

THE CLINICAL PSYCHOLOGIST



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

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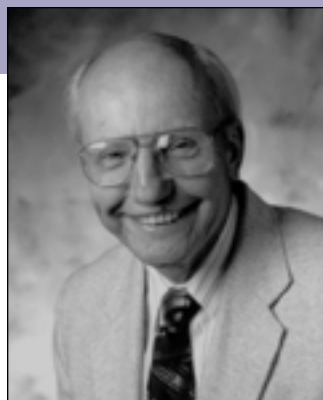
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PRESIDENT'S COLUMN



Larry Beutler, Ph.D.
Pacific Graduate School of Psychology

Advice to The Next APA President

Larry E. Beutler

When you read this, we will be electing a new APA President. Not knowing who that will be, I feel at some liberty to offer some opinions and advice to this new leader, based on what I've learned during the past several years as President of two Divisions, a member of APA Council, and a long time member who wears hats of both a scientist and a clinical practitioner. While I certainly want to give you advice, as you initiate your term as President, mostly I want to make you think about some of the priorities that will affect us, Division 12,

the Society of Clinical Psychology, during your term.

APA faces many challenges—the budget, a declining membership, changing roles for psychologists, a less than welcoming legislative agenda, etc. I would like to ask you what you're going to do about each of them. Being unable to do that, I want to draw your attention to just two issues that I think are terribly important to clinical psychology, and to offer you some suggestions/advice about addressing them. These are issues about which something really needs to be done, and probably sooner rather than later. I also want to comment, very briefly, on one other matter about which nothing needs to be done. I will start with the advice:

First, I think that something really should be done about Continuing Professional Education. As professionals who seek to be reassured that what we do is of value to the people we serve, it seems to me to be a critical shame that we have yet to find a way of ensuring that the many continuing professional education courses that purport to enhance our clinical skills (let's forget for a moment those courses that simply try to impart knowledge about ideas, record keeping, and software use, none of which have a direct bearing on how many people are harmed or helped) are, in fact, effective. While the departing Jo Linder-Crow has done a magnanimous job of improving accountability and introducing more consistency between APA and state (especially California) requirements, the profession has still failed to face the fact that some of the things we do as professional psychologists can cause harm. Some even cause death (witness "Rebirthing Therapy"). If we really accepted this truth, we would feel compelled, as professionals, to make sure that our practices were in line with the best scientific evidence available. We would want assurance that the things we learn in those courses are at least safe, and probably effective. Interestingly, continuing education (CE) standards of approval and review have stopped short of requiring evidence of safety and efficacy, except as supplied by the charisma and faith of the presenter. How can we not impose at least the modest assurance that the procedures we allow to be trained under the CE banner, produce better results than doing nothing at all.

I recommend that you consider bringing the APA Science and Practice Directorates

(continued on page 3)



The Summer issue of *The Clinical Psychologist* (TCP) stirred up strong reactions from some readers. With the exception of one letter criticizing Larry Beutler's presidential column on prescriptive authority, and one letter applauding the same column, all other comments were in response to the article by Lohr, Fowler, and Lilienfeld on the dissemination and promotion of pseudoscience in clinical psychology. You may recall, that the Lohr et al. article discussed the

Rorschach Inkblot Test, eye movement desensitization and reprocessing (EMDR), and critical incident stress debriefing (CISD) as examples of clinical procedures for which claims of efficacy and validity are often out of proportion to the available data. In response to the Lohr et al. article, I received 12 letters in support of the Rorschach, two letters in support of EMDR, and no letters defending CISD. I also received a number of e-mails in support of the Lohr et al. paper, and several other colleagues voiced their support more informally, during phone calls and other conversations. In short, the article generated considerable interest and controversy among readers.

Overall, I am pleased by the discussion generated by the Lohr et al. paper. However, I wish that I had published some commentaries or reactions to the paper in the same issue of TCP. In an effort to rectify that oversight, this issue includes a paper written by Irving Weiner, Charles Spielberger, and Norman Abeles defending the use of the Rorschach. It is my intention to publish a response by Lohr et al., as well as a final rejoinder by Weiner et al. in the next issue of TCP. I decided not to publish any of the other letters that I received about the Rorschach, because they raise many of the same points that were raised in the Weiner et al. response. Still, I want to thank those who took the time to write to me.

At a recent meeting of the Division 12 Board of Directors, questions arose regarding the true purpose of TCP, what its content

should be, whether articles published in TCP should reflect the opinions of the Division and its Board, or whether TCP is, or should be, an independent, peer-reviewed journal. In my view, TCP serves several functions. One purpose is to communicate official policies and announcements from the Board of Directors to the members of Division 12. However, a second function is to alert members to important issues in clinical psychology and to facilitate discussion about these issues. Therefore, most articles published in TCP do not necessarily reflect the views of the Board, and the Board does not review or vote on the content of TCP before it is published. As with most magazines, journals, and newsletters, the content of each article reflects only the views of the authors (TCP now has a statement to that effect on the back cover).

Finally, TCP is not a peer-reviewed journal; although some articles are peer-reviewed, others are invited and reviewed only by the editor. A disadvantage of not having all articles go through a rigorous peer-review process is that some articles may be less "tight" than they might be otherwise. However, given the newsletter format of TCP, there are many advantages of the current editorial philosophy. TCP avoids the long lag times that are characteristic of most journals, allowing communications to get out to members in a timely fashion. The current format also allows authors to express opinions that are more provocative or controversial, thereby facilitating some interesting discussion. In that way, I see TCP as serving functions somewhere in between a peer-reviewed journal and a professional e-mail list serve. I hope that Division 12 members enjoy reading TCP even if they don't agree with everything they read in any given issue.

Martin M. Antony, Ph.D.
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together with a mandate to develop criteria that includes both standards of practice and standards of knowledge that can be adapted to become a basis for judging the adequacy of any CE program. Then, I suggest, charging state and regional associations, Divisions, and Sections of Divisions—those who represent the expertise in various areas—collectively to develop a process by which the skills proposed to be taught in any CE program can be assessed before the fact and reviewed after the fact, to ensure that the practices are safe and effective and relevant.

My second concern is with preserving the objectivity of our clinicians as we take on the mantle of being prescribing psychologists. In my judgment, medicine, including psychiatry, has largely lost its ability to evaluate objectively, the effects and effectiveness of medicines. This ability has been lost both because many physicians have become unwittingly victims of a conflict of interest, and thereby lost credibility, and

“...the pharmaceutical companies have assumed the roles of gate keepers to what knowledge is made available to the masses.”

because drug companies have found ways to lobby and persuade physicians to change their practices and to ignore matters of evidence. The methods of persuasion frequently used exclude scientific

evidence or even simple charts that provide comparisons and evidence of efficacy. Instead, the methods most used involve honoraria, gifts, trips, and even cash, as incentives to change one's professional practices. Even the programs of major scientific meetings have been dictated by those with a vested interest in advancing one drug over another, independent of evidence of value and worth.

We must find ways of distancing ourselves from those methods and people that would influence our opinions independent of factual knowledge. We must lift ourselves above this fray as we take on prescriptive authority. I have not been an advocate of prescriptive authority, but since the profession has elected to adopt prescriptive authority as one of its professional roles, I want to see us succeed at being the best in doing it. But, I am concerned that we might lose the objectivity that is inherent in our scientific traditions and I do not think that we have any special moral injunction or abilities to avoid the conflicts of interest that (I think) have characterized psychiatry's relationship with the drug industry.

We, too, are likely to listen more attentively to the drug rep who offers us the chance of increasing our income than to one who simply discusses the relative merits of two or more drugs in a scientific test. We will listen to the financial incentive, especially when the one offering this avenue for us, is advocating a medication that we already believe is of value. It's easy to accept the monetary incentive when doing so doesn't produce an initial conflict of desires. But, at some point, we run the danger of listening only to the incentive and not to the evidence. This point may be understood if you attended the annual meeting of the American Psychiatric Association, or the Latin American Psychiatric Congress, this year. If you attended, you could not help but be impressed by how thoroughly and completely the pharmaceutical companies have assumed the roles of gate keepers to what knowledge is made available to the masses.

I suggest the development of some tools and the erection of practice structures that will help practitioners easily evaluate and then select medications for their patients that are independent of the marketing ploys of pharmaceutical houses. Specifically, I envision a two-pronged approach to combat the influence of drug company marketing: (1) develop a firewall of information, distributed by APA, to replace that of the “drug rep” in order to reduce the dependency of the frontline clinician on the pharmaceutical industry for “quick and accurate” knowledge; and (2) establishing decisional model to guide interactions with a patient, comprised of observations and questions that must be asked, along with a corollary set of questions to be asked of any drug representative. This may be complemented with computer based methods by which to assess and check the answers obtained. In part, this may consist of a list of principles that remind us of the psychological mechanisms that underlie personal change, so that clinicians will not lose sight of either the context of their work or the foundations of behavioral science that define psychology as a field.

Now, I would like to turn to the issue about which change is neither required nor implied—Thanks, Ray Fowler, for the hard work, the dedication, and the willingness to put your neck on the line for all of us. May you find rewards in the recollection of your good works to remind you that we have appreciated you and your commitment to us. □



Letters to the Editor

Dear Dr. Antony:

Division 12 President Larry Beutler's recent article in *The Clinical Psychologist* (Vol. 55[3], Summer 2002) entitled, "Prescriptive Authority: Moving Toward a New Clinical Psychology?" offers a novel look at what may happen next now that New Mexico and Guam have prescribing laws for psychologists. Among other things, Dr. Beutler posits that continuing disagreements concerning psychologists prescribing will be solved in the courtroom. More specifically, he describes three anticipated courtroom legal challenges which he believes will bring the training and practice of prescribing by psychologists into question. These expected challenges, however, are based upon misunderstanding of common law and on the legislature's role in developing credentials for professionals.

First, Dr. Beutler predicts that the adequacy of a prescribing psychologist's training will be evaluated through a lawsuit. In point of fact, it is a well established legal principle (dating back to a Supreme Court Ruling, *Dent v. West Virginia*, 129 U.S. 114[1889]) that state legislatures have the right to statutorily define the required education and training for professions. In the ensuing decades, state courts and the United States Supreme Court continue uphold this legislative prerogative. Specifically, the courts have continuously upheld that such regulation is a legitimate exercise of the "police" power of state legislatures. A prescribing psychologist's practice may be evaluated by a court in terms of the extent to which it has adhered to the customary standard of care for providing medication but the court will not second guess the law establishing the credential. Indeed, as lead plaintiff in the Blue Cross/Blue Shield State and Federal Antitrust Suites, the courts took "judicial notice" that it was not the function of the court to examine the wisdom of the legislation" (*Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476, 485(4th Circuit); *Cert. Denied*, 450 U.S. 916[1981]). And more recently, in Dr. Beutler's home state, the United States Court of Appeals for the Ninth Circuit ruled, yet again, in a case concerning the California psychology practice act and its regulations; "It is simply not the function of the court to tell California how to craft its legislation," 228 F.3d 1043 (2000).

Second, Dr. Beutler posits that some prescribing psychologists will be challenged for practicing medicine without a license for the use of psychoactive medica-

tion with a medically ill patient. Again Dr. Beutler has confused the role of the court with the role of the legislature. As with education and training, courts do not challenge the legislature's authority to determine, by statute, a profession's licensed scope of practice. In New Mexico, for example, the legislature determined that a prescribing psychologist's scope of practice would include the use of any psychoactive medications approved by the Food and Drug Administration for the treatment of mental disorders. Expanded practice for qualified psychologists within these parameters, whether or not the patient also has a medical illness, was exactly what the New Mexico legislature envisioned. To reiterate: legislative intent can not be altered by court fiat. As a side note, it should be noted that, in the history of the practice of psychology, organized medicine/psychiatry used unsuccessfully the same legal argument/challenge when we expanded our practice parameters to include tests and assessment, again when we added psychotherapy, and again with hospital privileges (Resnick, R.J., 1997: A brief history of practice—expanded. *American Psychologist*, 52, 463-468.).

Finally, Dr. Beutler argues that a prescribing psychologist will be challenged in court to prove that his or her unsuccessful practice was unaffected by pharmaceutical industry inducements, such as those for which physicians are currently under scrutiny. Once again, this is a conclusion based on a misunderstanding of the law. While conflicts of interest of all types could certainly be raised by a plaintiff in a malpractice action, the proof problem is not as Dr. Beutler describes. Rather than the defendant having to prove that his or her practice was unaffected by such conflicts, the plaintiff would have the burden of proving, by a preponderance of the evidence, that the plaintiff did not practice in accordance with the customary standard of care, as determined by the state licensing act, the regulations that govern practice, expert witnesses, text books and professional ethics and standards. The innocent until proven guilty maxim remains in effect.

I would close by noting that Dr. Beutler states that, "many of our colleagues are troubled by the decisions in New Mexico and Guam." I would add that many more colleagues are pleased by those decisions. Dr. Beutler and I agree that we must move on to the issues of training in an atmosphere of "cooperative and respectful interaction."

Sincerely,

Robert J. Resnick, Ph.D., ABPP
Professor, Department of Psychology
Randolph-Macon College

Letters to the Editor (cont.)

Ashland, VA

Dear Dr. Antony:

I think it is unfortunate that Lohr et al. (*The Clinical Psychologist*, 2002, Vol. 55, Issue 3) used bad science to make allegations of pseudoscience. The most recent EMDR article cited by these authors to substantiate their claims was dated 1994. Lohr et al. failed to mention the very large body of rigorous research investigating and supporting EMDR's efficacy as a legitimate treatment for PTSD. If the authors are as familiar with the EMDR literature as they assert, why would they ignore the findings of these 16 randomized clinical trials? Further, the authors stated that "the eye movements involved in EMDR appear to be irrelevant," and neglected to mention the findings of four studies demonstrating that

eye movements significantly decreased the vividness and emotionality of autobiographical memories, with effects significantly larger than those of control conditions. I agree with Lohr et al. that the application of scientific principles is crucial and am perplexed to find such an application lacking in their own paper.

Sincerely,

Louise Maxfield, MA
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Lakehead University
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Canada

New Editor Appointed



Phillip C. Kendall, Ph.D., ABPP
Temple University

Upon recommendation of the Publications Committee of the Society of Clinical Psychology, the Executive Board of the Society has appointed Philip C. Kendall as Editor-elect of its flagship journal, *Clinical Psychology: Science and Practice*. Dr. Kendall is the Laura Carnell Professor of Psychology at Temple University. He is also the immediate past editor of the *Journal of Consulting and Clinical Psychology*, as well as founding editor of *Cognitive Therapy and Research*. The author of numerous publications and the recipient of several NIMH grants, he is extremely active in the field of clin-

ical psychology.

Dr. Kendall will commence activities as Editor-Elect immediately and will receive manuscripts effective January 1, 2003. Official duties as Editor of the journal begin January 1, 2004 and run through December 31, 2008. Manuscripts should be sent to Dr. Kendall at his Temple University address:

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We are extremely delighted that Professor Kendall has accepted this assignment for the Society of Clinical Psychology and know that he will continue the outstanding tradition of excellence that characterized the tenure of our first editor, Alan E. Kazdin, as well as our current editor, David H. Barlow. We encourage you to submit ideas and manuscripts to Dr. Kendall and invite you to be an active player in the publication process that is so vital to the Society. □

Section VII Announces a Directory of APPIC Internships with Training in Behavioral Emergencies

Phillip M. Kleespies, Ph.D., Jason Spiegelman, M.A., and Daniel DeBrule, M.A.

Section VII Subcommittee on Education and Training

The Section on Clinical Emergencies and Crises (Section VII of Division 12) has been a strong advocate for increased graduate education and training in behavioral emergencies (i.e., training in the evaluation and management of life-threatening behaviors such as suicidal behavior, potential violence, and vulnerability to interpersonal victimization). The Section VII Task Force Report on Education and Training in Behavioral Emergencies (accessible on our web site at <http://www.apa.org/divisions/div12/section7>) provides evidence that (1) nearly all Psychology practitioners need to deal with clients or patients who are at risk of life-threatening behavior at some time in their professional careers; (2) the impact of dealing with such behaviors can be very stressful for clinicians and especially for those still in training; and (3) graduate education and training in this area of practice seems inconsistent across programs and is generally in need of far greater emphasis. Empirical research over the past 20 years has provided a foundation for an evidence-based approach to the evaluation and management of behavioral emergencies (Kleespies, 1998). The Section is committed to a model of education and training that is evidence-based (and which, of course, includes a discussion of the limitations of this type of evaluation and management).

With the cooperation of the APPIC Board of Directors, Section VII has continued its pursuit of information about training in this area of practice and compiled a Directory of APPIC Pre-Doctoral Internships that offer such training. One hundred and fifty-five (155) of the 562 APPIC programs (@28%) responded to a questionnaire stating that it is provided during their

internships. The Directory identifies these programs and includes information related to whether the training is required or optional, how much time is devoted to clinical experience with behavioral emergencies and crises, whether there are lectures or seminars on emergency-related topics, and whether there is supervision specifically for emergency cases. It is hoped that this directory will be a resource for internship applicants and graduate or professional program faculty who are interested in their students having this important training. The Directory can be accessed on the APPIC web site under Training Resources or by going directly to: http://www.appic.org/training/7_2_2_training_role_trainers.html. It is also posted on the Section VII web site at the internet address given above.

Although we are pleased to have completed and posted this directory on the internet, we believe that there is perhaps one sobering implication of the findings for graduate and professional programs; i.e., if only 28% of internship programs have indicated that they offer training in behavioral emergencies, it can hardly be assumed that students will necessarily obtain such training when they go on their internships. Section VII's position continues to be that there is a need (at all levels - graduate school, practicum, and internship) for an increased emphasis on education and training in this critical area of practice.

Reference

Kleespies, P. (Ed.). (1998). *Emergencies in Mental Health Practice: Evaluation and Management*. NY: Guilford Press.

Clinical Psychology Brochure

The popular brochure "What Is Clinical Psychology?" is available from the Division 12 Central Office. It contains general information about Clinical Psychology, and is suitable for both the general public and high school/college students.

**The cost is \$15 per 50 brochures.
Orders must be pre-paid.**

For more information, contact:

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Scientific Psychology and the Rorschach Inkblot Method


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 In the previous issue of *The Clinical Psychologist*, Lohr, Fowler, and Lilienfeld (2002) expressed concern about the use of assessment and treatment methods that lack scientific validation. Describing these methods as “pseudoscience,” the authors lament the extent to which the popularity of some of these techniques and the claims made on their behalf far outstrip the meager scientific evidence supporting them. They concluded by calling on the American Psychological Association and other professional organizations to “impose stiff sanctions, including expulsion if necessary, on practitioners who routinely use therapeutic and assessment practices that are devoid of scientific support” (p. 8). Throughout their article the authors cite the Rorschach Inkblot Method (RIM) as an example of “junk science” in assessment and presumably as a candidate for the sanctioning they urge.

We fully endorse the proper place of scientific methods in clinical psychological practice and research, and we concur with Stricker (1997) that all clinicians, whether working in a laboratory or providing mental health services, should strive to approach their tasks from a scientific perspective. However, casting Rorschach assessment as a pseudoscientific procedure that should be expunged and its practitioners expelled from psychology flies in the face of an abundant research literature documenting the psychometric soundness of the instrument. The present article summarizes the key data in this regard, and provides correctives for several misleading statements made by Lohr et al. (2002).

Psychometric Soundness of the Rorschach Inkblot Method

The psychometric soundness of an assessment instrument is defined by standardized procedures, intercoder agreement, reliability, normative data, and validity. In the course of recent controversy between advocates and critics of Rorschach assessment, it is generally agreed that this instrument, if properly administered, consists of a standard set of materials that are presented with uniform instructions to respondents. As for the other four psychometric components, Rorschach critics have raised various concerns but, for the most part, remained unconvinced either by empirical data generated to resolve these concerns, or by concerted efforts of Rorschach researchers to respond to criticisms by conducting additional studies that epitomize the scientific method.

Intercoder Agreement

Rorschach critics have alleged that the original data showing substantial intercoder agreement for the Rorschach Comprehensive System (e. g., Exner & Weiner, 1995, pp. 21-27) is undependable because it is based on percentage of agreement rather than more sophisticated statistics like Kappa or Intraclass Correlation coefficients that take account of chance agreement (Wood, Nezworski, & Stejskal, 1996). Subsequently, meta-analytic reviews and studies with patient and nonpatient samples have identified mean Kappa coefficients across various Comprehensive System coding categories, ranging from .79 to .88, which is in the excellent range for Kappa (Acklin, McDowell, Verschell, & Chan, 2000; Meyer, 1997a, 1997b). As for Interclass Correlations, Meyer et al. (2002) found median and mean interrater coefficients of .92 and .90, respectively, for 164 structural summary variables in two independent ratings of 219 protocols containing 4,761 responses. Of the 164 variables examined in this research, 156 (95%) met Intraclass Correlation criteria for excellent reliability, and none showed poor reliability. Without doubt, then, the RIM can be reliably coded using the Comprehensive System.

Reliability

Rorschach critics have alleged that the reliability of the RIM has yet to be established, because retest correlations have been published for only a portion of the variables in the Comprehensive System (Garb, Wood, Nezworski, Grove, & Stejskal, 2001). As noted by Viglione and Hilsenroth (2001), most of these so-called “missing” retest correlations involve either composite variables for which reliability data are available for their



component parts, or variables that occur too infrequently to allow for meaningful test-retest comparison. The truth of the matter is that almost all of the variables coded in the Comprehensive System and conceptualized as relating to trait characteristics show substantial short-term and long-term stability, with retest correlations in excess of .75. Among these are 19 important core variables that have 1-year or 3-year retest correlations of .85 or higher (see Viglione & Hilsenroth, 2001, Table 1). Without doubt, then, the Rorschach Comprehensive System yields reliable data.

Normative Data

Rorschach critics have alleged that the currently available normative data for the Comprehensive System, which were collected by Exner some 20 years ago and published most recently in 2001 (Exner, 2001), are outdated, inaccurate, and likely to overpathologize

by suggesting disorder where none is present (Wood, Nezworski, Garb, & Lilienfeld, 2001). Although Wood et al. cite research findings that appear to support their concerns, most of the studies they mention are methodologically compromised by small and unrepresentative sam-

ples of nonpatients, lack of systematic procedures, and use of inexperienced examiners (see Weiner, 2001a). Nevertheless, recognizing that assessment instruments require periodic restandardization, Exner (2002) has undertaken a new normative data collection project in which a large and demographically representative sample of participants are being tested by experienced examiners with a uniform set of instructions. The findings for the first 175 persons tested in this project closely resemble the earlier reference data and dispel any concerns about overpathologizing. Of the first 175 nonpatients in the new sample, only one has shown an elevation on the Comprehensive System index for perceptual and thinking disorder (PTI > 2); only 16% have elevated scores on the index for depression (DEPI > 4); and only 6% have shown indices of deficient coping skills (CDI > 3).

With further respect to normative standards, Rorschach critics have alleged that "Blacks, Hispanics, Native Americans, and non-Americans score differently

on important Rorschach variables for both the Comprehensive system and other approaches" (Wood & Lilienfeld, 1999, p. 342). Without reporting any specific Comprehensive System data in support of this allegation, these critics concluded that "Because there are important cross-cultural differences, and because appropriate norms have not been developed, it is doubtful whether the Comprehensive System should be used to evaluate members of American minority groups" (p. 341).

The facts of the matter, however, are quite different. First of all, cross-cultural differences in average test scores, should they exist, may reflect actual cultural differences that are being accurately measured by these test scores. Accordingly, such obtained differences have no necessary implications for the validity of using a test with diverse cultures. Second, recent studies with American minority groups indicate that there are no substantial Comprehensive System differences among them. Presley, Smith, Hilsenroth, and Exner (2001) found a clinically significant difference on only 1 of 23 a priori selected core variables between 44 African Americans and 44 demographically matched Caucasian Americans from the Comprehensive System nonpatient reference sample. Meyer (2002) found no association between ethnicity and any of 188 Rorschach scores among demographically matched European American, African American, Hispanic American, Asian American, and Native American respondents in a multicultural sample of 432 consecutive patients evaluated in a hospital-based psychological testing program. Employing sophisticated slope/intercept procedures for examining possible bias in test measurement, Meyer concluded that "the available data clearly support the cross-ethnic use of the Comprehensive system" (p. 127).

Validity

Rorschach critics have alleged that the RIM is a "shoddy" test with little or no criterion or construct validity (Dawes, 1994; Hunsley & Bailey, 1999; Lilienfeld, Wood, & Garb, 2000). In fact, however, a meta-analytic study by Hiller, Rosenthal, Bornstein, Berry, Brunell-Neuleib (1999; see also Rosenthal, Hiller, Bornstein, Berry, & Brunell-Neuleib, 2001) of Rorschach research studies published from 1977 to 1997, in which there was at least one external (i.e., non-test) variable and in which some reasonable basis had been posited for expecting associations between variables, identified an unweighted mean validity coefficient of .29 for Rorschach variables in 2,276 protocols. Similar methods applied to 5,007 MMPI protocols in studies published during that same period of time yielded an

"...cross-cultural differences in average test scores, should they exist, may reflect actual cultural differences that are being accurately measured by these test scores."

unweighted mean validity coefficient of .30 for MMPI variables. These virtually equivalent validity coefficients demonstrate that the RIM is generally as valid as the MMPI. Hiller et al. (1999) concluded with respect to both measures that the "validity for these instruments is about as good as can be expected for personality tests" (p. 291), and that the effect sizes for both the RIM and the MMPI warranted using these measures for their intended purposes.

In 1996 the Board of Professional Affairs of the American Psychological Association appointed a Psychological Assessment Work Group (PAWG) charged with assembling evidence on the efficacy of assessment in clinical practice, particularly with reference to the validity and utility of psychological testing

"Rorschach critics often appear unaware of or oblivious to the import of these and other data attesting the psychometric soundness of the instrument."

in health care delivery. The final PAWG report, published in the American Psychologist (Meyer et al., 2001) concluded from its review of predictive and meta-analytic studies that "psychological test validity is strong and compelling" and "comparable to medical test valid-

ity" (p. 128). The specific correlations they listed for comparison purposes included the following:

- Weight and height for U.S. adults (.44)
- MMPI validity scales and detection of malingered psychopathology (.44)
- WAIS IQ and obtained level of education (.44)
- Rorschach PRS scores and subsequent psychotherapy outcome (.44)
- Viagra and improved male sexual functioning (.38)
- Rorschach dependency scores and dependent behavior (.37)
- MMPI scale scores and average ability to detect depressive or psychotic disorders (.37)
- Hare Psychopathy Checklist scores and subsequent violent behavior (.33)
- Screening mammogram results and detection of breast cancer within 1 year (.32)
- Sleeping pills and short-term improvement in chronic insomnia (.30)

These correlations were considered by Meyer et al. (2001, p. 128) to be "comparable to medical test

validity." Detailed discussion of issues involved in assessing the validity of Rorschach variables and overviews of a vast body of research demonstrating the utility of Rorschach assessment are provided by Viglione (1999), Viglione and Hilsenroth (2001), and Weiner (1996, 2001b). To complete this presentation of facts concerning the psychometric soundness of the RIM, two noteworthy examples of its construct validity can be drawn from the Comprehensive System reference data. First, age-related changes in 1,390 5- to 16-year-old nonpatient children and adolescents closely parallel well-established developmental phenomena in young people. Egocentricity, or self-centeredness as conceived by Piaget (Piaget & Inhelder, 1969), has been documented in the developmental psychology literature as a phenomenon that decreases with age. The Rorschach Comprehensive System Egocentricity Index, which is conceptualized as a measure of self-centeredness, has a mean level of .69 in nonpatient 5-year-olds, after which it decreases in almost perfect linear fashion to .43 at age 16, at which time it is still slightly higher than the nonpatient adult mean of .40—as would be predicted from what is known about young people (Exner, 2001, chap. 11).

The second example of construct validity derives from the availability of Comprehensive System reference data for 600 nonpatient adults and adult samples of 535 psychiatric outpatients, 279 patients hospitalized with major depressive disorder, and 328 patients hospitalized with a first admission for schizophrenia. With allowance for individual variations, these four adult groups represent a continuum of increasingly severe psychological disturbance. Two key Rorschach indices of psychological disturbance are X-% (an index of impaired reality testing) and WSum6 (an index of disordered thinking). If X-% and WSum6 are valid measures of disturbance, they should increase in linear fashion across these four reference groups. Consistent with this expectation, the mean value for X-% increases from .07 in nonpatients to .16 in outpatients, .20 in depressed inpatients, and .37 in schizophrenic inpatients. The mean WSum6 values for these four groups, respectively, are 4.48, 9.36, 18.36, and 42.17 (Exner, 2001, chap. 11).

Rorschach critics often appear unaware of or oblivious to the import of these and other data attesting the psychometric soundness of the instrument. Moreover, those who acknowledge the existence of such evidence are fond of saying that it is not enough, that they are not satisfied, and that there should be a moratorium on the teaching and use of the RIM until more convincing evidence of its scientific merit has



been generated (e.g., Garb, 1999). How much evidence is enough, and what is required to be convincing? The small portion of the relevant research literature that we have referenced in this article should be more than sufficient to negate allegations that Rorschach assessment has no place in scientific clinical psychology. In the current edition of the *Mental Measurements Yearbook*, Hess, Zachar, and Kramer (2001) put the matter succinctly:

“The Rorschach, employed with the Comprehensive System, is a better personality test than its opponents are willing to acknowledge” (p. 1037).

Correctives to Misleading Statements

Because they are either unaware of or choose to ignore the nature and intended purposes of the RIM, Lohr et al. judge the utility of Rorschach assessment against

inappropriate criteria. These inappropriate judgments result in misleading statements like the following:

Although the Rorschach CS [Comprehensive System] possesses some validity for detecting schizophrenia and related conditions, its validity for detecting depression, posttraumatic stress disorder, psychopathy, and other

psychiatric conditions appears to be weak. Nor is there compelling evidence that the CS is helpful for the detection of child sexual abuse, even though it is used frequently for this purpose (2002, p. 5).

As a first corrective to the misleading implications of this statement, it should be noted that the RIM is not a diagnostic test. It is a measure of personality processes. To the extent that it measures disordered thinking, which it does very well, it assists in detecting schizophrenic disorder. To the extent that it measures dysphoric mood and negative cognitions, which it does very well, it assists in identifying depression. To the extent that it measures subjectively felt distress, which it does very well, it assists in identifying anxiety disorder. However, it is not intended to serve as a sole criterion for diagnosing schizophrenic, mood, or anxiety related disorders. Accordingly, the validity of Rorschach assessment cannot and should not be meas-

ured by its correlations with diagnostic categories.

As a second corrective, the RIM should not be expected to detect child sexual abuse, nor faulted for not doing so. Given the well-established heterogeneity of personality styles and reaction patterns found in youthful victims of abuse, there is little reason to expect any personality assessment instrument to identify whether a particular child has been abused. Moreover, the assertion that the RIM “is used frequently for this purpose” is presented without evidence, and we are not aware that any such evidence exists. We also do not know of a single instance in which a Rorschach teacher or scholar has recommended using the RIM to learn whether a child has been sexually abused. To the contrary, two recent research reports showing the sensitivity of certain Rorschach indices to the impact of sexual abuse concluded that these indices “do not establish with absolute certainty that sexual abuse actually occurred” (Leavitt, 2000, p. 320) and “should not be used as a sole indicator of past sexual abuse” (Kamphuis, Kugeares, & Finn, 2000, p. 221). The literature abounds with similar cautions against using Rorschach assessment in such ways. Rorschach responses will not indicate whether a person has a drinking problem, is an only child, or grew up on a farm. What Rorschach responses will do is what the method is intended to do—identify personality characteristics of the individual. The utility of the instrument then derives from the relevance of these identified personality characteristics to decision-making in clinical, forensic, health care, educational, and organizational settings.

In addition, Lohr et al. assert that proponents of Rorschach assessment have made extravagant claims that “this instrument possesses special, even remarkable capacities” (p. 6) and “have pointed to its longstanding use and popularity as indirect evidence of its scientific merit” (p. 7). The evidence they cite for extravagant claims consists of an enthusiastic endorsement of the RIM in the text of a citation by the APA Board of Professional Affairs when it bestowed on John Exner its 1998 Award for Distinguished Professional Contributions to Knowledge. Concerns that this citation was excessively effusive should be taken to the BPA and not used to tar the Rorschach community. Thorough reading of the relevant literature will reveal that authors of the major books, chapters, and journal articles concerned with Rorschach assessment are almost uniformly consistent in encouraging a conservative approach to interpreting the test data and cautioning against exceeding the boundaries of what the instrument can reasonably be expected to do.

The assertion that Rorschach advocates equate

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the long history and sustained popularity of the instrument with scientific merit is similarly misleading. Let us for the moment replace rhetoric with reason, and allow that the latter can provide reliable roads to truth. How likely is it that so many Rorschach assessors have been using the instrument for so long, in so many places and contexts, solely on the basis of illusory correlation? If this seems unlikely, is it unreasonable to infer that there has been some utility in their work?

On a different matter, Lohr et al. object to being “attacked . . . on the grounds that they do not regularly use the Rorschach in their clinical practice or research,” and they note that “the scientific worth of a technique cannot be evaluated solely by its friends” (p. 7). The issue, however, has nothing to do with being friendly. This issue concerns whether persons evaluating the scientific worth of a technique are intimately familiar

with the nature of the technique and how it works. In what field of science are criticisms of procedures welcomed from persons who do not themselves use or study these procedures?

Finally, we conclude where we began, with concern about Lohr et al.’s call for sanctioning psychologists who

conduct Rorschach assessments and expelling them from the APA and other professional organizations. Aside from identifying that their criticisms of the RIM are largely unwarranted and their conclusions frequently misleading, we are troubled that any small group of psychologists would take it on themselves to decide what is scientific and what is not, and on this basis to urge, in effect, a death penalty for the teaching and use of methods that do not pass their muster. Disagreeing with a widely held belief or challenging the validity of a frequently used procedure does not automatically render the belief scientifically suspect or the procedure ethically unacceptable. Disagreement and challenge have their proper place in scientific discourse, but unjustifiable criticism and disallowing the existence of that which one does not understand bears a disturbing resemblance to burning the books. □

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In Memoriam Lizette Peterson-Homer, PhD 1951-2002



Lizette Peterson-Homer, a prominent clinical psychologist and an active member of the Society of Clinical Psychology, died prematurely from acute pancreatitis on July 18, 2002 at the age of 51.

Lizette was the Byler Distinguished Professor and Curators' Professor of Psychological Sciences at the University of Missouri — Columbia at the time of her death. She was also the incoming editor and former associate editor of the *Journal of Consulting and Clinical Psychology*. Lizette also served our profession as associate editor and editor of *Behavior Therapy*, as founding editor of *Cognitive and Behavioral Practice*, as associate editor of *Health Psychology*, and as an editorial board member for numerous other psychological journals.

Lizette's distinguished career resulted in 4 books, 38 book chapters and 145 scientific publications.

In 1997, she received the *Distinguished Scientific Contribution Award to Clinical Psychology* from the Society of Clinical Psychology. In 1998, she received the *Significant Research Contributions Award* from the Society for Pediatric Psychology.

After graduating *summa cum laude* from Utah State University, Lizette earned her masters and doctorate in clinical psychology from the University of Utah. She completed her internship at the Salt Lake City Veteran's Hospital, and then moved to Columbia, Missouri where she spent her entire academic career in the Department of Psychological Sciences at the University of Missouri.

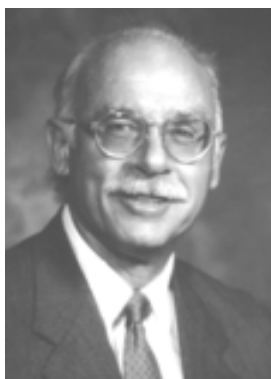
Lizette Peterson-Homer was a prolific and cherished colleague, and her sudden death robs the profession of one of its most distinguished members.

Danny Wedding, PhD
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Clinical Psychology in the Courtroom:

Part II. Being a Professional Critic

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 In the preceding issue of *The Clinical Psychologist*, Part 1, "Proper and Multiple Roles in Forensic Services," discussed the possibility of impropriety when the clinical psychologist serves in both clinical and forensic roles. Consideration was given to the distinction between the nurturant (clinical) and forensic (adversarial) scenarios, and how expert testimony is subject to the rules and expectations of the legal system, which may not always be in accord with clinical objectives or psychological ethics and standards. Nonetheless, there is, in addition to a legal mandate, ethical reason for clinical psychologists to participate in legal proceedings.

Once in the courtroom, potentially aggressive lawyering (as exemplified in the opening vignette in Part I) can result in the clinical psychologist's being drawn into critiquing the testimony given by other mental health colleagues. For example, a psychologist could be asked to comment on the standards maintained in an assessment conducted by another psychologist or about psychosocial principles or theories espoused by another professional witness.

Due to the large number of divorces, a clinical psychologist is especially apt to participate in child custody disputes, which could also include visitation and abuse issues. Thus, child custody cases will be used here for exemplary purposes.

Propriety of Professional Criticism

There are two reasons that justify a clinical psychologist's critiquing the work of another mental health col-

league. First, from the American Psychological Association (APA) ethics code: "Psychologists who perform forensic functions, such as assessments, interviews, consultations, reports, or expert testimony, must comply with all other provisions of this Ethics Code to the extent that they apply to such activities" (APA, 1992, p. 1610). Second and in accord with social responsibility, psychologists are directed to be "concerned about the ethical compliance of their colleagues' scientific and professional conduct" (p. 1599). Critiquing the work of other mental health professionals can, therefore, be considered consonant with the social responsibility that is inherent to professionalism.

The foregoing ethical permission is not *carte blanche*. In keeping with ethical requirements for competence, providing any type of expert testimony must be based on specialized knowledge. Commonly, the role of the expert witness is defined by the rules of evidence: "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise" (Federal Rules of Evidence, Rule 702). There are numerous other legal rules, which vary between jurisdictions, that will determine how and about what a mental health professional can testify. This means that, while being committed to ethical standards, the clinical psychologist should (must?) always tailor testimony to be in accord with the law.

The American Psychological Association's (APA, 1994) child custody guidelines add further support to professional criticism. The psychologist should have a clear scope of services, "based on the nature of the referral question" (p. 678), which includes the possibility that: "a psychologist may be asked to critique the assumptions and methodology of the assessment of another mental health professional" (p. 679). This seems applicable to the other mental health professions as well.

Serving as a professional critic is not without problems or limits. When clarifying the clinical psychologist's involvement in forensic activities, the APA ethics code cites psychologists being "called on to serve in more than one role in a legal proceeding—for example, as consultant or expert for one party or for the court and as a fact witness" (p. 1610). This ethical standard reveals two thorny issues—multiple relations and being a consultant (e.g., a professional critic) for one party; both of these issues will be discussed at various points in this article.

In the preceding issue of *The Clinical*

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Psychologist, Part I of this article discussed the dissonance between the clinical (nurturant) and the forensic (adversarial) scenarios. Now multiple roles within a particular legal case deserves attention.

No one can predict what legal situations lie in the future. In this litigious era, it is reasonable to consider every client to be a potential litigant in one way or another. Therefore, the clinical psychologist should approach the relationship aware of the possibility of a subsequent courtroom appearance or testimony about the services, whether it be a fact or expert witness. It seems probable that every practitioner-client relationship has the potential for introducing or at least bringing requests for multiple relations or roles, of which some will be appropriate while others are inappropriate.

Earlier discussion supports that some multiple relations can be ethical. Even if appropriate, however,

"In this litigious era, it is reasonable to consider every client to be a potential litigant in one way or another."

multiple relations always require caution to prevent one role (e.g., providing marital therapy to a couple who eventually decide to divorce) from contaminating another

role (e.g., testifying on behalf on one of the spouses and critiquing the testimony provided by an expert testifying more favorably for the other spouse). A later section will further explore multiple relations and roles.

The preceding example should alert the clinical psychologist, when asked to be an expert witness, to being concerned about the welfare of all persons involved in legal proceedings, which extends to reasonable consideration of the effect of the expert testimony on even the so-called opposing party.

When asked to critique the work of a colleague, the clinical psychologist should be sensitive to the possible effects for the client: "In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential patient's or client's welfare" (APA, 1992, p. 1605). For example, negative testimony about a colleague's opinions or services could lead the party who receives clinical services from the colleague to be less responsive to his or her future interventions.

Although the "patient" or "client" who is the

focal point may or may not be the source seeking the critique of the other professional's testimony, still the clinical psychologist has a responsibility to that person. From one perspective, one might argue that if the critic has never provided services directly to the party about whom the critique is directed, that party should not be deemed a patient or client, at least not in a clinical sense. Nonetheless, there are ethical standards that might apply here. For example, the APA code states that psychologists should "take reasonable steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable" (p. 1601).

Although the role of critiquing another professional is not specifically covered in the ethical codes for the mental health professions, an ethical responsibility follows from the general professional dictum of "do no harm." The "do no harm" dictum is applicable to all of the mental health professions. Any die-hard commitment to the adversarial process is inconsistent with professional ethics; the belief that "it's warfare" (as one forensic pundit cried) is to abandon being a mental health professional, and to attempt to be a pseudo-attorney and a quasi-legalist. For all mental health professionals, the guidelines doing no harm and protecting everyone are seemingly consonant with professional ethics, and would apply to people who are in legal proceedings.

The Interprofessional Relationship

When entering into a forensic scenario that involves critiquing and presumably refuting (at least in part) the opinions expressed by other mental health professionals, the clinical psychologist, serving as an expert witness, should always consider the "opposing" professional to be a colleague. The conduct of a clinical psychology should consistently convey respect to other professionals (as well as lay witnesses). For example, psychologists should consider interprofessional relations to be a matter of integrity, and be "honest, fair, and respectful of others" (APA, 1992, p. 1599); and this approach extends to those holding different values, attitudes, and opinions. Similarly, the ethics code for psychologists asserts they "do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status" (p. 1601).

Recalling the comments made about doing no harm to and protecting everyone in the legal proceed-

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ings, a clinical psychologist's critiquing the work of another mental health professional should be as free from negative attributions as possible. This does not mean, however, that the expert witness should ignore, condone, or reinforce testimony from any source that is wrong. On the contrary, such criticism is appropriate and necessary, but only if it has been determined objectively and is presented in a professional manner. Since some attorneys prefer to elicit "bad-mouthing" of other witnesses, maintaining standards and professionalism in this situation may sometimes be difficult.

When serving as an expert witness, there are complications for the clinical psychologist's critiquing the testimony of another mental health professional. One problem is addressing the mental health characteristics or needs of a party whom the expert witness has

***"...advocacy by the
clinical psychologist
(or other mental
health professional)
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sional objectivity."***

not seen directly. First, the propriety of the testimony is defined, in part, by the relationship between the expert witness and the person about whom the testimony is about; although for psychologists only, consider: "Psychologists perform evaluations,

diagnostic services, or interventions only within the context of a defined professional relationship" (p. 1603). Second, there must be sufficient direct contact, specifically, "psychologists provide written or oral forensic reports or testimony of the psychological characteristics of an individual only after they have conducted an examination of the individual adequate to support their statements or conclusions" (p. 1610). The ethics code for psychologists does allow for an exception: "When, despite reasonable efforts, such an examination is not feasible, psychologists clarify the impact of their limited information on the reliability and validity of their reports and testimony, and they appropriately limit the nature and extent of their conclusions or recommendations" (p. 1610). When combined, these standards create a restriction on what the expert witness can or cannot say in critiquing the testimony of, say, a treating therapist. Also, the limited direct contact with either of the parties makes the expert critique vulnerable to impeachment or exclusion.

Returning to clinical psychology and with spe-

cial reference to child custody matters, there should be no expressed opinion about "the psychological functioning of any individual who has not been personally evaluated" (APA, 1994, p. 679), but the clinical psychologist is not precluded "from reporting what an evaluated individual (such as the parent or child) has stated or from addressing theoretical issues or hypothetical questions, so long as the limited basis of the information is noted" (p. 679). In view of attorney tactics, the clinical psychologist may be tempted to move from hypotheticals to questions about the case at hand. Relatedly, the Code of Conduct for the Association of State and Provincial Psychology Boards (ASPPB; 1991), which may be used for guidance or ideas by state licensing laws for psychologists, holds that: "A psychologist rendering a formal professional opinion about a person, for example about the fitness of a parent in a custody hearing, shall not do so without direct and substantial professional contact with or a formal assessment of that person" (pp. 8-9).

The foregoing principles may or may not have been actually codified into the statutes of a given state, and may or may not be equally applicable to each of the mental health professions. However, an attorney could cite standards contained in positions statements, even from another mental health discipline, in an effort to qualify, impeach, or rehabilitate testimony of a professional witness; the decision about the applicability will rest with the court. Positions statements, again regardless of the particular mental health discipline that produced them, may be considered to some extent by licensing boards, and could be used in, for example, a complaint about a mental health professional's testifying inappropriately about a person in a child custody dispute.

Objectivity and Professionalism

Being legal advocates, attorneys commonly try to reinforce or manipulate the expert witness into an advocacy role. Even though certain legal rules might allow advocacy by the mental health professional, it is not an appropriate role. As stated earlier, it is for only the attorney to advocate legal interests. Of particular concern, advocacy by the clinical psychologist (or other mental health professional) carries the peril of compromising professional objectivity.

Maintaining objectivity is essential to any professional service, including courtroom testimony. For example, when interpreting assessment results, "psychologists take into account the various test factors and characteristics of the person being assessed that might affect psychologists' judgments or reduce the accuracy



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of their interpretations" (APA, 1992, p. 1603). One child custody guideline that is applicable to psychological services in general and certainly to any forensic work in specific is: "The psychologist neither overinterprets nor inappropriately interprets clinical or assessment data" (APA, 1994, p. 679). In fact, forensic psychologists must meet special standards, such as: "When hearsay or otherwise inadmissible evidence forms the basis of their opinion, evidence, or profes-

***"...multiple relations
or roles can be allowed
only with conditions
and caution."***

sional product, they seek to minimize sole reliance upon such evidence" (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 662).

The clinical psychologist, whose testimony is controlled or restricted by the question-answer method (as per by legal procedure), cannot allow certain kinds of evidence (e.g., information or documents presented by an attorney) to be transformed into pseudo-professional data. For example, an attorney may try to aggrandize the psychometric properties of psychologi-

cal tests, but the clinical psychologist's testimony must always include qualification in accord with professional standards for psychological data. Responding to evidence that is substandard according to behavioral science would be a derogation of professionalism.

When critiquing professional data collected by another mental health professional, the origin and conditions must be determined; for example:

When a forensic psychologist relies upon data or information gathered by others, the origins of those data are clarified in any professional product. In addition, the forensic psychologist bears a special responsibility to ensure that such data, if relied upon, were gathered in a manner standard for the profession. (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 662)

A further guideline applies here: "When evaluating or commenting upon the professional work product or qualifications of another expert or party to a legal proceeding, forensic psychologists represent their professional disagreements with reference to a fair and accurate evaluation of the data, theories, standards, and opinions of the other expert or party" (p. 664). By necessity, the clinical psychologist should, as stated in Part I, refuse to respond to any question that would require an answer that cannot be given with a

Applying for Fellow Status in Division 12

Fellows Applicants:

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

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

Send all applications to:

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To request applications:

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email: div12apa@attbi.com*

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reasonable degree of professional certainty as based on behavioral science (see also Woody, 2000).

Regardless of the role in a legal proceeding, the clinical psychologist must maintain the stance of a "professional expert who strives to maintain an objective impartial stance" (APA, 1994, p. 678). In keeping with the notion that the expert witness must not attempt to be the judge or engage in legal advocacy, the following dictum for psychologists should be heeded by all mental health professionals: "In offering expert evidence, they are aware that their own professional observations, inferences and conclusions must be distinguished from legal facts, opinions, and conclusions" (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 665). Being out of the clinic and in the courthouse must not be allowed to subvert the mental health professional's allegiance to ethics and standards, which means that maintenance of objec-

"It is potentially inappropriate for a therapist or evaluator to critique the testimony of another mental health professional."

tivity has special importance for fulfilling the proper role.

Multiple Roles in a Legal Case

It was acknowledged in Part I and earlier herein that multiple relations or roles constitute a "thorny" problem. For

several reasons (e.g., an attorney's wish to maximize the usefulness of expert testimony and get more "bang for the buck" for the client/party), an attorney may ask the clinical psychologist to provide services that constitute multiple roles. As mentioned earlier, multiple relations or roles can be allowed only with conditions and caution.

The clinical psychologist should try to avoid any relationship that appears likely to "impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party" (APA, 1992, p. 1601). This standard is the ethical foundation for concern about whether it is appropriate for a clinical psychologist (or any other mental health professional) to provide assessment and/or treatment (or other) services and also provide expert testimony. For psychologists, the APA ethics code is responsive to the problem:

In most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters. When psychologists may be called on to serve in more than one role in a legal proceeding—for example, as consultant or expert for one party or for the court and as a fact witness—they clarify role expectations and the extent of confidentiality in advance to the extent feasible, and thereafter as changes occur, in order to avoid compromising their professional judgment and objectivity and in order to avoid misleading others regarding their role. (p. 1610)

The child custody guidelines (APA, 1994) admonish: "The psychologist avoids multiple relationships" (APA, 1994, p. 678). The forensic guidelines (Committee on Ethical Guidelines for Forensic Psychologists, 1991) give some leeway:

When it is necessary to provide both evaluation and treatment services to a party in a legal proceeding (as may be the case in small forensic hospital settings or small communities), the forensic psychologist takes reasonable steps to minimize the potential negative effects of these circumstances on the rights of the party, confidentiality, and the process of treatment and evaluation (p. 659).

Therefore and assuming that the foregoing directives for psychologists are, to some degree, applicable to all mental health professionals, multiple roles are not patently inappropriate, but are generally to be avoided and certainly could elevate the risk of a legal or ethical complaint against the mental health professional (especially by the party who senses the professional witness did not help his or her legal cause). Child custody cases present a high-risk for multiple roles and concomitant legal and ethical complaints against all mental health practitioners. If the clinical psychologist has served as a therapist to the child or family, he or she should avoid conducting a child custody evaluation. For psychologists, the child custody guidelines (APA, 1994) state:

A psychologist asked to testify regarding a therapy client who is involved in a child custody case is aware of the limitations and possible biases inherent in such a role and the possible impact on the ongoing therapeutic relationship. Although the court may require the psychologist to testify as a fact witness regarding factual information he or she became aware of in a professional relationship with a client, the psychologist should generally decline the role of an expert witness who gives a professional opinion



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regarding custody and visitation issues . . . unless so ordered by the court (p. 678).

Although the child custody guidelines allow the clinical psychologist to testify as a fact witness concerning treatment, there are also proscriptions, such as: "during the course of a child custody evaluation, a psychologist does not accept any of the involved participants in the evaluation as a therapy client," (p. 678); and therapeutic involvement subsequent to the custody evaluation must be done "with caution" (p. 678). Some legislatures are codifying this matter; for example, a rule for the Florida Board of Psychology specifies:

It is a conflict of interest for a psychologist who has treated a minor or any of the adults involved in a custody or visitation action to perform a forensic evaluation for the purpose of recommending with which adult the minor should reside, which adult should have custody, or what visitation should be allowed. Consequently, a psychologist who treats a minor or any of the adults involved in a custody or visitation action may not also perform a forensic evaluation for custody, residence or visitation of the minor. This subsection does not limit a psychologist who treats a minor from providing a court or a mental health professional performing an evaluation with information about the minor from the psychologist's perspective as a treating psychologist so long as the psychologist does not violate confidentiality (Rule 59AA-18.006).

Any prudent clinical psychologist (or other mental health practitioner) should exercise extreme caution and avoid entering into inappropriate multiple roles. Attempting to fulfill multiple relations or roles in child custody or any other type of legal cases elevates the risk of legal, regulatory, or ethics complaints.

While being a therapist does not preclude the clinical psychologist from testifying in a legal case as a fact witness concerning treatment, critiquing the testimony from other mental health professionals would seem to entail conflicting roles. It is potentially inappropriate for a therapist or evaluator to critique the testimony of another mental health professional.

A dilemma arises when the testimony of a therapist or evaluator, which reflected professional decisions and/or opinions, is refuted by testimony from

another mental health professional witness. Although not contained in a formal position statement from a professional association or in the law, there is reason to assert: When another mental health professional (i.e., an expert critic) provides testimony that is used to impeach the testimony from a therapist or evaluator (i.e., a clinical services provider), the therapist or evaluator should refrain from rebutting the professional critique. Doing otherwise may cast the therapist or evaluator into multiple roles, which could prove to be problematic. For example, it would be easy, perhaps even by inadvertence, for the therapist or evaluator to engage in a professional critique of evidence or about issues beyond what occurred in the therapeutic or diagnostic services provided to one or more of the parties, thus creating a second and distinctly different role.

After cross-examination or subsequent to criticism from another expert witness, there is no restriction on the therapist's or evaluator's testifying further to rehabilitate his or her earlier testimony. That is, the therapist or evaluator can be recalled to justify his or her original clinical decisions or opinions. However, no attempt should be made by the therapist or evaluator to prove why the opinions and criticisms of the other mental health professional were wrong. This approach allows the therapist or evaluator to maintain a safe and singular role. □

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In addition to providing a forum for graduate student authors, we hope to use this space to publish columns that are of practical value to clinical psychology graduate students. In this vein, we invited Dr. C. R. Snyder to share advice regarding career planning, which he has developed from his decades of work as a mentor and educator of clinical psychology graduate students and as the former Director of Clinical Training for the Clinical Psychology Program at the University of Kansas. Dr. Snyder's suggestions will be presented in a two-part feature focused on career planning. In this, Part 1 of his feature, Dr. Snyder offers his

suggestions for actions that graduate students can take throughout their time in graduate school to help assure their marketability once they have completed their degree. In Part 2 of the feature, which will appear in the next issue of *The Clinical Psychologist*, Dr. Snyder will offer advice related to the application and interviewing stages of the job search. We are grateful to Dr. Snyder for sharing his advice, which we are confident will be valuable to all clinical psychology graduate students.

Zoë Patterson and Julia Woodward

Student Forum



Preparing for a Position in Clinical Psychology Part 1: The Graduate School Stages

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Introduction

When people ask me what I do for a living, my answer is that I help graduate students to prepare themselves for satisfying careers in clinical psychology. Indeed, I am proud of doing this. For this reason, when I was asked to prepare a column in the student forum about this very process, I gladly accepted. Therefore, as I begin my fourth decade of educating clinical psychology graduate students, I will share what I have tried to

teach “my own” students - half of whom have taken academic positions and the other half applied positions. What Do I Want to Be When I Grow Up?

Getting a job starts with knowing what kind of job you want. Although you have chosen a program in clinical psychology, the eventual job options that are available to you upon graduation are varied. First, there are applied positions where you will make diagnoses and provide therapy in order to help clients. These “practice” positions are located in agencies such as mental health centers or hospitals (private, state, armed services, Veterans Administration, etc.); likewise, you may want to join a private practice group, or even start out on your own. There also are applied jobs that are located in business organizations where clinical psychologists are called upon to provide a range of consultation services. In these applied positions, you will interact directly with clients, with most of your time being spent in helping them with problems, and a lesser amount of time in activities related to prevention or growth. Another recent trend is that Ph.D.-level clinical psychologists supervise and train master's level clinicians, they set up practice guidelines, and provide program evaluation. Lastly, applied careers may be aimed at working in public policy and government.

A second career option involves academics. In academic positions at smaller schools, you will be expected to teach about four to six courses per semester, and most of your job will entail classroom teaching, advising, and administrative work. Realize also that at a small institution, you may represent the entire field because you are the only clinical psychologist—this means you will be called upon to teach and to do many community-related activities in your job. At the larger schools, a typical



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teaching load is two or three courses per semester, with at least one of those courses probably being at the graduate level. Additionally, the larger schools will have departments where you will have many colleagues (20 to 40, and often more), and you will be expected to carry on an active research program in which you publish your findings in reputable journals. Some administrative work also may be part of this latter position. Note that clinical psychologists often take positions in university-affiliated teaching hospitals that combine aspects of applied positions (e.g., providing clinical service) and academic settings (e.g., teaching and research).

A third career option involves working at private or federally-funded research institutes. In this type of job, all of your workday is spent in

“Because a doctorate in clinical psychology involves skills in understanding people and their motives, entrepreneurial job options are really as open as one’s imagination.”

actual research that may be of an applied or basic science nature. As a part of such research positions, a common expectation is that you will write and obtain grants to help pay for your research activities.

A fourth career is one that is rarely dis-

cussed, but it does represent the eventual jobs of a some people who obtain their Ph.D. degrees in clinical psychology. For lack of a better term, I call this fourth career category the entrepreneurial one. This category contains a wide range of actual jobs, but they all have in common the fact that the person has creatively applied his or her skills and degree to a particular niche in our society. Some examples may help to bring this entrepreneurial type of job to life for the reader.

I have known clinical psychology graduates who have established computer software companies to help businesses and organizations to function better; other graduates have started companies to help people to find jobs matched to their skills and interests. Another example was a graduate who started bookstores aimed at the psychological markets in large urban areas; one graduate helped to bring musicians and music companies together; and yet another gradu-

ate became a successful writer. For short vignettes about 21 people who made creative uses of their doctorates, I would recommend the February, 2001 issue of *the Monitor* (Smith et al., 2001). Because a doctorate in clinical psychology involves skills in understanding people and their motives, entrepreneurial job options are really as open as one’s imagination.

A fifth career option may be the scariest. Getting into a graduate program in clinical psychology probably was the most difficult accomplishment in your life to date. Although you have succeeded in gaining admittance, you may be finding that graduate education in clinical psychology is not for you. Yes, let’s say these words out loud, because for a small percentage of students, the fit is not a good one. If you have such thoughts, I would strongly encourage you to share them with someone you trust. Perhaps your unhappiness has nothing to do with your clinical psychology graduate education per se, in which case you may want to seek personal psychotherapy or career counseling. Another option, if available in your program, would be to go on a one- or two-year leave of absence in which you take a break from school or psychology in particular. My point in this paragraph is that a clinical psychology degree will tend to make certain career options open to you. For some, it may make better sense to question whether this clinical psychology education and its associated career trajectories will make you happy. Generally, if you are not happy in graduate school in clinical psychology, you will not be happy in a career in this same field.

Although your faculty mentors may have an understandable desire for you to follow in their footsteps and pursue an academic career, it will be a mistake to go that direction unless it really is what you want. Don’t get me wrong here, because I think that an academic career in clinical psychology has been amazingly rewarding and satisfying for me. My point is to follow your desires. Remember that this is your career choice, and the one you need to satisfy is you—not a faculty mentor, a parent, a partner, or a peer. As the architect of your own education, I encourage you to “seize the day.” Do not expect your program director or mentor to set out the perfect course of study for you. Every student is different, and it is very important that you seek out a variety of educational opportunities that fulfill your needs.

Tailoring Your Education to Your Projected Job

The sooner you can commit to one of the aforementioned career trajectories, the better. Until the time when you can make such a commitment, however, do the things that will help your career regardless of its

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direction. Namely, work hard and make sure that several faculty members know you well—you will need them to write letters of recommendation. Also, dispatch your program requirements quickly, trying for excellent performances. Do not become overly consumed with getting As, however, because employers are not really interested in your specific grades. Rather, employers attend to whether you graduated in a reasonable time (about six years), and the strong level of support from your recommenders.

Let yourself be surprised. By this, I mean that you may have started graduate school being certain that you wanted just a research career, but with some experience you find that you absolutely love teaching—plus, you are very good at it. It makes sense for you

***“...for many students,
the first year or two of
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specializing.”***

to switch to an academic career in this example.

I have seen students go in other directions as they found that clinical work was their passion, or that research brought them great pleasure and excitement.

Because of these insights that are gained after some experience with the components of our field, I think that, for many students, the first year or two of graduate school is best spent in sampling experiences before specializing. For some students, even during the advanced years of graduate training, a focus may not have emerged. If you are such a student, do not panic. Instead, keep your options open by gaining as much experience as possible in all realms, taking advantage of every opportunity to become engaged in the practice and research aspects of clinical psychology. There is yet another small group of students who have planned their graduate educations based on a particular career trajectory, only to find that as they are about to receive their degrees that they do not want to go the planned route. Even at this point, I would suggest that you can change and retread so as to attain the education you desire. Often a postdoctoral experience can refocus you toward that aspect of clinical psychology about which you are enthused.

OK, however you got there, let's now assume that you have decided upon your career direction. Congratulations! If you experience a sense of relief and

exhilaration upon making this decision, chances are that it is a good one for you. It is now time for the “big push” in which you try to maximize your chances of success when later applying for and interviewing at jobs. In the Part 2 of this article, which will appear in the next issue of *The Clinical Psychologist*, I will discuss the steps to be taken once you are ready to apply and go on interviews. In the remainder of this article, I will talk about how to use your graduate school time so as to become competitive for subsequent coveted positions. In the following sections, I will describe the actions that you should take if you are preparing for an applied, an academic, a research, or an entrepreneurial position.

Preparing for an Applied Position

At the risk of stating the obvious, applied employers will want new doctorates who can perform the various duties pertaining to diagnosis and treatment. What this means practically is that you would be wise to take as many hours of applied content courses and practica as you can during your graduate career. With the present emphasis on empirically-supported treatments, as well as brief, short-term therapies, and group interventions, these would be good targets for extensive training. Likewise, your marketability is enhanced by developing an intensive concentration in a specific applied area of expertise, whether it pertains to advanced skills in a particular diagnosis or treatment modality. An extensive history of attending workshops also can expand your skill base.

Although my next point may surprise you, I do believe that it helps to have published in the area of the your applied expertise. This is especially true if you want to obtain an applied position at a prestigious private agency or a medical center. Another suggestion that applies across career trajectories is to become involved in some of the committee-related activities in your graduate program. For example, if there are student representatives to various committees, volunteer to participate. If there are leadership roles that you can undertake among the graduate students, give these roles a try. Likewise, volunteer to help the faculty in doing some of the not so glamorous, but absolutely necessary activities that are part of any clinical psychology program. For example, volunteer to squire around visiting prospective students or colloquia speakers; help your faculty members with receptions or group activities attended by program members; help in a small fund drive with alumni; and so on.

Such helping behaviors not only make your program function better, but it feels good to help. Moreover, I can guarantee that your faculty members



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will remember such help (as well as your helping of your peers), and they will comment on it in their letters of recommendation on your behalf. Likewise, at the risk of sounding sociopathic, such committee appointments make nice additions to your curriculum vitae. In turn, potential employers will be favorably disposed toward you as a job applicant when they see such committee work on your curriculum vitae, or hear from your faculty recommenders that you are the sort of person who helps out. Everyone wins with such helping activities.

Depending on your applied job goal, you may want to select an internship where you can either broaden your experiences with additional samples or case types, or develop new skills. Also, internships help

“...even small departments will want to see some display of scholarship in their new hires.”

to increase your personal contacts in given geographical areas. Thus, if you want an applied job in a given region, it helps to do your internship there. Likewise, some internships are recognized beyond their local areas,

and these high prestige places will help your job search all over the country. In considering internships, talk with your faculty members who have expertise in the admission process; furthermore, if your program has recent graduates who have attended internship at any sites you are considering, try to get their opinions.

Gaining admittance to internships will entail developing a strong application packet. First, you will need to obtain letters of recommendation from three people who know you well and who can write at length on your behalf. Do not be foolish at this stage and ask someone to write who has the reputation of being not very supportive of students. A good phrase to use in asking for such a letter is, “Would you be comfortable in writing a supportive and detailed letter on my behalf?” If the person hesitates at all, move on to find another recommender. My personal belief is that these letters of recommendation must be a minimum of two pages, and preferably three or four pages long. Even if it is positive, a brief letter bespeaks a lack of strong support for you. Second, carefully craft your personal statement, and have it read over by two people whom you respect and trust. Third, any coherent ordering of the

information on your curriculum vitae will work—contrary to legend, there is no one correct format—but be certain that it is neat, has ample margins, and is free of typos. Fourth, the internship sites also will request copies of your graduate and undergraduate transcripts. Because the registrar’s office at your school is swamped with such requests around the same time of year, get your request in as early as possible.

I think that it also is helpful to role-play internship interviews. Your mentor and fellow students can help in this process. How you present yourself is important in gaining admittance, so be sure to prepare thoroughly for the interview.

Lastly, given the tightness of the clinical applied job market, you also may want to consider taking a one- or two-year postdoctoral position in order to augment your skill base. There is another crucial reason for a postdoctoral experience. Namely, the soon-to-be applied clinician can obtain the needed supervised clinical hours so that he or she can be licensed quickly in a given state upon gaining employment. Because agencies want their psychologists to be licensed as soon as possible, it is to your advantage to get these supervised hours completed prior to the beginning of your first applied position.

Preparing for an Academic Position

In seeking an academic position, the key is to keep in mind what your potential employers – psychology departments – will want in the person whom they hire. If you are seeking positions at smaller schools, you will want to balance your education more toward teaching than research experiences. Conversely, larger psychology departments will want more preparation in research than teaching. Let’s start with research, because even small departments will want to see some display of scholarship in their new hires.

First, I would suggest that you find a mentor with whom you can learn the whole array of skills that are part of becoming a fine clinical psychology researcher. There are no ironclad rules about who constitutes a good mentor, but I do think that you should select someone with whom you feel comfortable and can talk openly about the things that you do not know. This mentor will be perhaps the single most important person in your graduate education. Remember also that this mentor will be your chief ally in writing a letter of recommendation for academic jobs. If there is a senior scholar who is widely known in the field, his or her strong letter will carry considerable weight in gaining recognition for you when it comes time to compete with the cohort of other would-be assistant professors. But do not go for reputation in selecting your potential

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mentor if you don't sense an open and solid relationship. Also, realize that good mentors come in all "sizes and shapes." Often a new assistant professor will offer a wonderful mentor match.

Assuming that you have a mentor, you now are ready to develop the requisite skills and performance bases. In terms of courses, I would suggest taking all of the research and methodology courses that you can, as well as the various advanced courses in statistics. You will use these in the rest of your career, and it is best to learn them now rather than later in your academic career. Academic positions also look favorably upon any training that you can obtain in the writing of grants. In fact, there are graduate student grants that are available at the local and national levels. Obtaining

one of these grants demonstrates your skills as both a researcher and grant-getter.

Although it may sound crass, one essential aspect of your curriculum vitae will be the display of raw output, that is, numbers of published articles and, to a lesser degree, presentations. It is best if most of these

"...it helps your marketability if you have a programmatic line of investigation in a specific area. There is a natural allure toward a person who is unique..."

publications appear in highly refereed journals. Likewise, it helps your marketability if you have a programmatic line of investigation in a specific area. There is a natural allure toward a person who is unique (Snyder & Fromkin, 1980), and this is true in psychology hires. Therefore, if you can present yourself, based on your record of performance, as being one of the experts on a particular scholarly topic or the author of a new theory, this increases your salience amidst a sea of other potential assistant professor applicants.

What I tell my own students is that they will need seven good publications in order to be competitive for an academic job. If possible, most of these should be theory-based, empirical, first-author works in top-notch journals (ask your mentor about the hierarchy of journals because it is part of the unwritten lore that will be crucial in your career). Two or three of these publications can be chapters that you have coauthored with your mentor. If you have such a core of programmatic

publications, these then can be augmented with additional smaller publications. There is no substitute for quality, however, and do not become seduced by "fluff" publications in marginal journals - these may well backfire and create a bad impression about your scholarly values, judgment, and motivation.

It also is highly useful for the would-be academician to attend as many psychological conventions as possible. Not only can one practice giving presentations, which will be helpful come interview time, but these presentations also help to fill out your curriculum vitae. Perhaps the best aspect of conventions, however, is that they offer a chance to network with other psychologists who already are in academia, as well as time to get to know some of the other graduate student contemporaries (at other schools) who are in your area. The former informal contacts may help to make your application more salient in that a member of the selection committee may have met you at a convention. This networking may take courage at first because you are the new person, but it will become easier and your people skills will improve with time. One bit of advice in talking to someone is to really listen to her or him - most people truly enjoy it when they sense that their ideas and views are being heard.

Increasingly, I believe that psychology departments—even those where research reigns—are wanting to see evidence of teaching skills in their assistant professor applicants. Therefore, I would encourage you to teach for two semesters, but not more than four semesters because of the diminished returns on improving your application. Such teaching need not be paid; but you can volunteer to give guest lectures. If you can, prepare two different courses because this will give you a head start when you actually get into your assistant professor position (note the positive thinking! OK, there I have let my positive viewpoint come out... more on this later).

Ask for feedback from the course's regular instructor about your teaching performance. Likewise, each department usually has a few truly stellar instructors. Ask to attend their classes so as to pick up tips. Also, use your local university office for advancing teaching skills, and go to workshops given by master teachers. In this process, I would warn you not to try to adopt another stellar teacher's style, however, because each style has been developed because it works for that instructor. What you need to find is an approach to teaching that works well for you.

By now, it is time for our would-be academician to apply for an internship. Most of my previously discussed tips for obtaining an internship if you are pursuing an applied career also are applicable to the pursuit



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of an academic career. I think that the internships at major medical centers offer the recognition to help in obtaining an academic job—with status being a plus when it comes time to apply for academic jobs. You also may want to ferret out those internships that expressly want their interns to do research during their internship. Use your research mentor to help in all stages of this internship application process.

The academic job market is a highly competitive one, and you should carefully consider your readiness for this process when you are about four months into your internship. An increasingly common practice is that the student on an academic career trajectory goes on a one- or two-year postdoctoral fellowship after obtaining his or her Ph.D. This postdoctoral time

“...many psychology departments prefer it if applicants have all of their supervised clinical hours completed prior to beginning the assistant professorship.”

enables the student to receive additional mentoring, often from a widely recognized scholar. The student can gain additional research skills, along with training in grant writing, and yet more publications and presentations can be added to the curriculum vitae. Lastly, the

postdoctoral experience, even though it has a research focus, may enable the student to accrue supervised clinical hours which are necessary for licensure should he or she want to attain this at the first academic job setting. It often may be difficult to obtain post-Ph.D. supervised clinical hours once the person is on the job, and accordingly the supervision while on the postdoctoral experience may be quite valuable. Indeed, my impression is that many psychology departments prefer it if applicants have all of their supervised clinical hours completed prior to beginning the assistant professorship.

Preparing for a Research Position

The preparation for a research position involves the same steps as are entailed in preparing for an academic position, except there is no need to gain teaching experience. The would-be research psychologist should load up on design, methodology, measurement, and statis-

tics courses. Even more than is the case for an academic career preparation, the would-be researcher should pursue all available grant-writing courses and tutorials. This follows because the researcher may be supported either all or in part by “soft money” (i.e., funds that are time-delimited such as grants) in the actual job setting, and hustling grants is an ongoing aspect of this job. Likewise, a postdoctoral year or two may be helpful in order to more fully train the researcher before taking his or her first position.

Preparing for an Entrepreneurial Position

Describing the preparation of the student for an entrepreneurial position is difficult because there are so many different possible jobs that the students with a clinical psychology doctorate may pursue. This student should sample courses within the clinical program that may relate to the eventual career, along with coursework in the other programs in psychology (e.g., social, cognitive, developmental, forensic, health, organizational, etc.). Likewise, the student should view the university more widely as a resource for potential training.

For our entrepreneurial student, it may help to set up an advisory committee with the chair being in the clinical program, but the other members being from other programs or departments. One other means of bridging to the entrepreneurial career would be to conduct masters and doctoral thesis research on a related topic or topics. Also, an internship may be selected because there is a person or rotation that would help in the eventual entrepreneurial job.

Perhaps an example or two may help to illustrate this entrepreneurial education. For a clinical student who wanted to start a daycare center for children, her coursework entailed developmental psychology, along with organizational and clinical practice content. Or consider the clinical student who wanted to start a bookstore that was focused on self-help literature. He took courses in education, marketing, English, and psychotherapy.

The Big Five: Writing, Typing, Talking, Computing, and Hoping

Whatever the particular job that you take after securing your clinical psychology degree, there are four common skills, plus a way of thinking, that will facilitate your success. Therefore, I believe that these should be part of your graduate preparation, and I will close this article with some thoughts about each.

First, I believe that most graduate students need to learn how to become better writers. This is not a fatal flaw, unless you ignore this skill deficit. The cure starts by heeding the mantra: write, write, write.



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Beyond your psychology writing, I also suggest taking a writing course or two offered at your university. Many schools have special writing courses for students in professions other than English. Because writing will be so crucial to your subsequent academic career, take every opportunity to practice it.

A second skill involves typing. Think about your 21st century world and job, and how critical the written word will be in those arenas. Increasingly because of word-processing programs and personal computers, you will be called upon to quickly transpose your thoughts into a written form so that others can read them. The commerce of words becomes easier for the person who is facile at typing.

Third, I recommend repeated practice at giving oral presentations. Much of your success in both getting a job and prospering in it will be related to your ability to articulate your ideas in front of other people. If you are anxious about such speaking, the very best intervention is to give talk after talk after talk. Also, why spend the rest of your career in clinical psy-

chology worrying about and dodging talks in front of other people? What would you tell a client who behaved this way?

Fourth, I suggest that you learn all that you can about the use of computers, along with special computer language skills. The computer already plays a major role in the professional lives of almost all psychologists. Imagine the greater importance of computers and computer-related skills as you travel farther into the 21st century! Computing-related skills are going to be so essential that you will be ahead of the curve if you prepare yourself as rigorously as possible during your graduate school years.

Finally, I would strongly encourage you to adopt a hopeful pattern of thinking about your quest to get whatever kind of job you want. For the last 15 years, I have been doing research on hope, which I define as a goal-directed pattern of thinking in which one has both the perceived ability to find route to goals (called pathways thinking), along with the motivation to use those routes (called agency thinking). Whether it is academics, sports, health, or psychotherapy, the high-rather than the low-hoper has shown significant advantages (Snyder, 1994, 2000). Although we have yet to do the study, I would wager that higher hope graduate students are more likely to get a good job than their lower hope counterparts. Simply stated, if you don't expect to reach your goal of getting a job, you probably will not use the pathways I have talked about in this article, nor will you display the requisite motivation to apply those pathways. In case you have not learned it already, graduate school and solid career preparation are not for the faint of heart. It takes long, sometimes grinding work, but if you are hopeful, I am betting on your success! ☐

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Citations for 2002 Division 12 Awards

Following are the citations for the four awards that were presented by the Society of Clinical Psychology at the August meeting of the American Psychological Association in Chicago. Congratulations to all four recipients.



Mark B. Sobell, Ph.D.
Award for Distinguished Scientific Contributions to Clinical Psychology
The Society of Clinical Psychology is pleased to present its 2002 award for Distinguished Scientific Contributions to Clinical Psychology to Mark Barry Sobell, Ph.D., Professor, Center for Psychological Studies at Nova Southeastern University. Dr. Sobell is an internationally known clinical scientist who, over the course of three decades, has made major theoretical and empirical contributions to the understanding and treatment of substance abuse. His contributions include innovations in measurement of drinking behavior, pace setting treatment research evaluating alternatives to abstinence, and more recently, innovations involving brief motivational behavioral interventions premised on a stepped care model of treatment.

During the early period of his career, Dr. Sobell identified several new conceptualizations of alcohol dependence, most notably that alcohol problems should be viewed as lying along a continuum of severity—a stark contrast to the accepted thinking of the time that people were either alcoholics or not. The concept of a continuum of alcohol problems has since been integrated into mainstream thinking in the field and serves as the basis for promoting behavioral interventions in primary health care settings. Dr. Sobell's research on treatment approaches that include moderation as a goal was pioneering and has stood the test of time and replication. Dr. Sobell's determination in pursuing empirical data and his courage in the face of controversy and sometimes vitriolic opposition have led to advances that broadened the base of services to provide a full spectrum of alcohol treatment to individuals at all levels of severity. He was one of the first to advocate a Stepped Care model of treatment for alcohol problems, which presents a way to provide services that are effective, efficient, and least restrictive.

In addition to his research contributions, Dr. Sobell is known for his continued training and mentoring of graduate and postdoctoral students, many of

whom have themselves made significant contributions to the field. The Society of Clinical Psychology is pleased to honor Dr. Mark Sobell with its Distinguished Scientific Contributions Award.



George Stricker, Ph.D.
Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

The Society of Clinical Psychology is pleased to present its Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology to George Stricker, Ph.D., Distinguished Research Professor, Derner Institute for Advanced Psychological Studies, Adelphi University. Professor Stricker's humanity, civility, integrity and concern for others, expressed over a 40-year career, exemplify the same distinguishing personal qualities of Florence Halpern, in whose name this award is given. Over those 40 years, Professor Stricker has gently, kindly, but firmly instilled in many hundreds of clinical psychology students the elements of psychodynamic psychotherapy, the rigors of research, and the supreme importance of ethics and integrity. He has played a leading role in the development of both the now-established psychotherapy integration movement and the local clinical scientist model. He has been a respected, influential administrator at his own institution, as well as a leader in the national organization of professional schools. He continues today as an articulate and responsible spokesperson for the ethical conduct of psychological practice and research. By his achievements, values, and commitments, George Stricker epitomizes the complete clinical psychologist.

George Stricker received a Ph.D. in Clinical Psychology at the University of Rochester in 1960 and an honorary Psy.D. from the Illinois School of Professional Psychology, Meadows Campus, in 1997. He has been at Adelphi University since 1963, and served as Dean of the Derner Institute for a decade. Dr. Stricker is a Diplomate in Clinical Psychology and was elected as a Distinguished Practitioner in Psychology. He received the American Psychological Association Award for Distinguished Contribution to Applied Psychology in 1990, the American Psychological Association Award for Distinguished Career Contributions to Education and Training in Psychology in 1995, the Karl Heiser Award for Advocacy in 1996 from the American Psychological Association, the

National Council of Schools and Programs of Professional Psychology Award for Distinguished Contribution to Education and Professional Psychology in 1998, and the Allen V. Williams, Jr. Memorial Award from the New York State Psychological Association in 1999. He has been President of the Division of Clinical Psychology of the American Psychological Association, the Society for Personality Assessment, the New York State Psychological Association, and the National Council of Schools of Professional Psychology. He is on the Board of Directors of the Council for the National Register of Health Care Providers, and has served on several APA Boards and Committees, including the Board of Educational Affairs and as Chair of the Ethics Committee. Dr. Stricker is the author or editor of about 20 books, about 30 book chapters, and more than 100 journal articles. His most recent books are *Comprehensive Handbook of Psychotherapy Integration*, with Jerry Gold, *the Scientific Practice of Professional Psychology*, with Steven Trierweiler, and *Handbook of Quality Management in Behavioral Health* with Warwick Troy and Sharon Shueman. His principal interests are psychotherapy integration, clinical training, ethics, and research in grandparenting.



Louis G. Castonguay, Ph.D.
David Shakow Award for Early Career Contributions

For his outstanding contributions to research in the area of psychotherapy process factors, and for advancing our understanding of the effects of relationship factors in psychotherapy, the Society of Clinical Psychology presents the David Shakow Award to Louis G. Castonguay, Ph.D. This award is dedicated to acknowledging the contributions of a deserving young scientist whose research has advanced the field of clinical psychology within seven years of graduation.

Dr. Castonguay received his Ph.D. in 1992 from the State University of New York at Stony Brook, under the tutelage of Professor Marvin Goldfried. He completed a pre-doctoral internship that same year at the University of California at Berkeley and went on to a Post-Doctoral Fellowship at Stanford University. His doctoral research earned First Place in the Student Paper Competition sponsored by the Division of Psychotherapy (29) of the American Psychological Association in 1993. His subsequent work has been widely acknowledged. In 1998 he was given the Early Career Contribution Award by the Society for

Psychotherapy Research (international), and the Jack D. Krasner Memorial Award (Early Career Award) by Division 29 (Psychotherapy) of the American Psychological Association.

To date, the published contributions by Dr. Castonguay include over 40 papers, nearly 10 chapters in scholarly books, and two books. This is truly an outstanding accomplishment for one who has graduated within a single decade. His careful inspection of what therapists actually do, has revealed some striking disparities with what they say or think they do. He has challenged the view that treatment factors can be separated from relationship factors, and vice versa, and has argued persuasively for an integrative view of relationship development and relationship repair. He has published widely on topics ranging from sexual dysfunction to aversion therapy, and has found his center in studies of the therapeutic alliance as expressed in diverse therapies and in diverse ways.

In the domain of research on treatment processes, Dr. Castonguay has few equals. As noted by one distinguished, senior scholar, "His work on treatment process is innovative, creative, and theoretically rich. He is one of the leaders in the field of integrative psychotherapy. His process research has cut across theoretical boundaries and informed researchers and practitioners across diverse and often competing orientations. His work on repairing alliance ruptures promises to improve the overall quality of treatment for many disorders."

For these and many other reasons, the Society of Clinical Psychology is pleased to honor Dr. Louis G. Castonguay with the presentation of the David Shakow Award.



Michael A. Goldberg, PhD
Theodore H. Blau Early Career Award for Outstanding Contributions to the Professional Practice of Clinical Psychology

For his outstanding contributions to the professional practice of clinical psychology early in his professional career, this award is given to Michael A. Goldberg, Ph.D. This award is given to a clinical psychologist, who early in his/her career, has performed outstanding professional service, provided innovative approaches to service delivery, has had a positive impact on the health delivery system, and who has developed creative educational programs. Dr. Goldberg has done all of these.

After receiving his Ph.D. from Saint Louis University,



Citations for 2002 Division 12 Awards (cont.)

Michael A. Goldberg, completed a post-doctoral fellowship in Clinical Psychology at the Judge Baker Children's Center/Boston Children's Hospital at Harvard Medical School where he also completed his post-doctoral fellowship in Clinical Child and Pediatric Psychology. He is currently the director of Child and Family Psychological Services, Inc. in Norwood, Massachusetts. Michael is also a supervising psychologist at Boston Children's Hospital and an Instructor in Psychology at Harvard Medical School

As a professional clinical psychologist, Michael has been extremely active in the psychological community having published over 17 articles and book chapters, and over 30 professional and community presentations. He has increased public awareness of clinical psychology through his frequent media interviews. As an early career psychologist, Michael has been very active in the Society of Clinical Psychology and has served two terms as chair of the post doctoral institutes, was founding chair of the Division 12 Task Force and Committee on APA Governance, and also served as division treasurer. Michael probably served in these roles earlier in his career than any previous Division 12 member. As Chair of the Post-Doctoral Institutes, Michael was responsible for overhauling much of the way the PDIs were run and is greatly responsible for their quality and success to this day. Since completing his term as Division 12 Treasurer, Dr. Goldberg has brought his wisdom in governance of psychology to the state level. Serving as the Chair of the


Massachusetts Psychological Association's Education Committee for the past 3 years, he has overhauled their educational programming and is credited with having greatly influenced the quality and success of professional education in Massachusetts. He is also been great a force on MPA's Board of Directors. In addition to his clinical practice, he has engaged in research activities, teaching, and clinical supervision related to children and adolescents.

As a psychologist Dr. Goldberg's application of empirical research in the Courts has been widely noted. His work was cited by the Massachusetts Supreme Court in their unanimous decision supporting the best interest of a child in a conflict with the religious freedom of a parent.

Dr. Goldberg's impact has gone beyond the state and national level. He was part of Division 12's efforts to build relationships with Canadian and Mexican psychologists and was part of a group that traveled to Haifa, Israel to lecture and consult on treatment of children and adolescents.

Dr. Michael Goldberg is one of a few individuals who have had a notable and important impact on the field of clinical psychology through professional practice at such an early point in his career. He has continued to be a vital force in the education, training, and treatment of others. The Society of Clinical Psychology is pleased to present Dr. Goldberg with the Theodore H. Blau Early Career Award for outstanding contributions to professional clinical psychology. □

Division 12 Election Results

 The Division is proud to announce the winners of this year's election process. Dr. Nadine Kaslow was elected President-elect Designate and will begin her term as President elect January 1, 2003; Dr. Robert Klepac was elected Treasurer of the Society, effective January 1, 2003; and, Dr. Jerome Resnick will serve a three-year term as Representative to APA Council for Division 12, also beginning January 1, 2003. □



Dr. Nadine Kaslow
President-elect Designate



Dr. Jerome Resnick
*Representative to APA
Council for Division 12*



Dr. Robert Klepac
Treasurer of the Society

ABBREVIATED MINUTES:

THE SOCIETY OF CLINICAL PSYCHOLOGY

JUNE 4-6, 2002, Atlanta, Georgia



Appointments and Elections

New Division Officers elected for next year are: Nadine Kaslow, President; Robert Klepac, Treasurer, and Jerome Resnick, Council Representative. They were announced by APA after the board meeting adjourned.

President Larry Beutler appointed Karen Calhoun to represent us on the Committee on Division/APA Relations (CODAPAR)

MOTION: to approve Phil Kendall as new Editor of Clinical Psychology: Science and Practice. Passed.

MOTION: that the President-Elect appoints the Program Chair-Elect, who becomes Program Chair the second year. In the third year the Program Chair becomes Cluster Chair. This individual then serves a three-year term. Passed.

Support for Various Proposals

MOTION: that Division 12 support the development of a proficiency in Sports Psychology, but with some concern that the nature of proficiencies is not sufficiently well developed to ensure the presence of core clinical skills and knowledge. Passed.

MOTION: to approve the document titled "Culture and gender awareness in international psychology," as guidelines for psychologists. Passed.

MOTION: to co-sponsor a planning conference, without funding, "Planning for a national center for disaster psychology." Passed.

MOTION: to accept the resolution by Bob Woody that: "Whereas procedural rules and court orders may allow non-psychologists to have access to psychological tests and information, the Board of Directors of the Society for Clinical Psychology strongly supports that efforts be made by the legal system to safeguard the integrity of psychological tests and information." Passed.

A potential new section on clinical psychology in the schools now has an e-mail list and 135 names. Robert Woody agreed to be an unpaid liaison to the group.

Larry Beutler created a task force to promote the advancement of the influence and role of clinical psychology in both its scientific and professional development. Members: Larry Siegel (Chair), Steve Ilardi, Diane Willis, Martin Antony, Lynn Rehm.

Finances

We have received \$212,000 from APA dues this year, to date. Expenses are up and income has declined, particularly with regard to membership. The Society has a \$40,000 deficit, but can cover our expenses from reserves.

MOTION: to give \$1000 to the competency conference for the available seat. Janet Matthews will go as a liaison at her own expense. Passed.

MOTION: to adopt the Finance Committee recommendation not to support the Latino Conference due to lack of funds. Passed.

MOTION: that the Finance Committee will not cover liaisons travel costs from this point forward. The board will revisit this motion in two years. Passed.

MOTION: to adopt the Finance Committee recommendation for two, rather than three, Board of Directors' meetings per year, and a conference call if needed. Passed.

MOTION: that the publications committee meet at APA convention in future years and/or use conference calls. Passed.

MOTION: that dues exempt members who currently pay a nominal fee for publications have their subscriptions increased to \$30 from \$25 to cover rising costs. Passed.

The next Society of Clinical Psychology Board Meeting is scheduled for the St. Louis Hyatt Regency Hotel at One St. Louis Station – Oct. 18-20, 2002. The President will be inviting Phillip Zimbardo, Russell Newman, and James McHugh to join the group.

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



Central Intelligence Agency



Psychologist

The Central Intelligence Agency (CIA) collects, evaluates, and reports on foreign intelligence to provide US policymakers with the most accurate, comprehensive and objective information available.

Full-time, immediate opportunities exist for licensed, doctoral-level psychologists with APA-accredited training and a strong background in psychological assessment. Clinical and/or counseling experience and interest in cross-cultural assessment issues are highly desirable. We are seeking team-oriented Psychologists with well-developed interpersonal, problem-solving, and communications skills, sound judgment and strong organizational and planning abilities to satisfy the following requirements:

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Please address the following in your cover letter:

- Types of psychological assessments performed including populations tested, tools used and venues for the assessments.
- Interviewing skills and experiences.
- Clinical assessment and/or counseling experience and the cultures involved.
- Identify any foreign travel and/or overseas living experiences.
- Willingness to travel and reside overseas.
- Foreign language proficiency.

In addition to your cover letter and resume or curriculum vitae, please submit one or two sample psychological assessments with all identifying information removed.

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POSITION OPENING

UNIVERSITY OF OTTAWA: Psychology. Subject to budgetary approval, the School of Psychology of the University of Ottawa anticipates filling three tenure-track positions effective July 1, 2003, 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/adolescent/family or in health, 2) cognitive psychology (including perception) and/or developmental psychology, and 3) gerontology. Excellent candidates in related areas are also encouraged to apply.

Applicants should meet the following minimum requirements: Doctorate in Psychology and research competence. Fluency in French and English is essential. The salary is competitive and is adjusted as a function

of experience. Start-up funds are also available.

Applications should be received before November 15, 2002. 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. Pierre Gosselin, Assistant Director, School of Psychology, Lamoureux Hall, University of Ottawa, Ottawa, Ontario, Canada, K1N 6N5.

In accordance with Canadian immigration requirements, this advertisement is directed to Canadian citizens and permanent residents. Equity is a University policy, and as such, the University strongly encourages applications from women.

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.

Submission deadlines for advertising and announcements:

January 15 (March 1 issue)

May 15 (July 1 issue)

September 15 (November 1 issue); November 15 (January 1 issue).

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.

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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 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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