorism. In brief, the challenge is to help individuals, institutions, and communities develop a realistic understanding of and acquire relevant adaptive responses to terror.

Since terrorism seeks to assault personal

security and national self-confidence, the clinical psychologist should be prepared to help an individual (as well as a community) cope with the negative effects of terrorism and develop resilience, that is, to be able to assertively apply adaptive strengths and competencies. Much of this effort connects to the time-honored clinical objective of ego strengthening or developing a strong, well-defined self concept. The situation can be likened unto a child's fear of others on the playground. As Levant (2002) describes it, "Like the school-yard bully, terrorism depends for its effect on its ability to induce fear in its intended victims" (p. 508). Levant adds that enhancing resilience can lead to a citizenry that reacts with less fear when terrorism occurs, which will "reduce not only the impact of terrorism but also the incentives for terrorists to engage in violent acts" (p. 508). Like reducing maladaptive-approach responses through conditioning and cognitive restructuring, the clinical psychologist can contradict doubts and insecurities, and build personal (and community) strength to deny terrorism its desired destructive effects.

In the realm of public service, the clinical psychologist should seek to influence the mass communication media (e.g., radio, television, newspapers, magazines) to be responsible in the information provided to the public. This strategy is not in pursuit of censorship, it is in service to promoting healthful conditions.

In psychology, it is well established that vicarious experiences can have a strong personal impact. Media accounts of terroristic disasters have vicariously changed countless people in obvious and immeasurable ways. Speaking of the September 11th travesty, Eidelson, D'Alessio, and Eidelson (2003) say: "The disaster was experienced not only directly by thousands of individuals but repeatedly by millions of television viewers from around the world. For many, the repetitive viewing of the attacks, eyewitness accounts, and stories of survivors and rescue workers had its own traumatizing and retraumatizing effects" (p. 144).

Relatedly, the potential for destructive effects from mass-media reporting goes beyond informing the public of news to potentially increasing the risk of criminal conduct by others: "Meta-analyses have confirmed that exposure to media violence promotes aggressive behaviors, engenders attitudes more accepting of violence, increases hostility, and

Letter to the Editor

results in other antisocial outcomes" (Bushman & Cantor, 2003). The clinical psychologist can appropriately educate media sources for constructive behavior, and oppose (irresponsible) reinforcement of destructive ideas, as might be pathologically embraced and acted upon by a would-be terrorist.

When it comes to a stance for clinical practice, graduate training seems to place little emphasis of stoicism and fortitude in the face of opposition. The time as come for clinical psychologists to be more firm and assertive in promoting healthful conditions, such as steadfastly contradicting the effects of terrorism. □

References

- Bushman, B. J., & Cantor, J. (2003). Media ratings for violence and sex. *American Psychologist*, 58, 130-141.
- Eidelson, R. J., D'Alessio, G. R., & Eidelson, J. I. (2003). The impact of September 11 on psychologists. *Professional Psychology: Science and Practice*, 34, 144-150.
- Johnson, K. (2003). Majority say terror strike likely within weeks. *USA Today*, August 29, 3-A.
- Levant, R. F. (2002). Psychology responds to terrorism. *Professional Psychology: Science and Practice*, 33, 507-509.

Continuing Education Workshops

DIVISION 12 SPONSORED CONTINUING EDUCATION WORKSHOPS will be offered this year in Honolulu, Hawaii at the Sheraton Waikiki Hotel, July 27, 2004, just prior to the APA Convention.

- | Half-day Workshops
4 CE Credits | Tuesday, July 27 |
|--|------------------|
| A - Contemporary Family Psychology Practice: Theories and Technique
Florence Kaslow, Ph.D.
8:00am-12:00pm | |
| B - Teaching "Diversity" in Graduate Mental Health
Beverly Greene, Ph.D.
Gladys Croom, Psy.D.
8:00am-12:00pm | |
| C - Child and Adolescent Anger Management
Eva Feindler, Ph.D.
8:00am-12:00pm | |
| D - Designing and Evaluating Strengths-Based Programs for Adolescents
Bonnie Leadbeater, Ph.D.
8:00am-12:00pm | |
| E - Meditation: An Introduction to Theory and Practice
Jean L. Kristeller, Ph.D.
James W. Jones, Ph.D., Psy.D.
12:30pm-4:30pm | |
| F - Treating Cocaine and Methamphetamine Abuse with Integrative Psychotherapy
Larry E. Beutler, Ph.D.
12:30pm-4:30pm | |
| G - Using Appetite Awareness Training within Interventions for Eating Disorders and Weight Concerns
Linda Craighead, Ph.D.
12:30pm-4:30pm | |

- | Full-day Workshops
7 CE Credits | Tuesday, July 27
8:00am-4:00pm |
|---|-----------------------------------|
| H - Dialectical Behavior Therapy for Borderline Personality Disorder
Marsha Linehan, Ph.D. | |
| I - Motivational Interviewing: Preparing People for Change
William R. Miller, Ph.D. | |
| J - Neuropsychological Assessment of Learning Disabilities Across the Lifespan
Jan L. Culbertson, Ph.D. | |

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Clinical Handbook of Health Psychology

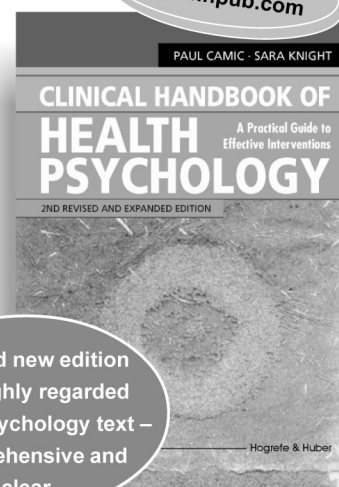
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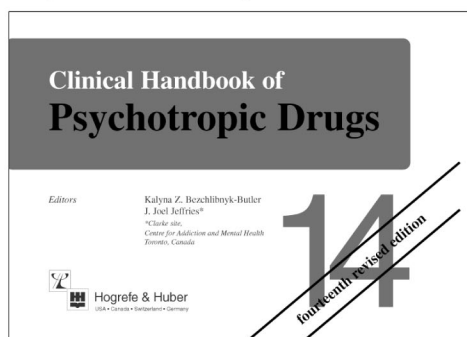
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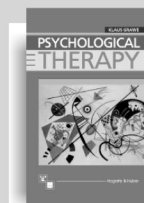
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American Psychological Association Convention Honolulu, Hawai'i Division 12 Program Summary, 2004

Wednesday, July 28, 2004

Symposium: Developing Emerging Scholars Through Community-Based Participatory Research

7/28 Wednesday: 8AM – 8:50AM

Hawai'i Convention Center, Meeting Room 323C

*Gary Bennett, Shani H. Peterson, Derek M. Griffith,
Michael A. Lindsey, Michele Cooley*

Symposium: Training Ethnic Minority Transplant Psychologists—A Vital Service for Minorities

7/28 Wednesday: 8AM – 8:50AM

Hawai'i Convention Center, Meeting Room 325A

*John D. Robinson, Clive O. Callender,
Jeffery A. Harvey, Larry C. James*

Symposium: Eating Disorders, Obesity, and Disordered Eating Among Minority Adolescents—Diagnosis and Treatment Issues

7/28 Wednesday: 8AM – 8:50AM

Hawai'i Convention Center, Meeting Room 306B

*Helen D. Pratt, Delores D. Walcott,
Elaine L. Phillips, Brandy M. Pratt*

Poster Session: Child and Adolescent Eating Disorders, Social Behavior, and Personality Disorders

7/28 Wednesday: 8AM – 9:50AM

Hawai'i Convention Center

Kamehameha Exhibit Hall

Division 12/Section 6 “Clinical Psychology of Ethnic Minorities” Board of Directors’ Meeting

7/28 Wednesday 9AM – Noon

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Invited Address: Florence Halpern Award for Distinguished Professional Contributions in Clinical Psychology

7/28 Wednesday: 9AM – 9:50AM

Hilton Hawaiian Village Beach Resort and Spa,
South Pacific Ballroom II

Lynn P. Rehm

Paper Session: Issues in Providing Services to Families and Adolescents

7/28 Wednesday: 10AM – 10:50AM

Hawai'i Convention Center, Meeting Room 307B

Leslie A. Sim, Carlos M. Grilo, Rebecca J. Cobb

Section IX (Assessment) Symposium:

Psychological Assessment and Ethics

7/28 Wednesday: 10AM – 11:50AM

Hawai'i Convention Center, Meeting Room 313B

*Norman Abeles, Charles J. Golden, Alan Raphael,
Richard Lewak, Irving B. Weiner, Peter F. Merenda,
Kurt Geisinger*

Symposium: New Developments in Research on Internalizing and Externalizing Psychopathology

7/28 Wednesday: 11AM – 12:50AM

Hawai'i Convention Center, Meeting Room 328

*Mark W. Miller, Thomas M. Achenbach,
Robert F. Krueger, Christopher J. Patrick,
Edelyn Verona*

Section VIII (Assoc. of Medical School Psychologists) Symposium: Psychologists in Academic Medicine Organizations)

7/28 Wednesday: 12 – 12:50PM

Hawai'i Convention Center, Meeting Room 307B

*Gerald Leventhal, Satoru Izutsu, Linda M. Garcia-
Shelton, Barry Hong, Richard J. Seime*

Symposium: Integrating Interventions and Services Research—Progress and Prospects

7/28 Wednesday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 325A

*Michael A. Southam-Gerow, Celia E. Wills,
Anthony L. Hemmelgarn, Ann Garland,
Heather L. Ringeisen, Joel T. Sherrill*

Symposium: Preventing Recurrence of Major Depression Among Previously Depressed College Students

7/28 Wednesday: 1PM – 1:50PM

Hilton Hawaiian Village Beach Resort and Spa,
South Pacific Ballroom I

*W. Edward Craighead, Alisha L. Brosse,
Linda W. Craighead, Erin S. Sheets*

Conversation Hour—Drs. Alan Marlatt and Nadine Kaslow

7/28 Wednesday 2 PM – 3 :00 PM

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

American Psychological Association Convention Honolulu, Hawai'i, Division 12 Program Summary

Division 12/Section 4, "Clinical Psychology of Women" Board of Directors' Meeting

7/28 Wednesday 6 PM – 9:00 PM

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Thursday, July 29, 2004

Division 12 Public Policy Workgroup

Drs. Deborah King

7/29 Thursday 8 AM – 9:00 AM

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Symposium: Trauma and Mental Health Issues for Diverse Populations

7/29 Thursday: 8AM - 8:50AM

Hawai'i Convention Center, Meeting Room 304A

Cheryl A. Boyce, Charlene LeFauve, Michael

DeArellano, Sean Joe, Michele Cooley

Symposium: Roles for Psychologists in End-of-Life Care and Research

7/29 Thursday: 8AM - 9:50AM

Hawai'i Convention Center, Meeting Room 313B

John R. Anderson, Dale G. Larson,

Julia E. Kasl-Godley, William E. Haley, Alexis D.

Bakos, Robert A. Neimeyer

Poster Session: Psychopathology and Psychotherapy

7/29 Thursday: 9AM – 9:50AM

Hawai'i Convention Center

Kamehameha Exhibit Hall

Section II (Clinical Geropsychology) Symposium: Suicide in Older Adults—Contemporary Considerations

7/29 Thursday: 9AM - 9:50AM

Hawai'i Convention Center, Meeting Room 316A

Barry Edelstein, Silvia Sara Canetto, James L. Werth,

Paul R. Duberstein, Jane Pearson

Section IV (Clinical Psychology of Women) Presidential Address: Gender, Culture, and Clinical Assessment—Individual Evaluation and Social Systems

7/29 Thursday: 9AM - 9:50AM

Hawai'i Convention Center, Meeting Room 317A

Sharon Rae Jenkins

Symposium: Diversity's Disruptions: Complications in Clinical Research With Communities of Color

7/29 Thursday: 10AM – 10:50AM

Hawai'i Convention Center, Meeting Room 302B

Donna K. Nagata, Joseph P. Gone, Rosario Ceballo,

Laura P. Kohn-Wood, Nnamdi Pole

Symposium: Psychological Effects of the WTC Attacks on Disaster-Relief Workers

7/31 Thursday: 11AM - 11:50AM

Hawai'i Convention Center, Meeting Room 315

Michael Eric Kramer, JoAnn Difede, Judith R. Cukor,

Nimali Jayasinghe

Section VII (Emergencies and Crises)

Presidential Address: The Psychological Autopsy in Clinical and Forensic Practice

7/29 Thursday: 11AM - 11:50AM

Hawai'i Convention Center, Meeting Room 317B

Alan Berman

Division 12/Section 2, "Clinical Geropsychology" Presidential Conversation Hour

7/29 Thursday 12:30 PM – 1:30 PM

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Section IX Business Meeting

7/29 Thursday: 1PM – 1:50PM

Hilton Hawaiian Village Beach Resort and Spa

South Pacific Ballroom I

Norman Abeles

Conversation Hour—Drs. John Norcross, Stanley Sue, and Thomas Ollendick

7/29 Thursday 2 PM – 3:00 PM

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Division 12/Section 8, "Association of Medical School Psychologists" Board of Directors' Meeting

7/29 Thursday 4 PM – 6:00 PM

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Section IV (Clinical Psychology of Women) Social Hour

7/29 Thursday: 6PM – 7:50PM

Hilton Hawaiian Village Beach Resort and Spa

South Pacific Ballroom I

American Psychological Association Convention Honolulu, Hawai'i, Division 12 Program Summary

Friday, July 30, 2004

Division 12/Section 2, "Clinical Geropsychology"

Board of Directors' Meeting

7/30 Friday 8 AM – 11:00 AM

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Paper Session: Provision of Clinical Services

7/30 Friday: 8AM – 8:50AM

Hawai'i Convention Center, Meeting Room 317B

Raymond C. Hawkins, Andrew M. Pomerantz,

Kanika D. Bell, Jean Spruill

Symposium: Assessment of Capacity in Older Adults—An APA--ABA Collaboration

7/30 Friday: 9AM – 9:50AM

Hawai'i Convention Center, Meeting Room 317A

Leonard Poon, Gregory A. Hinrichsen, Charles

Sabatino, Jennifer Moye, David V. Powers,

Robert T. Kinscherff

Poster Session: Topics in Clinical Psychology—Assessment, Diversity, Treatment Process and Outcome, Geropsychology

7/30 Friday: 9AM – 9:50AM

Hawai'i Convention Center, Kamehameha Exhibit Hall

Symposium: Psychology of Terrorism and Fear Management—What Leaders Need to Know

7/30 Friday: 9AM – 9:50AM

Hawai'i Convention Center, Meeting Room 312

Bruce Bongar, Phillip G. Zimbardo,

James N. Breckenridge, Timothy A. Kelly

Division 12 Presidential Address: Embracing the Diversity of Clinical Psychology

7/30 Friday: 9AM – 9:50AM

Hawai'i Convention Center, Meeting Room 316C

Nadine J. Kaslow

Section III (Society for a Science of Clinical Psychology) Discussion: Do Predoctoral Internships Value Clinical Science? Results From the 2004 SSCP Internship Directory Survey

7/30 Friday: 9AM – 9:50AM

Hilton Hawaiian Village Beach Resort and Spa

Nautilus Suite I

Kenneth J. Sher, Jack J. Blanchard

Division 12/Section 2, "Clinical Geropsychology" Business Meeting

7/30 Friday 11 AM – Noon

Division 12 Hospitality Suite

Hilton Hawaiian Village Hotel—Room tba

Section VIII (Assoc. of Medical School Psychologists) Business Meeting

7/30 Friday: 12 – 12:50PM

Hilton Hawaiian Village Beach Resort and Spa

Nautilus Suite Ii

Gerald Leventhal

Symposium: Predictors of Parent-Child Interaction Therapy Outcome

7/29 Thursday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 304A

Melanie D. McDiarmid, Sheila M. Eyberg,

Stephen R. Boggs, Michelle D. Harwood,

Laura Schoenfield, Daniel M. Bagner,

Donna B. Pincus

Section IV (Clinical Psychology of Women) Symposium: Gender, Culture, and Clinical Assessment—Celebrating Best Practices

7/30 Friday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 302B

Sharon Rae Jenkins, Lisa A. P. Sanchez-Johnsen,

Julia M. Ramos-Grenier, Martha E. Banks,

Maria Garrido, BraVada Garrett-Akinsanya,

Rosa T. Lawrence, Belle Liang

Symposium: Making a Difference in APA—How to Get Elected or Appointed to APA and Division Boards and Committees

7/30 Friday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 304A

Asuncion M. Austria, Lynn P. Rehm, Danny Wedding,

Diane J. Willis

Symposium: Hospice and What Psychology Has to Offer

7/30 Friday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 304B

John R. Anderson, Stephen R. Connor, Dale G. Larson,

William E. Haley, J. Donald Schumacher

Symposium: It's Time to Catch the CBT for Psychosis Wave

7/30 Friday: 12 – 1:50PM

American Psychological Association Convention Honolulu, Hawai'i, Division 12 Program Summary

Hawai'i Convention Center, Meeting Room 316A
*Tania Lecomte, Max Birchwood, Yulia Landa,
Mike Startup, Jean Addington, Alicia Spidel,
Eric Granholm, Paul Lysaker*

Section IX Presidential Address

7/30 Friday: 1PM – 1:50PM

Hawai'i Convention Center, Meeting Room 305B
Norman Abeles

Division 12 Award Ceremony

7/30 Friday: 1PM – 1:50PM

Hilton Hawaiian Village Beach Resort and Spa
Coral Ballroom IV

International Society of Clinical Psychology Meeting—Dr. John Norcross

7/30 Friday 2 PM – 3:30 PM

Division 12 Hospitality Suite
Hilton Hawaiian Village Hotel—Room tba

Meditation and Psychology Interest Group— Dr. Lynn Waelde

7/30 Friday, 4 PM-6:00 PM

Division 12 Hospitality Suite
Hilton Hawaiian Village Hotel – Room tba

Pacific Graduate School of Psychology Alumni Reception – Dr. Larry Beutler

7/30 Friday 6 PM – 9:00 PM

Division 12 Hospitality Suite
Hilton Hawaiian Village Hotel—Room tba

Division 12 Social Hour

Poster Session for Section III (Society for a Science of Clinical Psychology)

7/30 Friday: 6PM – 7:50PM

Hilton Hawaiian Village Beach Resort and Spa,
Tapa Ballroom I

Saturday, July 31, 2004

Section VIII (Assoc. of Medical School Psychologists) Symposium: Psychologists in Academic Health Centers—How Are They Doing?

7/31 Saturday: 8AM – 8:50AM

Hawai'i Convention Center, Meeting Room 305A
Danny Wedding, Jessica Kohout, Richard J. Seime

Section VI (Clinical Psychology of Ethnic Minorities) Symposium: Forging Alliances for Empowerment—Lessons From Minority APA Leaders

7/31 Saturday: 8AM – 8:50AM

Hawai'i Convention Center, Meeting Room 306A
*Maria Garrido, Lisa M. Porche-Burke, Melba J.T.
Vasquez, Asuncion M. Austria, Diane J. Willis*

Symposium: Trauma Risk Factors and Resilience—Making Connections

7/31 Saturday: 8AM – 9:50AM

Hawai'i Convention Center, Meeting Room 310
*Robin H. Gurwitch, Jan L. Faust, Steven N. Gold,
Annette M. La Greca, Merritt Schreiber,
Wendy K. Silverman*

Symposium: Building a Firewall Between Marketing and Science

7/31 Saturday: 8AM – 9:50AM

Hawai'i Convention Center, Meeting Room 316B
*William G. Danton, David O. Antonuccio, David
Healy, Morgan Sammons, Barbara Kohlenberg*

Symposium: Effectiveness Studies of Treatments for the Anxiety Disorders

7/31 Saturday: 8AM – 9:50AM

Hawai'i Convention Center, Meeting Room 327
*Norah C. Feeny, Lori A. Zoellner, Richard A. Bryant,
Raphael Rose, David Tolin, Michelle Craske*

Division 12 Section VII (Emergencies and Crises) Business Meeting

7/31 Saturday 9 AM – 10:00 AM

Division 12 Hospitality Suite
Hilton Hawaiian Village Beach Resort and Spa,
Room tba

Poster Session: Topics in Clinical Psychology— Stress and PTSD, Partner Abuse, Anger, Training Issues

7/31 Saturday: 9AM – 9:50AM

Hawai'i Convention Center
Kamehameha Exhibit Hall

Section II (Clinical Geropsychology) Invited Address: M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology Address

7/31 Saturday: 9AM – 9:50AM

American Psychological Association Convention Honolulu, Hawai'i, Division 12 Program Summary

Hawai'i Convention Center, Meeting Room 313C
Larry W. Thompson

Section III (Society for a Science of Clinical Psychology) Presidential Address

7/31 Saturday: 9AM – 9:50AM

Hawai'i Convention Center, Meeting Room 321B
Don C. Fowles

President's Freedom Commission on Mental Health Report: Implications for Psychology. A Cross-cutting Symposium submitted by Divisions 12, 18 and 20

7/31 Saturday, 10-11:50

Hawaii Convention Center, Meeting Room 323B
Nadine J. Kaslow, Larke Nahme Huang, Frederick J. Frese III, Mary A. Jansen, Jane Pearson, Barry Anton, Paul Wohlford

Paper Session: Depression and Substance Abuse

7/31 Saturday: 12 – 12:50PM

Hawai'i Convention Center, Meeting Room 323C
Christine M. Blasey, Chris L. Shriver, Mary Louise Cashel, Cherie L. Villano

Symposium: Cognitive Therapy Versus Medications—Treatment and Prevention of Severe Depression

7/31 Saturday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 313A
Steven D. Hollon, Robert J. DeRubeis, Kelly B. Vitousek

Symposium: Tribute to Leonard Eron—Clinical Implications of Aggression Research

7/31 Saturday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 321A
L. Rowell Huesmann, Brad J. Bushman, Eric F. Dubow, Nancy G. Guerra, Leonard D. Eron

Section III (Society for a Science of Clinical Psychology) Symposium: Scientific Foundations of Clinical Psychology at the Beginning of the 21st Century—Victories, Setbacks, and Challenges for the Future

7/31 Saturday: 12 – 1:50PM

Hawai'i Convention Center, Meeting Room 325A
Kenneth J. Sher, Stephen N. Haynes, Varda Shoham, John F. Kihlstrom, Timothy J. Trull

Symposium: Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology—Forging Diversity in Clinical Psychology: Recruitment, Retention, and Training

7/31 Saturday: 1PM – 1:50PM

Hilton Hawaiian Village Beach Resort and Spa
Coral Ballroom I

A. Toy Caldwell-Colbert, Joseph E. Trimble, Gail Wyatt, Frederick T.L. Leong, Guillermo Bernal

Section II (Clinical Geropsychology) Presidential Address

7/31 Saturday: 1PM – 1:50PM

Hilton Hawaiian Village Beach Resort and Spa
South Pacific Ballroom II

Paula E. Hartman-Stein

Section VII (Emergencies and Crises) Discussion: Youth and Suicidal Behavior: Do SSRI's DO More Harm Than Good"

7/31 Saturday: 2PM – 2:50PM

Hilton Hawaiian Village Beach Resort and Spa
Nautilus Suite I

Alan Berman Ph.D.

Section VI (Clinical Psychology of Ethnic Minorities) Business Meeting

7/31 Saturday: 3PM – 3:50PM

Hilton Hawaiian Village Beach Resort and Spa,
South Pacific Ballroom I

Sunday, August 1, 2004

Symposium: Dialectical Behavior Therapy Versus Nonbehavioral Treatment-by-Experts

8/1 Sunday: 8AM – 9:50AM

Hawai'i Convention Center, Meeting Room 318A
Janice Kuo, Marsha M. Linehan, Katherine A. Comtois, Kathryn E. Korslund, Noam Lindenboim, Steven D. Hollon

Section VIII (Assoc. of Medical School Psychologists) Symposium: Teaching, Mentoring, and Gender in Academic Health Centers

8/1 Sunday: 9AM – 9:50AM

Hawai'i Convention Center
Meeting Room 317B

Barbara A. Cubic, John D. Robinson, Cheryl A. King, Larry C. James

American Psychological Association Convention Honolulu, Hawai'i, Division 12 Program Summary

Invited Address: American Psychological Foundation Theodore Millon Award

8/1 Sunday: 9AM – 9:50AM

Hilton Hawaiian Village Beach Resort and Spa
South Pacific Ballroom II

Drew Westen

Section VII (Emergencies and Crises) Symposium: Responding to Violence in Hospitals and Communities—Two Innovative Programs

8/1 Sunday: 9AM – 10:50AM

Hawai'i Convention Center, Meeting Room 321B

Dean G. Kilpatrick, Connie L. Best, Heidi S. Resnick

Conversation Hour: New Directions for Alcohol, Substance Abuse, and Mental Health Research

8/1 Sunday: 9AM – 10:50AM

Hawai'i Convention Center, Meeting Room 325B

*Delores L. Parrone, Charlene E. Le Fauve,
Cheryl A. Boyce, Lula A. Beatty*

Symposium: Establishing Evidence-Based Treatments for Older Adults

8/1 Sunday: 10AM – 11:50AM

Hawai'i Convention Center, Meeting Room 323A

*Forrest R. Scogin, Adriana Coates, John Sorrell,
Dolores Gallagher-Thompson, George W. Rebok,
Barry Edelstein*

Paper Session: Stress and Distress

8/1 Sunday: 11AM – 11:50AM

Hawai'i Convention Center, Meeting Room 312

*Michaela Mendelsohn, Shamini Jain,
Barry D. Rosenfeld, Cheryl Gore-Felton*

Paper Session: Depression and Bereavement

8/1 Sunday: 11AM – 11:50AM

Hawai'i Convention Center, Meeting Room 323B

*Alex Harris, Korey K. Hood, Anthony D. Ong,
Devin A. Byrd*

Section II (Clinical Geropsychology)

Symposium: Bereavement and Grief Therapy— Beyond Conventional Wisdom and Clinical Lore

8/1 Sunday: 12 – 12:50PM

Hawai'i Convention Center, Meeting Room 323B

*William E. Haley, George A. Bonanno,
Robert A. Niemeyer, Dolores Gallagher-Thompson*

Thank you Division 12 APA Convention Program Reviewers!

Proposals to the Division 12 program of the 2004 APA convention were for symposia, discussion hours, papers, and posters. Each of the regular submissions was subjected to peer review by at least two reviewers; the identity of the proposals' author(s) were masked to the reviewers. Given the structure of APA convention programming, reviewers have a very short time line to review the proposals; the reviewers were outstanding in their timeliness and responsiveness. I am grateful to the over 70 colleagues listed here, who were kind enough to serve as reviewers this year. In addition to a number of reviewers who have served our Society of Clinical Psychology in this capacity year in and year out, several new professionals were invited and were willing to join the ranks of reviewers. I am very grateful to all of you for your expertise and important contributions to our Division.

Antonette M. Zeiss

2004 Program Chair

Division 12, Society of Clinical Psychology

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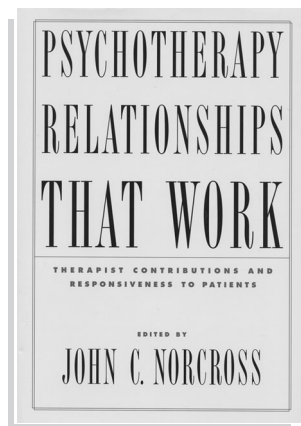
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Empirically Supported Therapy Relationships

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 Health care professionals around the globe are increasingly promulgating practice guidelines and evidence-based treatments in mental health. Foremost among these initiatives in psychology was the Society of Clinical Psychology's (American Psychological Association, Division 12) Task Force efforts to identify empirically supported treatments (ESTs) for adults and to publicize these treatments to fellow psychol-

ogists and training programs. A succession of APA Division 12 Task Forces (now a standing committee) constructed and elaborated a list of empirically supported, manualized psychological interventions for adult disorders based on randomized controlled studies (Chambless et al., 1996; Chambless et al., 1998; Chambless & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Subsequently, ESTs were applied to both older adults and children (e.g., Gatz et al., 1998; Lonigan, Elbert, & Johnson, 1998).

In Great Britain, a Guidelines Development Committee of the British Psychological Society authored a Department of Health (2001) document entitled *Treatment Choice in Psychological Therapies and Counselling: Evidence-Based Practice Guidelines*. In psychiatry, the American Psychiatric Association has published a dozen or so practice guidelines, on disorders ranging from schizophrenia to anorexia nervosa to nicotine dependence.

These and other efforts to promulgate evidence-based psychotherapies have been noble in intent and timely in distribution. They are praiseworthy efforts to distill scientific research into clinical applications and to guide practice and training. They wisely demonstrate that, in a climate of increasing accountability, psychotherapy stands up to empirical scrutiny with the best of health care interventions. At the same time, as with any initial effort, the EST effort was incomplete and potentially misleading.

In particular, two important omissions detracted from these first-generation compilations of evidence-based practices. First, they neglected the therapy relationship, an interpersonal quality that makes substantial and consistent contributions to psychotherapy outcome, independent of the specific type of treatment. The therapy relationship accounts for as much treatment outcome as the specific treatment method (Lambert, 2003; Wampold, 2001).

Second, the initial efforts at ESTs and practice guidelines largely ignored matching the treatment and the relationship to the individual patient beyond his or her diagnosis. Virtually all were directed toward single, categorical disorders; DSM diagnoses have ruled the evidence-based roost to date. Although the research indicates that certain psychotherapies make better marriages for certain disorders, psychological therapies will be increasingly matched to people, not simply to diagnoses. As every clinician knows, different types of patients respond more effectively to different types of treatments and relationships. Clinicians strive to offer or select a therapy that accords to the patient's personal characteristics, proclivities, and worldviews—in addition to diagnosis.

Within this context, an APA Division of Psychotherapy Task Force was established to identify, operationalize, and disseminate information on empirically supported therapy relationships. We aimed to identify empirically supported (therapy) relationships rather than empirically supported treatments – or ESRs rather than ESTs. Specifically, the twin aims of the Division 29 Task Force were to: identify elements of effective therapy relationships, and to identify effective methods of tailoring therapy to the individual patient on the basis of his or her (nondiagnostic) characteristics. In other words, we sought to answer the dual pressing questions of “What works in general in the therapy relationship?” and “What works best for particular patients?”

The Task Force reviewed the extensive body of empirical research and generated a list of empirically supported relationship elements and a list of means for customizing therapy to the individual

Empirically Supported Therapy Relationships

client. For each, we judged whether the element was *demonstrably effective*, *promising and probably effective*, or whether there was *insufficient research to judge*. The evidentiary criteria for making these judgments were the number of supportive studies, the consistency of the research results, the magnitude of the positive relationship between the element and outcome, the directness of the link between the element and outcome, the experimental rigor of the studies, and the external validity of the research base.

The research reviews and clinical practices were compiled in *Psychotherapy Relationships That Work* (Norcross, 2002) and summarized in a special issue of *Psychotherapy* (Norcross, 2001). The following synopses are drawn from those documents.

General Elements of the Therapy Relationship

As noted, the first aim of the Task Force was to identify those relationship elements or behaviors, primarily

“...empathy involves entering the private, perceptual world of the other.”

provided by the psychotherapist, that are effective in general. For each of these relationship elements, we provide a brief definition, a summary of the

research linking the element to therapy effectiveness, and a few clinical implications.

Demonstrably Effective

- *Therapeutic alliance*. The alliance refers to the quality and strength of the collaborative relationship between client and therapist, typically measured as agreement on the therapeutic goals, consensus on treatment tasks, and a relationship bond. Across 89 studies, the effect size (ES) of the relation between the therapeutic alliance and therapy outcome among adults was .21, a modest but very robust association. (A subsequent and independent meta-analysis of 23 studies of child and adolescent therapy found a weighted mean correlation between alliance and outcome of .20; Shirk & Karver, 2003). The alliance is harder to establish with clients who are: more disturbed, delinquent, homeless, drug abusing, fearful, anxious, dismissive, and preoccupied. On the therapist side, a stronger alliance is fostered by strong communication skills, empathy, openness, and a paucity of hostile interactions.

- *Cohesion in group therapy*. Cohesion refers to the forces that cause members to remain in the group, a sticking-togetherness. Approximately 80% of the

studies support positive relationships between cohesion (mostly member-to-member) and therapy outcome. Methods to increase cohesion include pre-group preparation, addressing early discomfort using structure, encouraging member-to-member interaction, actively modeling and setting norms (but not being overly directive). In addition, both feedback and establishing a good emotional climate contribute to cohesion.

- *Empathy*. Carl Rogers' definition, which has guided most of the research, is that empathy is the therapist's sensitive ability and willingness to understand clients' thoughts, feelings, and struggles from their point of view. In other words, empathy involves entering the private, perceptual world of the other. A meta-analysis of 47 studies (encompassing 190 tests of the empathy-outcome association) revealed an ES of .32. Furthermore, a causal link between empathy and outcome has been demonstrated, with suggestions that empathy is linked to outcome because it serves a positive relationship function, is a corrective emotional experience, promotes exploration and meaning creation, and supports clients' active self-healing efforts.

- *Goal consensus and collaboration*. The former refers to therapist-patient agreement on treatment goals and expectation; the latter is the mutual involvement of the participants in the helping relationship. 68% of the studies found a positive association between goal consensus and outcome, and 88% of the studies reported the same for collaboration and outcome. It is not concretely clear from the research how to build goal consensus or collaboration, but clinical experience suggests that clinicians should begin to develop consensus at intake, verbally attend to patient problems, address topics of importance to patients, resonate to patient attributions of blame regarding their problems, and frequently discuss or reevaluate goals.

Promising and Probably Effective

- *Positive regard*. This therapist quality is characterized as warm acceptance of the client's experience without conditions, a prizing, an affirmation, and a deep nonpossessive caring. The early research reviews were very supportive of the association between positive regard and therapy outcome, with 80% of the studies in the positive direction. More recent and rigorous reviews report 49% to 56% of the findings in the positive direction, with no negative associations between positive regard and outcome.

Empirically Supported Therapy Relationships

When treatment outcome and therapist positive regard were both rated by clients, the percentage of positive findings jumped to 88%. Clinically, results indicate that therapists cannot be content with feeling good about their patients, but instead should ensure that their positive feelings are communicated to them.

- *Congruence/genuineness.* The two facets here are the therapist's personal integration in the relationship (freely and deeply him or herself) and the therapist's capacity to communicate his or her personhood to the client as appropriate. Across 20 studies (and 77 separate results), 34% found a positive relation between therapist congruence and treatment outcome, and 66% found nonsignificant associations. The percentage of positive studies increased to 68% when congruence was tested in concert with empathy and positive regard, supporting the notion that the facilitative conditions work together and cannot be easily distinguished. Therapist congruence is higher

“...effectively managing countertransference aids the process and probably the outcome of therapy.”

when therapists have more self-confidence, good mood, increased involvement or activity, responsiveness, smoothness of speaking

exchanges, and when clients have high levels of self-exploration/experiencing.

- *Feedback.* Feedback is defined as descriptive and evaluative information provided to clients from therapists about the client's behavior or the effects of that behavior. Across 11 studies empirically investigating the feedback-outcome connection, 73% were positive and 27% were nonsignificant. To enhance the effects of feedback, therapists can increase their credibility (which makes acceptance of feedback more positive), give positive feedback (especially early to establish the relationship), and precede or sandwich negative feedback with positive comments.

- *Repair of alliance ruptures.* A rupture in the therapeutic alliance is a tension or breakdown in the collaborative relationship. The small body of research indicates that the frequency and severity of ruptures are increased by strong adherence to a treatment manual and an excessive number of transference interpretations. By contrast, the research suggests that repairs of ruptures can be facilitated by the therapist responding nondefensively, attending directly to the alliance, and adjusting his or her behavior.

- *Self-disclosure.* Therapist self-disclosure is defined as

therapist statements that reveal something personal about the therapist. Analogue research suggests that nonclients generally have positive perceptions of therapist self-disclosure. In actual therapy, disclosures were perceived as helpful in terms of immediate outcomes, although the effect on the ultimate outcome of therapy is unclear. The research suggests that therapists should disclose infrequently and, when they disclose, do so to validate reality, normalize experiences, strengthen the alliance, or offer alternative ways to think or act. By contrast, therapists should generally avoid self-disclosures that are for their own needs, remove the focus from the client, or blur the treatment boundaries.

- *Management of countertransference.* Although defined in various ways, countertransference refers to reactions in which the unresolved conflicts of the psychotherapist, usually but not always unconscious, are implicated. The limited research supports the interrelated conclusions that the therapist acting out countertransference hinders psychotherapy, whereas effectively managing countertransference aids the process and probably the outcome of therapy. In terms of managing countertransference, five central therapist skills have been implicated: self-insight, self-integration, anxiety management, empathy, and conceptualizing ability.

- *Quality of relational interpretations.* In the clinical literature, interpretations are interventions that bring material to consciousness that was previously out of awareness; in the research literature, interpretations are behaviorally coded as making connections, going beyond what the client has overtly recognized, and pointing out themes or patterns in the patient's behavior. The research correlating frequency of interpretations and outcome has yielded mixed findings; however, it appears that high rates of transference interpretations lead to poorer outcomes, especially for clients with low quality of object relations. By contrast, other research has highlighted the importance of the quality of interpretations: better outcomes are achieved when the therapist addresses central aspects of client interpersonal dynamics. The clinical implications are to avoid high levels of transference interpretations, particularly for interpersonally challenged clients, and to focus interpretations on the central interpersonal themes for each patient.

Customizing the Therapy Relationship to Individual Patients

Emerging research indicates that adapting the thera-

Empirically Supported Therapy Relationships

py relationship to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment. Accordingly, the second aim of the Task Force was to identify those patient behaviors or qualities that served as reliable markers for customizing the therapy relationship

Demonstrably Effective as a Means of Customizing Therapy

- *Resistance.* Resistance refers to being easily provoked by external demands. Research confirms that high patient resistance is consistently associated with poorer therapy outcomes (in 82% of studies). But matching therapist directiveness to client level of resistance improves therapy efficiency and outcome (in 80% of studies). Specifically, clients presenting with high resistance benefited more from self-control methods, minimal therapist directiveness, and paradoxical interventions. By contrast, clients with

“Most of the available studies (76%) found a significant, inverse relation between level of impairment and treatment outcome”

low resistance benefited more from therapist directiveness and explicit guidance. The clinical implication is to match the therapist's level of directiveness to the patient's level of resistance.

- *Functional impairment.*

This complex dimension

reflects the severity of the patient's subjective distress as well as areas of reduced behavioral functioning. Most of the available studies (76%) found a significant, inverse relation between level of impairment and treatment outcome. These results indicate that patients who manifest impairment in two or more areas of functioning (family, social, intimate, occupational) are more likely to benefit from treatment that is lengthier, more intense, and that includes psychoactive medication. Furthermore, patients who have little support from other people will more likely benefit from a lengthier psychotherapy that explicitly targets the creation of social support in the natural environment.

Promising and Probably Effective as a Means of Customizing Therapy

- *Coping style.* Although defined differently across theoretical orientations, coping style broadly refers to habitual and enduring patterns of behavior that characterize the individual when confronting new or

problematic situations. In the research, attention has been devoted primarily to the externalizing (impulsive, action or task-oriented, stimulation seeking, extroverted) and internalizing coping styles (self-critical, reticent, inhibited, introverted). 79% of the studies investigating this dimension demonstrated differential effects of the type of treatment as a function of patient coping style. Hence, interpersonal and insight-oriented therapies are more effective among internalizing patients, whereas symptom-focused and skill-building therapies are more effective among externalizing patients.

- *Stages of change.* People progress through a series of stages—precontemplation, contemplation, preparation, action, and maintenance—in both psychotherapy and self-change. A meta-analysis of 47 studies found ESs of .70 and .80 for the use of different change processes in the stages; specifically, cognitive-affective processes are used most frequently by clients in the precontemplation and contemplation stages and behavioral processes most frequently by those in the action and maintenance stages. The therapist's optimal stance also varies depending on the patient's stage of change: a nurturing parent with patients in the precontemplation stage; a Socratic teacher with patients in the contemplation stage; an experienced coach with patients in the action stage; and a consultant during the maintenance stage. The clinical implications are to assess the patient's stage of change, match the therapeutic relationship and the treatment method to that stage, and systematically adjust tactics as the patient moves through the stages.

- *Anaclitic/sociotropic and introjective/autonomous styles.* In the psychoanalytic tradition, there are two broad personality configurations: a relatedness or anaclitic style that involves the capacity for satisfying interpersonal relationships, and a self-definitional or introjective style that involves the development of an integrated identity. Similar distinctions are made in cognitive therapy between sociotropic and autonomous styles. A small but growing body of research indicates that these two personality styles are differentially related to psychotherapy outcome. Specifically, anaclitic/sociotropic patients benefit more from therapies that offer more personal interaction and closer relatedness, whereas introjective/autonomous patients tend to do better in therapies emphasizing separation and autonomy. The identification of the patient's personality organization may enable therapists to adapt the degree of interpersonal closeness

Empirically Supported Therapy Relationships

to the individual patient.

- *Expectations.* Expectancy refers to client expectations of therapeutic gain as well as of psychotherapy procedures, the therapist's role, and the length of treatment. Of 24 studies on clients' outcome expectations, 12 found a positive relation between expectations and outcome, 7 found mixed results, and 7 found no relationship. Of 37 studies on clients' role expectation, 21 found positive relationships with outcome, 12 mixed support, and 8 found no association with outcome. The research literature encourages therapists to explicitly assess and discuss client expectations, address overt skepticism, arouse positive expectations, and activate the client's belief that he or she is being helped.

- *Assimilation of problematic experiences.* The assimilation model suggests that, in successful psychotherapy, clients follow a regular developmental sequence of

“...the research suggests that as the client changes, the therapist should change responsively...”

working through problematic experiences. The sequence is summarized in eight stages, from the patient being warded off/dissociated from the problem at the one end, to integration/mastery of the problem at the other end. A series of intensive

case studies and two hypothesis-testing studies indicated that clients in the mid to late stages of assimilation prosper more from directive, cognitive-behavioral therapy. Furthermore, the research suggests that as the client changes, the therapist should change responsively, reflecting the evolving feelings, goals, and behaviors that represent therapeutic progress.

Insufficient Research

The state of the current research was insufficient for the Task Force to make a clear judgment on whether customizing the therapy relationship to the following

patient characteristics improves treatment outcomes: Attachment style; gender; ethnicity; religion and spirituality; preferences; and personality disorders.

Practice and Research Recommendations

The Task Force reports (Norcross, 2001, 2002) close with a series of recommendations, divided into general, practice, training, research, and policy recommendations. The general recommendations encourage readers to interpret the findings in the context of the limitations of the Task Force's work (such as the modest causal connection between the relationship element and treatment outcome) and remind readers that the current conclusions represent initial steps in aggregating and codifying available research. Here, we conclude by highlighting several of the research and practice recommendations.

Research Recommendations

1. Researchers are encouraged to examine the specific mediators and moderators of the links between demonstrably effective relationship elements and treatment outcome.
2. Researchers are encouraged to progress beyond experimental designs that correlate frequency of relationship behaviors and outcome measures to methodologies capable of examining the complex associations among patient qualities, clinician behaviors, and therapy outcome.
3. Researchers are encouraged to avoid a “therapist-centric” view of the therapeutic relationship and to study both patients' and therapists' contributions to the relationship and the ways in which those contributions combine to impact treatment outcome.
4. Observational perspective (i.e., therapist, patient, or external rater) is a fundamental consideration that ought to be addressed in future studies and reviews of “what works” in the therapy relationship. Agreement among observational perspectives provides a solid sense of established fact; divergence among perspectives holds important implications for clinical practice.

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Empirically Supported Therapy Relationships

5. Since many of the important variables reviewed in the Task Force reports are not subject to randomization and experimental control, we recommend that standard research paradigms include the use of rigorous qualitative methods and statistically controlled correlational designs.

Practice Recommendations

6. Practitioners are encouraged to make the creation and cultivation of a therapy relationship characterized by the elements found to be demonstrably and probably effective in this report a primary aim in the treatment of patients.
7. Practitioners are encouraged to adapt the therapy relationship to specific patient characteristics in the ways shown in the report to enhance therapeutic outcome.
8. Practitioners are encouraged to routinely monitor patients' responses to the therapy relationship and ongoing treatment. Such monitoring leads to increased opportunities to repair alliance ruptures, to improve the relationship, to modify technical strategies, and to avoid premature termination.
9. Concurrent use of empirically supported relationships and empirically supported treatments tailored to the patient's disorder and characteristics is likely to generate the best outcomes. □

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Other Resources

- American Psychological Association Division of Psychotherapy Homepage (includes a link to the Task Force on Empirically Supported Psychotherapy Relationships).
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Evidence-Based Clinical Assessment

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It is difficult to imagine any professional service offered by clinical psychologists that does not include or—more to the point—rely on assessment. Regardless of the work setting or the population of clients who are the recipients of services, all psychologists engage in assessment activities, such as clinical interviewing and case formulation, on a regular basis. The number and scope of clinical assessment-related books has grown in recent years and there are several high quality journals devoted to publishing research on psychological assessment, all of which bodes well for the field. Despite all these indications of the importance and vitality of clinical assessment, there has been relative little effort to ensure that psychologists have available to them clear, clinically relevant, and scientifically based guidelines on providing assessment services. Recent initiatives to promote greater attention to empirical findings in the treatment domain, such as Empirically Supported Treatments (ESTs; Chambless & Ollendick, 2001) and Empirically Supported Therapy Relationships (ESRs; Norcross, 2001), are important steps in grounding our profession in the scientific literature, yet no comparable initiatives exist to establish directions for what “counts” as evidence-based assessment.

The importance of evidence-based assessment has been raised many times over the past two decades. Kazdin, Kratochwill, and VandenBos (1986), for example, suggested that one strategy for promoting the use of research findings in routine clinical practice was to encourage greater use of what they called *empirically validated assessment* (i.e., psychometrically strong measures) to evaluate the outcome of treatments provided by psychologists. Several commentators have recently advocated that, much as has been done for treatments, standards for what constitutes evidence-based assessments should be developed and applied (Davison, 1998; McClure,

Kubiszyn, & Kaslow, 2002; Ollendick, 1999, 2003). Indeed it is obvious that both ESTs and ESRs can be identified as empirically supported only on the basis of solid assessment data. For example, in their criteria for identifying empirically supported therapies, Chambless and Hollon (1998) required that outcome data be available on measures that had demonstrated reliability and validity in previous research. They also suggested that it is desirable to have outcome evaluations based on multiple assessment methods, not just self-report measures. It is also obvious that a key aspect of the clinical utilization of ESTs is the use of adequate assessment strategies to monitor and evaluate the impact of the treatment. Furthermore, when there is a need to individually tailor the EST (e.g., Kendall, Chu, Gifford, Hayes, & Nauta, 1998) or when clients present with problems for which there are no ESTs, evidence-based assessments are likely to be crucial for ensuring the quality and success of the interventions.

Our goal in this article is to examine some of the practical and empirical issues involved in conducting evidence-based assessments (EBA). To this end, we consider a number of issues related to both the clinical practice of assessment and the assessment training received by graduate students in clinical psychology programs. Further information on these and related assessment issues can be found in forthcoming special sections devoted to evidence-based assessment in the journals *Psychological Assessment* (Hunsley, Mash, & Strauss, in press) and *Journal of Clinical Child and Adolescent Psychology* (Mash & Hunsley, in press).

Foundations of EBA

The task of developing and documenting EBA is a far greater challenge than that encountered in the various evidence-based treatment initiatives. This is due to at least four factors: the sheer number of assessment measures and procedures for particular problems relative to the number of available treatments, the many purposes of assessment as compared with treatment, the range of population-specific and problem-specific psychometric qualities that must be considered for each assessment tool, and the fact that assessment is an iterative decision-making process and not just the utilization of a collection of strategies and measures (see Antony, 2002 for further discussion). Any attempt at delineating EBAs must be sensitive, therefore, to the multifaceted nature of clinical assessment.

As a starting point, it is important to recognize that there can be many purposes to assessment.

Evidence-Based Clinical Assessment

At a minimum, there is a distinction between situations in which the assessment serves as that primary clinical service (e.g., neuropsychological evaluation, custody and access evaluation, psychoeducational assessment) and situations in which assessment data are used to develop, guide, and/or evaluate other clinical services (e.g., psychotherapy, program development and implementation). Although this distinction is often ignored or downplayed in graduate assessment courses and in surveys of assessment practices (Hunsley, 1996), it is critical to recognize that assessment procedures and measures that have supporting empirical evidence for one of these activities may not have comparable supporting evidence for other activities. Moving beyond this simple binary distinction within assessment, a number of inter-related purposes can be identified that form the basis for the whole gamut of clinical assessments: these include screening, diagnosis, prognosis, case formulation, treatment design and planning, treat-

“...there are many commonly used measures and procedures that do not meet contemporary standards for psychometric adequacy.”

ment monitoring, and treatment evaluation. Although some assessment measures are used for several of these purposes, the

conditional nature of test validation requires that the assessment purpose be considered in determining whether a measure can be considered evidence-based for that purpose.

In order to establish the level of empirical support for a measure or procedure, it is essential that we draw upon not just assessment research per se, but also other relevant scientific literatures, including psychopathology and psychotherapy research (Frick & Cornell, 2003). If we consider research relevant to a service consisting of assessment only, this would mean focusing on measures that tap key aspects of the presenting problems (as indicated in the relevant psychopathology research) and that are directly relevant for screening purposes or for providing a diagnosis and possible prognosis. Alternatively, if we are considering the evidence for treatment-related assessment, this would mean using measures that have demonstrated value in the psychotherapy literature for treatment planning, treatment monitoring, and treatment evaluation. Clinical guidelines that summarize the relevant

information are clearly desirable. As an extensive (and ongoing) review of the scientific literature would be required for to establish the evidence base of a given measure, such an undertaking is clearly beyond what is feasible, in terms of expertise, time, and resources, for most individual psychologists. It is in this context that problem-specific clinical assessment guidelines can serve an important function for both practice and research.

Don't Psychologists Already Practice EBA?

It could be argued that, because of their training, most (if not all) clinical psychologists should have the requisite knowledge to ensure that their assessment practices are already evidence-based. Along similar lines, as psychologists are required to follow the *Standards for Educational and Psychological Testing* (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 1999) in developing and using tests and assessment procedures, it might be reasonable to expect that psychologists are providing assessment services that are based on solid empirical evidence.

Although we have little doubt that most psychologists strive to base their assessment work on empirical evidence, it is clear that there are many commonly used measures and procedures that do not meet contemporary standards for psychometric adequacy (Hunsley, Lee, & Wood, 2003). One example will suffice to illustrate our point. Over several decades, projective drawings have ranked consistently among the ten most common assessment procedures used by clinical psychologists (Watkins, Campbell, Nieberding, & Hallmark, 1995) and are among the most common assessment procedures used in evaluating both adults and children in custody disputes (Ackerman & Ackerman, 1997). Yet, given the large number of different projective drawing tests and a myriad of scoring systems, even proponents describe the normative base as inadequate (Handler & Habenicht, 1994). Furthermore, interrater reliability tends to be poor (Palmer et al., 2000), and there is little evidence to support the validity of most projective drawing procedures (Joiner, Schmidt & Barnett, 1996). As a result of these and other weaknesses, Lally (2001) recently concluded that projective drawings do not meet current standards for the admissibility of evidence into courts.

It seems, therefore, that relying solely on psychologists' knowledge and application of the Standards is unlikely to ensure that consumers receive evidence-based assessment services. There

Evidence-Based Clinical Assessment

are many other obstacles to ensuring that clinical assessment is, indeed, evidence-based. One such obstacle is that, because establishing the psychometric properties of a measure is an ongoing process, psychologists cannot simply rely on assessment knowledge they gained during their training. Offering evidence-based assessment services requires that psychologists continually update their knowledge and, based on this information, alter their practices when necessary. As all psychologists know, such continuing education is a very time-consuming activity. Given that most psychologists indicate that assessment activities constitute only a small percentage of their professional activities (Camara, Nathan, & Puente, 2000) it seems likely that only a very limited amount of their continuing education efforts would be devoted to maintaining current knowledge of assessment.

Another obstacle to maintaining an evidence-based assessment practice is that it is simply not

“...psychologists cannot simply rely on assessment knowledge they gained during their training.”

enough to rely on the *Standards* for guidance on what might constitute appropriate assessment. The *Standards* are intentionally nonprescriptive with

respect to the level and quality of scientific evidence needed to ensure a measure is adequate for clinical purposes. To illustrate the problem with this, consider a situation in which a psychologist is diligently tracking the assessment literature and is attempting to apply the requirements outlined in the *Standards* to what she or he is reading. Based on the *Standards*, the psychologist would know the importance of having reliability values reported for each subscore or total score derived from a measure. However, beyond these basic requirements, the psychologist would find no guidance from the *Standards* regarding such crucial aspects as the size and composition of the reliability sample and the optimal level of reliability for clinical use. In the absence of such guidance, the psychologist may be tempted to rely on the commonly used level of an alpha of .80 as an indicator of adequate reliability. However, as Nunnally (1978) cogently argued, when considering measures used for classification purposes the size of the standard error of measurement should be considered in establishing the required level of a measure's internal consistency value. As a result, he suggested that

an alpha of .90 should be the minimum acceptable level for measures used to make clinical decisions.

EBA guidelines could be developed to provide substantial aid to clinical psychologists. By drawing upon contemporary research in psychopathology, psychological intervention, and psychological assessment, guidelines could help focus assessment efforts on the variables that are most likely to be relevant to a specific assessment task. By providing clear and consistent criteria for psychometric adequacy, guidelines could provide summary information on assessment strategies and measures that are sufficiently supported by replicated research to be used to assess these identified variables. The psychometric criteria would need to be sensitive to the purpose of the assessment: continuing with the previous example, the reliability criterion might be set at .80 for measures designed to be used for screening purposes (based on the assumption that supplemental data will be collected that could clarify the clinical description given by the screening instrument), whereas it should be set at .90 for measures that are being used for categorization purposes (such as in the case of intelligence tests in the context of a psychoeducational assessment). Clinically useful guidelines could also be designed to yield information on gender, ethnic, and age-related validity considerations and, going beyond purely psychometric criteria, could provide data (when available) on the costs and consumer acceptability of a strategy or measure.

EBA in the Context of Current Assessment Practice

Given the centrality of assessment to ESTs/ESRs and to accountability concerns about psychological services, it is ironic that assessment appears to be underused and undervalued by many psychologists. One survey of clinical psychologists found that the majority spent less than four hours per week on assessment services (Camara et al., 2000). It is particularly noteworthy that there is almost no overlap among the psychological measures found to be commonly used by psychologists in such surveys and the measures necessary to (a) implement and monitor ESTs or (b) adapt treatments based on the consideration of ESR elements (such as therapeutic alliance). Other survey data suggest that only a minority of psychologists routinely use objective outcome assessment measures to evaluate their services (Plante, Andersen, & Boccaccini, 1999) and that, for example, when providing marital therapy, few clinicians regularly use any type of formal assessment method in their practices (Boughner, Hayes, Bubenzer, & West, 1994). Of course the decline in and devaluation of

Evidence-Based Clinical Assessment

assessment services is partly the result of refusals by cost-conscious managed care providers to reimburse for assessment services; in one survey of 40 managed care companies, 30% did not provide any reimbursement for psychological assessment (Stout & Cook, 1999). Based on other survey data, it appears that such constraints are leading clinicians to rely less on time-consuming tests (such as projectives, intelligence tests, and personality inventories) and to rely more on self-report measures and checklists (Groth-Marnat, 1999; Piotrowski, Belter, & Keller, 1998).

It must be recognized, however, that in the past two decades the very nature of what constitutes psychological assessment has changed dramatically. Psychological assessment is no longer what Lowman (1996, p. 339) once characterized as the rote application of an intelligence test, a projective test, and one or two broadband measures of psychopathology.

Among other changes, there has been a significant

“...what is needed is a set of evidence-based clinical guidelines that can serve as decision-making aids.”

move in clinical assessment research and practice to the use of disorder-specific, brief, face valid, symptom/problem focused measures that are inexpensive and that are integrated into intervention services. These

measures are designed specifically to aid in the formulation and evaluation of psychological services and, as such, are directly beneficial to clinicians in their daily work (Groth-Marnat, 2000). Recent surveys suggest that these are exactly the type of assessment measures that psychologists and other clinicians seek in providing treatment services, as they can be used to assess psychosocial functioning prior to treatment, aid in treatment planning, and provide continuous feedback on client progress (Barkham et al., 2001; Bickman et al., 2000). Moreover, as demonstrated by Lambert and his colleagues (e.g., Lambert et al., 2003), routine treatment monitoring has the potential to affect treatment outcome by reducing the likelihood of client deterioration and enhancing the positive effects of psychotherapy.

At this point in time there are several valuable books that provide important psychometric data on this disorder-specific measures (e.g., Antony, Orsillo, & Roemer, 2001; Nezu, McClure, Ronan, & Meadows, 2000) or that demonstrate how to effectively integrate sound assessment strategies into routine clinical practice (e.g., Woody, Detweiler-

Bedell, Teachman, & O'Hearn, 2003). Relatedly, Antony and Barlow's (2002) recent volume serves as an excellent illustration of how current assessment strategies and measures can be used to guide and evaluate treatment for a host of frequently encountered problems among adult clients. However, for psychologists to be able to capitalize on current research knowledge and to assess in a manner that is truly evidence-based, what is needed is a set of evidence-based clinical guidelines that can serve as decision-making aids. As we indicated earlier in this article, such guidelines would need to have a number of features, including, at a minimum, (a) comprehensive coverage of measures and procedures that are likely to have clinical utility for addressing specific disorders and presenting problems, (b) evidence of how reliable a measure is likely to be when used for various assessment purposes, (c) summaries describing replicated evidence for a measure's concurrent, predictive, discriminative, and, if available, incremental validity, and (d) descriptions of the relevance of these psychometric properties for each population or group for which a measure is intended to be used. With such guidelines in hand, clinical psychologists would find the task of staying current with the scientific assessment literature much easier. Moreover, the effort required to continually ensure that their assessment activities meet the requirements of the Standards would be greatly reduced. Developing and updating these guidelines would be a considerable task, but one that is essential if we are to ensure that our assessments are based on solid empirical evidence.

EBA and Training in Clinical Assessment

Just as there appears to be a disjunction between the assessment knowledge and skills possessed by some psychologists and the requirements for providing EBAs, there is a substantial lag between contemporary knowledge in clinical assessment and what is typically taught to graduate students. Over the past three decades survey after survey has found that the nature of what constitutes training in clinical assessment has been remarkably stable. It seems that, for the most part, assessment course instructors frequently are teaching their students assessment strategies and instruments that are very similar to what they themselves were taught as graduate students. In essence, for almost 40 years, it appears that much of what clinical psychology students learn about assessment instruments can be boiled down to a core of intelligence and personality testing, and that various versions of the Wechsler intelligence scales, the MMPI, and projective tests have been and contin-

Evidence-Based Clinical Assessment

ue to be a mainstay of graduate assessment courses (e.g., Stedman, Hatch, & Schoenfeld, 2001).

In their survey of American Psychological Association accredited clinical psychology programs, Childs and Eyde (2002) found that most programs addressed topics such as psychometrics (73%), intellectual assessment (100%), personality assessment (99%), neuropsychological assessment (81%), learning disability assessment (68%), and behavioral assessment (57%), although the depth of the coverage in these topics varied greatly. They also indicated that only a few of the programs they surveyed reported integrating training in assessment with key service activities such as diagnosis and intervention. By artificially separating the activities of assessment from the activities of intervention, training programs give the inappropriate message, whether explicit or implicit, that these activities involve separate different skills sets and knowledge bases.

“...the gap between what is taught to students and the clinically relevant assessment research now available has grown enormously.”

assessment. The diverse methods of behavioral assessment such as structured/semi-structured interviews, symptom and disorder specific self-report measures, self-monitoring measures, observational methods, and psychophysiological methods are now commonly recommended for assessing psychological disorders and developing appropriate treatment plans (Antony & Barlow, 2002). Moreover, many of the prototypic features of behavioral assessment (including the emphasis on scientifically sound measures, the importance of assessing context, the value of obtaining multiple forms and sources of information, and the need for exercising caution in drawing inferences about a variable's stability and cross-situational generalizability) have been adopted more generally as features of scientifically and ethically informed psychological assessment (Mash & Hunsley, 2004). Indeed, one could convincingly argue that one of the features that underlie the efficacy of ESTs is that they rely on repeated, intervention-relevant evaluations during therapy to moni-

The apparently limited emphasis on so-called behavioral assessment in many training programs is particularly problematic, as the growth of behavioral assessment over the past 30 years has dramatically transformed the practice of psychological

tor and adjust services. As modern assessment now incorporates so many aspects of what has traditionally been seen as behavioral assessment, those teaching assessment courses should ensure that the central concepts of behavioral assessment are covered in their courses (see Haynes & Heiby, 2004).

While longstanding debates continue about whether students receive enough training in assessment, whether there is sufficient (or too much) attention to projectives in students' training, and how best to share the training obligations between academic programs and internship settings, the gap between what is taught to students and the clinically relevant assessment research now available has grown enormously. In many respects this is analogous to the situation noted by Aiken et al. (1990) in the graduate level training of students in statistical and methodological domains. In their survey of graduate programs they found that this central aspect of all doctoral level psychology training had changed little in over two decades and, as a result, the authors called for the revamping of the required curriculum in statistics, measurement, and methodology to ensure that students are informed about current research and analytic techniques. It appears to us that a similar retooling is necessary regarding the assessment knowledge and skills taught to clinical students.

Psychologists' training and continuing education must encompass more than just the knowledge of how to administer, score, and interpret a limited range of standard measures. Students need to know not only that psychological assessment can be valid for a number of tasks (e.g., Meyer et al., 2001), but that contemporary practice increasingly requires the use of measures developed for very specific purposes. For example, surveyed diplomates of the American Board of Forensic Psychology recommended that, in addition to the commonly taught WAIS-III and the MMPI-2, a number of specific forensic instruments should be considered for use in assessing mental status at the time of the offense, competency to stand trial, malingering, risk for violence, and risk for sexual violence (Lally, 2003). Whether the assessment is to be the primary service or is to be used in the context of treatment provision, students must receive training in how to select the assessment strategies and measures that are relevant in light of the assessment purpose and the client's specific presenting problems, possible diagnoses, and general characteristics (such as age, gender, and ethnicity). Such knowledge, when combined with the type of foundational training in psychometrics and clinical data integration recommended by the Division 12 "Assessment for the Twenty-First

Evidence-Based Clinical Assessment

Century” task force (APA Division 12 Presidential Task Force, 1999), would ensure that students are well-prepared for practicing evidence-based assessment.

Conclusion

In order to be used effectively and efficiently by psychologists, EBA guidelines must summarize a comprehensive range of measures and procedures in terms of their demonstrated reliability and validity for each population, purpose, and context in which they are meant to be used. Despite the considerable challenges involved in developing such guidelines, they have the potential to yield greater measurement accuracy, improved diagnostic reliability, and significant clinical utility for case formulation, treatment planning, treatment monitoring and treatment evaluation. Full implementation of EBAs will necessitate large-scale changes in how most clinicians currently conceptualize and practice psychological assessment, and how graduate students are trained

“Full implementation of EBAs will necessitate large-scale changes...”

in psychological assessment. As we have noted, there is already a shift away from assessment as a general screening activity and toward the use of specific measures that can be integrated with treatment planning and monitoring. The development of EBA guidelines will facilitate this trend by making it easier for clinicians to make informed decisions when choosing measures for different client groups and varying assessment purposes. Currently, there exists a tremendous amount of research on assessment measures that is rarely used to benefit the care of patients in psychological practice. The development of EBA guidelines

has the potential to allow clinical psychology to capitalize on its fundamental strength in assessment and to help assessment attain a more valued status among practitioners. □

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Applying for Fellow Status in Division 12

Fellows Applicants:

For those individuals who would like to apply to Division 12 as “new” Fellows, (those who are not yet a Fellow in any other Division) should submit their application to the Division Central Office by December 1st of any given year. Notification will be in February of the following year. Ratification of the Fellows Committee's choices, however, must be done by APA's Membership Committee when they meet in August at the Convention. The Fellow status will begin the following January 1st.

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

Send all application to:
Fellowship Committee Chair
Div 12 Central Office
P.O. Box 1082
Niwot, CO 80544-1082

To request applications:
Tel: 303-652-3126
Fax: 303-652-2723
email: div12apa@comcast.net

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Society of Clinical Psychology—New Fellows for 2005

The 2004 Society Fellowship Committee, led by Fellowship Chair Alfred J. Finch, Jr., Ph.D., has approved the following individuals for Fellowship status, effective January 1, 2005:

Initial Fellows:

Deborah A. King, Ph.D.
Alec L. Miller, Ph.D.
David A. Smith, Ph.D.
Lawrence A. Vitulano, Ph.D.

We have received word that APA Membership Committee has approved these individuals. However, Council must give final approval in August.

The members of the 2004 Fellowship Committee are: Bruce Bongar, Ph.D., David Antonuccio, Ph.D., Gary B. Melton, Ph.D., Lillian Comas-Diaz, Ph.D., Lauren Alloy, Ph.D., and Alfred J. Finch, Jr., Ph.D., Chair.

Fellows Who are Already Fellows in Another Division:

Barry S. Anton, Ph.D.
Thomas H. Brandon, Ph.D.
Armand R. Cerbone, Ph.D.
W. Miles Cox, Ph.D.
John F. Curry, Ph.D.
Patricia M. Dubbert, Ph.D.
Thomas J. Fagan, Ph.D.
Sherryl H. Goodman, Ph.D.
Jerry R. Grammer, Ph.D.
Alan S. Gurman, Ph.D.
Barbara S. Held, Ph.D.
Jeffrey J. Magnavita, Ph.D., ABPP
Susan H. McDaniel, Ph.D.
Frederick L. Newman, Ph.D.
Edmund J. Nightingale, Ph.D., ABPP
John C. Norcross, Ph.D.
Susan G. O'Leary, Ph.D.
Oakley S. Ray, Ph.D.



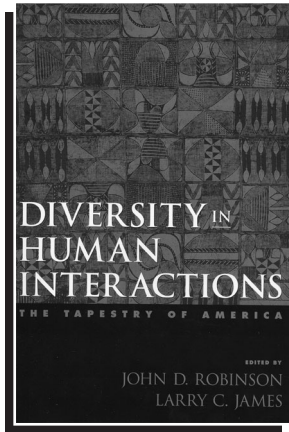
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Diversity in human interactions: The tapestry of America. New York: Oxford.

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Reviewed by Gordon C. Nagayama Hall, Ph.D., Department of Psychology, University of Oregon



“Where does it end?” This is a question that I have heard during discussions of diversity. The person asking the question is sometimes overwhelmed with the complexity of diversity. At other times, the person asking the question is attempting to avoid diversity issues because it is easier not to have to contend with them. Our response to this question is “Where does it begin?” Ignoring

diversity will not cause it to disappear. A starting point is needed for someone who is unfamiliar with diversity issues and wants to begin to learn. Diversity in human interactions is an excellent starting point.

The scope of diversity addressed in this book is comprehensive. Whereas many considerations of diversity focus primarily on race and ethnicity, this book includes ethnic groups, mixed race individuals, sexual orientation, aging, religiosity, and disability. The final chapter also provides an overview of research issues and challenges in studying diverse populations. Many of the authors who have contributed to this book are acknowledged leaders in psychology.

The first chapter by Beverly Greene is incisive and thought-provoking, and is an appropriate way to begin a consideration of diversity. Greene describes the disconnect between espoused values of diversity and the discomfort in actually addressing diversity issues in interpersonal contexts. She discusses privilege as something that is often transparent to those who have it. Moreover, many of us have multiple identities, some privileged, some not. Therefore, persons from disadvantaged groups who are relatively privileged are not necessarily more tolerant or accepting of other disadvantaged groups. Greene

offers the example of tensions between ethnic and sexual minority groups.

The chapters that follow offer informative overviews on various diverse groups. Particularly valuable in each of these chapters are the historical and cultural contexts that are presented. Although the relatively brief length of each chapter does not allow much depth, some of the chapters address within-group variability and multiple identities that transcend categories of diversity. For example, although African Americans are often described as if they are homogeneous, Toy Caldwell-Colbert and colleagues discuss skin color, age, language, socioeconomic status, class, cultures of origin as dimensions of within-group variability. Similarly, Douglas Haldemann and colleagues cover race/ethnicity, ability status, and generation as identities that interact with sexual orientation.

As Greene eloquently communicates in the first chapter, diversity is much more than a philosophy or an intellectual exercise. It involves the lives of real people. Thus, practical guidance on diversity issues is necessary. Some of the chapters offer useful practical recommendations for clinical work, including the chapters on African Americans, Hawaiian Americans, and religiosity. Although all the chapters whet our appetites for more information on each group, some are short on practical implications.

Readers should understand that this book is a starting point for discussions on diversity. There is much conceptual and empirical work on diversity that is beyond the scope of this book and is not reviewed. Whole volumes have been devoted to some of the chapter topics in this book. For example, the Handbook of racial and ethnic minority psychology (Bernal, Trimble, Burlew, & Leong, 2003) is an in depth review of the conceptual and empirical literature on ethnocultural issues. Diversity in human interactions was written as an introductory textbook for the study of individual differences, and its purpose is to foster open and frank discussion of the issues surrounding diversity. This book accomplishes this purpose well. □

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**ABBREVIATED MINUTES
SOCIETY OF CLINICAL PSYCHOLOGY,
BOARD OF DIRECTORS MEETING
SAN ANTONIO, TEXAS, JANUARY 9-11, 2004**

President Nadine Kaslow opened the meeting with a half-day retreat agenda to develop a vision statement and strategic plan for the division. Perceptions of the division's strengths, challenges, and priorities were shared. Strengths include size, diversity, the Journal, science and practice integration and central office. Challenges include being inclusive regarding all of clinical psychology, membership communication, coordinating with other organizations/divisions, and remaining solvent. Priorities included keeping the journal, maintaining members, new revenue streams, reaching across clinical specialties. Future meetings will address these and other identified issues.

**SELECTED ANNOUNCEMENTS/ACTIONS/
ACKNOWLEDGEMENTS**

Sheila Woody will prepare all proposed new amendments to the bylaws for a membership vote in the TCP.

Deborah King will be the liaison to Federal Advocacy groups, and lead a group of Section advocacy representatives.

Nadine Kaslow's monthly announce-only listserv is up and running for members.

Linda Sobell's presidential initiative for 2005 will be on substance use in special clinical populations. The end product is to be a book for health care practitioners.

The Council of Representatives apportionment for Division 12 remains at 5.

The Hawaii convention program will be expensive, but excellent. PDIs, special symposia, the hospitality suite, social hours are all planned.

The Journal (Clinical Psychology: Science and Practice) will be evaluated by Division members through a survey, either in TCP or on-line.

The budget is within \$5000 of being balanced.

Commendations were given to Lynn Peterson for her coordinating the midwinter meeting for the 5 divisions that joined us this year in San Antonio – and to Antonette Zeiss for her skill as Program Chair in setting up the Hawaii convention program.

MOTION: The Division authorizes a fund through the American Psychological Foundation for the Society of Clinical Psychology. PASSED

MOTION: Chairs of committees are in charge of appointing one or two student representatives for a one-year term. These appointments may be renewed each year by the current chair. Chairs are encouraged to consider students who are active in sections. The students must be Division 12 members. PASSED

MOTION: The Florence Halpern award for distinguished professional contributions honors psychologists who have made distinguished advances in psychology leading to the understanding or amelioration of important practical problems, and honors psychologists who have made outstanding contributions to the general profession of clinical psychology. PASSED

MOTION: The Division will eliminate the position of Postdoctoral Development Institute (PDI) Chair beginning January 1, 2005. PASSED

MOTION: The President-Elect will preside over the PDI and be reimbursed up to \$1500 for travel during the presidential year. PASSED

MOTION: The Division will provide up to \$500 for presidential travel for 2004, if needed. PASSED

MOTION: The Division will appoint a federal advocacy coordinator who can help to develop the various ideas discussed for advocacy. PASSED

SECTION REPORTS/AWARDS/FULL MINUTES

The written reports of sections and the lists of awardees are elsewhere in The Clinical Psychologist, or are available from Central Office, along with the full minutes of all the meetings. The next Board Meeting will be in Las Vegas, June 26-27.

**Respectfully submitted,
Annette Brodsky, Secretary**

Call for New Editor

The Clinical Psychologist

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

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

The editorial appointment will be made for a four year term, starting in January 2006. The Editor is responsible for all content, for overseeing the publication's annual budget, and for managing the production of the newsletter. The Editor reports to the Publications Committee of the Society, and is a non-voting board member of the Society. The Editor also receives an annual stipend.

Individuals interested in applying for the position should arrange to have a letter of application, curriculum vitae, and three letters of recommendation sent to the address below by October 1, 2004.

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

Questions about the position can be addressed to the current Editor, Martin M. Antony, Ph.D.,
Tel: (905) 522-1155, ext. 3048; E-mail: mantony@stjosham.on.ca.

INSTRUCTIONS FOR ADVERTISING

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

Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, phone number, and advertisement to the editor. E-mail is preferred.

For display advertising rates and more details regarding the advertising policy, please contact the editor.

Please note that the editor and the Publication Committee of Division 12 reserve the right to refuse to publish any advertisement, as per the advertising policy for this publication.

Submission deadlines for advertising and announcements:

November 15 (January 1 issue).
February 15 (March 15 issue)
May 15 (July 1 issue)
September 15 (November 1 issue);

Editor:

Martin M. Antony, PhD,
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Instructions to Authors



The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Division 12 of the American Psychological Association). Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Division. Topic areas might include issues related to research, clinical practice, training, and public policy. Also included will be material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. Examples of submissions include: position papers, conceptual papers, data-based surveys, and letters to the editor. In addition to highlighting areas of interest listed above, *The Clinical Psychologist* will include archival material and official notices from the Divisions and its Sections to the members.

Material to be submitted should conform to the format described in the Fifth Edition of the Publication Manual of the American Psychological Association (2001). It is preferred that a single electronic copy of a submission be sent as an attachment to e-mail. Alternatively, send four copies of manuscripts along with document file on computer disk for review. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries may be made to the editor:

Martin M. Antony, Ph.D., ABPP

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Articles published in *The Clinical Psychologist* represent the views of the authors and not those of the Society of Clinical Psychology or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

THE CLINICAL PSYCHOLOGIST

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