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PRESIDENT'S COLUMN

Advocacy, Embracing our Diversity, and Thank You

Nadine J. Kaslow, Ph.D., ABPP

In my final President's column, I would like to share my thoughts on a topic about which I care deeply, advocacy. Then, I focus on my presidential theme, embracing our diversity. I close by acknowledging the people who made my presidential year gratifying.

Advocacy

The excellent training I received through a Primary Care Public Policy Fellowship sponsored by the U.S. Public Health Services—Health Resources Services Administration and the APA sparked my fascination with the advocacy process. I came to appreciate that our education and experience as clinical psychologists makes us well-suited to the role of advocate. Some of my most empowering experiences have been when I have been involved in policy development and advocacy at the local, state, or federal level.

To facilitate the process of Division 12 members becoming effective advocates, I offer some tips that I have found helpful. I hope you find these suggestions useful whether you are advocating for matters directly relevant to psychology or for policies meaningful to you as an individual.

- **Be Knowledgeable**—Policies emerge through a developmental process. Understand this process and work skillfully in it. Learn about the ecology of policy (e.g., legislative process); be familiar with policy development and policy practice frameworks; and be informed about the issues about which you are advocating.
- **Develop a Vision**—You need a vision of a preferred state of affairs that derives from your values, beliefs, and ideology, and takes into account multiple perspectives. Devise a plan of action consistent with your vision and goals.
- **Remember that Change is a Process**—Change is complex. Consider the phases in the stages of change model (precontemplation, contemplation, preparation, action, maintenance, relapse) as a guide throughout the multidimensional, long, and often arduous change process. Remember that sometimes you advocate for change with people who are in a stage before precontemplation, which I refer to as anti-contemplation. Move them step by step toward action, and be patient.
- **Develop Multiple Skills**—Hone an array of analytic, political, interactional, and value clarification skills for use in specific situations

Inside:

- Call for nominations
for 2005 Elections
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Bylaws Changes
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and during ongoing deliberations.

- Utilize Your Interpersonal Competencies—Establishing and maintaining relationships is an ongoing process for effective advocacy. Productive relationships occur if you are understanding, friendly, reasonable, thoughtful, trustworthy, loyal, charitable, fair, and generous. Listen well; be constructive in your feedback; and be a good opponent by fighting issues - not personalities or people. Win and lose gracefully, and recognize that your opposition on one issue may be your supporter on another.
- Communicate, Communicate, Communicate—

Ongoing communication that is clear in its message, concise, understandable, focused, informative, positive, and geared to the appropriate audience is essential. Use real-life examples to make your points come to life and appear relevant. Communication may be two-way and relationship based (e.g., hill visits, sites visits, receptions, providing briefing memos and testimony), one-way and message based (e.g., emails, letters, telephone calls, faxes), or indirect and media based (e.g., editorials, press releases, demonstrations). Let people know that you are available and appreciative.

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- **Be Persuasive and Passionate**—Persuasiveness is key to policymaking. Convey your ideas passionately. Advocate for issues about which you genuinely care. However, be sure that your passion does not override your capacity to listen to others' views or work cooperatively.
- **Be Persistent**—The inspirational lives of effective social reformers (e.g., Jane Adams, Dr. Martin Luther King, Jr., President Jimmy Carter) highlight the importance of persevering in the face of defeat and formidable obstacles. Maintain perspective and avoid pessimism, self-deprecation, and cynicism in response to defeats or partial successes. Persistence pays off in the short-run or longer term.
- **Balance Flexibility with Planning**—Devise plans to guide your work, while simultaneously improvising during unexpected events.

"I encourage all of my Division 12 colleagues to engage in policy practice efforts to change policies..."

- **Develop Power**—Pay attention to the nature and distribution of power and employ various forms of power—person-to-person, substantive, indirect, decision-making, process,

etc. Obtain and maintain power through personal credibility, networking, and collaborating.

- **Take Sensible Risks**—On the one hand, use your finite time and energy wisely and do not squander your efforts on trivial or hopeless causes. On the other hand, you need to participate in difficult battles wisely and be realistic and practical when you engage in these battles. Taking sensible risks requires discipline, timing, flexibility, vigilance, and strategic action.
- **Tolerate Uncertainty**—Since policy practice often lacks clear structure and boundaries, you must remain calm and composed in the face of confusion and uncertainty. It is often impossible to predict responses to policy recommendations or the resource that will be required to effect a specific change.
- **Consider the Context**—Multiple spheres of influence need to be considered when engaging in advocacy efforts: your individual competence, your social environment, the organization or institution in which you are embedded, the larger community, and the broader society. Policy advocacy efforts need to be contextually-based.
- **Cope with the Challenges**—You often will encounter opposition or controversy due to divergent inter-

ests, values, ideologies, and opinions about what policy will be most effective at addressing and specific problem, as well as the politics of making policy. These challenges often can be overcome through forging alliances and coalitions, often through grassroots efforts; engaging in partnerships; using research data to buttress the case that a specific policy will or will not work; and conducting investigations or program evaluations geared toward policy formation and implementation. Although advocacy is challenging, it can be incredibly rewarding.

I encourage all of my Division 12 colleagues to engage in policy practice efforts to change policies in legislative, institutional, or community settings, whether by establishing new policies, improving existing ones, or defeating the initiatives of others.

Embracing Our Diversity

How can we embrace the diversity of clinical psychology? We need to welcome and value a broad array of individuals. This includes people at career stages ranging from graduate student to retired, with different degrees, from diverse cultural backgrounds, with differing abilities, and with different approaches to clinical psychology (scientist-practitioner, clinical scientist, scholar practitioner, practitioner scholar). They run the gamut of theoretical orientations, work in a multiplicity of settings, and assume myriad roles. Clinical psychologists study and serve a multitude of people who vary according to the demographic backgrounds, types of problems, and settings. We serve a variety of systems: individuals across the life span, couples, families, organizations, and communities.

Our profession includes scientists, educators, practitioners, and people who focus on the public interest. Many of us wear two, three, or four of these hats. The scientists among us engage in research on experimental psychopathology, life-span development, links between basic and clinical processes, interventions (efficacy, effectiveness), program evaluation, and education. Practitioners who self-identify as clinical psychologists conduct assessments, interventions, and consultations guided by clinical wisdom based on theory, research, and experience; engage in evidence-based practice; and are sensitive to the fact that for practice to be effective the relationships must work. Those of us who are educators teach others from the high school through the post-doctoral level and beyond. We are classroom teachers, supervisors, advisors, and mentors, and we inculcate in our trainees a value on life-long learning.



Clinical psychologists focused on the public interest are involved in community and professional organizations, train students to be advocates, engage in advocacy endeavors and policy development, and are committed to public education and awareness. To be strong as a profession, we must integrate these sometimes disconnected parts of ourselves.

Despite our diversity, we have many things in common. We seek to promote individual psychological health and well-being; better adaptation and quality of life; healthy relationships; psychologically informed education; culturally-competent, developmentally-informed, and gender-sensitive research, practice, education, and policies; environments that promote growth; policies that are ethical, humane, and effective; and ethical practice, science, and education. A number of principles guide our professional endeavors. We believe that competency-based education should be informed by science, practice,

"We believe that competency-based education should be informed by science, practice, and the needs of the public..."

and the needs of the public, and we appreciate the importance of interdisciplinary approaches to education. We value practice that is informed by science, science that is informed by practice, and collaborations

between scientists and practitioners. We are invested in policy development and implementation that is informed by science, practice that is guided by major public health issues and concerns, and science that is conducted to address major public health issues and concerns. We stand for active involvement in the community, at the local, state, national or international level. And we have commitment to welcoming the next generation into our profession and discipline.

Acknowledgements

Many people helped make this year a very successful one for the Society of Clinical Psychology. I want to thank Lynn Peterson, our Executive Director, for her energy, enthusiasm, dedication, attention to details, investment in keeping us on track, and winning personality. She is the glue that holds us together. I express my sincere appreciation to the Executive Committee members for their sound counsel and

guidance, and their efforts toward advancing the division's agenda: Linda Sobell, Ph.D. (President-Elect), Diane Willis, Ph.D. (Past-President), Annette Brodsky, Ph.D. (Secretary), and Robert Klepac, Ph.D. (Treasurer). Thanks to our four delegates to the APA Council of Representatives, who serve as the Division's voice to this important decision- and policy-making body: Norman Abeles, Ph.D., Lynn Rehm, Ph.D., Jerome Resnick, Ph.D., and Charles Spielberger, Ph.D. Much of the Division's work is accomplished through our sections. I am grateful to our section representatives to the Division 12 Board for their enthusiasm, astute insights, and investment in accomplishing the goals of their section: Deborah King, Ph.D., Sheila Woody, Ph.D., Gloria Gottsegen, Ph.D., Toy Caldwell-Colbert, Ph.D. Richard McKeon, Ph.D., Danny Wedding, Ph.D., and Irving Weiner, Ph.D. A number of people's terms on the board will end December 31, 2004, and I will miss their contributions: Drs. Willis, Rehm, and Weiner. Two board members will end their current roles, but assume new positions on the board: Dr. Brodsky will be one of our delegates to the APA Council of Representatives and Dr. Abeles will be the section representative from Section 9. I am pleased they will continue to be on the Board.

One reason the Division was so productive this year was that our committees were so effective. Therefore, I express my heartfelt thanks to our committee chairs: Asuncion Miteria Austria, Ph.D. (APA Governance), Alice Carter, Ph.D. (Professional Development Institutes), Publications (W. Edward Craighead, Ph.D.), Alfred J Finch, Ph.D. (Fellowship), John Robinson, Ed.D. (Membership), Stanley Sue, Ph.D. (Science and Practice), Beverly Thorn, Ph.D. (Education and Training), Diane Willis, Ph.D. (Awards Committee and Nominations and Elections), and Antonette Zeiss, Ph.D. (Program). I want to acknowledge the contributions of all the members of the aforementioned committees, as well as the student task force. We all benefit from the contributions of our listserv manager, Joseph Plaud, Ph.D., our website manager, Emily Visser, and the editor of our journal, Philip Kendall, Ph.D. We owe a debt of gratitude to Martin Antony, Ph.D. for the fantastic job he does editing *The Clinical Psychologist*. Finally, I thank all of you for your contributions to and support of the Division. It has been an honor and a pleasure to serve as your President. □

Letters to the Editor

Dear Editor,

Robert Henley Woody, in his Letter to the Editor "Confronting Terrorism: The New Challenge for Clinical Psychology" in the Summer 2004 issue writes, "Effective September 11, 2001 human psychology was changed profoundly and pervasively" and he puts the attack in the category of "senseless violent acts." If psychologists, the U. S. public, and U. S. policymakers see the attack as "senseless" there is no hope for us. The attacks made brilliant "sense," and unless we fathom that "sense" and deal profoundly and creatively with it, such attacks will increase. I propose that psychologists explore deeply

the causes of terrorism perpetuated by individuals and nations, including our own, rather than simplistically label terrorism by our enemies as "senseless." I tried to make sense of assassinations in a chapter: Greening, T. (1972). *The Psychological Study of Assassins*. In W. Crotty (Ed.), *Assassination and the Political Order*. New York: Harper and Row. I hope psychologists will do similar studies of terrorists. Efforts to prevent terrorism must be based on a profound knowledge of its roots. □

Thomas Greening, Ph. D.
Saybrook Graduate School

Dear Editor:

Below is our response to an article, "For Psychotherapy's Claims, Skeptics Demand Proof" by Benedict Carey, published in the New York Times on August 10, 2004. The article refers to "a civil war" in psychology, pitting advocates of evidence-based therapy (the use of therapies that have been tested and shown to work) against advocates of traditional intuitive, open-ended therapy. The letter below was composed by current members of the Board of Directors of Division 53, the Society of Clinical Child and Adolescent Psychology, for distribution to the professional community. The letter was approved by the Division 53 Board and signed by the most recent presidents of the Society to demonstrate our long-standing interest in and commitment to issues that affect the children, adolescents, and families we serve. Because this issue is also of vital importance to members of the Society of Clinical Psychology, we ask you to publish it in *The Clinical Psychologist*.

As current and recent past Presidents of the Society of Clinical Child and Adolescent Psychology, the largest professional organization in our field, we read with great interest Benedict Carey's thoughtful article in the New York Times (August 10, 2004). In our professional organization, which includes both practitioners and clinical scientists, we have worked hard to avoid "warfare" among professionals. We have sought ways to make treatment outcome evidence available to a wide audience, and we have discussed openly and often various strategies for bringing science and practice closer together. We have been helped in this process by the fact that most clinicians and most clinical scientists in our professional organization share one important common goal: Providing the best possible care for children,

adolescents, and families who seek professional help.

Many in our professional organization believe that the best possible care is fostered by combining scientific evidence on what works with the clinical expertise of practitioners who work on the front lines of mental health care. Thus, we see clinical scientists and clinical practitioners as essential partners. Because our professional organization is a division of the American Psychological Association (APA), we were particularly interested in the comment attributed to the current President-Elect of the APA, Dr. Ronald Levant. Dr. Levant is quoted as saying, "This entire approach to develop manuals and require practicing psychologists to use them is fundamentally insane." This unfortunate comment, if correctly attributed to Dr. Levant, is a disappointment to us. The statement threatens to undermine the kind of collaboration we have sought to build between clinical practitioners and clinical scientists. Independently of its potential impact, the comment warrants attention on its own merits.

Is it insane to use scientific procedures such as clinical trials to identify treatments that work? On the contrary, efforts to identify effective treatments would seem to be our professional and ethical obligation to those who seek our help. In doing this, we must of course describe the treatments being tested, and this requires the development of "manuals," essentially descriptions of the therapy procedures being used. Presently, manuals exist for all major forms of psychotherapy. Indeed, the current initiative to develop and test treatments that work and disseminate them into the community is one of the main foci of the National Institute of Mental Health.

Do we seek to "require practicing psychologists to use [manuals]"? No. It seems unlikely that

Letters to the Editor (cont.)

these manuals would be used effectively by those who object. However, we do seek to provide maximum information to practitioners and consumers on what the evidence shows, regarding various therapies (see www.effectivechildtherapy.com). Some therapists may choose to use the information in making practice decisions; other therapists may not. Some consumers may choose to use the information in deciding which therapies to seek for themselves or their family members; other consumers may not. Our goal is to help professionals and consumers make the best-informed decisions possible and, more broadly, to reduce the risk of ineffective therapy that prolongs the suffering of vulnerable people.

One other theme voiced in the Carey article is that therapies tested in scientific studies may not be well-suited to everyday practice. Psychologist Drew Westen is cited in the article as stating that these therapies are "by necessity short," that "many participants are excluded because their problems are too complicated for a single diagnosis," and that "the chaos of real life is blocked out." These are caricatures of the actual evidence-based therapies, which are in fact quite diverse. Regarding length, some of the therapies are indeed as brief as ten or fewer sessions, but if these are effective, what reason could there be for adding time and cost? Other evidence-based therapies extend for months or years and include the option of repeated periodic follow-up or booster sessions. An advantage of the evidence-based approach is that outcome assessment is emphasized, so that treatment length can be tailored to the response of the treated individual. Regarding exclusion of participants, some clinical trials have ruled out some potential participants who have conditions thought to interfere with the therapy (chronic drug abuse, for example). But other studies are highly inclusive, and the current emphasis in the field is to make samples as representative of everyday clinical practice as possible. The statement about "blocking out" the chaos of real life ignores the evidence-based therapies that dive full-force into real life, with therapists addressing the needs of youths who have multiple felonies, youths in the foster care system, and youths who have serious adjustment problems at home and in school. Indeed, on the dealing-with-real-life front, a number of evidence-based approaches compare quite favorably to the traditional once-a-week visit to the therapist's office and in many instances surpass them.

In conclusion, it is important to note that these are stressful times for many who practice psychotherapy, but that many of the stressors are generated by forces much larger than the work of researchers and practitioners who believe in an evidence-based approach. These larger forces include massive cuts in mental health budgets, the press by payers for accountability, and the highly visible and effective marketing of pharmaceutical alternatives to psychotherapy. Within this context, science should be seen not as an enemy of psychotherapy but as a close ally, making the case that therapy can indeed work and helping to identify those therapies that do. □

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2004 Award Winners

Congratulations to all 2004 award recipients from the Society of Clinical Psychology and its Sections. Below is a list of this year's award winners. All awards were presented at the 2004 APA convention in Honolulu.

2004 Awards from the Society of Clinical Psychology

Distinguished Scientific Contributions to Clinical Psychology
Recipient: Sidney J. Blatt, Ph.D.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology
Recipient: Lynn P. Rehm, Ph.D.

David Shakow Award for Outstanding Early Career Contributions to the Science and Practice of Clinical Psychology
Recipient: Jonathan S. Abramowitz, Ph.D.

Theodore H. Blau Early Career Award for Outstanding Early Career Contributions to the Profession of Clinical Psychology
Recipient: Mitchell J. Prinstein, Ph.D.

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

The American Psychological Foundation Theodore Millon, Ph.D. Award
Recipient: Drew I. Weston, Ph.D.

Distinguished Student Research Award
Recipient: Bunmi Olatunji

Distinguished Student Practice Award
Recipient: Carrie Spindel

Distinguished Student Service Award
Recipient: Jessica Foley

2004 Awards from the Sections

Clinical Geropsychology Distinguished Clinical Mentorship Award
Awarded by: Section 2, Clinical Geropsychology
Recipient: Antonette Zeiss, Ph.D.

Clinical Geropsychology Student Research Paper Award
Awarded by: Section 2, Clinical Geropsychology
Recipient: Amanda Schafer

M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology
Awarded by: Section 2, Clinical Geropsychology
Recipient: Larry W. Thompson, Ph.D.

Society for the Science of Clinical Psychology Dissemination Award
Awarded by: Section 3, Society for a Science of

Clinical Psychology

Recipients: Anil Chacko, Gail H. Chang, Rebecca E. Ford, Amy Przeworski, Jennifer A. Steinberg

Society for the Science of Clinical Psychology Award for Distinguished Scientist

Awarded by: Section 3, Society for a Science of Clinical Psychology

Recipients: Lauren Alloy, Ph.D. and Lyn Abramson, Ph.D.

Clinical Psychology of Women Mentor Award

Awarded by: Section 4, Clinical Psychology of Women
Recipient: Ruth H. Striegel-Moore, Ph.D.

Clinical Psychology of Women Student Research Award

Awarded by: Section 4, Clinical Psychology of Women
Recipient: Michele Boivin, M.A.

Clinical Psychology of Ethnic Minorities Mentor Award

Awarded by: Section 6, Clinical Psychology of Ethnic Minorities
Recipient: Asuncion Miteria Austria, Ph.D.

Emergencies and Crises Career Achievement Award

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Recipient: Larry E. Beutler, Ph.D.

Student Research Award

Awarded by: Section 7, Section for Clinical Emergencies and Crises

Recipient: Elizabeth T. Dexter-Mazza

Association of Medical School Psychologists Distinguished Achievement in Teaching Award

Awarded by: Section 8, Association of Medical School Psychologists

Recipient: Susan McDaniel, Ph.D.

Association of Medical School Psychologists Distinguished Achievement in Research Award

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Recipient: Ann Streissguth, Ph.D.

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Recipient: Alan Raphael, Ph.D.

Commitment to Clinical Psychology and Assessment Award

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Recipient: Janet Matthews, Ph.D.



Student Forum

Voices of the Future: Graduate Students' Views on Training to Prescribe

Stacey A. Hofflich, M.A.

Louisa Grandin, M.A.

Ilana Blatt-Eisengart, B.A.

Torrey A. Creed, M.A., M.S.Ed.

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There has been considerable debate in the literature as to whether professional psychologists should be granted the right to prescribe psychoactive medications (for review, see Gutierrez & Silk, 1998). Recent research has found that psychologists are already discussing medications with

their clients (VandenBos & Williams, 2000) as well as actively managing and monitoring their clients' medications (Wiggins & Cummings, 1998). In addition, the Office of Technology Assessment found that nonphysicians (e.g., nurse practitioners, physician assistants) provided "as good or better" pharmacological care than that provided by physicians (p. 19, United States Congress, Office of Technology Assessment, 1986). More specifically, one pilot study conducted by the Department of Defense found that after a 2-year training program, psychologists could be trained to provide safe and high-quality pharmacological care (Newman, Phelps, Sammons, Dunivin, & Cullen, 2000). However, a survey of 1,505 members of the American Psychological Association found that 42% of this sample did not favor prescription privileges for psychologists (DeLeon, Folen, Jennings, Willis, & Wright, 1991).

A primary reason for the lack of support among psychologists is the difficulty in training (Moyer, 1995). For example, one proposed curriculum would require psychology students to take 39 additional credits (or 390 class hours) in areas such as biochemistry, psychopharmacology, chemical

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dependency, and neuropsychology (Fox, Schwelitz, & Barclay, 1992). Completing these courses would be very difficult without adding at least a year to graduate school, thus creating more financial strain for students, their advisors, or their institution. Other training options include developing a specialty track in predoctoral graduate programs for interested students (Fox et al., 1992) or requiring additional postdoctoral training to avoid changing existing graduate programs (Brentar & McNamara, 1991). However, potential training programs continue to be controversial and still require feasibility studies to ascertain the costs and benefits of such programs. These concerns are echoed by a study that found that the percentage of psychologists who favored prescription privileges increased from 36% to 59%, if there was appropriate training available (Bascue & Zlotowski, 1981).

There are many other concerns among psychologists about granting prescription privileges, for example, graduate programs could make a controversial shift of focus from teaching therapeutic to biological interventions. In addition, with the chance of malpractice suits increasing against psychologists with prescription privileges, psychology students will be more likely to focus on learning medication-based treatments than therapeutic interventions (DeNelsky, 1996). Thus, some psychologists worry that these changes could lead to the public believing that psychotherapy is less efficacious than other interventions such as psychotherapy, for example.

The aim of the present study was to determine how doctoral students currently enrolled in Clinical Psychology programs feel about gaining prescription privileges and the potential training involved. Although past studies have shown that graduate students are generally in favor of prescription privileges (Smith, 1993; Smyer et al., 1993; Richardson, 1996), only one of these studies (Smyer et al.) has been published, and only two (Smith, 1993; Richardson, 1996) investigated graduate students' opinions regarding training in pharmacological treatment. It is important to replicate such findings given that the issues of this debate continue to evolve (e.g. Louisiana on April 21, 2004 became the second state, after New Mexico, to grant prescription privileges to psychologists) and so may graduate students' opinions. In addition, granting prescription privileges to psychologists will change health services for the mentally ill. As a result, the present study is vital to understanding the current state of this debate from the next generation of clinical psychologists.

Method

Participants

Students ($n = 363$) in clinical psychology Ph.D. programs responded to an online survey distributed through the Council of University Directors of Clinical Psychology (CUDCP) listserv. Students who chose to participate represented twenty-eight states, three Canadian provinces, and the District of Columbia. Participants varied with respect to gender (24% male, 75% female, 1% not reporting gender), program year (first year = 22.5%, second = 19.2%, third = 18.6%, fourth = 14.6%, fifth = 14.9%, sixth = 7.0%, seventh and beyond = 3.1%), amount of therapy experience (range = 0 to 220 months, $M = 26.05$ months, $SD = 25.92$ months), theoretical orientation (cognitive or behavioral therapy = 64.6%, eclectic = 22.3%, interpersonal psychotherapy = 3.9%, psychodynamic = 3.0%, emotion-focused = 1.4%, other = 4.7%) and primary area of interest after graduate school (clinical work = 55.6%, research = 23.6%, teaching = 7.3%, other = 13.5%).

Measures

The survey developed for this study consisted of 23 questions addressing the opinions of graduate students about prescription privileges for clinical psychologists. Two questions (date of birth and initials) were used to sort data in an effort to prevent multiple submissions from individuals. Information about demographics (location of program, gender, year in program) and professional characteristics (months of therapy experience to date, personal therapeutic orientation, primary area of interest after graduate school) were also gathered.

Participants were asked to indicate their stance toward prescription privileges and the use of medication as part of a treatment plan, as well as the participant's perception of his or her program's position on prescription training and use. Six common arguments for prescription privileges (client can see one professional for all needs, therapist has direct control over all of treatment, increased stature in public eye, increased earning power, more flexibility in treatment, combination of medication and therapy perceived as the most effective treatment approach) and seven common arguments against it (concerns about adequate supervision, malpractice complications, increased training intensity, weakened public perception of the efficacy of psychotherapy, potential rift with medical professionals, unnecessary overlap with medical professionals, managed

care over-involvement) were listed and participants were asked to indicate which, if any, reflected their own opinions.

Participants were asked to indicate how much their choice of graduate program, internship, and post-doctoral work would be influenced by the availability of prescription training, as well as how much additional time they would be willing to spend in each training phase. Participants were also asked how much their choice of the state in which they would establish their career would be influenced by the state's laws governing prescription privileges.

Additional questions addressed participants' opinions about whether prescription privileges, if granted, should resemble traditional medical training (i.e. rotations), whether continuing education requirements would need to be changed to reflect prescription privileges, and to whom prescription

privileges should be granted (no one, on an individual basis, all clinical psychologists).

Procedure

Training directors and student representatives to the CUDCP listserv were asked to distribute an e-mail, containing a

cover letter about the study and a link to the survey, to all students in their program. The cover letter requested the voluntary participation of students in clinical psychology Ph.D. programs. Recipients of the email were asked to click on an attached link, which opened a new web browser window displaying the survey. At the bottom of the survey, participants were given the option to submit, thereby consenting to participate. Submitted forms were channeled through a central server so that data received did not contain the e-mail address of the original sender and confidentiality was maintained.

Data Analysis

Frequencies were calculated to determine demographics and percentages of participants who endorsed individual responses. Additionally, a series of chi-squares were calculated to examine whether participants' interest in obtaining prescription privileges varied by theoretical orientation, months of therapy experience, or area of interest post-graduation.

Results

Participants' degree of interest in having prescription privileges was relatively evenly distributed and did not differ significantly by predicted area of future employment (research, teaching, clinical work, other), therapeutic orientation, or months of therapy experience (see Table 1). Most participants indicated that psychologists should have the right to decide individually whether to pursue these privileges. The majority of participants indicated that they think that medication is useful in select therapy cases and that their training program integrates the use of medication in some cases while addressing medication issues in the context of coursework focused on other subjects.

At least half of the participants endorsed the following pro-prescription privilege arguments: (1) It might allow patients to see one professional for all of their needs, (2) It might give psychologists more direct control over the treatment of their clients, (3) It might offer more flexibility in treatment modalities, (4) It might be the most effective approach for treating clients. One argument against prescription privileges, that psychologists may not be adequately supervised or trained, was endorsed by over half of the participants.

Most participants indicated that their choice of graduate school, internship and post-doctoral work would be influenced "not at all" or "somewhat" by the availability of prescription privilege training. The amount of additional time participants would be willing to spend training in these sites to earn prescription privilege varied greatly. Similarly, most participants also indicated that a state's decision to grant psychologists prescription privileges would influence their decision where to practice "somewhat" or "not at all."

The majority of participants reported that if psychologists were granted prescription privileges, training should resemble traditional medical training (e.g., specific coursework, rotations) and that continuing education requirements should change for psychologists who are licensed to prescribe.

Discussion

Given the current politic climate and recent granting of prescription privileges for clinical psychologists in some states (e.g., New Mexico and Louisiana), it is important to gather the opinions of psychologists-in-training about the right to prescribe medication and related training. This survey extends and updates the

"The amount of additional time participants would be willing to spend training in these sites to earn prescription privilege varied greatly."

Table 1. Graduate Student's Opinions on Prescription Privileges and Training

How interested are you in having the right to prescribe psychiatric medications?

- Not at all: 32%
- Some interest: 40%
- Definitely interested: 32%

Who do you believe should be trained to prescribe medication?

- * No psychologist should be granted to right to prescribe medication: 18%
- The decision should be made on an individual basis: 71%
- All psychologists should be trained to prescribe medication: 11%

What is your stance on prescription medication as part of a treatment plan?

- Against it in almost all cases: 4%
- It is useful in select cases: 88%
- It is useful for the majority of therapy clients: 8%

Do you disagree with allowing prescription privileges for any of the following reasons?

- Psychologists may not be adequately supervised and/or trained: 56%
- Potential malpractice complications (i.e. increased rates, potential for more malpractice suits): 44%
- Do not want to increase training intensity: 25%
- It might weaken the public's belief in the efficacy of psychotherapy: 36%
- It might create a rift with medical professionals: 21%
- It might create unnecessary overlap with medical professionals: 28%
- Managed care may become over-involved in therapeutic practice: 41%

Do you agree with allowing prescription privileges for any of the following reasons?

- It might allow patients to see one professional for all of their needs: 70%
- It might give psychologists more direct control over the treatment of their clients: 68%
- It might increase the stature of psychologists in public opinion: 35%
- It might increase potential earning power for psychologists: 42%
- It might offer more flexibility in treatment modalities: 52%
- It might be the most effective approach for treating clients: 50%

How does your program's curriculum currently address the use of medication?

- Does not address the use of medication in any courses: 15%
- Integrates information about medication interventions within classes: 41%
- Offers specific courses about use of medication: 29%
- Requires courses about use of medication: 15%

What is your program's stance toward using medication in clinical training?

- Discourages it in almost all cases: 9%
- Integrates it in some cases: 78%
- Regularly integrates it into treatment plans: 13%

How much would your choice of graduate school programs have been affected by whether a school offered a prescription privilege track?

- Not at all: 40%
- Somewhat: 43%
- Very much: 17%

How many additional courses would you be willing to take to be trained to prescribe psychiatric medications?

- No additional classes: 20%
- 1 additional course: 3%
- 2 additional courses: 11%
- 3 additional courses: 21%
- 4 additional courses: 20%
- 5 additional courses: 3%
- 6 or more additional courses: 22%

How much would your choice of internship be affected by whether a program offered a prescription privilege track?

- Not at all: 32%
- Somewhat: 47%
- Very much: 21%

How many additional months would you be willing to spend during internship to be trained to prescribe psychiatric medications?

- No additional time: 26%
- 1-6 additional months: 37%
- 6-12 additional months: 26%
- More than 12 additional months: 11%

How much would your choice of a post-doctoral fellowship be affected by whether a program offered a prescription privilege track?

- Not at all: 37%
- Somewhat: 45%
- Very much: 18%

How many additional months would you be willing to spend during post-doctoral training to be trained to prescribe psychiatric medications?

- No additional time: 32%
- 1-6 additional months: 31%
- 6-12 additional months: 26%
- More than 12 additional months: 11%

How much would a state's decision about prescription privilege influence your decision of where to practice?

- Not at all: 31%
- Somewhat: 46%
- Very much - I DO want to work in a state with prescription privilege: 15%
- Very much - I DO NOT want to work in a state with prescription privilege: 8%

Should training for attainment of prescription privileges resemble medical training (specific coursework, rotations, etc)?

- Yes: 77%
- No: 23%

If privileges were granted, should continuing education requirements change for those who are licensed to prescribe?

- Yes: 96%
- No: 4%

current literature, which has previously included opinion pieces (e.g. DeNelsky, 1991; Moyer, 1995) and samples of current, rather than future, clinical psychologists. (e.g. Bascue & Zlotowski, 1981; VandenBos & Williams, 2000).

Most participants indicated a belief that psychologists should be given the individual choice to earn prescription privileges, with a fairly even distribution of students who were very, somewhat, or not at all interested in those rights for themselves. These results suggest that the current climate among training psychologists favors a pro-choice policy for prescription privileges, and that there would be variability in whether that right was exercised. In other words, let those who want to prescribe train to do so, and allow those who do not want to prescribe to avoid such training. Given the range of interest in prescription privileges, it is particularly interesting to examine reasons why graduate students support, or do not support, this right.

“...let those who want to prescribe train to do so, and allow those who do not want to prescribe to avoid such training.”

scription privileges was that clinical psychologists would be inadequately supervised, yet only a quarter of participants endorsed concern that training intensity would increase.

Given that the majority of participants would be willing to take three or more classes and add six or more months to internship to train for prescription privileges, additional training might be a welcomed opportunity that could assuage supervision concerns. However, it is unclear whether the amount of training that participants were willing to add would be adequate, given proposed curriculums for prescription privileges training (i.e., Fox, Schwelitz, & Barclay, 1992). Potential malpractice complications and potential over-involvement of managed care were other concerns frequently endorsed by clinical psychology students. Although concerns about the potential creation of a rift between psychologists and medical professionals and unnecessary overlap of these two health professions have been highlighted in previous work (e.g., DeNelsky, 1991), these were among the least frequently endorsed concerns among participants.

The majority of respondents endorsed pro-privileges statements that indicated that having pre-

scription privileges might be in the best interest of their clients (e.g., seeing one professional for all mental health needs, more control over treatment, more flexibility in treatment, and access to most effective treatment). The two pro-privileges arguments that were least frequently endorsed were by students were self-enhancing arguments (e.g., increased earning power and stature). This may suggest that a client-focused rationale for gaining the right to prescribe medication may be more compelling than more self-serving reasons.

If training programs were to consider adding a training component addressing the prescription of medication by clinical psychologists, these findings may begin to inform training directors about student opinions regarding the timing and length of additional training. The majority of participants indicated that they would be willing to take three or more additional classes during graduate school. A majority also reported that they would be willing to extend internship and post-doctoral training, most frequently by one to six months. The majority of students also felt that training for prescription privileges should resemble training in the medical professions. If implemented, training programs like the one outlined by the American Psychological Association's Committee for the Advancement of Professional Practice (see <http://www.apa.org/apags/profdev/prespriv.html>) may be enhanced by consideration of student preferences.

There were somewhat mixed results regarding the impact of an individual state's prescription privileges laws on participants' choice of where to practice. Most participants indicated that it would "somewhat" influence their decision, although a sizable percentage (31%) indicated that it would "not at all" influence their decision. Future research may examine whether offering prescription privileges in underserved areas (e.g., Mental Health Professional Shortage Areas) might attract or discourage clinical psychologists from practicing in those areas.

Given that two states have granted prescription privileges to clinical psychologists despite the ongoing debate, a clarification of each side of the debate may help to move the profession toward a decision, and perhaps a more unified front, as well as a plan to execute the decision. The voices of graduate students, the future generation of clinical psychologists, are an important piece of clarifying the future direction for the field. □

Voices of the Future: Graduate Students' Views on Training to Prescribe

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APA Apportionment!

APA sent out their apportionment letter on October 15th.

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

Above all, remember to return your ballot.



Treating Panic Disorder: Medications, Psychosocial Treatments, and Combined Approaches

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There is little question that the use of combined treatment approaches, in which the administration of medication is coupled with psychosocial intervention, is a common treatment method for most mental disorders (see Sammons & Schmidt, 2001, for a review). For example, Sammons, Gorny, Zinner, and Allen (2000) reported moderately high rates of medication use among patients of psychologists. Pincus et al. (1999) found that nearly 90% of patients of psychiatrists were receiving medication and that 55.4% of outpatients received both medication and psychotherapy. The use of combined treatment approaches is particularly evident in the treatment of panic disorder.

One possible explanation for the high rate of combined treatments in clinical practice is that mental-health professionals may regard this approach as the most effective mode of intervention. Yet, are combination treatments more effective than singular approaches? Unfortunately, this topic has received limited empirical investigation. The purpose of this article is to provide some discussion of issues surrounding combined treatment by presenting a brief evaluation of the support regarding singular versus combined treatments for panic disorder. In addition, clinical recommendations are provided.

Why Utilize Combined Treatments?

The most common rationales for combining psychosocial and pharmacological treatments include: (1) treatment specificity, (2) facilitation of psychosocial treatment with pharmacotherapy, and (3) facilitation of pharmacotherapy with psychosocial treatment (see Telch & Lucas, 1994). The treatment specificity argument rests on the assumption that drug and psychological treatments affect different facets of a disorder. For example, psychosocial interventions may address behavioral aspects of the disorder whereas medication could be used to impact neurobiological features. In comparison, the psychosocial facilitation line of reasoning suggests that

the primary mode of treatment should be psychological but the adjunctive use of medication may be indicated in some cases.

Unfortunately, there is relatively little research to bolster the assumption that combined treatment approaches are superior to singular interventions, despite the intuitive appeal of the above perspectives (Sammons & Schmidt, 2001). Notwithstanding the lack of research in this area, it is important to make such treatment selection decisions based on an examination of the existing research literature.

Relative Efficacy of Singular and Combined Treatments for Panic Disorder

Panic disorder has been the subject of far more controlled treatment outcome investigations than other anxiety disorders. Although the literature clearly indicates high efficacy for several classes of medications and for cognitive behavior therapy (CBT) when used alone, there is little evidence to suggest that combining these treatments leads to improved outcomes.

In examining the literature, it is useful to keep in mind several limitations of the extant research. First, there have been very few studies that have evaluated multimodal cognitive-behavioral therapy (CBT) approaches in combination with medication. Instead, a majority of the research in this area has focused on *in vivo* exposure. Additionally, most of the combined-treatment studies have focused on short-term efficacy, failing to investigate long-term outcomes. Finally, in this literature, there has often been systematic exclusion of certain types of patients. For example, many investigations have excluded patients with little or no phobic avoidance, despite the fact that patients without an agoraphobia diagnosis constitute a substantial percentage of all patients with panic disorder. Given these limitations, how do singular versus combined approaches fare in the treatment of panic disorder?

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Pharmacotherapy

Several classes of medication have been efficacious in ameliorating panic-related symptoms in a number of double-blind placebo controlled trials, including tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), and benzodiazepines (Sheehan, 1985; Telch, Tearnan, & Taylor, 1983; Zitrin, Klein, Woerner, & Ross, 1983). Selective serotonin reuptake inhibitors (SSRIs) are also effective in the treatment of panic disorder (Rapaport et al., 2001; Schneier et al., 1990).

Michelson and Marchione (1991) devised a useful method to evaluate pharmacological treatments in which an overall efficacy index is calculated for each class of medications based on three factors: (1) level of attrition, (2) percentage of patients achieving high end-state functioning, and (3) relapse rates. When the authors applied this index to available empirical studies, the beta blockers and benzo-

"A recent meta-analysis concluded that SSRIs and TCAs are equally efficacious..."

diazepines evidenced low efficacy. In comparison, MAOIs are somewhat more efficacious, although their effects are limited by high attrition. Of all the medication classes evaluated for the treatment of panic disorder, TCAs and SSRIs received the highest efficacy ratings (see Michelson & Marchione, 1991, for more details). Since this meta-analysis, further research has been conducted on the efficacy of pharmacological interventions for panic disorder. These findings are reviewed below.

Antidepressants. Antidepressants have become the medication of choice in the treatment of panic disorder, reducing symptoms without causing the withdrawal and dependency that can occur with benzodiazepines. A recent meta-analysis concluded that SSRIs and TCAs are equally efficacious, although there is a higher dropout rate among patients who use TCAs (Bakker, van Balkom, & Spinhoven, 2002). Similarly, an effect-size analysis of recent controlled trials of SSRIs found these medications were not more efficacious than older antidepressants in the treatment of panic disorder (Otto, Tuby, Gould, McLean, & Pollack, 2001). Recent studies of selective norepinephrine reuptake inhibitors (e.g., reboxetine; Dannon, Iancu, & Grunhaus, 2002; Versiani et al., 2002) and serotonin norepinephrine reuptake inhibitors (e.g., venlafaxine; Pollack et al., 1996) have found these

newer antidepressants to be effective, although further research is necessary.

Other medication. In contrast to the conclusions based on the earlier literature in which other medication classes were used to treat panic disorder, recent longitudinal studies have found that relapse rates are not greater in patients who have been treated with benzodiazepines compared to antidepressants (Bruce et al., 2003; Simon et al., 2002). These studies suggest that nearly half of all medicated patients who initially achieved remission relapsed within the two-year period (Simon et al., 2002). Findings such as these indicate a need for further investigation of the long-term efficacy of pharmacotherapy in the treatment of panic disorder.

Psychosocial Treatments

In addition to pharmacological treatments, several psychosocial treatments have been found to be efficacious in the treatment of panic disorder, including in vivo exposure (Mathews, Gelder, & Johnston, 1981), cognitive therapy (Beck, 1988; Beck & Emery, 1985; Clark, 1986), and CBT (Barlow, Craske, Cerny, & Klosko, 1989; Schmidt, Staab, Trakowski, & Sammons, 1997; Telch et al., 1993). Historically, the practice of encouraging patients to repeatedly confront situations that produce intense fear and avoidance (i.e., in vivo exposure) has been the hallmark of behavioral treatments for agoraphobia and panic (Mathews et al., 1981). The newer CBT protocols derived from this framework (Barlow et al., 1989; Schmidt et al., 1997; Telch et al., 1993) focus on correcting the patient's hypersensitivity to bodily sensations and the misinterpretation of these sensations as signaling immediate threat. The main components of treatment typically include: (1) education, (2) training in cognitive reappraisal (i.e., cognitive restructuring), (3) repeated exposure to bodily sensations connected to the fear response (i.e., interoceptive exposure), and (4) repeated exposure to external situations that trigger a fear response (i.e., in vivo exposure).

Adopting the Michelson and Marchione (1991) method for calculating overall treatment efficacy, it appears that CBT that includes interoceptive exposure provides the highest level of efficacy, followed by in vivo exposure coupled with cognitive treatment and cognitive treatment alone. In vivo exposure, while still efficacious, was found to be less so than the other treatment protocols.

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Combined Treatments

The current data on the short-term efficacy of combined treatments are mixed. There is some support for the superiority of the combination of buspirone plus CBT (Bouvard, Mollard, Guerin, & Cottraux, 1997), fluvoxamine plus CBT (de Beurs, van Balkom, Lange, Koele, & van Dyck, 1995), and paroxetine plus CBT (Stein, Norton, Walker, Chartier, & Graham, 2000) relative to CBT alone or placebo plus CBT. However, in the case of combined benzodiazepines plus CBT, it appears that CBT alone predicts better outcome than the combination treatment (Westra, Stewart, & Conrad, 2002).

It is also critical to examine the long-term impact of combined treatments. Although there are fewer studies examining long-term efficacy, the literature indicates that the preliminary benefits of combined treatment are lost during follow-up and that, in some cases, combined treatment may yield poorer

“...combined treatments may lose their advantage in the long term and in some cases may have deleterious effects”

long-term outcome. In the case of combined treatments using TCAs, for example, the superiority of the combined treatment is lost over time, with increased relapse rates among patients receiving combined treatment and continuous improvement for patients who had received in vivo exposure (Marks et al., 1983). The same trend has been observed in studies of benzodiazepines. For example, despite initial improvements, patients receiving a combination of benzodiazepines and in vivo exposure displayed poorer outcome at follow-up than those who received in vivo exposure alone (Marks et al., 1993). Similar findings occur with the use of CBT protocols. Barlow, Gorman, Shear, and Woods (2000) found that although combined imipramine plus CBT resulted in better outcome at post-treatment and post-maintenance, CBT alone predicted the best outcome at 6-month follow-up. The addition of imipramine to CBT appeared to reduce the long-term efficacy of CBT. Further, CBT did not mitigate relapse following medication discontinuation.

In summary, the literature suggests that combined treatments may promote some short-term beneficial effects. However, combined treatments may lose their advantage in the long term and in

some cases may have deleterious effects. On the other hand, it is worth considering the possibility that these medication trials typically require discontinuation at the end of treatment. The length of medication treatment may not be sufficient in these cases to produce the desired neurobiological changes. Thus, long-term benefits of combined treatments may be underestimated. Further work is needed to clarify this important issue.

Which Patients Respond Best to Which Treatments?

Many practitioners believe that particular patients would be better suited to treatment with either medication or psychotherapy. Unfortunately, there is very little research directly addressing this interesting issue. In fact, we could locate no studies that might answer this question for any anxiety disorder. There is some evidence in other literatures to suggest that some individual differences may be associated with differential treatment responses among different psychotherapies. For example, in the depression literature, there is some evidence to suggest that different coping styles are associated with differential responses to psychotherapies (e.g., Beutler et al., 1991). In the alcohol literature, there is some evidence to suggest matching effects in areas such as psychiatric severity and motivation (Project MATCH Research Group, 1997). Once again, further work is required to determine whether treatment matching is viable in panic disorder.

Practical Recommendations for Treating Panic Disorder

What do the data suggest for clinicians? For both unmedicated and medicated patients, tentative treatment algorithms can be derived based on the current research findings. When an unmedicated patient presents for treatment, it appears to be most conservative to start with a trial of CBT without pharmacological intervention, as the data suggest that the singular effects of CBT will be highly effective for the majority of individuals. Are there any instances when CBT should be immediately combined with pharmacological intervention? We believe that there are several. For example, a panic disorder patient with co-occurring severe depression may not be capable of undertaking a CBT trial and should be considered for a combination of CBT plus antidepressant medication. Also, patients that are extremely distressed may

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benefit from utilization of high-potency benzodiazepines on a time-limited basis.

As for medicated patients, there are not good data suggesting that the addition of CBT will yield positive benefits though CBT has been shown to be effective for medicated patients failing to respond to pharmacotherapy (e.g., Otto, Pollack, Penava, & Zucker, 1999). Also, it is important to recognize that CBT is often useful should medication discontinuation be a treatment goal. There are good data to suggest that CBT may facilitate discontinuation. For example, evidence suggests that CBT can be helpful for fading antidepressants and benzodiazepines (e.g., Schmidt, Woolaway-Bickel, Trakowski, Santiago, & Vasey, 2002; Whittal, Otto, & Hong, 2001).

Final Thoughts

Examination of treatment outcome studies of panic disorder suggests that a fair amount is known about

“...CBT is often useful should medication discontinuation be a treatment goal.”

singular treatments but relatively little is known about combined treatments. This is particularly unfortunate given the wide use

and acceptance of combined treatments in clinical practice. At best, it appears that there may be some short-term benefits to combined treatment, but it is unclear that combined treatment offers an advantage in the long term. In fact, combined treatments may have deleterious long-term effects in some cases.

While it is somewhat surprising that combined treatments are not more efficacious for individuals with panic disorder, a variety of factors may contribute to the lack of clear advantages, including: (1) the way in which the treatment approach is explained (or not explained) to the patient, (2) a tendency to over rely on medication (or under rely on cognitive-behavioral skills), and (3) misattribution of gains. Each of these issues is discussed below as a caution to mental health professions when implementing combined treatments.

First, when combined treatments are implemented, it is critical to provide the patient with a compelling rationale for their utilization. Too many patients in research protocols report confusion regarding discrepant etiologies that have been provided to them by different health care professionals. If combined treatments are implemented in order to treat panic disorder based on an integrated biopsychological

model, the possibility of neurochemical imbalances serves as one of many possible factors that contribute to panic. It is also important to explain to patients that perceptual processes and attributional problems constitute additional necessary steps in the generation of fear.

A second potential factor in the poor outcome of combined treatments may result from the temptation for patients to over rely on medications in the context of panic. Cognitive-behavioral interventions require that patients utilize skills and knowledge in fear-provoking situations in order to learn that they can master their anxiety. However, patients who take medications prior to entering fear-provoking situations experience lower levels of anxiety and therefore may not have the opportunity to practice cognitive-behavioral skills. There is also the possibility that these patients may experience state-dependent learning under the influence of medications that may interfere with the emotional processing that should take place during exposure treatments.

Third, many patients in combined treatments have expressed the belief they are at risk for relapse once the medications are discontinued. Further, patients who have been taking medications for years but experience substantial clinical improvements only after completing CBT appear to overly attribute their gains to medication use. These misattributions appear to be particularly common for patients using benzodiazepines. It is therefore advisable to have medicated patients discontinue their medications in the context of a CBT trial in order to shift these misattributions.

In the absence of compelling data regarding the effectiveness of combined treatments, we would generally recommend unimodal treatment for panic disorder. However, these recommendations are necessarily tentative inasmuch as there has been so little work on integrated treatments. We hope that future research will offer new insights and understanding into effective combination treatments, including methods for effectively sequencing different treatment modalities. □

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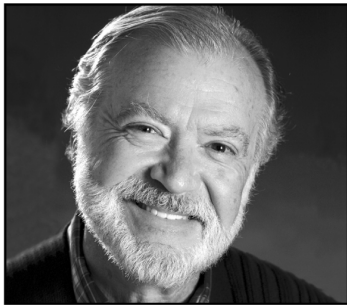
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Reflections and Recommendations on the Role of Supervision in Clinical Training

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"It may be that professional training provides at best a limited, if crucial, preliminary function rather along the lines of ambulation as a necessary precursor to athleticism"
(Lidmila, 1997, p. 103).



This article seeks to highlight the role of supervision in the evolution of psychotherapists-in-training. It offers several professional and personal reflections on the matter in the form of recommendations in the hopes that these recommendations may contribute to more productive and meaningful supervisor-supervisee dyads. The recommendations were born from two decades of providing and receiving supervision combined with principles derived from the empirical literature, where available. As I begin to articulate these recommendations, I am reminded of Jay Haley's introduction to a workshop on supervision voiced in 1985, "If the field shows little agreement on what psychotherapy is, what can we say about supervision!"

Supervision has been one of the most widely recognized methods of training almost since psychotherapy's inception (Bernard & Goodyear, 1998). Contemporarily, there is legislation recognizing supervision as a required method to facilitate proficiency when training mental health professionals. In

California, for example, in order for a person to become eligible for licensure as a mental health practitioner, having earned a degree is not enough; he or she is required to complete 3,000 supervised hours of service provision in a ratio that ranges from 5:1 to 10:1 between service delivery and supervision hours. Furthermore, recently introduced legislation now requires supervisors to have undergone training on supervision. Close supervision has been part of the recommendations for developing new skills among licensed professionals and remediating shortcomings in troubled professionals (American Psychological Association, 2002). Orlinsky and collaborators (Orlinsky, Botermans, & Rønnestad, 2001), based on the ratings that almost 5000 psychotherapists from over 20 countries made on various influences in their career development, found that formal supervision or consultation was the second highest positive influence, second only to working directly with patients.

Nonetheless, it could be argued that much of the supervisory focus has been on quality control and assurance in the provision of services (i.e., safeguarding patient's welfare) and not as much on the development of the psychotherapist-in-training, possibly curtailing the maximum potential of supervision. Although supervision is an accepted method of training in psychotherapy, there is little research supporting its use and differential benefits (Holloway & Neufeldt, 1995). That is to say, "few studies exist that examine directly the relation of therapist performance and client change to supervision" and "there are virtually no studies that compare the efficacy of supervision to other training methods" (p. 207). The remainder of this article focuses on a number of recommendations for improving the quality of supervision.

Recommendations

Recommendation # 1: Emphasizing Personal and Professional Development

The supervising encounter ought to address two intricately related aspects in the development of psychotherapists. These two aspects are the personal evolution of the therapist and his or her skills acquisition process. Although potentially misleading in their oversimplification, I refer to the first aspect as therapists' personal development and to the second as their professional development. This dichotomy is only for descriptive purposes since the two dimensions are inherently dialectical. The first dimension, that of the personal development of the supervisee, addresses the recognition of a need for an ongoing, thoughtful process in the development of reflective



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practitioners (Nelson & Neufeldt, 1998; Schön, 1983, 1987). This process seeks to generate meaning in the training psychotherapists' professional mission. The second dimension, that of professional development, addresses the necessary proficiency goals of psychotherapists.

Recommendation # 2: Prioritizing the Focus of Supervision

Building on the recommendation above, I believe the supervision encounter needs to be orchestrated around acquiring and, most importantly, actualizing the skills shown to account for most of psychotherapy outcome. For example, Lambert (1992) has indicated that 30% of psychotherapy outcome is accounted for by common factors (e.g., instillation of hope, acceptance and support, collaborative relationship, increase self-understanding, generation of an alternative view on the problems that motivated consultation, etc.), 15% by expectancy and placebo effects (including the client's perception of the rele-

"I find discussions on 'theoretical orientation' particularly unhelpful..."

vancy of the proposed intervention to his or her problems), 40% by extratherapeutic change (e.g., spontaneous remissions, extratherapy dimensions such as social support, specific client variables such as ego-strength, therapist-client match), and 15% by techniques. More recently, Wampold (2001) has argued that at least 70% of psychotherapy effects are accounted by general effects (i.e., common factors) while no more than 8% are accounted by specific effects (i.e., techniques); the remaining 22% are unexplained but are due, in part, to client differences.

Based on these findings, a supervision dyad will find it most helpful to focus on the providers' capacity to establish working alliances with patients. Supervisors ought to concern themselves with exploring supervisees' characteristics that are facilitative of working alliances, as well as those that may impede them (Najavits & Strupp, 1994). Similarly, supervision dyads should include formal evaluations of therapeutic alliances via standardized instruments such as the Working Alliance Inventory (Horvath & Greenberg, 1989). As the therapeutic relationship evolves, the supervisor could help the supervisee to identify and adequately deal with alliance ruptures (Safran & Muran, 1996). Similarly, the ability to conceptualize a case in a relevant manner has been

shown to be of significant importance in treatment efficacy (Orlinsky, Grawe, & Parks, 1994). Therefore, supervisors would want to focus on supervisees' capacities to make sense of patients' struggles and on the manner in which interventions are appropriately derived from the conceptualization proposed (for a discussion on clinical formulation, see Butler, 1998).

Recommendation # 3: Professional Collaboration

Similarly to psychotherapy, effective supervision is also characterized by a collaborative professional relationship. The professional aspect of the relationship operationalizes treating supervisees as colleagues-in-training. The collaborative relationship acknowledges important power differences in the dyad while it systematically seeks to develop ever-increasing degrees of empathy, mutuality, respect, and dialogue. It is many times in the context of the supervisory relationship where some aspects of the treatment recommendations get modeled by the supervisor, or experienced or experimented by the supervisee.

Recommendation # 4: Facilitating Change and Affirming Stability

I have found that a discussion and ongoing dialogue on the personal and professional views of human change and stability processes held by the supervisor and the supervisee is one of the most productive conversations in the supervisory dyad. I find discussions on "theoretical orientation" particularly unhelpful as the use of traditional approaches terminology seems too removed from day-to-day practice while creating an illusion of shared or divergent language and knowledge.

To facilitate such discussion, I resort to an adapted version of Fernández-Alvarez' (1992) taxonomy that recognizes four main and significant conceptual contributions in the field of psychotherapy. These contributions can be ordered on two axes. The horizontal axis represents the processes considered when explaining the origins and maintenance of human strengths, resiliencies and psychopathology. At one end of this axis is the psychodynamic cluster of approaches with its emphasis on motivational processes, and at the other is the behavioral cluster accentuating learning processes. Each cluster has been characterized by important evolutionary developments over time. Rather than focusing on the transitions from orthodox psychoanalysis, to ego psychology, to object relations theory, to self psychology, to control mastery theory, etc., I insist on repre-

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ciating the evolution of our understanding of human motivation from primarily an intrapsychic phenomenon to a more interpersonal phenomenon and the implications of these changes for psychotherapy practice. Similarly, rather than focusing on the transitions from classical conditioning, to operant conditioning, to authoritarian CBT, to constructivistic CBT, etc., I insist on focusing on the implications of the evolution of our understanding of human learning from a mostly environmentally driven phenomenon to a dialectical one between the individuals and their circumstances. The vertical axis represents the relative emphasis given to the person or the context in the facilitation of normalcy and in the genesis of disorders. At one end of the axis is the humanistic-existential-experiential cluster that emphasizes individuals and their capacities for self-determination and healing, choice, life-projects, as well as alienation and inauthenticity. At the other of this second axis is the systemic, multicultural and feminist cluster with its emphasis on the interpersonal, cultural, and gender

"Treatment needs to be formulated based not only on diagnostic dimensions but also on other client dimensions..."

der context in which every individual comportment is embedded. The clusters are inevitably dynamic in

that a) they dialectically interact with one another facilitating their evolution and resulting in a continual rapprochement over time and, b) they are traversed by sociopolitical, economic, and cultural vectors that shape them and give meaning to their existence. The space generated by the intersection of the two axes bundles an integrative, pluralistic cluster of approaches that attempts to honor the main contributions of the four clusters (so called "forces") while seeking to articulate an evolving synthesis.

The supervisor-supervisee dyad may find it helpful to review the four dimensions above, (motivation, learning, person, context) as they relate to change and stability processes to discern the dyad's similarities and differences in conceptualizing psychotherapy practice and case formulation.

Recommendation # 5: A Developmental Perspective in Supervision

Supervision needs to be conceptualized, organized, delivered, and implemented in a manner that is congruent with the stages of development of evolving

therapists-supervisees (Skovholt & Rønnestad, 1995; Stoltenberg & Delworth, 1987) and their individual differences (e.g., level of experience, cognitive complexity, reactance, preferred learning style). Supervisors would want to focus on a sequential program of skills acquisition. It has been amply demonstrated that certain relevant therapeutic abilities take much longer than others to acquire. For example, basic skills such as interviewing skills can be relatively quickly learned early in one's professional development while more advanced skills such as the timing of interventions come with much effort and over longer periods of time (Dobson & Shaw, 1993). Similarly, supervisors will find it effective to focus not only on patients' dynamics but also on supervisees' behaviors (Henry, Schacht, Strupp, Butler, & Binder, 1993) while encouraging supervisees to articulate the intentionality informing their therapeutic actions. Furthermore, the shift from "the need for support and greater structure at the beginning levels of training and a new relationship in supervision, to more personal challenge and autonomy for latter stages of training and in a more mature supervisory relationship" (Holloway & Neufeldt, 1995, p. 210), ought to guide the structuring of the supervisory encounter.

Recommendation # 6: Honor the Tension Between Nomothetic and Idiographic Perspectives

As supervision needs to be personalized, so should the supervisory dyad personalize treatment with respect to clients' processes and stages of change. Treatment needs to be formulated based not only on diagnostic dimensions but also on other client dimensions (e.g., personal and interpersonal resources, ethnic identity development, coping style, resistance, problem severity and distress, problem complexity). Congruent with the humanistic tradition in medicine, it is as important to know the disease a person has, as it is to know the person who has the disease. Similarly, the popular saying adopted by Beutler to overcome the uniformity of results in psychotherapy, "different folks benefit from different strokes" ought to guide treatment delivery. Ultimately, as the authors of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, American Psychiatric Association, 2000) cautioned the readers, "Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable additional information about the person being evaluated beyond that required to make a



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DSM-IV diagnosis" (p. XXXIV-XXXV).

Having stated the importance of an individualized approach to supervisory and clinical work, such an approach is moderated by rule-bound, nomothetic articulations. Perhaps the most explicit expression of these articulations is the initiative known as empirically supported treatments (ESTs; Chambless & Hollon, 1998), now appropriately moderated and complimented by the empirically supported treatment relationship initiative (Norcross, 2001). Unfortunately, ESTs have focused on brand-name psychotherapies and practically ignored the principles of change articulated by the different theoretical frameworks (Garfield, 1998; Rosen & Davison, 2003). Nevertheless, manualized therapy as expressed in the manuals on which ESTs are based can be a place to start in helping therapists-in-training to organize their actions and be systematic about implementing treatments. At the same time, supervisors and supervisees should keep in mind that therapists

"Unfortunately, ESTs have focused on brand-name psychotherapies..."

who follow such manuals have been found to become less empathic, supportive and optimistic, and more authoritative and defensive (e.g.,

Beutler, 1999; Henry, Strupp, Butler, Schacht, & Binder, 1993) though they are able to maintain flexibility (e.g., Connolly Gibbons, Crits-Christoph, Levinson, & Barber, 2003; Kendall & Chu, 2000).

Recommendation # 7: The Myth of Uniformity Among Supervisors

As has been determined in the context of manualized training and provision of services where significant differences were found among equally trained providers, similar differences can be found among supervisors. For example, Henry and collaborators (Henry, Schacht, Strupp, Butler, & Binder, 1993) found important differences on training outcome based on teaching styles of the supervisors along dimensions such as the specificity of learning task, the focus on patient versus therapist dynamics, and the content of the feedback to therapists. The more effective trainer tended to be specific about the learning task, focused on the therapist dynamics and his or her own thinking process, discuss personal cases to illustrate implications for further specific explorations and interventions, offer specific feedback as to what the supervisee had done that was desirable, and respectfully confronted or challenged resistance

on the part of the supervisee. In contrast, the less effective trainer tended to be relatively less task specific and focused more on the patient dynamics and behavior in relation to the therapeutic process, did not directly address the supervisee's thought processes, discussed personal cases in broader theoretical terms, rather than as they related to a potential specific intervention, made more global positive comments, tended to be less confrontational, and displayed more respect for the therapist's autonomy. Not all supervisors will be as helpful as one would like; beyond acceptance of this "fact of professional life," the dimensions from research such as Henry et al. (1993) may help the supervisory dyad negotiate specific aspects that may make the dyad more productive.

Recommendation # 8: Differences in Supervision

Although every supervisory dyad is different, certain differences may be more pronounced, relevant, and immediate. Specifically, cultural diversity needs to be a welcomed topic in the dyad's ongoing dialogue, not only in its supervisory work but also on service delivery. For example, in the context of supervision I find it most helpful to present myself as a cultural being, made of many privileges and shortcomings. Most poignant among the latter is my life-long work on myself as a "recovering prejudist" as I have sought to overcome unfair discriminatory practices which I was indoctrinated in during my youth.

Supervisory dyads ought to explore their cultural similarities and differences and to systematically recognize racial, ethnic, cultural, socioeconomic, and political dimensions in their supervisory and clinical work. Every effort should be made to consistently expand the spectrum of culturally diverse clients with whom therapists-in-training work. A supervisor must model an unflinching willingness to raise questions about how differences along the dimensions indicated above shape their supervisory and clinical duties. These duties take place in a defined context and therefore we must evaluate on an ongoing basis the extent to which this context is welcoming of diverse clients.

Recommendation # 9: Generate a Shared Agenda

I find it quite helpful to organize the beginning of a supervision dyad around a frank dialogue on expectations. Perhaps one of the most helpful ways to do this is by reviewing evaluation forms that most supervisors and supervisees will be expected to fill out in the course of supervision. As a supervisor, I

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encourage supervisees to fill out these forms about themselves to obtain a baseline that will help us prioritize our work and develop a shared agenda. I do the same with the form supervisees eventually complete regarding my supervisory performance. I try to keep in mind that as we begin our work some regression in proficiency is likely to take place, in part due to the evaluative nature of our work, in part due to our attempts to figure out a way to work together.

Based on the evaluative forms, I am struck with how many times supervisees want supervision to focus on acquiring a repertoire of interventions and techniques, yet when reviewing their work I more frequently find them struggling with their ability to deeply connect with their clients while eliciting their stories without preconceived notions. As Parker Palmer put it, "technique is what you use until the therapist arrives. Good methods can help a therapist

"A supervisee needs to be willing to experiment with an ever increasing, broad set of interventions..."

find a way into the client's dilemma, but good therapy does not begin until the real-life therapist joins with the real life of the client" (1998, p. 5). As one of

my supervisors was fond of saying, "when feeling stuck with a client, think ECT. Not electroconvulsive therapy, but empathy, collaboration, and technique, in that order" (David Burns, personal communication, December 1995). That is, to what extent is empathic resonance being expressed by the therapist and perceived by the client, to what extent is the therapeutic relationship characterized by collaboration on a mutually agreed upon agenda, and finally, to what extent are the techniques utilized relevant to a particular client's difficulties? As indicated here and in recommendation #2 described earlier, techniques are important but a supervisory focus on them should come after the most fundamental aspects of therapy are present in the therapist's delivery and in the client's experience of the therapist.

Recommendation # 10: Openness to the Experience

What I have come to term "supervision-by-recall" is not as helpful, relevant, or incisive as supervision that is framed by a set of questions formulated by supervisees and where session segments in the form of an audiotape or better, a videotape, capture the questions raised by supervisees. I recognize that

supervision-by-recall gives us a sense of control and feels a lot safer in the role of supervisee. Therefore, much of the work in supervision is facilitating a sense of safety, respect and appreciation of the learning of this "impossible profession" enough for supervisees and supervisors to take risks in showing their actual work to each other.

In my repertoire of typical supervisory questions, the one that supervisees appreciate the most is an open invitation to understand their intentions. I may say something like "Help me understand what prompted you to say or do that?" or "What was your intention when you said or did that?" Many supervisees are puzzled by such questions at first but as they experience my genuine interest in knowing their intentions they begin to wonder aloud about them. This line of questions plants a seed in their therapeutic awareness to invite them to reflect in action.

Ethical issues aside, the openness to the experience also involves a momentary suspension of preconceived notions. A supervisee needs to be willing to experiment with an ever increasing, broad set of interventions, at times in spite of our "inner or outer talk:" (e.g., "It won't work," "I can't do that."). Allow me to share a personal example with Larry Beutler as my supervisor and me as the therapist/supervisee. I was working with a client who had an abusive, discounting, critical interpersonal style. Larry suggested that I implement a modified token economy, handing my client poker chips of different colors to distinguish interpersonally appropriate and inappropriate narrative. I was somewhat reluctant at first, as I had had a mixed experience using a token economy in group homes with adults with persistent and severe mental illness. Larry helped me to get to a more comfortable place with the proposed intervention and I followed suit by taking the risk. The client was puzzled at first (the intervention required the client to discern the pattern of chips as handed to him) but soon began to appreciate the intervention. He was delighted that "for the first time" in his life, another person was providing immediate feedback as to how he was coming across. I felt the experience enlarged not only my repertoire of techniques but also my willingness to meaningfully incorporate a set of learning principles about which I was previously ambivalent.

Recommendation # 11: The Gift of Feedback

Supervisors who take the risk of providing timely feedback are indeed taking a risk that is not easy to



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appreciate from the point of view of the supervisee. I have come to term this feedback as a gift. Gifts are many times not chosen. We may expect them at times and at other times be surprised by them. We treasure some gifts and replicate them while we pass others on. Some gifts stretch our taste and we eventually warm up to them.

Supervisory feedback may have much in common with gifts. For example, Lambert and his research group (Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001) showed that when psychotherapists receive feedback on the improvement status of their patients, they can change their interventions accordingly. When outcomes of a feedback group and a control condition were compared, results showed that feedback increased the duration of treatment and improved out-

“...I see more junior trainees expected to conduct ever-briefer treatments...”

come for patients who were predicted to be treatment failures. For those patients who were predicted to have a positive response to treat-

ment, feedback to therapists resulted in a reduction in the number of treatment sessions while maintaining positive outcomes.

Addendum

I am particularly troubled by what I have witnessed at my workplace over time. On one hand, I see more junior trainees expected to conduct ever-briefer treatments (I am reminded of the adage "the shorter the therapy, the longer the training," quoted in Levenson & Strupp, 1999) and on the other, such trainees seem to be working with ever more seriously mentally ill patients. Clinical practice is an apprenticeship process that combines art and science. Training via sink or swim exposure strategies is not conducive to emancipatory learning. In fact, I find such strategies leading many beginning therapists to resort to inappropriate compensatory strategies, to maladaptive habits that are difficult to change, and to burnout. None of this is helpful to the clients we intend to serve. To the extent that a supervisor has some control over the training environment, I strongly recommend an active selection of clients whose presenting complaints are developmentally appropriate for the degree of professional maturity of the supervisee (James, Blackburn, Milne, & Reichfelt, 2001). When such selection is not possible, supervisors ought to anticipate the difficulties. As in

the Spanish saying "espina que se avise," a foretold difficult is not as painful.

Conclusion

Perhaps most important to the supervision dyad is a renewed commitment to embrace our humanities in the experience of training and provision of mental health services. Doing so implies the celebration of our strengths and resources as well as the acknowledgment of our shortcomings. Said in traditional psychodynamic terms, it is not a question of whether one will experience countertransference reactions, but when. As such reactions happen, supervisors need to see a commitment from supervisees that they will do their homework and take steps in the right direction. Supervisees need supervisors who tread gently and respectfully on these matters. □

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Ethics made simple: Using the RRICC Model of Personal and Professional Ethics

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 The American Psychological Association (APA) has revised its code of ethics nine times since 1953 with its newest revision published in December 2002 (American Psychological Association, 2002). The Association has spent a great deal of time, energy, and money over the years designing the code in order to provide a useful contemporary document that can guide the wide range of professional behaviors of all psychologists. The committees who have worked hard to create and improve the code of ethics deserve much praise and thanks.

Although the APA ethics code is a remarkable achievement, it can be cumbersome and challenging for the average psychologist or psychology trainee to use in his or her personal and professional life. Few will take the time and energy to read the document from cover to cover and fewer still will use it as a regular resource in their office or by their nightstand when ethical questions and conflicts emerge. Many may consider it challenging to distill the wisdom of the code into an easy to use and memorable set of principles that can be incorporated into all professional (and even personal) decisions. The purpose of this brief article is to articulate and introduce a way of thinking about the ethics code so that it is very easy to remember and use on a daily basis. The approach uses the "RRICC model," which stands for the following aspirational virtues or values: responsibility, respect, integrity, competence, and concern. This model and how to use it in daily life is articulated in much more detail elsewhere (Plante, 2004). It represents an "ethics made simple" way of using the wisdom of the APA ethics code in all professional and personal decisions.

There are many different ways to approach ethics. Several thousand years of moral philosophy

have well articulated the various ways one can think about and manage ethical conflicts and questions. In a nutshell, one can choose to use a utilitarian, justice, absolute moral rule, egoism, common good, rights, cultural relativism, social contract or virtue approach to ethical decision making (Rachels, 2003). Combinations of these approaches can also be used as well. It is beyond the scope of this brief article to carefully review each of these approaches to ethical decision making. However, there are many useful and easy to read books written for a general audience that outline the various approaches to ethics that the reader may wish to consult (e.g., Kidder, 1995; Kreeft, 1990; Lewis, 2000; Rachels, 2003; Smith, 2000).

The American Psychological Association, uses primarily a virtue-based approach in its ethics code, as do other psychological associations such as the Canadian and British associations, for example. The virtue approach articulates particular values that guide behavior. These values include principles such as honesty, integrity, first do no harm, responsibility and so forth. Other organizations, such as the boy scouts, also use a virtue approach to ethical guidance. Additional ethical principles, besides the virtue approach, such as cultural relativism and the rights approach are also integrated into the APA's and other ethics codes. However, the virtue approach is the primary one used by various professional psychological organizations.

A review of the 1992 version of the APA ethics code (American Psychological Association, 1992) makes it quite clear what values the organization wishes to highlight and support. These include the elements of the RRICC model noted earlier, including responsibility, respect, integrity, competence, and concern. The newest version of the code has altered these aspirational principles somewhat and additional words

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such as "beneficence" and nonmaleficence" have emerged as guiding principles. While there is not a significant difference between the values highlighted in the current and former ethics code documents, the values articulated in the 1992 version of the code might be easier to remember and apply to all behavior both personal and professional. For example, "non-maleficence" used as the first aspirational principle in the current 2002 APA ethics code may not be an easy word to say or understand for the average person.

One does not need to be a psychologist to be able to learn from and embrace the aspirational ethical virtues highlighted in the APA ethics code. Being respectful of others, being responsible for our behavior, maintaining integrity, being competent, and showing concern for others are values that most people feel comfortable supporting regardless of their professional, educational, or cultural background. Ethical conflicts have been in the news a great deal of late. Corporate corruption associated with companies such as Enron, Tyco, WorldCom, and the mutual

"Perhaps we can all be more careful to filter our behavior through the lens of respectfulness..."

fund scandals have highlighted the need for better ethical guidance in business and finance. The clergy sexual abuse crisis in the Roman Catholic Church, the lack of integrity in politics, the recent prison abuse crisis in Iraq, the constant attention to the shenanigans of celebrities and sport figures all underscore the ethical conflicts and troubles people get themselves into. The wisdom of the APA ethics code, along with its roots in moral philosophy, are applicable to these contemporary issues that span the political, business, church, sport, entertainment, and many other fields and industries. Couldn't all of these areas benefit from the RRICC model of ethics? Wouldn't we all be better off if, as a society, we agreed to strive towards respect, responsibility, integrity, competence, and concern in all that we say and do?

A few examples associated with each of the five RRICC principles may be helpful. The examples will focus on situations that are especially relevant for psychologists but could potentially apply to others as well. The examples are certainly not exhaustive but reflect a few common examples of ethical misbehavior among colleagues.

Respect

Although, psychologists strive towards being respect-

ful to all, there are too many every day examples where psychologists do not treat everyone with respect. For example, most of us have attended professional conferences and conventions where audience members have asked questions or made comments to presenters in a disrespectful manner. This is often also apparent in hospital grand round presentations, continuing education workshops, public lectures, and elsewhere. Too often the theme of these encounters appeared to be that the person asking the question or making the comment was trying to demonstrate his or her perceived superior intellect or skill by putting down the presenter. Another example includes too many psychology students reporting that their professors treat them in a disrespectful manner if they disagree with them or if they pursue educational or career goals contrary to those respected and most valued by their professors. A third example includes clinical patients who feel that their cultural, religious, or ethnic values and perspectives were not treated respectfully by professionals. Perhaps we can all be more careful to filter our behavior through the lens of respectfulness even when we strongly disagree with others in public or private.

Responsibility

It always surprises me that so many psychologists fail to return telephone calls in a timely manner (especially when these calls involve the clinical care of patients). It is also remarkable that people will promise to send a clinical report, a reprint, a book chapter, or another professional task and then fail to do so. It is also incredible that professionals who are very comfortable in their theoretical orientation or professional world view refuse to alter their perspective based on new research and clinical findings that support results contrary to their particular point of view. Striving towards responsibility and accountability in all that we do is necessary to fulfill this important ethical principle and goal. Responsibility includes fulfilling our commitments and promises, returning phone calls and emails in a timely manner, being open to potentially useful ideas different than our own, and so forth.

Integrity

Integrity means being honest, just, fair, whole, and complete. It is surprising that so many graduate students over the years have reported that their psychology professors have engaged in marital infidelity with graduate students. Many professionals also engage in behaviors that are misleading or decep-

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tive. Perhaps they present themselves as having more experience, training, credentials, and skill than they actually do. Many may find it hard to admit that they are not expert enough to engage in certain professional activities.

Competence

Research has demonstrated that incompetent people just don't know that they are incompetent (Kruger & Dunning, 1999). Therefore, it is unreasonable to expect that incompetent people will work towards competence if they are clueless about their inferior competence level. This applies to psychologists as well. Some colleagues give the same lecture from yellowed legal pad notes that are older than the students they are teaching. Some colleagues offer clinical services to patients that were state-of-the-art decades ago but are no longer perceived by the professional community as effective. While we must strive towards competence in all that we do, it is certainly a chal-

"...it is unreasonable to expect that incompetent people will work towards competence if they are clueless about their inferior competence level."

lenge to be clear about what defines competence when we often disagree about what is indeed competent professional behavior. There are many ways to define effective teaching, research,

and professional practice. Although it can be hard to define, we must still strive towards competence in all that we do and get the necessary consultation to ensure that we do not slip into incompetent behavior.

Concern

One of the most important ethical principles involve concern for others. There appears to be too much careerism in our profession (as well as other professions too) such that research and practice can often primarily be a vehicle for egoism, narcissistic gratification, and career advancement. In a field such as psychology, we have the knowledge base and skills to help create a much more humane and just world by helping to make the world a much better place for everyone. Since so many of the problems of society and of the world involve people behaving badly (e.g., violence, substance abuse, poor parenting, aggression, poor health behaviors, greediness) and so forth, perhaps we all could work harder to

use our skills in expressing our concerns for others in order to improve the quality of life for all.

We all fall short at times of the five ethical virtues discussed in this paper and in the APA ethics code. However, if we commit ourselves to the code and try our best to generalize these principles to both our professional and personal lives, we may increase the odds of making solid ethical choices most of the time.

While the APA code can certainly be successfully applied to other professions and to the general population, we need to use ethical approaches that are easy to use and understand. The RRICC model meets these criteria. Regardless of the decision being considered, the RRICC model can likely help filter our thinking in a way such that an ethical path is more clearly visible. Reminding ourselves of the five simple words that comprise the RRICC model each time we face an ethical dilemma will hopefully help all of us to live the code. Choosing to take that ethical path and dealing with the consequences, of course, is another matter altogether. □

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Text on Proposed Amendment to the Division 12 APA Bylaws

MEMORANDUM

To: Division 12 Members

From: Division 12 Board of Directors

Date: October 15, 2004

At its June 2004 meeting, the Division 12 Board of Directors voted to submit the following six proposed bylaws amendments to the Division 12 voting membership for approval. Below are four of the changes with a pro/con statement for your perusal. The final two changes did not merit a pro/con statement due to their content. Please review the recommended changes carefully. Upon completion, please tear out the ballot insert, check those changes that you agree should be made, and those you do not think should be done. Sign the ballot. Mail to: Div 12 APA, PO Box 1082, Niwot, CO 80544-1082. The ballots will be tallied within 14 days of the deadline and an announcement of the results will be sent via the Division 12 listserv.

Unsigned ballots will not be processed. Ballots must be returned by Tuesday, November 30, 2004.

The changes: An amendment to these Bylaws may be proposed by a majority of the Board of Directors or by a petition of three percent (3%) or one hundred Fellows and Members, whichever is greater, presented to the Board of Directors. After an amendment has been reviewed by the Board, it shall be mailed as soon as is practical, and no later than the subsequent scheduled mailing from the Society within sixty (60) days to the last known post office address of each Fellow and Member along with statements which specify the arguments for and against the proposed change. Ballots shall be counted sixty (60) days after mailing, and the voting period shall then be considered closed. An affirmative vote of a majority of the Fellows and Members returning their ballots shall be required to ratify the amendment which shall then go into effect.

1. Article XI, Section A

“within 60 days” changed to “as soon as is practical and no later than the subsequent scheduled mailing from the Society”

Arguments for the change: Each mailing to the membership costs a minimum of \$2,500 – even more for a package with many pages, like the by-laws. It is much more cost efficient to include by-laws changes

with another scheduled mailing than to send a separate mailing just to comply with the 60 days rule.

Arguments against the change: This change may result in some by-laws changes taking longer to bring to a vote than would have occurred under the 60 days rule.

2. Article IX, Section A

Deletion of the requirement to provide statements for and against each proposed change.

Arguments for the change: Some proposed by-laws changes raise such rich debate that no brief set of arguments for and against the change would do justice to the issues. Other proposed by-laws changes are trivial, no more than correcting an error. Most changes are more moderate, and members of this Society, all of whom are bright and well educated, can themselves generate ideas about the benefits and downsides of a particular proposed change. Furthermore, the Board of Directors debates and approves all proposed amendments to the by-laws before sending them to the membership; after this process, it can sometimes be difficult to generate arguments against the proposed changes. Rescinding the requirement that the Board provide arguments for and against each change does not preclude the Board from presenting such statements in those instances in which they are deemed both practical and helpful to those voting on an issue.

Arguments against the change: The Board often proposes changes to the by-laws because it has encountered some difficulty with a rule established by the by-laws. The general membership does not have access to the back story on what prompted most proposals to change the by-laws, and they are not always obvious. Take as an example the proposal to change the rule about mailing by-laws votes to the membership from “within 60 days” to “as soon as is practical and no later than the subsequent scheduled mailing from the Society”. Without context, it is not intuitive that this proposal is designed to save money. Providing arguments for and against each by-laws change requires the Board to explain the issues they considered in proposing the change.

The Change: The Finance Committee, which shall consist of the Treasurer and three (3) members of the Board of Directors, serving staggered terms of three years and the Treasurer without vote. The



Text on Proposed Amendment to the Division 12 APA Bylaws (continued)

Finance Committee shall oversee the fiscal practices and planning of the Society, monitor its financial records, and cause a final audit of the annual financing affairs of the Society to be prepared.

3. Article VII, Section D, 5

Change regarding voting status of the Treasurer on the Finance Committee.

Arguments for the change: The Treasurer is charged with the overall and day-to-day management of the Society's budget and finances. The Finance Committee's job is twofold: to recommend policy to the Board of Directors to guide the Board in its management of issues with financial implications and to advise the Treasurer on specific financial questions on which the Treasurer requests others' knowledgeable opinion.

The vast majority of professional (and business) organizations define the Treasurer not only as a voting member of the Finance Committee, but also as its Chair. The reason behind this arrangement is to assure that the financial life of the organization and policies that govern it are largely in the hands of the person charged with the detailed management of finances, and hence with the most intimate knowledge of the financial issues facing the organization. To charge a person with the trust and responsibility for major financial decision-making and management of the treasury, and at the same time deny that person a vote on matters with financial implications is illogical, detrimental to the financial well-being of the organization, and demeaning to the person willing to assume the responsibilities of the office of Treasurer.

Arguments against the change: The job of the Treasurer is to tend to the immediate budgetary concerns of the Society; the Finance Committee attends to longer-term financial considerations. The current arrangement, denying the Treasurer a vote on the Finance Committee, enhances the system of checks and balances that mitigates against misjudgments on the part of a Treasurer.

The Change: The Division 12 representation to the APA Council will include at least one ethnic minority member. Whenever a position is open for a Division 12 representative to the APA Council and there is no current ethnic minority member of the Division 12 representation to the APA Council, the

committee on Nominations and Elections shall prepare a dedicated slate of ethnic minority candidates. For this purpose, ethnic minority status will be as defined by APA Council. In this case, requirements of Article VIII, Section C shall be suspended for the dedicated ethnic minority position ballot.

4. Article VIII, Section D

Creation of a dedicated ethnic minority slate for Society Representatives to the APA Council of Representatives.

Arguments for the change: In 2001, APA's Council of Representatives encouraged Divisions to be more inclusive of ethnic minorities and voted to approve a motion to increase ethnic minority participation on Council. They also encouraged Divisions, and State and Provincial Associations to submit one or more slates of nominees comprised solely of ethnic minorities. Given that few ethnic minorities have been elected to leadership positions in the 16 elected offices of Division 12, the Division's Board of Directors approved the Bylaws amendment on a dedicated ethnic minority slate in 2003. Because Bylaw changes must be approved by the general membership with pro and con statements, the pro statement is as follows:

The 21st Century population in the US is undergoing radical transformation with people of color now representing one third of our citizens. Our society is among the most ethnically diverse in the world and international relationships are increasing. This diversification of America brings with it challenges and changes in our society, especially as different lifestyles and worldviews collide. There will be changes in American life, and clinical psychologists, must be prepared to serve as leaders in teaching, research, and clinical service to this great diversity. Attention to diversity is necessary to address these developments.

Despite the Society's commitment to diversity as evidenced by the number of resolutions passed on this issue, ethnic minority members continue to be underrepresented on the Board of Directors and on Council. A review of the Society's election slates for the Board of Directors and for Council, from 1990-2000 revealed that only seven ethnic minorities had been nominated (out of a total of 49 nominees) and only one ethnic minority had been elected to Council. This deficit reflects several systemic prob-

Text on Proposed Amendment to the Division 12 APA Bylaws (continued)

lems. An examination of the history of the Division's governance suggests that very few members of ethnic minorities have held leadership roles in the past several years (a problem endemic to all APA leadership). Multiple data sources about recruitment and retention of minority psychologists indicate that when an organization is perceived as primarily White, it is only the unusual ethnic minority psychologist who is able to overcome this systemic perception of exclusion. The combination of these two factors (the recycling of leadership roles and perceptions of systemic exclusion) has limited the participation of ethnic minority psychologists in the Division's Board of Directors and Council representation. The limited participation must be placed in proper perspective.

Some would say that it is difficult to identify a sufficient number of ethnic minority group members to run competitively for office in the Division, but that is not true. Several very prominent and well-known ethnic minorities have run repeatedly for office, but have lost to members of the majority culture. The creation of a dedicated minority slate for one office out of 16 on the Board of Directors is a step toward rectifying this exclusionary problem.

Ethnic minority members of APA migrate to Divisions where they feel accepted and where their research, teaching, and practice issues are valued. Many of the ethnic minority leaders in APA are clinical psychologists, but do not join Division 12 because of the perceived notion that they can never be elected to a governance position. Despite the good intentions of many who want to see increased diversity, all available evidence from APA and its Divisions shows that diversity will not increase unless some systemic solutions are established. It is felt that representation and diversity will not be achieved unless great effort is taken, thus, the Division Board of Directors voted overwhelmingly to revise the by-laws to include ethnic minority representation and to submit this to the membership for a vote.

Voting YES to this proposal will enable the Society to take the lead in finding a solution to the systemic problem of under-representation by including ethnic minority leadership. It is a modest proposal that will help the Society to search for, and elect top psychologists who will add diversity. Any number of the

leaders and members of this division have stated that diversity would enrich our division by bringing an appreciation of cultural differences, a greater acceptance of those different from white middle-class members, bringing new training ideas given the populations we are serving in the U.S.A., and generating cross-cultural research which includes ethnic-minorities. Someone once wrote that our organization needs to be a microcosm of the population we serve and passage of this by-law change is a step toward meeting that goal.

In summary, the creation of a designated ethnic minority slate promotes Division 12's commitment to diversity beyond an aspirational goal. We all benefit with the inclusion of new voices into our leadership.

Arguments against the change: The intent behind this proposed amendment is to increase ethnic minority representation on the Division 12 Board of Directors and the APA Council of Representatives. This is an important goal that is supported by all who have been involved in the debate over this bylaws amendment. We differ, however, in whether we see the creation of a dedicated ethnic minority slate as an acceptable means to work towards this worthy goal. Articulating and understanding arguments against a flawed means of achieving a highly valued and important goal is a challenge in today's world. The leadership and membership of the Division are capable of acting in a socially responsible and ethical manner without requiring them to engage in ethnic separatism inherent in the proposed amendment.

Those of us who marched in the streets in the 60s fought fiercely for a system that could not deny opportunities for jobs, offices and other valued resources to any individual based upon ethnicity, religion, gender, sexual orientation, or other characteristics irrelevant to legitimate qualifications for access to such things. Favoritism for straight, Caucasian males was seen as an evil to be discarded in our system. That should remain our goal today. One concern with the proposed amendment is that the creation of a slate specifically dedicated to ethnic minority candidates actually works contrary to the intention of avoiding exclusionary patterns in filling important leadership positions. While presumably eliminating elections that exclude certain groups through voting, it substitutes an unavoidable de



**Text on Proposed Amendment
to the Division 12 APA Bylaws
(continued)**

facto exclusionary system that forces racially based voting by design.

The proposed creation of an ethnic minority slate perpetuates the elevation of ethnicity above the acquired characteristics that are most relevant to the position for which elections are held. The fact that a dedicated slate favors members of ethnic groups that have been historically discriminated against in our society does not compensate for the loss of freedom that it imposes upon current members of the society who neither have participated in discriminatory behavior in the past, nor happen to belong to one of the designated minority groups. The proposed dedicated slate is designed to base opportunity specifically on ethnicity, and it therefore reduces opportunities available to those of other ethnic or demographic backgrounds—issues unrelated to serving in the offices in question. Such discrimination is antithetical to the philosophy of a color-blind system that provides equal opportunity to all members, regardless of ethnic, racial, or other characteristics irrelevant to leadership positions.

Some argue that creating a dedicated ethnic minority slate sends a message that the Society is serious in its dedication to increasing minority representation in governance. Others contend that whether this amendment sends such a message is debatable at best, and that the stronger and more persuasive message sent by this action is that the Society does not believe that members of ethnic minority groups are capable of demonstrating their competence for leadership positions to the same degree as are those who are not defined as minorities. This is a message demeaning to those elected from such slates, to all members of groups defined as ethnic minorities, to the Division leadership, and to the membership at large. It assumes either that minorities are incapable of competing on a level playing field, or that those voting cannot fairly evaluate a candidate's qualifications because they are blinded by racial and ethnic stereotypes. These are strongly negative messages, inconsistent with the long-standing values of the Society.

Defining membership in a particular set of ethnic groups as a primary qualification for candidacy for an office decreases opportunities for those not included in the arbitrary definition of the group of favored members. This includes white Anglo-Saxon

males, who have been disproportionately elected as Council Representatives in the past, but it also affects members of other groups who have also been underrepresented in leadership positions, and who would also provide diversity in the Society's leadership, such as gay and lesbian members, women, people with visual or hearing impairment, those confined to wheelchairs, etc. Creating a dedicated ethnic minority slate is a blunt instrument for achieving more diverse representation, as it creates a clear competitive advantage to members of certain favored groups.

Finding effective, fair, and philosophically and ethically sound means of increasing the representativeness of governance bodies in the Division and in APA is both a critically important and tremendously difficult proposition. Creating a system of quotas based on race and ethnicity is not an appropriate answer. If it has been difficult to identify a sufficient number of ethnic minority group members to run competitively for office in the past, the creation of a dedicated minority slate offers no solution to that problem. A more effective and ethically defensible solution is needed. One element in such a solution might be for the Society leadership to develop an organized and sustained effort to identify young clinical psychologists of color (and members of other underrepresented groups) who show promise of having the skills and motivation necessary to serve as leaders in the profession. We should be providing the support and mentoring needed to help these promising young professionals to attain the kinds of background experiences and qualifications needed to compete successfully for offices in the Society and in APA without needing to prop them up with dedicated slates. This approach would ensure that the leadership of organized psychology is more diverse through explicitly promoting skills and experience and mentoring people to a competitive level rather than assuming that different standards must be created for those we hope to recruit to a more diverse and representative governance.

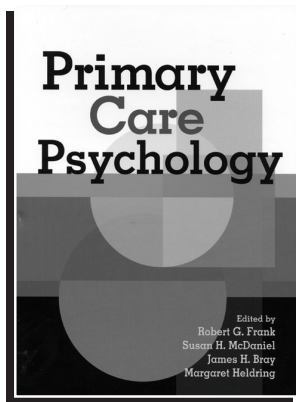
We should not have to "rig the system" in order to elect qualified ethnic minority members to office, and thus achieve the important goals towards which we are all striving. Creation of ethnic minority slates is an easy way out of the difficult situation we face, but one fraught with unintended inequities and pitfalls. □

Book Review

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Reviewed by Risa B. Weisberg, Ph.D.
& Lisa A. Uebelacker, Ph.D.



Psychologists are poised to play an important role in delivering high quality health care in primary care settings. Behavior changes, such as modifications in diet, exercise, and smoking, can have a significant impact on reducing the burden of physical illness in the United States. Further, primary care patients often present with comorbid mental

health problems that have an impact on quality of life and may influence the severity and course of their nonpsychiatric medical problems. Psychologists have the clinical skills needed to foster behavior change, as well the empirical skills required to scientifically evaluate interventions. However, few psychologists are trained to work in primary care settings, and most are accustomed to a traditional referral model. *Primary Care Psychology* introduces new models of practice and collaboration to psychologists. For psychologists currently working or considering work directly in primary care, this book provides valuable practical advice, training ideas, and collaborative care models.

Importantly though, this book is also valuable for psychologists who do not plan to work directly within a primary care setting. Most individuals who receive care for a mental health problem obtain at least some of this treatment in a primary care setting. Further, for many patients who seek specialty mental health care, the primary care physician serves as a gatekeeper to care and a provider of referrals. Additionally, in our aging society, more and more of our patients who present with psychological problems may also suffer from numerous medical comorbidities. Knowledge of the culture of

primary care practices and the way in which psychological problems are viewed and treated in these settings is thus important for all psychologists. Regardless of whether one plans to work directly within a primary care setting, the ability to interact with primary care providers will increase one's opportunities for referrals, collaboration, and continuity of patient care.

Primary Care Psychology is an edited text, compiled and, in part, written by members of the American Psychological Association's Primary Care Task Force. The editors and chapter authors are thus among the influential leaders in this burgeoning field within psychology. The book begins by providing an historical framework for understanding health care policy affecting primary care. It describes the impact of this policy on psychological practice and gives a political and economic context for the more detailed information that follows. Subsequent chapters provide practical information for the psychologist who wants to learn about working in primary care setting. Chapters describe an education and training plan; helpful tips for working in the primary care setting; descriptions of successful, real-world, psychology—primary care collaborations; and advice for working with specific populations including children, older adults, women, the chronically ill, and those living in rural areas. The book concludes by once again broadening the focus and examining U.S. health policy and methods for analyzing health outcomes.

Several chapters were of particular interest. One such section describes the physician-patient relationship, providing the psychologist with a valuable inside view of the way in which a primary care provider conceptualizes and treats mental health problems. A useful chapter is also included on recommendations for education and training in primary care psychology. This provides a model curriculum and helpful ideas on how one might obtain training or train others to work in this field. Two chapters, one on practical tips for clinicians in the primary care setting and one on how to conduct primary care psychology in the context of an independent practice, are extremely relevant for psychologists hoping to conduct a collaborative practice. They provide excellent practical advice in a reader-friendly format. This includes information such as how to clarify patient confidentiality in order to share information with the primary care provider,

Book Review (continued)

how to best explain to general medical patients why they are seeing a psychologist, how to foster referrals from primary care, and how to negotiate collaborative relationships with patients and physicians as well as with support staff and insurance companies or other payors.

Throughout the various chapters on specific populations and issues, the key differences between primary care and tertiary care practice are highlighted. The book provides psychologists with a sense of the culture and nature of primary care settings, the challenges primary care providers face, and how to

“...psychologists are trained in a culture that is foreign to primary care and...we must adapt in order to succeed...”

best adapt to this setting. All of this is done with a focus on the multitude of skills and values that psychologists can bring to the setting and a continuous emphasis on forming a true working col-

laboration with primary care providers. This book does not preach to psychologists that we must forfeit our ideals in order to work within the medical setting. Instead, the editors and authors highlight the common ground between our disciplines and the shared goal of good patient care. The authors realis-

tically acknowledge that psychologists are trained in a culture that is foreign to primary care and that we must adapt in order to succeed, but they also highlight the ways in which genuine collaboration is a deserving and attainable goal.

Because Primary Care Psychology is an edited book written by multiple authors, each chapter can stand on its own and is accessible without having read the rest of the book. However, because of the "stand alone" nature of the chapters, many contain varying degrees of overlapping information about collaborative care and the primary care environment. Therefore, if we have one criticism, it would be that at times the book is repetitive, if read cover-to-cover. However, the repeated message is an important one—to work in primary care, psychologists must adapt from their traditional tertiary care model. Overall, Primary Care Psychology is an excellent overview of the challenges faced working in the primary care setting, and an in-depth and thorough primer on how and why to face those challenges to build a productive and high-quality practice. This should be required reading for any psychologist working in primary care and is relevant and thought-provoking for psychologists who have never considered the primary care setting. □

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



ABBREVIATED MINUTES SOCIETY OF CLINICAL PSYCHOLOGY LAS VEGAS BOARD MEETING JUNE 26-27, 2004

Board meetings for 2005 include: Feb 11-13 in Alexandria, Virginia, (jointly with other divisions) and June 24-25, site yet to be determined. The board will rethink having the multi-divisional joint meetings for the Winter, 2006 meeting.

2005 Program Chair is John Hunsley (University of Ottawa)

Election Results (for 2005-2007):

President Elect: Gerald Davison; Secretary: Linda Knauss; Council Representatives: Annette Brodsky and Barry Hong

A draft of the Policy and Procedures Manual for the Division will be presented at the next board meeting to refine existing policies, and help curb unintentional confusion by board members on policies currently in place.

APA Convention Schedule: Antonette Zeiss was commended for her work as program chair. Division President, Nadine Kaslow, appointed Division Board members to various meetings to act as liaisons during Convention.

2004 budget: The Finance Committee reviewed various "belt-tightening" measures, leading to several motions (below). New income is expected from publications, (royalties from the agreement between Danny Wedding, as Editor, and Hogrefe & Huber for a book series have already been received), and from the PDIs at the Hawaii convention.

The Fellowship Committee reported that there were four new Fellows approved and 14 Current Fellows approved, effective January 1, 2005. This is an increase from the prior year when the total was 11 approved Fellows.

Science and Practice Committee copies of the report of lists of empirically supported treatments are still being sold for \$30 through the Central Office. There was discussion about how to continue the empirically supported treatments project.

The Journal: The Board deliberated what to do with the Journal as the deadline for the end of the Oxford contract nears. A survey on reader satisfaction is being prepared, and negotiations with various publishers is being handled by the Publications Chair. Ed Craighead, the publications chair, will be meeting with various publishers over the next few months and recommendations will be made to the Board regarding publisher options.

Website update: Joe Plaud, Webmaster, will be asked to develop a students-only listserv, and a student-only section

will be developed on the web site by Brandon Briery. A new listserv manager is being sought.

New Task Forces: President-elect Linda Sobell announced that she is appointing a new Task Force on developing a statement of purpose for the Society of Clinical Psychology. It will be charged with a mission to find out how the division can market its identity better. A new Student Task Force, building upon the current student workgroup, is also planned. The board is encouraging students to apply.

APA Council Report: A letter will be sent asking Division 12 members to give 10 votes for Council seats for Division 12 representatives. Council items discussed included APA buildings as investments, Public Interest resolutions, and Ray Fowler's retirement.

Advocacy: Donna Rasin-Waters is organizing representatives from the Sections of Division 12 to meet in Hawaii about goals for advocacy group. Advocacy will continue to be a priority for the Division.

Sections: The Board of Directors voted that sections will not be required to write reports for each board meeting. A written annual report will be required, with verbal reports at meetings. Section news can be found in their newsletters, in the full minutes and in voluntary written reports appended to meeting agendas. The sections will be described in one of the monthly listserv notices to members.

The following motions were made at the meeting:

MOTION: The Division shall establish a fund to support student participation in division and APA activities. PASSED. (The Training committee will be asked to develop the advertising plans and guidelines. This money is in addition to the current student awards.)

MOTION: (Regarding E-mail Voting) Any board member may make an initial motion via email. A week for discussion will follow. If, in the judgment of the President, it is deemed appropriate for an e-mail vote, the President will request a final motion and call for a vote. Any board member may request that the Executive Committee review and concur with the President's determination that the motion is appropriate for an e-mail vote. If the executive committee concurs with the President, the vote will proceed. There will be one week to vote. Votes shall be sent to the administrative officer to tally. The administrative officer will send the vote tally to

the Secretary, who will track all motions for which there have been completed votes and include these in a report at the subsequent board meeting. PASSED

MOTION: The division shall raise the dues to \$35 for student members and dues exempt members who receive the journal. NOT PASSED. (The discussion reflected that any raise for students is a problem and it is important not to do so now.)

MOTION: The division shall raise the dues for dues exempt members who receive the journal to \$35. PASSED.

MOTION: The division shall donate \$1000 to the National Multicultural Conference. PASSED

MOTION: The Clinical Psychologist shall list all the voting board members with email addresses in each published issue. PASSED

MOTION: The Board of Division 12 authorizes Dr. Craighead to negotiate with John Wiley & Sons Publishers in regard to Division 12 sponsorship of the Journal of Clinical Psychology with the following conditions:

1. The Division will serve as a sponsor of the journal provided that members have the option to purchase the journal at a reduced rate
2. The Division will receive a "commission" for Wiley for serving as a sponsor and will present option to subscribe as a member benefit.
3. The Division sponsorship will not include the option of members to select the Journal of Clinical Psychology to replace Clinical Psychology: Science and Practice as a membership benefit.

MOTION: The Division 12 Board of Directors will honor the six year commitment of the contract for Editor of Clinical Psychology: Science and Practice. This increases the normal editorial term by one year. PASSED

MOTION: The Board of Directors clarifies the ethnic minority slate bylaws proposal such that ethnic minorities can run for any slate at any time. However, if there might otherwise be no ethnic minority in a Division 12 APA Council seat, the Board of Directors will invoke the minority slate for the next election. PASSED

MOTION: Voting members of the Division 12 Board of Directors will not be eligible to receive Division Awards while serving on the board. PASSED (All division awards should have this statement in their criteria.)

Nadine Kaslow was commended for her work this year as President, and for leading the board meetings. She commended her mentor, Lynn Rehm, who will be leaving the board after this year, as well as other members to depart at the end of 2004: Norman Abeles (Council Representative), Gloria Gottsegen (Section 4 Representative), and Irving Weiner (Section 9 Representative).

Personal Statement from the Secretary

As I submit these brief highlights of the final minutes of my three year term as secretary of Division 12, I wish to thank the Board of Directors and the membership of the Division for the honor of serving such a dynamic group of hard working and caring psychologists.

**Respectfully submitted,
Annette Brodsky, Secretary**

Division 12 Election Results

Congratulations to Division 12 Election Winners!



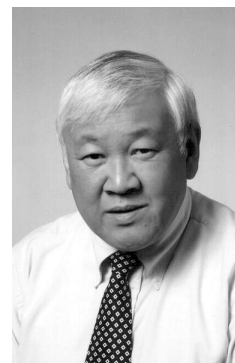
Gerald C. Davison
President Elect



Linda K. Knauss
Secretary



Annette M. Brodsky
APA Council
Representative



Barry A. Hong
APA Council
Representative

UNIVERSITY OF OTTAWA: Psychology (<http://www.socialsciences.uottawa.ca/psy/>). The School of Psychology of the University of Ottawa anticipates filling two tenure-track positions effective July 1, 2005, preferably at the Assistant Professor level. Priority will go to applicants in the areas of 1) clinical psychology (eligible for registration with the College of Psychologists of Ontario), with a preference for a specialist in child or adolescent clinical psychology, 2) social psychology 3) developmental psychology, 4) quantitative methods, or 5) psychometrics. Excellent candidates in related areas are also encouraged to apply. Applicants should meet the following minimum requirements: Doctorate in Psychology and strong research potential. Fluency in French and English is essential. The salary is competitive and adjusted as a function of experience. Start-up funds are also available. Applications should be received before November 15, 2004. Please submit a letter of application, curriculum vitae, three letters of reference, and reprints of two recent publications in refereed journals or other visible evidence of scholarly publication to: Dr. Claude Messier (cmessier@uottawa.ca), Assistant Director, School of Psychology, Lamoureux Hall, University of Ottawa, P.O. Box 450, Station A, Ottawa, Ontario, Canada, K1N 6N5. In accordance with Canadian immigration requirements, this advertisement is directed in priority to Canadian citizens and permanent residents. Equity is a University policy and we strongly encourage applications from women.

Applying for Fellow Status in Division 12

Fellows Applicants:

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

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

Send all applications to:

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

To request applications:

Tel: 303-652-3126
Fax: 303-652-2723
Email: div12apa@comcast.net

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:

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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:
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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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