

# THE CLINICAL PSYCHOLOGIST



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

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### Division 12 Central Office

P.O. Box 1082  
Niwot, CO 80544-1082, USA  
Tel: 303-652-3126  
Fax: 303-652-2723  
E-mail: [div12apa@comcast.net](mailto:div12apa@comcast.net)  
Lynn Peterson, Administrative Officer

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**Linda C. Sobell, Ph.D., ABPP**  
Professor and Associate  
Director of Clinical Training,  
Center for Psychological  
Studies, Nova Southeastern  
University

## PRESIDENT'S COLUMN

### Identity and Diversity: Two Issues Facing our Division

Linda Carter Sobell

I would like to use my last column to update members on two important issues facing the division—Identity and Diversity.

**Identity:** The first issue, *the Division's Identity*, relates to a concern I raised when I was running for office. This is not a new issue by any means and in fact has been a topic of continuing discussion by the Board. Although Division 12 has had a successful record of accomplishment, clinical psychology as a whole is facing serious and major questions. Many of these questions similarly affect the viability of other divisions as well. In this regard, the Board approved the creation of a "Task Force on Identity" whose major agenda will be to articulate issues and objectives within a broad context of re-evaluating what our Division is about, what it stands for, and why new graduates should join our Division. The goal will be to develop a statement of purpose, including who we are and what can we offer members that is unique and not offered by other divisions and to what potential members we should be appealing—e.g., MA students, counseling psychologists, early career psychologists. As the task force prepares to meet, one key issue that I believe it will face is how specialization in the profession has affected our division. Clearly, there has been a proliferation of specialties within clinical psychology. The result, while reflecting increased knowledge, has perhaps served to distract us from unifying themes that bind clinical psychologists together. In short, if we are to survive in a competitive marketplace, we need to clearly articulate why clinical psychology is unique among the health professions. Lastly, I recognize that developing a long-term plan to address the identity problems confronting our Division is a tall order and as such, I welcome your comments and suggestions.

**Diversity:** The ethnic landscape in the United States will experience dramatic changes in the next few decades. In 2000, the United States Census Bureau reported significant differential rates of growth between the United States White population and other racial and ethnic minority groups from 1990 to 2000. The growth of minority groups is projected by the United States Bureau of the Census to make current "minority" groups a combined numerical majority by the year 2050. In contrast to these population figures, minority representation in the American Psychological Association (APA) has not kept pace with the general population. Figures compiled by

### Inside:

- Call for nominations for 2006 elections
- Ballot for proposed bylaw changes.

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(continued on page 2)

APA's Research Office based on the 2004 APA Membership Directory figures reveal that among 95,330 members only 5.4% report themselves as minorities.

The above disparities between population statistics and APA's membership figures for minorities underscores an urgency for our profession to develop a plan to increase recruitment, engagement and retention of underrepresented groups within the APA. In this regard, one of APA's task forces is focused specifically on enhancing diversity, includ-

ing making APA a more welcoming place for psychologists who are members of underrepresented groups. In comparison to the APA's figures, 6.0% of Division 12's 4,903 members identified themselves as minority, a figure similar to most other practice divisions. At its June meeting, the Board agreed unanimously to support a Standing Committee on Diversity whose purpose will be to consider the broad issues pertinent to the under representation of diverse groups (ethnicity, race, disability status, aging, sexual orientation, religion, and gender) in

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Email: sobell@nova.edu

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Email: spielber@cas.usf.edu

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Email: hongb@psychiatry.wustl.edu

Annette M. Brodsky, Ph.D. (1/05 - 12/07)  
Email: abrodsky@labiomed.org

**Section Representatives**

II - Deborah King, Ph.D.  
Email: dking005@rochester.rr.com

III - Sheila Woody, Ph.D.  
Email: swoody@psych.ubc.ca

IV - Gloria Gottsegen, Ph.D.

Email: ggottsegen@aol.com

VI - Toy Caldwell-Colbert, Ph.D., ABPP  
Email: toy\_caldwell-colbert@ace.nche.edu

VII - Richard McKeon, Ph.D.  
Email: rtmckeon@hotmail.com

VIII - Danny Wedding, Ph.D.  
Email: weddingd@mimh.edu

IX - Norman Abeles, Ph.D., ABPP  
Email: norman.abeles@ssc.msu.edu

**Editors**

*The Clinical Psychologist*

Martin Antony, Ph.D., ABPP  
Email: mantony@stjosham.on.ca

*Clinical Psychology: Science and Practice*

Phillip C. Kendall, Ph.D., ABPP  
Email: pkendall@temple.edu

**EDITORIAL STAFF**

**Editor**

Martin M. Antony, Ph.D., ABPP  
Anxiety Treatment and Research Centre  
6th Floor, Fontbonne Building  
St. Joseph's Hospital  
50 Charlton Ave. East  
Hamilton, ON L8N 4A6 Canada  
Tel: (905) 522-1155, ext. 3048  
Fax: (416) 599-5660  
Email: mantony@stjosham.on.ca

**Editorial Assistant**

Cynthia E. Crawford, M.A.Sc.  
Anxiety Disorders Clinic  
Centre for Addiction and Mental Health  
250 College St.  
Toronto, ON M5T 1R8 Canada  
Tel: (416) 535-8501, ext. 4677  
Email: cynthia\_crawford@camh.net

**Artwork and Design**

Visser Design Associates  
48 Hickson Street  
Toronto, ON M6K 1T3 Canada  
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Web: www.visserdesign.com  
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“...the Board agreed unanimously to support a Standing Committee on Diversity...”

the Division. This committee will be charged with helping to increase recruitment, retention, equitable representation, and involvement of culturally diverse groups in our Division. The Chair of the Standing Committee would also be a Member-at-Large on the Division's Board, with a voting seat. The recommendation for a standing committee on diversity along with an elected member who will chair

the committee will require a bylaws change that has to be presented to members for a vote. Shortly, these bylaws changes will be sent to members. I urge you to support the establishment of the Standing Committee on Diversity as well as the creation of a Chair who will be elected by the members and will serve on the Board as a voting member. In summary, a vote for this bylaws change will allow Division 12 to be a stronger and more effective professional and scientific organization with a more diverse membership. □

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# Empirically Supported Treatments: 10 Years Later

Sheila R. Woody, Ph.D.<sup>1</sup>  
University of British Columbia

John Weisz, Ph.D.  
Judge Baker Children's Center  
Harvard University

Carmen McLean, Ph.D.<sup>2</sup>  
University of British Columbia

<sup>1</sup>Correspondence may be addressed to: Sheila R. Woody, Ph.D.,  
Department of Psychology; University of British Columbia,  
2136 West Mall, Vancouver, BC V6T 1Z4, Canada;  
Tel: 604-822-2719; Fax: 604-822-6923; E-mail: swoody@psych.ubc.ca.

<sup>2</sup>Now at University of Nebraska - Lincoln



## Abstract

Division 12 of the American Psychological Association (APA) first established a Task Force to identify and promote empirically supported psychological treatments in 1993. This Task Force, headed by Dianne Chambless, conducted a survey of doctoral and internship training programs in clinical psychology, focused on training and supervision in empirically supported treatments (ESTs). The present article reports on a 10-year follow-up to that survey. APA-accredited programs in the U.S. and Canada indicated the degree to which they provide training in 26 treatments listed as empirically supported by the Task Force since the 1990s. Results indicated improvements in didactic dissemination, although supervised training in ESTs appears to be declining. Comments solicited from Training Directors point to several important obstacles to providing training in ESTs.

## Empirically Supported Treatments: 10 Years Later

The concept of evidence-based medicine rests on the premise that the quality of patient care is enhanced when practitioners use treatments with empirical support (Sackett, Richardson, Rosenberg, & Haynes, 2000). In an effort to identify and promote empirically supported psychological treatments, Division 12 of the American Psychological Association (APA) first established a Task Force to examine this issue in 1993. The aim was to define empirically supported psychological procedures, along with examples of interventions that met those criteria, and to explore issues of dissemination of this information to professionals, consumers, and policymakers. Dianne Chambless headed the first Division 12 efforts in this process

in the 1990s, chairing the Task Force on Promotion and Dissemination of Psychological Procedures, which has now evolved into the Committee on Science and Practice. This article describes a survey conducted when Drs. Woody and Weisz were members of this Committee.

In their initial report, which was adopted by the Division 12 Board of Directors in 1993, the Chambless Task Force provided a list of 25 examples of treatments that met their criteria for empirical support in treating children, adolescents, and adults. The group continued to review and evaluate treatments in subsequent years, providing an expanding set of examples of treatments with empirical support (Chambless, 1998; Chambless et al., 1996). As the Task Force documents have always emphasized, these lists provide examples rather than exhaustive accounts. Many widely used treatments have yet to be rigorously tested, and, due to limited resources, the Task Force undoubtedly failed to identify some treatments that in fact have empirical support.

Widespread use of an evidence-based approach to psychological practice is possible only when research results are disseminated to professionals and incorporated into training programs. The initial Task Force conducted a survey of APA-accredited doctoral and internship training programs in clinical psychology in the United States and Canada. The survey assessed the degree to which these programs were providing didactic instruction or supervised training in treatments identified by the Task Force as having empirical support. The survey listed all 25 treatments the Task Force had identified as examples of empirically supported interventions on the basis of the research literature. Directors of Clinical Training were asked to simply indicate each treatment for which their program provided didactic or supervised training (rated separately). Internship Directors were asked to indicate the degree to which "interns are trained to a level of competence or receive formal supervision during their year-long experience." Responses remained anonymous. The response rate was 83% for the 167 doctoral programs surveyed and 55% for the 428 internship programs.

As many readers are aware, the Task Force reports were successful in generating discussion and debate within the field of psychology about the value and definitions of empirically supported treatments (ESTs). Although the initial report was highly controversial, it served to motivate several other groups to identify and publicize more examples of ESTs (e.g., Chambless & Ollendick, 2001; Weisz, 2004). The publicity and professional debate surrounding ESTs has



# Empirically Supported Treatments: 10 Years Later

sparked other changes as well: APA now espouses the value of science as the empirical basis of practice in its accreditation guidelines, the Canadian Psychological Association (CPA) accreditation guidelines explicitly require that students learn skills in using research to inform practice, and both APA- and CPA-approved continuing education (CE) providers are asked to disclose the degree of empirical support for treatments they teach. Critical to the movement for evidence-based practice is the question of whether training programs have changed the degree to which they include empirically supported treatments in the curriculum. To answer this question, we undertook this survey under the aegis of the Division 12 Committee on Science and Practice.

## Method

### Participants

Directors of all APA-accredited clinical psychology doctoral (Ph.D. and Psy.D.) programs ( $n = 333$ ) and predoctoral internships ( $n = 468$ ) in the United States and Canada were invited to participate. Respondents included 136 directors of clinical training (doctoral programs) and 184 internship directors, for a response rate of 40.8% and 39.3%, respectively. We were unable to determine the degree to which respondent programs are the same as those who responded to the 1993 survey.

### Measure

The survey was designed to be as brief as possible and to adhere rather closely to the questions that were asked in the 1993 survey. Respondents reviewed a list of treatments and indicated the degree to which their program teaches each psychotherapy modality. Response options included “taught in course briefly,” “taught in course thoroughly”, “supervised clinical training,” and “formal clinical training or certifica-

Table 1

Treatment	Taught in Course			Supervised Training	
	2003 Briefly	2003 Thoroughly	1993	2003	1993
<b>Anxiety and Stress</b>					
Cognitive therapy for panic	88.5	65.2	64.4	60.5	69.6
Applied relaxation for panic disorder	79.1	56.6	65.9	48.8	61.5
Exposure treatment for agoraphobia*	75.2	50.4	64.4	44.2	59.3
CBT for generalized anxiety disorder	89.2	72.1	69.6	66.7	77.0
Exposure for social phobia*	78.3	47.3	64.4	41.9	59.3
Stress inoculation training for coping with stressors†	31.8	11.6		6.2	
Exposure and response prevention for obsessive-compulsive disorder	71.4	55.9	58.5	48.1	48.1
Exposure / guided mastery for specific phobia*	79.9	56.6	64.4	48.8	59.3
Systematic desensitization for specific phobia	35.7	13.2	68.9	11.6	62.2
<b>Depression</b>					
Behavior therapy for depression	71.3	46.5	36.3	42.6	16.3
CBT for depression	92.3	78.3	89.6	72.1	80.0
Interpersonal therapy for depression	72.9	56.6	25.9	53.5	16.3
<b>Health</b>					
CBT for bulimia†	72.2	36.5		35.7	
Interpersonal therapy for bulimia	59.7	31.0	20.7	25.6	31.9
CBT for chronic lower-back pain	46.5	22.5	47.4	21.7	46.7
Behavior therapy for headaches	49.7	26.4	38.5	25.6	27.4
Multi-component CBT for pain associated with rheumatic disease†	31.1	11.7		0.8	
Multi-component CBT with relapse prevention for smoking cessation†		19.4		17.8	
<b>Problems of Childhood</b>					
Behavior modification for enuresis	58.2	25.6	45.2	24.0	40.0
Parent training for children with oppositional behavior	35.7	14.0	57.8	10.9	60.0
<b>Marital Discord</b>					
Behavioral marital therapy	57.4	35.7	57.0	31.0	60.7
Emotionally focused couple therapy for moderately distressed couples	74.3	69.4	39.3	68.9	46.7
<b>Other Problems</b>					
Family education for schizophrenia	45.7	20.9	24.4	18.6	22.2
Dialectical behavior therapy for borderline personality disorder	69.8	41.9	17.0	35.7	16.3
Habit reversal and control techniques	51.2	24.8	41.5	21.7	35.6
Behavior modification for sex offenders	36.5	18.7	23.7	17.1	27.4

### Right: Table 1

Percentage of Doctoral Programs Offering Training in Empirically Supported Treatments in 2003 and 1993

Note: † denotes treatments not surveyed in 1993. \* denotes target problems that were grouped together as one item (i.e., phobias) in the 1993 survey. “Cognitive therapy” for panic was described as cognitive behavior therapy (CBT) in 1993. CBT for depression was described as “cognitive therapy” in 1993, although both surveys explicitly mentioned Beck’s approach. “Chronic lower back pain” was described simply as “chronic pain” in 1993.



## Empirically Supported Treatments: 10 Years Later

Table 2

Treatment	2003	1993
<b>Anxiety and Stress</b>		
Cognitive therapy for panic	68.9	66.0
Applied relaxation for panic disorder	61.7	70.0
Exposure treatment for agoraphobia*	36.6	38.0
CBT for generalized anxiety disorder	74.3	78.0
Exposure for social phobia*	44.8	38.0
Stress inoculation training for coping with stressors†	43.7	
Exposure and response prevention for obsessive-compulsive disorder	49.7	36.0
Exposure/guided mastery for specific phobia*	41.5	38.0
Systematic desensitization for specific phobia	49.2	53.0
<b>Depression</b>		
Behavior therapy for depression	31.6	16.0
CBT for depression	82.5	66.0
Interpersonal therapy for depression	42.6	14.0
<b>Health</b>		
CBT for bulimia†	24.6	
Interpersonal therapy for bulimia	12.0	28.0
CBT for chronic lower-back pain	31.7	54.0
Behavior therapy for headaches	26.2	32.0
Multi-component CBT for pain associated with rheumatic disease†	16.4	
Multi-component CBT with relapse prevention for smoking cessation†	23.5	
<b>Problems of Childhood</b>		
Behavior modification for enuresis	22.4	43.0
Parent training for children with oppositional behaviour	37.2	64.0
<b>Marital Discord</b>		
Behavioral marital therapy	16.4	41.0
Emotionally focused couple therapy for moderately distressed couples	14.8	42.0
<b>Other Problems</b>		
Family education for schizophrenia	24.6	50.0
Dialectical behavior therapy for borderline personality disorder	38.3	15.0
Habit reversal and control techniques	17.0	31.0
Behavior modification for sex offenders	14.8	26.0

### Above: Table 2

#### Percentage of Internship Programs Offering Formal Supervision in Empirically Supported Treatments in 2003 and 1993

Note: † denotes treatments not surveyed in 1993. \* denotes target problems that were grouped together as one item in the 1993 survey. "Cognitive therapy" for panic was described as cognitive behavior therapy (CBT) in 1993. CBT for depression was described as "cognitive therapy" in 1993, although both surveys explicitly mentioned Beck's approach. "Chronic lower back pain" was described simply as "chronic pain" in 1993.

tion." "Briefly" was arbitrarily defined as course instruction for one week or less.

Survey items are listed in Tables 1 and 2. The 1993 survey included all treatments listed as "well established" or "probably efficacious" in that initial report. Although most of these treatments were also included in the 2003 survey, several treatments that did not have a specific target of intervention (i.e., behavior modification for developmentally disabled individuals, token economy programs, brief dynamic therapies) were not included in this survey. Two other treatments from the 1993 survey were also left off the 2003 survey because of a significant evolution in the way the treatment was described over the various Task Force reports. These treatments were group cognitive behavioral therapy (CBT) for social phobia (not specifically identified as a group treatment in the 1998 report) and behavior therapy for female orgasmic and male erectile dysfunctions. (No treatments were judged to be empirically supported for erectile dysfunction in the 1998 report; the probably efficacious treatment for female orgasmic dysfunction was "Masters and Johnson's sex therapy.")

In addition to most of the treatments from the 1993 survey, the present survey included all of the well-established treatments from the 1998 Task Force report (Chambless et al., 1998) even if those treatments had not been identified as empirically supported at the time of the 1993 survey. In cases for which the exact name of the treatment might be confusing or a matter of scholarly debate (e.g., cognitive or cognitive behavioral?), the surnames of researchers known for testing that treatment were included as a prompt. Because including all treatments judged to be probably efficacious in the 1998 report ( $n = 56$  treatments) would have been impractical, only the four treatments that were listed as "well established" were added. These included CBT for bulimia (erroneously left off the 1993 list), stress inoculation training for coping with stressors, and multi-component CBT for both rheumatic disease pain and smoking cessation.

#### Procedure

The survey, including a brief explanatory cover letter and a stamped addressed return envelope, was mailed to all members of the APA mailing lists for Directors of accredited doctoral and internship programs in clinical psychology in early 2003. The cover



letter explained that the survey was a repeat of the 1993 survey and that responses would remain anonymous. Directors who did not respond by the deadline (approximately 4 weeks following receipt) received a second mailing with the same materials.

### Results and Discussion

The results from the 2003 survey are shown in Table 1 for doctoral programs and Table 2 for internships. For convenience of comparison, the 1993 survey results are reproduced in these tables as well. Note that the responses were considered on a Guttman scale, meaning that the responses are hierarchical, with items lower than the item endorsed by the respondent are also considered to be true. For example, if a respondent indicated that a given treatment was covered thoroughly in a course, then that program was also counted in the frequency for brief instruction but

**“...there seems to be little agreement among doctoral and internship programs about the appropriate training curriculum for clinical psychologists.”**

not for supervised training.

The most popular empirically supported treatment in both 1993 and 2003 was cognitive therapy for depression. The vast majority of doctoral and

internship programs provide supervised training in this treatment. Most programs also provide supervised training in empirically supported treatments for anxiety disorders, including cognitive therapy for panic and CBT for generalized anxiety disorder (GAD), and most doctoral programs provide supervised training in emotionally focused couple therapy.

*How have things changed during these 10 years of debate about ESTs in our profession?*

Of 22 treatments that were included in both the 1993 and 2003 surveys, 18 are covered (at least briefly) by a higher percentage of doctoral programs in 2003 than in 1993. Within accredited doctoral programs, supervised training for ESTs has increased for only four treatments since 1993: behavior therapy for depression, stress inoculation training for coping with stressors, interpersonal therapy for depression, and emotionally focused couple therapy. In contrast, supervised training is less frequently offered for 16 ESTs than was true in 1993. At the internship level, supervised training has become more widely available

for eight (of 22) treatments in the last 10 years and less widely available for 14 treatments.

In 1993, most doctoral programs provided supervised training for 11 out of 22 ESTs. This figure has dropped since that time, with the results of the 2003 survey indicating that only 5 out of 26 ESTs were included as part of supervised training in the majority of programs. Recall, however, that the same respondents may not be represented in both surveys.

*To What Degree do Programs Provide Training in any EST?*

On average, doctoral programs reported that they provide supervised training to graduate students in an average of 9.5 ( $sd = 5.4$ ) interventions out of the 26 surveyed. This compares with a mean of 11.5 in the 1993 survey. The distribution had two modes, 9 and 13 interventions ( $n = 18$  each), with a range from 0 ( $n = 8$  programs) to 26 ( $n = 1$  program). Internship programs reported similar figures, providing supervised training in an average of 9.3 ( $sd = 7.1$ ) interventions out of 26 surveyed. This average, however, represents a distribution for which the *mode was zero*, meaning no supervised training in any of the ESTs we surveyed. The range extended from zero ( $n = 21$  programs) to 26 ( $n = 1$  program). Comparable data for internship programs were not provided in the report of the 1993 survey.

*How Consistent is Training in ESTs Across Programs in Canada and the USA?*

One (admittedly liberal) definition of consistency is whether more than half of responding programs provide training in a given topic. By this definition, graduate programs responding to the survey show consistency in teaching about some ESTs. Most doctoral programs at least touch on 17 (out of 26 surveyed) treatments in didactic instruction, but only nine treatments are covered *thoroughly* in didactic graduate school instruction. (The 1993 survey did not distinguish between brief and thorough instruction.) Internships show less consistency; only four treatments are taught by more than 50% of internship programs responding to the survey. These four treatments include strategies for treating some of the most commonly encountered problems in clinical practice (depression, generalized anxiety, and panic). In 1993, eight treatments were taught by at least half of the internships.

Overall, there seems to be little agreement among doctoral and internship programs about the appropriate training curriculum for clinical psychologists. This is likely due to the APA accreditation



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standards that encourage programs to establish their own model and follow it. Although there is undoubtedly good agreement about the general topics that programs should cover (e.g., assessment, breadth courses), there is apparently little general agreement about content or supervised training experiences that should be provided in each program. Other than relatively good agreement that cognitive therapy for depression and panic or GAD are important, most of the treatments that have robust empirical support are not taught (in a supervised way) by the majority of training programs. While the EPPP licensing exam provides some standardization of the knowledge about psychology that licensed psychologists have, it would appear that there is little overlap in supervised practical skills and knowledge obtained in various training programs, particularly at the internship level.

***“...most of the treatments that have robust empirical support are not taught (in a supervised way) by the majority of training programs.”***

*How Valid are the Results of this Survey?*  
Several decisions related to the design of the survey place limitations on its interpretation. A major consideration was the ability to compare the 2003 results with the 1993

results. Another consideration was keeping the survey as brief as possible to increase the probability of response. (Directors of training programs receive many surveys each year.) Maximizing these aims meant that we did not include most treatments that have been identified as empirically supported by other groups after 1993 (see Chambless & Ollendick, 2001). As described above, we were unable to completely achieve the aim of comparing with the 1993 results because we cannot identify which programs responded to that survey.

The nature of the survey presents some issues related to validity. For example, most of the treatments listed in the survey are targeted toward individual therapy with mid-life adults. Programs that focus on preparing students for working with individuals at either end of the lifespan would not check many treatments on this survey. As another example, Directors of programs may have used their “best guess” about the level of training provided for each treatment for several reasons. Although Directors of Clinical Training programs have access to syllabi

for all clinical courses (because of accreditation reviews), it is doubtful that they took the time to study these syllabi before responding to the survey. Accordingly, they likely responded on the basis of recall, which is subject to many biases with which researchers are familiar.

Furthermore, many (or most?) clinical programs do not provide training based on diagnoses or treatment types, which is how the survey was organized. Rather, many programs provide training based on a coherent theoretical rationale (e.g., evidence-based, cognitive-behavioral, psychodynamic, family systems) as it is applied to whichever clients are admitted to the training clinic. These programs undoubtedly vary in the degree to which they find the results of randomized controlled trials to be valuable sources of information for treatment planning. The point is that even Directors of programs dedicated to clinical science would have to guess about the degree to which their students or interns receive training in each of the treatments on the survey. In some programs, students’ training is almost entirely contingent on their supervisors, so it would be difficult to make blanket judgments about which ESTs are covered in the program.

*What are Some of the Obstacles to Providing Training in ESTs?*

After conducting this survey, we posted listserv questions asking for feedback from our colleagues in the Council of University Directors of Clinical Psychology (CUDCP) and the Association of Psychology Postdoctoral and Internship Centers (APPIC). Many Directors of Clinical Training ( $n = 28$ ) and Internship Directors ( $n = 12$ ) provided thoughtful responses articulating perceived obstacles to providing training in ESTs. The main obstacles indicated were uncertainty about how to conceptualize training in ESTs, lack of time, shortage of trained supervisors, inappropriateness of established ESTs for a given population, and philosophical opposition.

*Nature of training in ESTs.*

Some Training Directors expressed uncertainty about what it means to train students in evidence-based practice. They questioned the implied training structure of the survey, which was that students learn to conduct manualized treatments one-by-one. They called for a wider discussion on how to train students in principles of behavior or principles of evidence based practice. Without such a higher level approach, respondents argued that students may become technicians, able to articulate a client’s diagnostic



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label and to point to a tested treatment manual for that diagnosis, but unable to propose a conceptualization about what various behaviors mean for the individual or how the individual came to have the presenting problem.

*Lack of time.* Training directors indicated that there is insufficient time in the curriculum to provide training in specific manualized treatments, particularly among programs that emphasize research training. Others noted that proper training in a treatment protocol involves repeated experiences under close supervision, and the rapid pace of graduate and internship training rarely permit this, particularly for generalist training. This problem is compounded in training centers that focus on research because faculty members are often too busy with research to become

heavily involved in supervision.

*Shortage of trained supervisors.* Many clinicians who serve as supervisors are generalists who cannot justify the time and expense of learning specialized treatments. One needs to be quite proficient in a given treatment to be sufficiently flexible to provide supervision, and it may be hard for generalists to see the payoff of the expense of continuing education and supervision in a new, highly specific, approach if their practice involves clients with a wide variety of problems. Some Training Directors also noted that many supervisors say they use certain ESTs, but they lack specific training in those approaches. Several Directors of Clinical Training argued that a training clinic controlled by clinical faculty is required to provide all students with a good foundation in evi-

### AMERICAN PSYCHOLOGICAL FOUNDATION CHARLES L. BREWER DISTINGUISHED TEACHING OF PSYCHOLOGY AWARD

The American Psychological Foundation (APF) invites nominations for the APF 2006 Charles L. Brewer Distinguished Teaching of Psychology Award.

#### THE AWARD:

The awardee receives a plaque, a \$2,000 check, and a two-night, three-day, all-expenses-paid trip to the American Psychological Association's (APA) 2006 annual convention, in New Orleans, LA where the award will be presented.

#### REQUIREMENTS:

The award recognizes a career contribution to the teaching of psychology. The APF Teaching Subcommittee selects a psychologist for the award who has demonstrated:

- Exemplary performance as a classroom teacher;
- Development of innovative curricula and courses;
- Development of effective teaching methods and/or materials;
- Teaching of advanced research methods and practice in psychology;  
and/or,
- Administrative facilitation of teaching;
- Research on teaching;
- Training of teachers of psychology;
- Evidence of influence as a teacher of students who become psychologists.

#### APPLICATION PROCESS:

APF provides nomination forms. Nominations should include the form, a statement that illustrates how the nominee fulfills the guidelines of the award, and the nominee's current vita and bibliography. Letters in support of the nomination are welcome. All materials should be coordinated and collected by the chief nominator and forwarded to APF at the same time.

The deadline for receipt of materials is **December 1, 2005**. Requests for nomination forms and completed nomination packets should be mailed to the APF Charles L. Brewer Teaching Award Coordinator, 750 First Street, NE, Washington, DC, 20002-4242. Requests for nomination forms may also be sent to [foundation@apa.org](mailto:foundation@apa.org).



dence-based practice. Numerous Training Directors lamented their options for practicum placements, pointing to a disconnect between the values of the training program and the values of training clinics.

*Narrowness of established ESTs.* Although the lists of examples of ESTs have grown quite long, they are still rather narrow compared to the diversity of practice settings and the clientele of those settings. Sadly, segments of the population that are underserved due to issues such as poverty, age, language barriers, or rural settings are also underrepresented in research. Generally speaking, few ESTs have been developed or tested with these factors in mind (although children and the elderly are receiving increased attention). Furthermore, while some studies have addressed simple issues of comorbidity, the scientific method underlying randomized controlled trials requires manipulation of one variable (i.e., intervention) at a time. Manualized treatments tested in this way may not always be so easily applied in a straightforward way to complex cases; therapists often find themselves adapting the treatment extensively because they see a pure EST as inadequate to address the client's complicated set of problems.

*Philosophical opposition.* Some Training Directors indicated principled opposition to the notion of ESTs. Some of this opposition was based on the idea that lists of ESTs reflect a political or theoretical bias more than they reflect treatments that work. Others opposed what they see as an erosion of their autonomy as professionals due to pressure to conduct ESTs. In this view, the manualized approach is seen as too rigid and objectifying rather than humanizing clients. Some Training Directors also expressed a lack of trust in researchers, pointing to stories of misleading reporting of clinical trials from the drug industry in support of this view.

### Conclusion

Whether doctoral and internship programs provide more or less training in ESTs than they did in 1993 depends on how one asks the question. On one hand, training programs teach (to some degree) a greater number of ESTs than they did 10 years ago. Only two treatments are taught less frequently than they were in 1993 (parent training for children with oppositional behavior and systematic desensitization for specific phobia). On average, doctoral and internship programs reported that they provide graduate students

with supervised training in an average of 9.5 ( $sd = 5.4$ ) interventions out of the 26 surveyed.

On the other hand, supervised training in most ESTs is less widely available, at both the doctoral and internship levels, than it was in 1993, although some increases in supervision were observed. Aside from relatively good agreement that cognitive therapy for depression, panic and GAD are important, most of the treatments with robust empirical support are taught (in a supervised way) by fewer than half of the training programs. Further, the consistency with which students can expect to receive training in ESTs is declining. Although 11 of 22 treatments with well-established empirical support were included in most predoctoral supervised training curricula in 1993, the figure was down to a handful out of 26 in 2003. While most programs responding to this survey indicated that they provide supervision in a variety of ESTs, many accredited programs still provide no training in ESTs. If the results of this survey are any indication, graduate training in clinical psychology has a long way to go before it reflects the scientific basis of the discipline. □

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## CANDIDATES FOR FELLOWS WELCOME!

Any member who has made outstanding contributions to clinical psychology is eligible. **Members who are Fellows of other APA divisions are also encouraged to apply and the application process is much less demanding.**

As a guide to determine if you or somebody you are thinking of nominating fit the criteria for "Fellow" status, here is a list that APA, as well as our Division, considers when going through applications. Note that these are minimum standards under the APA Bylaws so one must meet all of these criteria:

- The receipt of a doctoral degree based in part on a psychological dissertation, or from a program primarily psychological in nature
- Prior membership as an APA member for at least one year and a member of division 12
- Active engagement at the time of nomination in the advancement of psychology in any of its aspects (for our division, the aspect would be clinical psychology)
- 5 years of acceptable professional experience subsequent to the granting of the doctoral degree
- Evidence of unusual and outstanding contribution or performance in the field of clinical psychology; this requires evidence or documentation that the person nominated has enriched or advanced the field of clinical psychology on a scale well beyond that of being a good practitioner, teacher, researcher, administrator or supervisor. The nominee's contributions have to be unusual, innovative or of seminal nature. Fellowship status is simply not conferred based on seniority or competence.
- More specifically, criteria for Fellowship can have a broad range, including direct therapeutic services, consultation, administration, research and involvement in national, regional, state and local professional governance activities. Outstanding service to APA Boards or Committees, or to Division 12 Committees meet the criteria for fellowship, provided that such services can be shown to have had a positive impact on the field of clinical psychology as a profession or science.
- For nominees in predominately clinical practice, there is a need to specify how their therapy or practice represents an innovative application with, for example, a difficult disorder or an atypical patient population. Endorses for a candidate will need to specify clearly how the nominee has made a visible impact on the field of clinical psychology. Based on experience, the person should already be on a clear career path, typically with a substantial number of publications

Applicants need to complete the Uniform Fellows Blank and provide a self-generated written statement setting forth the justification that they believe exists for election to the status of Fellow. Self-nominations are welcomed. Lastly, part of the application requires letters from three fellows. Materials are due December 1st.

**If you are already a Fellow of another division, approval by the Division 12 Committee is sufficient to make you a Fellow of Division 12.** To apply, please send a letter of achievements and 2-3 letters of recommendation from those who are members and fellows of Division 12. Applicants who are already APA Fellows should send their materials to the Fellows Committee no later than March 11, 2005. In addition, a statement of accomplishments outlining your contributions to the field would be helpful.

Any applicant needing additional information or if you have questions concerning criteria or the steps involved in the nomination process, please contact Charles Golden, Ph.D. Chair Fellows Committee, Society of Clinical Psychology Central Office, P.O. Box 1082, Niwot, CO 80544-1082, [div12apa@comcast.net](mailto:div12apa@comcast.net).



# Student Forum

## Why are Graduate Students not talking about Prescriptive Authority?: A Discussion of Prescription Training for Psychologists


Louisa D. Grandin, M.A.

Temple University

Michelle A. Blackmore, B.A.

Temple University

Correspondence regarding this article may be sent to: Louisa D. Grandin, M.A., Department of Psychology, Temple University, 1701 N. 13th St., Philadelphia, PA 19103, USA; Tel: 215-204-6851; E-mail [lgrandin@temple.edu](mailto:lgrandin@temple.edu)

 In 1996 the American Psychological Association (APA) drafted a training model for psychologists to gain prescriptive authority. This was approximately a decade ago; yet current psychology graduate students do not appear to be discussing their thoughts on prescriptive authority and, even more importantly, *how* they would gain this authority (Hanson et al., 1999). A recent article raised the question of whether there may even be a “sense of malaise or blunted momentum” (p. 351, Fagan et al., 2004) associated with this prescriptive authority debate given that after 25 years of published discussion, psychopharmacology still feels like a remote possibility to many graduate students. Why has this movement been stunted, particularly in psychology graduate programs, thus limiting the developmental progress of prescriptive authority training programs?

There are several potential obstacles, but a prominent one is that there appears to be resistance from the academic community as they would be affected by such training programs (Ax, Forbes, & Thompson, 1997). Interestingly, most Directors of Clinical Training (DCTs) of psychology graduate programs support prescriptive authority for psychologists; however, many seem to have concerns about predoctoral training requirements such as availability of faculty expertise in the area, changes in current curricula, and the costs of developing such a training program (Ax et al., 1997; Council of University Directors of Clinical Psychology, 2001; Evans & Murphy, 1997; Fagan et al., 2004; Walters, 2001). These concerns are perhaps not surprising given these possible ramifications of predoctoral psychopharmacology training, but nonetheless, they

may hinder active discussions in graduate programs regarding the current state of the debate, particularly the possible implementation of existing training options. Thus, this may be a form of indirect ‘resistance’ that is quite powerful and discourages graduate students from being informed about the issues or exploring their options (Ax et al., 1997).

The premise of this article is derived from findings that education of prescriptive authority significantly impacted a group of psychologists’ opinions on the debate (Pimental, Stout, Hoover, & Kamen, 1997). Results indicated that the more one was informed on the topic, the more likely they were to favor prescriptive authority for appropriately trained psychologists. We believe that education and discussion of this topic are essential in order to move this debate forward. Thus, the first aim of this article is to present issues related specifically to prescription training for psychologists given that training models have been proposed, approved, and utilized in some states (i.e., New Mexico, Louisiana). A secondary aim is to stimulate further discussion amongst graduate students and their programs on training options, particularly those recommended by the APA.

### The APA Model

The only currently approved psychopharmacology training model was developed by the APA Council of Representatives (1996) and incorporates both pre- and post-doctoral training, with an emphasis on the latter. Three levels of training in psychopharmacology have been proposed: Level 1 consists of basic education in psychopharmacology, Level 2 involves collaborative practice with licensed prescribers, and Level 3 consists of education and training for independent prescriptive authority (Robiner et al., 2002). The current APA model does not specify undergraduate prerequisite courses, but instead requires “demonstrated knowledge in human biology, anatomy and physiology, biochemistry, neuroanatomy, and psychopharmacology” (p. 2, APA, 1996). A minimum of 300 part-time or full-time hours of didactic instruction (e.g., research and clinical psychopharmacology, laboratory exams and physical assessments, pharmacotherapeutics) are also recommended. Although the APA approach does not provide specifics on how the model should be incorporated into graduate or postdoctoral programs, it does appear to emphasize postdoctoral training.



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The model further requires that 100 patients be seen during an inpatient and outpatient practicum, with a minimum of two hours per week of individual supervision by a qualified practitioner. However, the breadth of mental health conditions, duration of patient contact, and various medication regimens to which trainees should be exposed are not indicated (Robiner et al., 2002). Further specification of these requirements might be helpful in developing a comprehensive training program. It appears feasible to complete this training in approximately two years, and thus it diverges from the longer, more time intensive, medical model (Robiner et al., 2003). The APA also requires that a certified prescribing psychologist must be licensed with a doctoral degree in psychology, pass a psychology examination developed by the state, and participate in continuing education.

### **Implications and Current Training Issues**

Several issues have been raised with regard to this model. At the center of this debate is whether pharmacology training should more closely follow a medical model as well as whether it should occur at the pre- or post-doctoral level. For example, the current APA model requires undergraduate and graduate school courses, but considerably more courses are required for entry into medical schools. As mentioned, the current medical model also requires more patient contact, which necessitates a longer duration of training than suggested by the APA model (Robiner et al., 2003).

Interestingly, a recent survey of psychology graduate students, of which 73% were at least somewhat interested in prescriptive authority, found that 77% believe that a prescriptive training model for psychologists should resemble a medical training model (Hofflich, Grandin, Blatt-Eisengart, & Creed, 2004). These data should be interpreted cautiously however, as participant familiarity with the medical model or with other prescription options, such as limited prescriptive authority was not measured. Nevertheless, even within a sample where the majority were at least somewhat interested in gaining prescriptive authority, these findings are actually more consistent with individuals opposing prescriptive authority as they believe that psychologists should attend medical school (or similar schools that grant prescriptive authority) in order to gain prescriptive authority (Heiby, 1998; Kovacs, 1988; Moyer, 1995).

In contrast, most current clinicians who support prescriptive authority believe that training does not need to resemble a medical model (DeLeon, Sammons & Sexton, 1995; McGrath et al., 2004). They fear that such a model would require psychologists to take unnecessary courses or change the students' focus from psychological to pharmacological treatments (Council of University Directors of Clinical Psychology, 2001; DeLeon et al., 1995; Klusman, 2001; McGrath et al., 2004; Newman, Phelps, Sammons, Dunivin, & Cullen, 2000). To minimize these concerns, the current APA training model encourages a clinical rather than a pharmacological focus given that training is done within the context of the field of clinical psychology (APA, 1996). Further, with respect to coursework, some are concerned that predoctoral requirements, particularly undergraduate courses, will require students to specialize too early in their careers (Hanson et al., 1999) or force psychology students to take courses they are uninterested in, have anxiety about taking, or in which they typically do not excel (deMayo, 2002). These findings are particularly concerning as students who are not interested in prescriptive authority may feel pressure to take these requirements to remain competitive with their prescribing colleagues.

These concerns appear warranted and emphasize the substantial changes to psychology graduate programs that would follow if predoctoral training were implemented. For instance, one survey found that only 7% of psychology students have a background in physical sciences (Tatman, Peters, Greene, & Bongar, 1997) and that only 12% of psychologists versus 67% of psychiatrists had an undergraduate major in the physical sciences (Robiner et al., 2003). These data are likely due to the current variation in requirements for psychology graduate schools versus medical schools, but they also highlight the changes required if predoctoral training becomes a requirement for gaining prescriptive authority. However, it has been argued that such basic science training may not be the best or only option for training in psychopharmacology (Kozak, 1997). Instead, it may be possible to further develop computerized information tools to be utilized by prescribing providers to determine and process pharmacology information (Kozak, 1997).

For these reasons, postdoctoral training offered as a specialty track may be considered

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a preferable option that would limit additional requirements and training to only those interested in prescriptive authority. This model is supported by the APA, which stated that a prescriptive training track should be conceptualized as a “specialized” program based on “careful selection criteria, focusing on those psychologists with the necessary science background (p. 400, Smyer et al., 1993).” Such an option would help prevent psychologists who do not feel competent to prescribe or have no interest in doing so from feeling obligated to obtain prescriptive authority. Also, offering a specialized track might help to alleviate the concern that psychological training may begin to focus more on pharmacological and less on psychological interventions, particularly if predoctoral training is implemented. A potential complication that might result if some graduate schools do implement predoctoral training whereas others do not is that programs might begin to vary, particularly in their training orientation (i.e., pharmacological versus psychological focus). Further, determining the ‘careful selection criteria’ as well as how training would be monitored in these programs by the APA should be carefully considered.

With respect to a ‘specialized’ program, it is important to note the APA recommends independent, but limited prescriptive authority (Smyer et al., 1993). This would allow psychologists to prescribe independently, or without needing a supervisor’s approval for medication prescribed, but only for psychotropic medications. This models other professions such as dentistry, podiatry, and optometry, where practitioners are restricted to prescribing medications that treat conditions within their area of expertise (DeLeon, Fox, & Graham, 1991). Accordingly, this type of limited authority may in turn limit changes necessary to program curricula and place less demand on psychology graduate schools. More importantly, it might help limit concern over decreases in standard of care resulting from psychologists prescribing outside their area of experience and expertise.

The issues discussed thus far are critical in that they will not only determine the degree of change to graduate school curricula, but they will also directly impact graduate school faculty members, particularly the role of DCTs. As previously mentioned, DCTs (and likely other members of the faculty) might be hesitant to implement predoctoral prescriptive authority training as it would require

extensive changes to their programs. For example, faculty members with psychopharmacology expertise would be needed to provide sufficient training and supervision within the area. The APA suggests that such faculty members would be expected to conduct research in this area to allow for the supervision of graduate student dissertations in psychopharmacology (Smyer et al., 1993). Moreover, the APA highlights the importance of communication of such research among the psychology community. For instance, they recommend the publication of a new journal, such as *Journal of Experimental and Clinical Psychopharmacology* (Smyer et al., 1993).

These suggested changes would involve potentially significant costs, making it necessary to conduct cost-benefit analyses of psychopharmacology training options. For instance, costs will likely increase if graduate programs hire faculty with psychopharmacology expertise and increase the number of required courses and practicum experiences within this area. The added financial impact of supporting graduate students for possibly longer periods of time while they obtain the necessary additional training is another substantial factor to consider. To limit such financial impacts to graduate school programs, a cost effective option may be to disperse training throughout undergraduate and pre- and post-doctoral level education; however, as mentioned, this may require students to specialize too early (Fagan et al., 2004; Hanson et al., 1999). Further, determining whether training should be offered part-time or full-time, or whether distance learning training utilizing web-based or teleconferencing options could be incorporated, are other noteworthy cost considerations.

The financial effect on the practicing psychology community should also be taken into account. Some estimate that such changes will be very costly (i.e., the price of liability insurance, as well as application and renewal fees for licensure will increase substantially), suggesting that gaining prescriptive authority may not be a good decision for psychologists (DeNelsky, 1991; Wagner, 2002). Additionally, Wagner (2002) asserts that increasing liaisons with professionals who already have prescriptive authority would be more economically efficient and overall less costly for psychologists.

Others offer a more optimistic view of the costs associated with prescriptive authority (Dörken, 1990; Gutierrez & Silk, 1998; Norfleet, 2002;



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Pimental et al., 1997; Wiggins & Wedding, 2004). Specifically, they mention that it is unlikely that malpractice rates for prescribing psychologists would increase substantially, and underserved areas where there is an unmet need for psychotropic medication may benefit from psychologists with the ability to prescribe. Further, limited prescriptive authority, as recommended by the APA, may have fewer costs associated with it than full independent authority. Several authors have supported limited prescriptive authority (Chafetz & Buelow, 1994; Smyer et al., 1993; Wiggins, 1992), while others have suggested that it may create unnecessary overlap with psychiatry (DeNelsky, 1991; Gutierrez & Silk, 1998). In short, there does not seem to be a clear understanding, or consensus, of the costs associated with psychopharmacology training. Thus, this debate would benefit from an objective cost-benefit analysis to address the related concerns of DCTs, their universities and faculty, psychology graduate students, individuals receiving such treatment, and the general practicing psychology community.

### Conclusion

This article reviews several of the key issues associated with prescription training, particularly in regard to the model proposed by the APA. As mentioned, one key issue to consider is whether training should occur at the predoctoral level, postdoctoral level, or both. Prescription training, especially at the predoctoral level, would significantly impact the current psychology training model in that it would likely require changes to the course curricula and practica, faculty, program focus, clinical training, and research. Further, the costs associated with such changes must be considered as they will also likely impact training requirements and the feasibility of particular training protocols. Moreover, whether training should be geared towards a dependent, independent, or limited independent model should be considered, as well as the potential costs associated with each type of training.

Also important to address is whether prescription training should be available to all psychologists or offered only to those willing to follow a specialized track, and if the latter, what would be the selection criteria? How would the APA monitor the differing training programs and continuing education requirements? Additionally, if psychologists diverged in their skills and training, particularly their ability

to prescribe, how might that impact competition among colleagues? How might state-by-state laws governing psychopharmacology training requirements create differences in the training and rendering of psychological services?

In sum, we hope that this brief discussion of the current APA model and the implications of executing such a training program may help educate psychology students, highlight the prominent issues being debated, and stimulate discussion at the graduate school level. Although the question of whether psychologists should be eligible for prescriptive authority has not reached unanimity, we believe that it is time to move forward with planning for the possibility in order to regain momentum and stimulate debate. It is essential for psychology graduate students, as they will be affected by these changes, to take part in the process of further developing the training programs. Thus, it is important that students be well informed of the issues, actively contribute to the debate, and continue to monitor developments of the current training model to help ensure they are adequately trained and prepared for the future job market. □

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## 2005 Division 12 Award Winners

**Congratulations to all 2005 award recipients from the Society of Clinical Psychology and its Sections. Below is a list of this year's award winners. All awards were presented at the 2005 APA convention in Washington, DC.**

### 2005 Awards from the Society of Clinical Psychology

Distinguished Scientific Contributions to Clinical Psychology  
Recipient: **Martin E. P. Seligman, Ph.D.**

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology  
Recipient: **W. Edward Craighead, Ph.D.**

David Shakow Award for Outstanding Early Career Contributions to the Science and Practice of Clinical Psychology  
Recipient: **Kelly L. Klump, Ph.D.**

Theodore H. Blau Early Career Award for Outstanding Early Career Contributions to the Profession of Clinical Psychology  
Recipient: **Martin M. Antony, Ph.D., ABPP**

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology  
Recipient: **Beverly Greene, Ph.D.**

The American Psychological Foundation Theodore Millon, Ph.D. Award  
Recipients: **Paul R. Duberstein, Ph.D. and Robert F. Bornstein, Ph.D.**

Distinguished Student Research Award  
Recipient: **Sona Dimidjian and LaRicka R. Wingate**

Distinguished Student Practice Award  
Recipient: **Kelly C. Cukrowicz**

Distinguished Student Service Award  
Recipient: **Ignacio David Acevedo-Polakovich**

### 2005 Awards from the Sections

Clinical Geropsychology Distinguished Clinical Mentorship Award  
Awarded by: Section 2, Clinical Geropsychology  
Recipient: **Bob Knight, Ph.D.**

M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology  
Awarded by: Section 2, Clinical Geropsychology  
Recipient: **John Santos, Ph.D.**

Society for the Science of Clinical Psychology Award for Distinguished Scientist  
Awarded by: Section 3, Society for a Science of Clinical Psychology  
Recipients: **Richard McNally, Ph.D.**

Society for the Science of Clinical Psychology Dissertation Grant Award  
Awarded by: Section 3, Society for a Science of Clinical Psychology  
Recipients: **Stephanie Cassin, Lindsay M. Collins, and Susan C. Smith**

Clinical Psychology of Women Mentor Award  
Awarded by: Section 4, Clinical Psychology of Women  
Recipient: **Marsha Marcus, Ph.D.**

Clinical Psychology of Women Student Research Award  
Awarded by: Section 4, Clinical Psychology of Women  
Recipient: **Darby Saxbe**

Clinical Psychology of Ethnic Minorities Mentor Award  
Awarded by: Section 6, Clinical Psychology of Ethnic Minorities  
Recipient: **Samuel M. Turner, Ph.D. (posthumously)**

Dalmas A. Taylor Award for Outstanding Student Research  
Awarded by: Section 6, Clinical Psychology of Ethnic Minorities  
Recipient: **Angel G. Lugo-Steidel, M.A.**

Presidential Award for Distinguished Contributions in Science  
Awarded by: Section 6, Clinical Psychology of Ethnic Minorities  
Recipient: **Stanley Sue, Ph.D. and Guillermo Bernal, Ph.D.**

Presidential Award for Distinguished Contributions in Education  
Awarded by: Section 6, Clinical Psychology of Ethnic Minorities  
Recipient: **Richard Suinn, Ph.D. and Gail Wyatt, Ph.D.**

Presidential Award for Distinguished Contributions in Practice  
Awarded by: Section 6, Clinical Psychology of Ethnic Minorities  
Recipient: **Lillian Comas-Diaz, Ph.D. and Dolores Bigfoot, Ph.D.**

Presidential Award for Distinguished Contributions in Public Interest  
Awarded by: Section 6, Clinical Psychology of Ethnic Minorities  
Recipient: **Bertha Holliday, Ph.D. and Diane J. Willis, Ph.D.**

Special Presidential Award for 2005  
Awarded by: Section 6, Clinical Psychology of Ethnic Minorities  
Recipient: **Norman Anderson, Ph.D.**

Emergencies and Crises Career Achievement Award  
Awarded by: Section 7, Section for Clinical Emergencies and Crises  
Recipient: **Marsha M. Linehan, Ph.D.**

Student Research Award  
Awarded by: Section 7, Section for Clinical Emergencies and Crises  
Recipient: **Laura Guy**

Association of Medical School Psychologists Distinguished Achievement in Teaching Award  
Awarded by: Section 8, Association of Medical School Psychologists  
Recipient: **Nadine J. Kaslow, Ph.D.**

Association of Medical School Psychologists Distinguished Achievement in Research Award  
Awarded by: Section 8, Association of Medical School Psychologists  
Recipient: **Peter Vitaliano, Ph.D.**

Enduring Contributions to Education in Assessment Psychology  
Awarded by: Section 9, Assessment Psychology  
Recipient: **Norman Abeles, Ph.D.**

Enduring Contributions to Training in Assessment Psychology  
Awarded by: Section 9, Assessment Psychology  
Recipient: **David Lachar, Ph.D.**

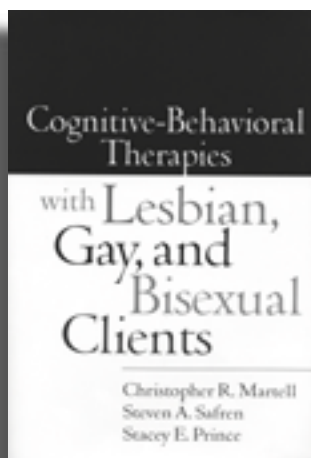


**Martell, C.R., Safren, S.A., & Prince, S.E.**  
(2004) *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients.*

New York: Guilford.

ISBN: 1-57230-954-7/ \$35.00 (hardcover) US List

Reviewed by Kathleen A. Mooney, Ph.D., Co-Founder,  
Center for Cognitive Therapy, Huntington Beach, California



Traditionally, a matchmaker is one who brings two people together with the belief they will find each other attractive and enrich each others' lives. High hopes are placed on the match and many in the community participate to make it successful. Historically most matches were politically and financially motivated, not designed for the welfare of the two individuals being matched.

Modern day pairings focus more on relationships such as Rogers and Hammerstein, Gertrude and Alice, Lucy and Ethel, and even Will and Grace.

Martell, Safren, and Prince's pairing of cognitive-behavioral therapies (CBT) with lesbian, gay, bisexual (LGB) mental health issues fortunately is a match made for all the right reasons. The authors are our modern day matchmakers and this volume, *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients* is a most welcome introduction.

A most useful feature of this book is found in the Preface. The section on "Definition of Terms" conveys a wealth of valuable and insightful information to therapists not familiar with LGB issues of self-definition. In just three pages, the authors review the complexities of cultural sensitivity to the many ways people express their sexual orientation and behavior. In addition, this section is infused with helpful and specific examples.

Succinct and clear case examples in Chapter 1 introduce readers to developmental and identity issues many LGB individuals face. These profiles and clinical vignettes highlight relevant, critical

issues and are enriched with references to research findings, biases (heterosexual assumptions), and life-span coverage. Martell et al. discuss CBT's emphasis on environmental factors as an important focus in working with LGB clients and encourage therapists to strongly consider its impact when making suicide risk ratings.

Chapters 2 and 3 are devoted to CBT assessment, conceptualization, goal setting and therapy basics. This lays the groundwork for Chapters 4, 5, and 7, which cover a variety of CBT protocols and procedures for depression, social anxiety, generalized anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, substance abuse, grief, bereavement and HIV-related problems.

Three models of cognitive and behavioral couples therapy adapted from behavior therapy for work with same sex couples are presented in Chapter 6. The two detailed case examples, which include case information, treatment plans, and therapy outcomes, both demonstrate the commonality of couples' problems. One case focuses more on emotional acceptance whereas the other emphasizes a cognitive approach, exploring the interaction of belief, affect and behavior. Issues more specific to same sex couples such as negative bias, gender role socialization, and societal prejudice toward gay and lesbian parents are highlighted as well. To assist the clinician in developing a treatment plan, a useful set of assessment questions is provided.

Chapter 8 reviews "emerging" behavioral and cognitive-behavioral therapies such as mindfulness-based cognitive therapy for depression. Self-disclosure, therapist bias, and conversion therapy are addressed in Chapter 9 along with examples and research findings. The discussions on ethics and clinical judgment are a useful asset in recognizing our own negative biases. Questions are provided for therapists to ask themselves regarding their LGB clients such as, "Am I more likely to assume psychopathology if I know my client is LGB?" For any "yes" answers to these questions, consultation with a LGB-affirmative colleague is recommended. In addition, suggestions for managing complicated feelings and maintaining ethical boundaries are offered.

The book concludes with a discussion of the past and future of CBT. One of the strengths CBT brings to therapy with LGB clients is its emphasis on framing client behavior in ways that do not pathologize behavior. CBT evaluation and concep-



tualization tend to focus on the interrelatedness of behavior, environment, belief, and emotion. While much in CBT's past has neglected or even negatively approached LGB issues (invisibility in research studies, conversion therapy), the authors' hope for the future of CBT is continued emphasis on the environment and strengthened emphasis on the therapeutic relationship.

*Cognitive-behavioral therapies with lesbian, gay, and bisexual clients* is a good first attempt to delineate CBT protocols that specifically take into account critical issues for LGB clients. While much of this information is scattered throughout CBT and LGB writings, this book succinctly joins it together in a coherent framework. Since CBT is not a unified field but rather represents a wide variety of philosophies and approaches, the use of the plurality "cognitive-behavioral therapies" in the title alerts readers that the authors intend to offer a spectrum of therapies. As a result, readers only get a glimpse of the power and usefulness of various CBT approaches.

Unfortunately the authors fail to emphasize that CBT is not a series of techniques but a comprehensive psychotherapy. Instead the authors offer a table of CBT techniques (Chapter 3) that point the reader to more than a dozen separate sources for further study. This reviewer would have liked the authors to encourage readers to learn more in depth about a particular school of CBT and the associated protocols. In their final statement, the authors offer the hope that readers use this volume as a "springboard" to further training (in CBT and/or LGB issues). To back up that hope, the Appendix includes useful resources of LGB organizations for therapists and families as well as CBT associations and

training organizations.

Two earlier publications that present specific CBT application to LGB clients, not referenced in the book, are cited here since they are useful to therapists learning CBT with LGB populations. Padesky (1989) describes how A.T. Beck's cognitive therapy can be used to foster positive identity in lesbians. Scott's (1993/2005) video series includes an introduction by Aaron T. Beck and presents an excellent clinical demonstration of how CBT can help clients navigate coming out issues.

With this publication, the matchmaking has formally begun. Therapists who work with LGB clients and therapists who use CBT have been introduced. Hopefully this book inspires us to continue to get to know each other, seek commonalities, combat weaknesses, share strengths, and form an alliance that informs and improves our work. The ultimate goal is the enrichment of our clients' lives. □

### References

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## JOIN A DIVISION 12 SECTION

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

- Clinical Geropsychology (Section 2)
- Society for a Science of Clinical Psychology (Section 3)
- Clinical Psychology of Women (Section 4)
- Clinical Psychology of Ethnic Minorities (Section 6)
- Section on Clinical Emergencies and Crises (Section 7)
- Section of the Association of Medical School Psychologists (Section 8)
- Section on Assessment (Section 9)

## Society of Clinical Psychology — Fellowship Committee, 2005

The Society Fellowship Committee, led by Fellowship Chair Charles Golden Ph.D., has approved the following individuals for Fellowship status, effective January 1, 2006:

### Initial Fellows:

Gary Groth-Marnat, Ph.D.  
Norman Bradley Schmidt, Ph.D.

### Fellows Who are Already Fellows in Another Division:

Frank Andrasik, Ph.D.	Mary A. Fristad, Ph.D., ABPP	John E. Lochman, Ph.D.	Richard Rogers, Ph.D., ABPP
Jacques P. Barber, Ph.D.	Ronald A. Giannetti, Ph.D.	Christopher R. Martell, Ph.D., ABPP	Kirk J. Schneider, Ph.D.
Sharon S. Brehm, Ph.D.	Michael C. Gottlieb, Ph.D., F.A.F.P.	Robert E. McGrath, Ph.D.	Wendy K. Silverman, Ph.D., ABPP
G. Leonard Burns, Ph.D.	Doug Johnson-Greene, Ph.D., ABPP	Scott S. Meit, Psy.D.	Glenn E. Snelbecker, Ph.D.
Kate B. Carey, Ph.D.	Mary Beth Kenkel, Ph.D.	Michael G. Perri, Ph.D.	Ruth Striegel-Moore, Ph.D.
Edward Carr, Ph.D.	Elizabeth Adele Klonoff, Ph.D.	Joseph G. Poirier, Ph.D., ABPP	Daniel Tranel, Ph.D.
John E. Carr, Ph.D., ABPP		Scott W. Powers, Ph.D., ABPP	Luis A. Vargas, Ph.D.
Paul F. Dell, Ph.D., ABPP		Lisa J. Rapport, Ph.D.	Karen Fraser Wyche, Ph.D.
Marie A. DiCowden, Ph.D.			
Jack W. Finney, Ph.D.			

The members of the 2005 Fellowship Committee are: Gary B. Melton, Ph.D., Lillian Comas-Diaz, Ph.D., Lauren B. Alloy, Ph.D., Alfred J. Finch, Ph.D., Gerald C. Davison, Ph.D., and Charles J. Golden, Ph.D. Chair

## Apply for Koppitz Child Psychology Fellowship

Graduate students are encouraged to apply for one of three \$20,000 Elizabeth Munsterberg Koppitz Fellowships to support graduate studies in child psychology in 2006 and 2007.

The Koppitz fellowships aid child psychology scholarship on such topics as developmental psychopathology and child-clinical, school, pediatric, developmental and educational psychology. Consideration will be given to psychological research that breaks new ground or creates significant new understandings that facilitate the development and/or functioning of children and youth.

The award includes travel costs to attend a pre-conference workshop for Koppitz graduate fellows in conjunction with APA's 2007 Annual Convention in San Francisco, California, August 16-19, and other conferences as funds allow. APF will also award \$4,000 travel stipends to runners-up.

Graduate students who have achieved doctoral candidacy are eligible to apply. Students can apply before having passed their qualifying exams, but proof of having advanced to doctoral candidacy is required before funding will be released.

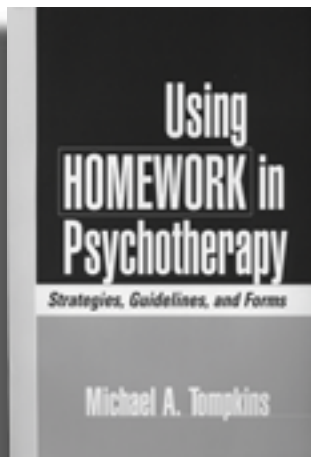
The selected fellows' institutions must provide a tuition waiver. Institutions may nominate only one applicant each year (APF will not accept nominees from separate departments or programs within the same university). Financial support will extend from September 1, 2006, to August 31, 2007. Results or progress of the research should be presented the following year at the pre-convention workshop.

Applications are due **November 15, 2005**. Recipients will be announced on or after February 15. For complete application guidelines, visit the APF website at [www.apa.org/apf/koppitz.html](http://www.apa.org/apf/koppitz.html). For more information, contact [foundation@apa.org](mailto:foundation@apa.org) or (202) 336-5843.

**Tompkins, M.A. (2004).**  
***Using homework in psychotherapy:  
Strategies, guidelines, and forms.***  
**New York: Guilford.**

ISBN: 1593850492 / US\$35.00 List

Reviewed by **Randi E. McCabe, Ph.D.,**  
McMaster University



In effective psychotherapy, much of the important work transpires between therapy sessions. The integration of therapeutic themes and concepts into the everyday life of the client is greatly facilitated by homework assignments. Although homework assignments may be used in a variety of different types of psychotherapy, it is a central component of

cognitive behavioral therapy (CBT). Despite the importance of homework as a vehicle for therapeutic change, there has been relatively little attention paid to important aspects of the homework component of therapy such as design, implementation, and managing difficulties that arise — the largest one being noncompliance. *Using Homework in Psychotherapy* by Michael Tompkins fulfills a vital need by providing a comprehensive text devoted to homework with careful attention paid to the homework “nuts and bolts” including the defining features of clinically meaningful homework assignments, tailoring homework to the client, reviewing homework, and enhancing motivation for homework completion. Tompkins also aims to provide a framework for clinicians to design homework for a range of clients and clinical problems.

The book consists of 10 chapters that are divided into two parts. In Part 1, three chapters provide a detailed description of the basic steps for designing and implementing homework, increasing homework compliance, and conducting

homework review. This section would have been strengthened had it included an initial chapter providing a detailed review of the research literature on the use of homework in psychotherapy and its importance.

In Part 2 of the book, separate chapters provide different types of homework assignments as well as strategies for overcoming noncompliance organized around five therapy targets: increasing awareness, scheduling activities, increasing emotional regulation, increasing interpersonal awareness, and testing assumptions. The organization of content around therapy targets versus disorders or therapeutic strategies makes sense given the author’s intention to appeal to a variety of psychotherapy approaches. The emotional regulation chapter was somewhat disappointing as it was quite short and seemed overly narrow in focus, covering only relaxation exercises (breathing, progressive muscle relaxation) as homework. It would have been beneficial to expand the scope of the chapter to include other homework techniques such as strategies to examine episodes of intense distress (e.g., identify specific emotions, triggers, and associated thoughts) as well as application of strategies to improve tolerance of discomfort such as problem-solving, behavioral strategies (e.g., distraction), and mindfulness.

Probably one of the most frustrating issues for therapists is managing clients who do not follow through with their homework. A full chapter is devoted to addressing obstacles in homework completion and how to overcome them, providing therapists with many useful strategies. Another important issue that is addressed with a chapter is the modifications necessary for using homework with special populations. Brief sections cover homework applications for children, adolescents, older adults, personality disorders, neurocognitive disorders (e.g., learning disabilities, developmental delays), and highly depressed or anxious clients.

Although *Using Homework in Psychotherapy* was written to appeal broadly across theoretical approaches to psychotherapy (cognitive behavioral, experiential, psychodynamic, couples, family, etc.), the strategies and guidelines provided

are essentially cognitive behavioral in nature (e.g., working collaboratively, using Socratic questioning to elicit homework ideas, providing a rationale for homework, linking homework to specific therapy goals, using worksheets to monitor homework completion) and most of the forms are designed for implementation of specific CBT techniques (e.g., activity scheduling, exposure monitoring, etc.).

***“The consideration paid to sociocultural factors is pertinent and useful.”***

Thus, this book is probably best suited for beginning therapists and CBT therapists, or therapists who wish to expand their practice to include CBT techniques. The broader coverage of homework issues may appeal to clinicians from a variety of approaches; however, it is unlikely this book would fit with the approach of a stricter psychodynamic therapist. This book would also be useful for veteran therapists who would appreciate the strategies for managing noncompliance and working with more challenging clients.

The strengths of this book are numerous. It is very well-written and provides a wealth of useful clinical strategies that are described in a clear and organized style. Numerous case examples and therapeutic dialogue throughout highlight the implementation of these clinical strategies in a way that is relevant to clinical practice and interesting for the reader. In addition, the tables in the book provide a concise summary of the guidelines presented and make for helpful teaching tools. The consideration paid to sociocultural factors is pertinent and useful. Finally, the blank forms provided in the appendices are an attractive feature for clinicians.

In summary, given the importance of homework assignments in facilitating therapeutic change and the lack of attention given to this topic, Tompkins has filled a significant gap with *Using Homework in Psychotherapy*. This book is a valuable resource for clinicians and a definite must read for beginning therapists, particularly cognitive behavioral therapists. □



### TCP Editor Signs Off

This is my last issue as editor of *The Clinical Psychologist*. Dr. William C. Sanderson will take over official duties as Editor beginning in 2006, and will continue in the position through December 2009. Effective immediately, all manuscripts, advertisements,

and other correspondence regarding this publication should be sent to Dr. Sanderson at his Hofstra University address:

William C. Sanderson, Ph.D.  
Professor of Psychology  
Hofstra University  
Hempstead, NY 11549  
Tel: 516-463-5633

E-mail: [william.c.sanderson@hofstra.edu](mailto:william.c.sanderson@hofstra.edu)  
Thank you to the Division 12 Board of Directors for their encouragement, and a special thank you to Lynn Peterson in the Division's central office for all of her help and support over the past few years. Thanks also to the members of Division 12 and others who took the time to read TCP during my tenure. Bill has some exciting changes planned for next year, and I hope you will join me in wishing him the best of luck in his new position as Editor.

Sincerely,

Martin M. Antony, Ph.D., ABPP  
Editor, *The Clinical Psychologist*



# ABBREVIATED MINUTES

Society of Clinical Psychology  
Board of Directors Meeting  
Portland, Oregon  
June 25-26, 2005

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## Minutes - February 2005 & June 2005

**MOTION:** To approve the minutes.

**ACTION:** Passed unanimously

## 2006 Meeting Year

The February 2006 meeting will be held in conjunction with the Immigration Conference in San Antonio, Texas. The meeting will be held February 3-5, 2006.

The June 2006 meeting will be held on June 10th -11th in Santa Monica, CA.

## 2006 Election Results

**President-elect:** Marsha Linehan, Ph.D.

**Treasurer:** Robert Klepac, Ph.D.

Division Representative to APA Council: Nadine Kaslow, Ph.D.

## Finance

*The Clinical Psychologist* - The number of issues will be changed from four to three issues per year until further notice (not just for one year as previously decided).

**MOTION:** The *Clinical Psychologist* will be published three times per year.

**ACTION:** Passed unanimously

As non-voting members of the Board, the editors of *The Clinical Psychologist* and *Clinical Psychology: Science and Practice* will be invited to all Board meetings. In 2006 this will be funded by Blackwell.

APA has changed the policy for Council Representatives, and will now cover airfare to the winter meeting, as well as other minor additions.

**MOTION:** To add \$2,400 to the 2005 budget to support the work of the Society.

**ACTION:** Passed unanimously

## Immigration Conference

The Division will pay all expenses for the President, President-elect, and Past-president to attend the Immigration conference.

**MOTION:** To fund a request from Section 6 for \$550 for four registrations for Section 6 Board members to attend and meet at the Immigration Conference.

**ACTION:** Not passed

Other Board members are encouraged to attend at their own expense for room, registration fee, and meals. Transportation costs will be covered by the Society, since the Board meeting is in the conference city.

## Program Committee

There will be a moment of silence for Samuel Turner, Ph.D. at the Award Ceremony at the Convention. This will be followed by the announcement of a new award in memory of him that will be given in 2006.

**MOTION:** To create the Samuel M. Turner Clinical Research Award.

**ACTION:** Passed unanimously

## Fellowship Committee

Thirty-two people who are Fellows of other divisions will be promoted to Fellow status of Division 12. In addition, two new Fellows will be elected in August at the Convention.

## Committee on Science and Practice

The EBPP Task Force has been grappling with issues that are extremely important across all areas of Psychology. Colleagues from a broad segment of Psychology are very favorably impressed with the efforts to achieve a constructive synthesis of science and practice. However, the scope and importance of the task require great care and deliberation be taken in finalizing this report.

The Board of Directors of the Society of Clinical Psychology (Division 12), at its June 25-26, 2005 meeting, voted unanimously to request that the latest version of the Policy Statement on Evidence-Based Practice in Psychology be made available for further comment and that it be voted on no earlier than the February 2006 Council of Representatives meeting. Given the amount of comment on the first version earlier this year, a similar period is needed for adequate vetting of the current Task Force document, especially if it evolves into a formal statement of APA policy.

**MOTION:** The Division 12 Council Representatives will read the above letter to Council on the EBPP Policy Statement

**ACTION:** Passed unanimously

## Publications Committee

The contract with Blackwell has been signed. The Board is





# ABBREVIATED MINUTES

## Society of Clinical Psychology (CONTINUED)

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very pleased with the contract. Dr. Craighead was thanked for his work on the Publications Committee.

Hogrefe Series - There has been good promotion of the books. The first two volumes will be sold at the APA Convention. One volume is on Bipolar Disorder and the other addresses Problem and Pathological Gambling. So far the series has 10 contracts. There will be 20 books in the series. The books will include the statement: Developed and edited in consultation with the Society of Clinical Psychology (APA Division 12)

The Board agreed to this statement by consensus. Dr. Wedding was thanked for his work on this series.

### Education and Training Committee

There has been a great deal of interest in the Professional Development Institute workshop on Psychological Services for Warriors During Combat and Combat-related Missions.

### Task Force on Diversity

The Task Force proposed the creation of a standing committee on Diversity and a Vice-president for Diversity. The Vice-president for Diversity would be a position elected by the Division membership.

**MOTION:** To establish a standing committee of Division 12 on Diversity.

**ACTION:** Passed unanimously

**MOTION:** To create a voting Member-at-large position on the Division 12 Board of Directors. This position will serve as chair of the Diversity Committee and

will be elected by the Division membership.

**ACTION:** Passed

This will result in two By-laws changes: 1. To establish the committee; and 2. the second to create the Member-at-large position.

Public Policy Workgroup - Dr. Donna Rasin-Waters has organized a media-training workshop at the APA convention. Information about the workshop is on the Section website. The purpose of the workshop is to train psychologist to represent their research to the public. It is important for research psychologists to get their findings out to the media

### Accreditation

APA has proposed to stop accreditations of programs in Canada. They have been accrediting programs there for about 30 years. Some programs in Canada are now both APA and CPA accredited and some are just CPA accredited, but none are just APA accredited. CPA would like reciprocity, but APA has been resistant.

**MOTION:** To ask the Committee on Accreditation to take reciprocity with Canada into account as they are revising the accreditation process.

**ACTION:** Passed unanimously

The Committee on Accreditation has also proposed creating three separate panels to accredit Clinical Psychology programs based on the model of the program. The panels are as follows: 1) Practitioner-scholar, 2) Scientist-practitioner, and, 3) Clinical scientist.

**MOTION:** The Division 12 Board is opposed to the Committee on Accreditation creating three separate panels to accredit Clinical Psychology programs.

**ACTION:** Passed unanimously

## Vote for Division 12!

APA mailed out Apportionment  
Ballots on October 15. Be sure  
to assign all your votes to Division 12!

## New Division 12 Award Samuel M. Turner Clinical Research Award

Beginning in 2006, the Samuel M. Turner Clinical Research Award will be given each year to honor a psychologist who has made distinguished contributions in applied clinical research. The deadline for the award is October of each year. Look for the Call for Nominations in the first 2006 issue of *The Clinical Psychologist*.

## American Psychological Foundation Gold Medal Awards

The American Psychological Foundation (APF) invites nominations for the APF 2006 Gold Medal awards. The awards include a medal, \$2,000 (to be donated by APF to the charitable institution of the winner's choice), and an all-expense-paid trip for the award winner and one guest to the 2006 APA convention in New Orleans, LA, for two nights and three days. (Coach round-trip airfare, and reasonable expenses for accommodations, and meals for two individuals will be reimbursed.) The Gold Medal awards recognize life achievement in and enduring contributions to psychology. Eligibility is limited to psychologists 65 years or older residing in North America. Awards are conferred in four categories:

- Gold Medal Award for Life Achievement in the Science of Psychology recognizes a distinguished career and enduring contribution to advancing psychological science.
- Gold Medal Award for Life Achievement in the Application of Psychology recognizes a distinguished career and enduring contribution to advancing the application of psychology through methods, research, and/or application of psychological techniques to important practical problems.
- Gold Medal Award for Enduring Contribution by a Psychologist in the Public Interest recognizes a distinguished career and enduring contribution to the application of psychology in the public interest.
- Gold Medal Award for Life Achievement in the Practice of Psychology recognizes a distinguished career and enduring contribution to advancing the professional practice of psychology through a demonstrable effect on patterns of service delivery in the profession.

Nomination Process: Gold medal award nominations should indicate the specific award for which the individual is nominated and should include a nomination statement that traces the nominee's cumulative record of enduring contribution to the purpose of the award, as well as the nominee's current vita and bibliography. Letters in support of the nomination are also welcome. All nomination materials should be coordinated and collected by the chief nominator and forwarded together in one package. (Note: There is no nomination form.)

The deadline for receipt of complete nomination materials is **December 1, 2005**; complete nomination packets may be emailed to [foundation@apa.org](mailto:foundation@apa.org) or mailed to the Gold Medal Awards Coordinator, American Psychological Foundation, 750 First Street, NE, Washington, DC 20002-4242.

## UNIVERSITY OF OTTAWA: Psychology

<http://www.socialsciences.uottawa.ca/psy/>

Subject to budgetary approval, the School of Psychology of the University of Ottawa and the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO anticipate filling one tenure-track position effective July 1, 2006. We welcome applications from excellent researchers in child or adolescent clinical psychology with an emphasis on mental health in this population. Applicants should meet the following minimum requirements: Doctorate in Psychology and strong research potential. Preference will be given to applicants who are fluent in both English and French. The salary is competitive and adjusted as a function of experience. Start-up funds are also available. Applications should be received before November 15, 2005. However, we will continue to accept applications until the position is filled. Please submit a letter of application, curriculum vitae, three letters of reference, and reprints of two recent publications in refereed journals or other visible evidence of scholarly publication to: Dr. Claude Messier ([cmessier@uottawa.ca](mailto:cmessier@uottawa.ca)), Assistant Director, School of Psychology, Lamoureux Hall, University of Ottawa, P.O. Box 450, Station A, Ottawa, Ontario, Canada, K1N 6N5. In accordance with Canadian immigration requirements, this advertisement is directed in priority to Canadian citizens and permanent residents. Equity is a University policy and we strongly encourage applications from women.

## *The Clinical Psychologist*

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**To subscribe contact:**  
Lynn Peterson, Administrative Officer  
Division 12 Central Office  
P.O. Box 1082, Niwot,  
CO 80544-1082, USA  
Tel: 303-652-3126 Fax: 303-652-2723  
E-mail: [div12apa@comcast.net](mailto:div12apa@comcast.net)

## INSTRUCTIONS FOR ADVERTISING

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

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

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

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


### **Submission deadlines for advertising and announcements:**

February 1<sup>st</sup> (Winter/Spring Issue – mails in early April)  
May 1<sup>st</sup> (Summer Issue – mails in early July)  
September 1<sup>st</sup> (Fall Issue – mails in early November);

### **Editor (2006 – 2009):**

William C. Sanderson, Ph.D.  
Department of Psychology  
Hofstra University  
Hauser Hall  
Hempstead, NY 11549 USA  
Tel: 516-463-5633  
E-Mail: [william.c.sanderson@hofstra.edu](mailto:william.c.sanderson@hofstra.edu)

## Instructions to Authors

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

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

Inquiries may be sent to the editor:  
William C. Sanderson, Ph.D.  
Department of Psychology, Hofstra University  
Hauser Hall, Hempstead, NY 11549 USA  
Tel: 516-463-5633  
E-Mail: [william.c.sanderson@hofstra.edu](mailto:william.c.sanderson@hofstra.edu)

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

## THE CLINICAL PSYCHOLOGIST

Division of Clinical Psychology  
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