

# THE CLINICAL PSYCHOLOGIST



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

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Gerald C. Davison, PhD

## PRESIDENT'S COLUMN

**An Invitation to Auseinandersetzen about the Evidence-Based Practices in Psychology Task Force Report**  
Gerald C. Davison, PhD

At its August 2005 meeting, the Council of Representatives unanimously adopted an APA policy based on the report from Ron Levant's Presidential Task Force on Evidence-Based Practice in Psychology (EBPP). This report has for months been available online at [www.apa.org/practice/ebpreport.pdf](http://www.apa.org/practice/ebpreport.pdf). I regard Council's action and especially the report as important an achievement of

our national organization as anything in my memory since joining APA in 1965 right out of graduate school.

Like any action or product by an organization as large and as diverse as APA -- or like any product issuing from human effort -- the task force report on EBPP is not perfect. But to my mind, considering the enormous complexity of the issues of empirically based practices and the mind-boggling heterogeneity among the membership of APA, it is as good a statement as can be expected on a matter that goes to the heart of psychology as a science and profession. And the report is particularly relevant for our Society of Clinical Psychology. If you have not yet read it, I urge you to do so sooner rather than later. If you work primarily in an applied setting, it is important that you know the issues and conclusions and discuss them in-house and at other professional gatherings. And if you work primarily as a researcher and/or teacher, it is important not only that you know the report but that you initiate and maintain thoroughgoing conversations with your colleagues and especially with your students from the undergraduate through the postdoctoral level. It's a good read.

Students of my own may recall, perhaps ruefully, my frequent use of the German term "auseinandersetzen." I heard it a lot during a year of study at the University of Freiburg after I graduated from college and before I started graduate school. The German students, both in classes and in the evening over delectable southwest German wines, showed a great love for the word, perhaps even more than did faculty in what was at the time a rather more hierarchical educational system than we are accustomed to in the US. Like most long German words, auseinandersetzen (actually the construction is a bit more complicated in that it is a reflexive verb and requires a particular grammatical context) cannot easily be translated into one English word. My own understanding of the term is something like this: To engage in a thoroughgoing analysis and passionate discussion; to study a complex issue from all possible angles. But even as I write these words, they don't adequately reflect what the process is like experientially. Like the study of philosophy, it is perhaps better to do it than to talk about it. So in this the first of my three presidential columns in *The Clinical Psychologist* this year, I would like to invite

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Candidate  
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## President's Column (cont.)

you to engage in an *auseinandersetzen* exercise with me. To begin the process, I offer here a couple of my own reactions to the APA Task Force Report on Evidence-Based Practice, and in my next two columns I will discuss some additional questions and concerns about the report and related issues. Whether you agree with my opinions or not, I hope the report and the following brief comments will generate some *auseinandersetzen* activity of your own.

### What Passes for Evidence?

The report defines evidence-based practice in psychology as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.” This is based on a definition from the Institute of Medicine in 2000. I have seldom come upon as succinct a statement that is as full of promise and ingenuity as it is fraught with problems.

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Above all, there is the question of how one defines “evidence” and a term that is almost always used in conjunction with or instead of it, namely “research.” Some of the more hard-nosed members of Division 12 (which, you will recall, initiated the empirically supported thrust within APA in 1993 under the leadership of divisional president Dave Barlow) and other individuals and groups not affiliated with our division or even with APA, restrict acceptable research to such methodologies as randomized clinical trials or, for the more adventurous, Skinnerian-type single-subject designs. This is certainly a viable position. But the core meaning of the word “empirical,” a term that has always been part of the discourse of what we are now calling “evidence-based,” is “based on experience.”

***"Consider how much more nuanced things get when we enter the domain of complex interpersonal phenomena..."***

And here's where Pandora's box is opened. Whose experience are we talking about? Are reports from clinicians to be accorded the same epistemological respect

as the conclusions drawn by researchers based on a randomized clinical trial?

In collaboration with Arnold Lazarus, I have argued for over 35 years that it is a serious mistake to discount the experiences (empirically based observations) of practitioners. The critical epistemological question is what status such observations, which of course are not theory-free and which are subject to a host of well-known biases, should have in our conceptualization and designation of “evidence.” Put more generally, what kinds of information should we pay attention to? I don't believe that the EBPP report addresses this issue fully. Here is how Lazarus and I put it a while ago:

While it is proper to guard against ex cathedra statements based upon flimsy and subjective evidence, it is a serious mistake to discount the importance of clinical experience per se. There is nothing mysterious about the fact that repeated exposure to any given set of conditions makes the recipient aware of subtle cues and contingencies in that setting which elude the scrutiny of those less familiar with the situation. Clinical experience enables a therapist to recognize problems and identify trends that are usually beyond the perceptions of novices, regardless of their general expertise. It is at this

level that new ideas come to the practitioner and often constitute breakthroughs that could not be derived from animal analogues or tightly controlled investigations. Different kinds of data and differing levels of information are obtained in the laboratory and the clinic. Each is necessary, useful, and desirable (Davison & Lazarus, 1994, p. 158).

### **The Importance of Theories and Paradigms**

And this takes me to the second aspect of the APA report that I want to highlight in this communication. I have already alluded to it in reminding the reader that observations are not theory-free. Scholars far more philosophically sophisticated than I have argued for eons that people don't simply observe what is out there. Even at the basic perceptual level, we encounter the world with conceptual filters or what Thomas Kuhn called paradigms (and in fact he used perception research as a way to explain the concept of paradigms). Our perceptions of even simple inanimate phenomena are not simply experiential summaries of what stimulates the sensorium. The eye, for example, is more than a camera. Consider how much more nuanced things get when we enter the domain of complex interpersonal phenomena, which is surely how we must characterize the arena of clinical and other applied psychologists.

Let me mention just a few places where the EBPP Task Force Report glosses over the sometimes subtle role of theories or paradigms. In a section entitled “Multiple Types of Research Evidence,” the report suggests that clinicians must create “optimal combinations” of different kinds of research, their own individual personality and values, the treatment relationship, and the particularities of the patient to devise the best intervention; and that when empirical data are sparse, “clinicians use their best clinical judgment and knowledge of the best available research evidence to develop *coherent* treatment strategies”. My question is simply this: How can we define “optimal” or “coherent” outside of the boundary conditions of a theory (or on a broader scale, a paradigm)?

And to take but one other example, in the section on Patient Characteristics, Culture, and Preferences, the report states that “It is important to know the person who has the disorder in addition to knowing the disorder the person has.” Nicely put. My question: What does it mean to know a person outside of the parameters of a particular theory or paradigm? Psychological assessment methods from projective tests to behavioral observations cannot be understood

## President's Column (cont.)

outside of a particular conceptual system. It follows that any knowing of a patient is possible only within a general perspective of what makes people tick. Indeed, the very definition of a datum and the means by which one garners that datum are not theory- or paradigm-free. The report does not deal with this core epistemological issue.

In my next column I will offer some comments about the implications of the task force report for graduate education in clinical psychology.

So, colleagues and friends, in the spirit of *ausinandersetzen* perhaps you will be moved to share your reactions with fellow members of the Division. I am very eager to know how the membership of Division 12 — and I definitely include student members — weigh in on these very important issues:

1. What should pass as evidence? Of course, this is central to the concept of evidence-based practice. Can reports from clinicians ever be accorded more value than as a heuristic? Can they ever be given the same epistemological respect as the conclusions drawn by researchers based on a randomized clinical

trial or a tightly controlled single-subject design?

2. Clinicians are supposed to use their best clinical judgment and knowledge of the best available research evidence to develop coherent treatment strategies. But can we define "coherent" outside of the boundary conditions of a theory (or on a broader scale, a paradigm)? □

**Bill Sanderson has agreed to publish as many responses as space allows in the next issue of TCP. If you are interested in having your response included, email a paragraph of no more than 200 words per question to [William.C.Sanderson@Hofstra.edu](mailto:William.C.Sanderson@Hofstra.edu). Early replies will be given preference and the deadline is 4/30/06.**


### Reference

Davison, G. C. & Lazarus, A. A. (1994). Clinical innovation and evaluation: Integrating practice with inquiry. *Clinical Psychology: Science and Practice*, 1, 157-168

## New Editor Signs On



**William C. Sanderson, PhD**  
*Editor, The Clinical Psychologist*

 Hello Division 12 Members. This is the first issue of *The Clinical Psychologist* published under my editorship. Let me take a moment to introduce myself. During the past 17 years of my professional career I have had a variety of experiences demonstrating the breadth of opportunities available in clinical psychology. I spent my first 9 years as a faculty member at a medical school (Albert Einstein College of Medicine) where I was

involved in research and training interns and residents. During the past 8 years I have worked in a University setting (first Rutgers, now Hofstra). I am currently Professor of Psychology at Hofstra University and involved with both the graduate and undergraduate programs. I also maintain a small private practice. So I believe I have some exposure to many of the issues relevant to the general membership.

I have been involved with Division 12 on and off during the past ten years, serving in various roles

(program chair, PDI chair, member of the Committee on Science and Practice). Being involved with the Division has allowed me to work with many excellent colleagues all devoted to the field of clinical psychology. I believe many of the products produced by the Division have had an impact upon the field, and thus, the works has been very rewarding.

In my role as Editor of TCP, I welcome the opportunity to be involved with Division 12 once again. Past editors have each put their own touch on TCP and it has evolved over the years. The most recent Editor, Marty Antony, should be commended for doing an outstanding job, and I appreciate his efforts to facilitate a smooth transition. In my attempt to continue in the footsteps of those before me, I have made a few changes. My overall goal is to make TCP into more of a "newsletter." So rather than having the long "journal-like" articles, I have recruited contributing section editors to provide brief updates on a variety of areas relevant to clinical psychology. You will notice these "updates" throughout this issue.

I welcome any feedback that you have, good or bad, so please do not hesitate to contact me at *William.C.Sanderson@Hofstra.Edu*. □



## 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 April 30, 2006. 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 Lauren B. Alloy, 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).



# INTERNET UPDATE

Simon A. Rego, PsyD

 In late December 1994, I found myself at a holiday party, making polite conversation with a good friend's uncle. I had just completed the first semester of my MA, and was excitedly explaining to Uncle X that I had been asked to help run a research project for the City University of New York in the Spring which, after the completion of some paperwork, would allow me to get my very own email account! I also spoke with a great deal of excitement about my first experiences on the "world wide web" - which I had been able to access via the College's computer lab. Perhaps it was the late hour, or perhaps it was the holiday punch, but Uncle X became quite annoyed, and proceeded to inform me how email and the Internet were simply a fad, and in due time, we would see them go the way of the short wave radio!

My name is Simon Rego, and I am the editor of the Internet Update section of TCP. I chose this story to open my first column in this new section of TCP to remind myself (and perhaps a few of you), how far things have progressed in such a relatively short period of time. By way of history, 1994 was the year Netscape was founded, Yahoo was created, and only about 10,000 websites were in existence. The next year (1995), when I started my work for the City University of New York, Amazon.com officially opened, EBay was founded, and about 100,000 websites were in existence.

Fast forward to today: a recent Internet article ("Digital Divisions: Clear Differences Between Broadband And Other Internet Connections, October 2005) states that 68.5 percent of American adults were accessing the Internet as of June 2005 - which is up from 63 percent one year ago and up from 56% in 2000. In addition, according to ClickZ, a JupiterWeb online magazine, 78% of users state they have accessed the Internet for doing research on products and services (which includes psychotherapy) and 31% have used the Internet to access health information. ClickZ also estimates that by 2010, 74% of all adults will be accessing

the Internet, and 98% of households with incomes of \$75,000 or more will have Internet access.

With such phenomenal growth, the web has become an increasingly complex and confusing place to visit - especially for those late to join the global party. In addition, many of us in clinical psychology don't have the time to stay on top of recent additions or advances on the web. Therefore, I intend to use this column to focus on areas in which clinical psychology and the Internet intersect. At present, I anticipate two fertile subjects: (1) identifying and reviewing useful Internet sites, and (2) providing tips and strategies for developing a presence on the web. Of course, I am also very interested in hearing from you, so if there is a site you feel warrants mention/review, an Internet tip you have to share that would benefit TCP readers, or an entirely different Internet topic you are interested in hearing about, please let me know. In keeping with the theme of this column, you can contact me via email at: [dr.rego@gmail.com](mailto:dr.rego@gmail.com) or visit my website: [www.simonrego.com](http://www.simonrego.com).

Before I go, since you all now know me, let me suggest one site that you can check to see just how easy it would be for me to get to know you: [ZabaSearch.com](http://ZabaSearch.com). Dubbed "Google on steroids" this free people search site allows users to enter anyone's name and home state, and then returns an address, phone number, and sometimes even a date of birth for the person entered. Try it on yourself and see what the world can find out about you with the click of a button! Oh, and by the way, the site does provide a way for individuals to have their information removed, but it is not easy to find (Hint: scroll to the bottom of the homepage, click on "Terms", then scroll to the bottom of that page and find the header, "How to Submit Records, Edit Records or BLOCK records FROM APPEARING IN ZABASEARCH" and click the "ZabaTools" link). □

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## Early Learning: Lessons from the First Five Years

Katherine L. Muller, Psy.D.

 Welcome to the very first edition of the “Early Career Column”! It is my pleasure to be part of this column- a timely inclusion in *The Clinical Psychologist*. My name is Katherine Muller, but you can call me Kate. At present, I am an Associate Director of Psychology Training and the director of the Cognitive Behavior Therapy Program at Montefiore Medical Center of Albert Einstein College of Medicine in Bronx, New York. I received my degree in clinical psychology from Rutgers University Graduate School of Applied and Professional Psychology in 2001. That last bit officially makes me an “early career psychologist”. With this column, I hope to provide other early career psychologists with ideas, advice, and support.

As hard as it is for me to believe, I graduated with my doctoral degree in clinical psychology almost five years ago. The evidence of those five years is in my face (“fine lines” are not so fine) and my bank account (freedom from student loans at last!), but the most important evidence of those five years is what I have learned. I’m not talking about what I’ve learned by reviewing the latest literature on exposure therapy for anxiety disorders or by cramming in every possible workshop at a major conference. I’m talking about the unique learning that happens when one is a “new psychologist”. This type of learning often includes the following: stumbling, fumbling, and, what I like to call, “acting as if”. You know, acting as if you actually know what you’re doing! This learning process has not always been fun, but it’s been necessary. A few of these lessons:

### Lesson 1 Anatomy

There are these things called toes. As you enter the career world, yours will be stepped on and you will likely step on a few. Try as they might, graduate training programs cannot completely prepare you for the huge variety of professional environments (and co-worker personalities!) that are out there. Programs almost never talk about the politics of work environments. In fact, the “warm and fuzzy” holding environments of certain training programs may result in culture shock when you arrive at your first workplace. Prepare yourself for this. Observe the existing dynamics of the site. Get to know the support staff. They are incredibly knowledgeable about the important details, like the best place to grab lunch or why Dr. H always sits on the right side of the conference table. Don’t expect lots of guidance and orientation- or an immediate invitation to join the department softball team. Do expect your co-workers to need some transi-

tion time to get to know you and include you as part of the crew. Be open and friendly, but don’t overdo it.

### Lesson 2: Math

You do not need to subscribe to every listserv that exists online. It is tempting, especially when you are juggling a new career with licensing exam studying and all of your other commitments (e.g., family, eating, sleeping, etc.). We all want to find the magic equation for acing the exam, formatting the perfect CV, or identifying the right practice billing software. However, it is incredibly time-consuming to review all of the postings, even when they are in digest form. Not to mention that most of them raise, rather than lower, your anxiety level. I did my own experiment with this and actually tracked my distress ratings before and after reading my daily dose of listserv postings. After my frantic scramble to copy and paste all the names of the articles that “Sue in NJ” suggested I use to teach an intro psych course and a subsequent episode of yelling at the screen while reviewing an online debate about managed care, I was certainly not feeling any better. Take the number of listservs you currently subscribe to (or are thinking of subscribing to) and then divide by 3. That should be about right.


### Lesson 3: Business

Graduate school in psychology is not business school. On some level we all know this, but it smacks you right in the face after the final notes of Pomp and Circumstance fade. Regardless of your particular professional track, psychology is a business. Educate yourself about the basics of finance, marketing, and networking. There are a number of good books out there for “idiots” and “dummies” that can help a lot. Find a mentor whose career track reflects what you’d like to see yourself doing and ask lots of questions. Use the goal-setting skills you perfected with clients during all those years of practica on yourself. Draft a “business plan” that includes 1-year, 5-year, and 10-year goals. Brainstorm the steps you will need to take to reach these goals and review your progress every few months. Whether your ultimate goal is to become a full professor or to grow a thriving practice, business planning can help you stay focused.

As you can see, the learning doesn’t stop when you leave school. It’s just that the classroom changes. I hope you find these lessons helpful and I wish you all the best on your journey as an early career psychologist. Please let me know how your journey is going- I welcome your comments and any suggestions you may have for other early career psychologists. If you have any ideas for topics you would like to see covered in this column, please do not hesitate to contact me at: [kmuller@montefiore.org](mailto:kmuller@montefiore.org). □

## The Three Organizations that Preceded Division 12

Donald K. Routh, PhD

 In February, 2005, I received an email from William Sanderson. He mentioned that he was taking over the editorship of *The Clinical Psychologist* as of 2006 and wanted to include a history column in the publication. In response to this request, I agreed to write a series of such columns. Sanderson thought these columns might reproduce material from earlier versions of *The Clinical Psychologist*, provide information about the early presidents of the Division, and discuss issues confronted by the Division in its earlier days. This is the first such history column.

Division 12 had its origin in the reorganization of APA in 1945, at the end of World War II, and its first newsletter (the forerunner of *The Clinical Psychologist*) appeared in 1947. Many readers may not be aware that Division 12 was not the first organization of American clinical psychologists; indeed, there were three organizations that preceded it: the American Association of Clinical Psychologists (1917-1919), the Clinical Section of the American Psychological Association (1919-1937), and the Clinical Section of the American Association of Applied Psychologists (1937-1945).

The American Association of Clinical Psychologists (AACP) was founded as a separate organization on December 28, 1917 at the meeting of the American Psychological Association at Carnegie Institute of Technology (now Carnegie Mellon University) in Pittsburgh. Its founder and President was J. E. Wallin, a man perhaps better remembered today as a special educator than as a clinical psychologist. Wallin had received his Ph.D. in psychology in 1901 from Yale but had gotten some of his clinical training from Lightner Witmer at the University of Pennsylvania and Henry Goddard at the Vineland Training School in New Jersey. Witmer is generally considered the founder of the field of clinical psychology (his Psychology Clinic at the University of Pennsylvania began in 1896), while Goddard was the founder of the first clinical psychology internship program at Vineland, in 1908.

What motivated the founding of the American Association of Clinical Psychologists? Its bylaws specified that the organization was intended to increase the morale and esprit de corps of its members, raise professional standards, and encourage research in clinical psychology. Its founder, Wallin, had become expert at administering and interpreting the relatively new Binet Scale (devised by Alfred Binet and Theodore Simon in 1905 in France and translated into English at the behest of Henry Goddard). Wallin was concerned that this procedure was being administered by school teachers untrained in psychology and by experimental psychologists with no clinical training and wished to restrict the use of such assessment measures to persons with the

proper training and experience.

Forty-eight persons were nominated as potential members of the AACP in 1917, 46 of whom agreed to join it. Among the best known of these was Leta S. Hollingworth, a professor at Teachers College, Columbia University, who served as Secretary. She was an effective advocate of the rights of women (readers will recall that women in the U.S. achieved the right to vote only in 1920) and one of the pioneers in the education of gifted children. In addition, she was the first to suggest the need for a Doctor of Psychology degree. Another well-known member was Lewis M. Terman, a professor at Stanford University and the developer of the Stanford-Binet test which had just been published in 1916.

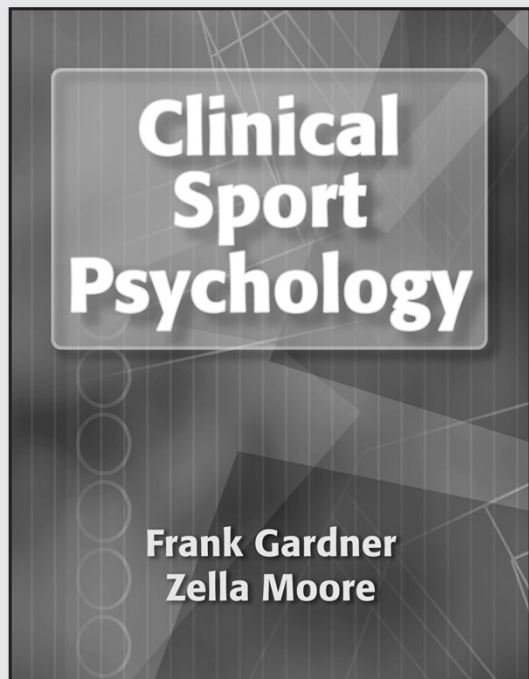
The founding of the AACP caused an uproar in the APA because many thought its creation to be a divisive influence at a time when psychology needed unity. It lasted only two years, and its only activity was to sponsor a symposium at the 1918 APA meeting. This was published in the *Journal of Applied Psychology* the next year. In 1919, Robert M. Yerkes, then President of APA negotiated an arrangement by which the AACP would be disbanded and replaced by a Clinical Section within APA. As part of the deal, APA agreed to set up a procedure for certifying qualified "consulting psychologists" and tried to do so for a time.

The Clinical Section of APA lasted from 1919 to 1937 and eventually attracted almost 300 members. Its major activity was sponsoring programs at the annual meetings of APA. Its bylaws resembled those of the AACP, with both professional and scientific goals. These were in some conflict with the explicit purposes of APA, which at the time were restricted to the promotion of psychology as a science. Eventually, this conflict was responsible for the demise of the Clinical Section, because APA restricted the Section's activities to sponsoring scientific papers at its meetings. One of the best known leaders of the APA Clinical Section was David Mitchell, a Ph.D. graduate of the University of Pennsylvania who became one of the first successful full-time practitioners of clinical psychology, in New York City.

The Clinical Section of APA disbanded itself in 1937 and transferred its assets to a new organization, the Clinical Section of the American Association of Applied Psychologists (AAAP). The AAAP grew out of the organizational activities in the 1920s and 1930s of various applied specialties in psychology including not only clinical but also areas such as organizational/industrial, educational, and guidance counseling. It generally met with APA but on occasion separately from it and emphasized professional as opposed to scientific activities. The AAAP began its own publication, known as the *Journal of Consulting Psychology*. This later became the premier journal of clinical psychology, the *Journal of Consulting and Clinical Psychology*. The best known leader of the Clinical Section of the AAAP was Carl Rogers. In conclusion, Division 12, APA, was not the first clinical psychology organization. □



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## Protective Factors against Substance Abuse in Latino Adolescents

Elvia Y. Valencia, PsyD, MHS, Center of Alcohol Studies, Rutgers University

 Latinos are not only the largest minority group in the United States today but they are also the group with the highest increase in population in the United States from 2000 to 2004 (US Census Bureau 2000, 2004). Prevalence estimates of drug use patterns of Latinos in the United States have yielded mixed results. Nonetheless, the most recent National Survey on Drug Use and Health (NSDUH) report on Latino drug use patterns (SAMHSA 2005) estimates that Latino youth report less alcohol and marijuana

***“...strong Latino values, especially familism, and parental respect might be one of the most important protective mechanism for Latino adolescents...”***

use than non-Latino youth. These prevalence estimates vary when we examine patterns of use by different Latino subgroups as well as use rates of different substances among Latinos. Whereas Cuban youth report the highest use of alcohol, Puerto Ri-

can youth report the highest use of illicit drugs (i.e., SAMHSA 2005). Furthermore, Latinos born in the United States are more likely to report use of illicit drugs than immigrant (born outside of the United States) Latinos (SAMHSA 2005).

The above finding has been well documented in the literature. Several studies have indicated that acculturation is a risk factor for Latino adolescent drug use (Glick & Moore, 1990; Mayers, et al., 1993) and higher acculturation among Latino groups has been found to lead to an increase in substance use and dependence (Amaro, et al., 1990; Burnam, et al., 1987; Vega, et al., 1993; Wagner-Echeagaray, et al., 1994; Zayas, et al., 1998). Similarly, drug use rates have been found to be positively correlated to level of acculturation and years of residence in the US among immigrant Latinos (Vega & Gil, 1998; Vega, et al., 1998). Substance use patterns of immigrants, for example, have been found to reflect those of their country of origin (Arciniega, et al., 1996; Vega, et al., 1998). Whereas, the use pat-

tern of more acculturated Latinos have been found to reflect the overall use pattern among native-born Americans (Farabee, et al., 1995). On the same vein, Khoury, and colleagues (1996) found no differences in use of substances by US born Latinos and non-Latino Whites but found that immigrant Latinos had lower prevalence rates than either group. There appears to be a clear pattern indicating that as Latino youth grow up in the United States they become more susceptible not only to substance abuse problems but also to mental health problems (Vega, et al., 1998). This leads to the notion that there is something about being a recent immigrant, which serves as protective factor for these adolescents. Much work has been devoted to identifying factors contributing to this phenomenon leading to the realization that strong Latino values, especially familism, and parental respect might be one of the most important protective mechanism for Latino adolescents (Gil, et al., 2000).

Other theories point to the difference between voluntary (immigrant) and involuntary minorities as a possible explanation for these differences (Gibson & Ogbu 1991). These authors make an excellent distinction between involuntary and voluntary minorities on different dimensions. For example, immigrant (voluntary) minorities are believed to have generally moved to their present societies because they presume that the move would lead to more economic well being, better overall opportunities or greater political freedom. Whereas those who are termed “involuntary” minorities were most likely brought into their present society through slavery, conquest, or colonization. They usually resent the loss of their former freedom and perceive the social, political, and economic barriers against them as part of their underserved oppression.

Similarly, immigrants interpret the barriers against them as temporary problems, or problems they will or can overcome with the passage of time, hard work or more education. They often compare their situation to that of their peers back home and find evidence that enables them to believe that they have more and better opportunities in their host society for themselves or for their children. They interpret their exclusion from better jobs and other positions as attributable to the fact that they are “foreigners,” or that they were educated elsewhere. Therefore they view education as a central role for getting ahead in the host society. Another factor that aids the immigrants is the nature of their social identity. They bring with them

## ***Protective Factors against Substance Abuse in Latino Adolescents (cont.)***

a sense of who they are which they had before emigration, and they seem to retain this social identity although they are learning the language and culture of the host culture. In other words, they interpret some of the cultural and language differences that they encounter as barriers to overcome in order to achieve the goals of their emigration. They, therefore, selectively learn English and other cultural features of the American mainstream without interpreting such behaviors as giving up their own culture and language (Gibson & Ogbu 1991).

Involuntary minorities on the other hand interpret the economic, social and political barriers against them differently. Because they do not have a "homeland" with which to compare their present situation – they do not interpret menial jobs and low wages as 'better' than the situation of others like them in a foreign country. Instead, they compare their status with that of the members of the dominant group and usually conclude that they are worse off than they ought to be for no other reason than they belong to a subordinate and disparaged minority group. Unlike immigrants, involuntary minorities, do not see their situation as temporary, on the contrary, they tend to interpret the discrimination against them as permanent and institutionalized. This frame of reference affects their view of education. Therefore, although they often express the wish that they could get ahead through education and ability as members of the dominant group do, but they think that they cannot. They have, therefore, come to realize or believe that it requires more than education, individual effort and hard work to overcome the barriers against them in the society's opportunity structure.

It is important in any treatment with culturally diverse populations to take into consideration

contextual and cultural factors contributing to presenting problems. This is also true in the treatment of adolescent substance abuse problems. As we have discussed, familism and parental respect are strong cultural values for Latinos and they have consistently been found to provide a protective factor for Latino adolescent substance abuse problems. Unfortunately, because the concept of familism is not always understood, counselors who are not culturally sensitive may erroneously diagnose culturally appropriate behaviors as pathological. Deficit models have prevailed in research and treatment with Latinos and other culturally diverse populations, often resulting in negative biases (Garcia Coll et al., 1998; Rogoff & Morelli, 1989). Imposing strength versus deficit perspectives to understand Latino individuals and families is an essential framework. The strength framework allows counselors and researchers to suspend preconceived thinking, often in the form of stereotypes and to consider the multidimensionality of individuals and families who are continuously evolving and moving between contexts (Santiago-Rivera, et al., 2002). In summary any treatment with Latino adolescents should include the strengthening and retention of traditional Latino values such as familism and parental respect. Preventive and treatment interventions with Latino adolescents should include fostering of a "healthy bicultural ethnic identity." In other words helping Latino adolescents realize that they do not have to choose one culture over the other but rather integrate positive aspects of both cultures. This framework would allow adolescents to "acculturate" by learning the language and decreasing the "instrumental" difficulties of adapting to a new culture without losing their traditional values. □

### ***Clinical Psychology Brochure***

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

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Hello readers! Bill asked me to introduce myself and let you know what we hope to offer through this section. I'm a Professor of Clinical Psychology in the Department of Psychiatry and Behavioral Medicine at the University of Illinois College of Medicine, Peoria. I direct medical student education here as well as a training project charged to empirically-inform pharmacotherapeutic and psychosocial practices in the state mental health system. These responsibilities have certainly immersed me in the world of medicine and of pharmacotherapy. With this column, Bill and I hope to highlight a variety of topical issues in psychopharmacotherapy relevant to the various roles and responsibilities psychologists assume including clinical, administrative, and academic. Examples of topics include psychologist-physician roles and relations, combined treatment considerations, new agents, safety issues, recent trials, and legislative efforts. We welcome your comments and suggestions at [tjbruce@uic.edu](mailto:tjbruce@uic.edu). In this first article, Peter Alahi and I highlight recently published results of the most comprehensive independent trial comparing existing agents for schizophrenia, and overuse references to the expression, "Katy, bar the door!" I hope you find it and future articles worthwhile reading. Best Regards, TJB

## Pharmacotherapy for Schizophrenia: Will CATIE Open Doors?

Timothy J. Bruce, Ph.D. and Peter Alahi, M.D.  
University of Illinois College of Medicine

 Results of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) were recently published in the *New England Journal of Medicine* (Lieberman, Stroup, McEvoy, et al., 2005). CATIE was a NIMH-funded, 57-site randomized clinical trial that compared a first-generation antipsychotic (FGA), perphenazine, to several second-generation antipsychotics (SGA) including olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), and ziprasidone (Geodon).

FGAs were introduced in the 1950s and 60s and principally targeted dopamine D2 receptors. Their ability to reduce the intensity of hallucinations and delusions was credited with opening the doors of deinstitutionalization and facilitating integrated community-based care. Unfortunately, the FGAs revealed a risk of acute extrapyramidal side effects such as pseudoparkinsonism, akathisia, and dystonia as well as tardive dyskinesia with long term use. These unwanted effects of presumptive dopaminergic dysregulation in the basal ganglia left the field wanting for better agents (Miyamoto, Duncan, Marx, et al., 2005).

In 1989, Clozapine (Clozaril) emerged as a possible improvement in the class of antipsychotics with its FDA approval for refractory schizophrenia. It demonstrated the capacity to reduce positive symptoms better than the FGAs while reducing the risk for movement disorders. Unfortunately, it was found to produce toxic side effects including agranulocytosis, a condition that can leave the patient immune compromised, vulnerable to infection, and at risk for death from uncontrolled sepsis (Wahlbeck, Cheine, Essali, et al., 1999).

Clozapine was believed to have weaker D2 antagonism and stronger antagonism at D4 and sero-

tonin 5-hydroxytryptamine<sub>2A</sub> (5HT<sub>2A</sub>) receptors. With the hope of reproducing clozapine's therapeutic benefit but without its toxicity, several pharmaceutical companies have developed SGAs, designed to have a lower affinity for D2 and greater affinity for 5HT<sub>2A</sub> among other serotonin and norepinephrine receptors. SGAs have been reported to have efficacy comparable to FGAs, less risk for movement disorders, and better efficacy with negative symptoms (e.g., blunting of affect, interest, and expression; Rosenheck, Perlick, Bingham, et al., 2003; Tollefson & Sanger, 1997). Currently, the SGAs account for the majority of antipsychotic drugs prescribed for all psychiatric uses, including schizophrenia, holding a 90 percent market share in the United States (Harrington, Gregorian, Gemmen, 2000). In addition, many best-practice guidelines, including the model medication algorithm cited in the Report of the President's New Freedom Commission on Mental Health (SAMHSA, 2003), recommend SGAs as the first-line treatment of choice for schizophrenia (Miller, Hall, Crismon, et al., 2003).

Debate surrounds the heightened status of SGAs, however. For example, although clozapine was marketed after it had shown efficacy superior to FGAs, the SGAs have been advanced after showing efficacy only comparable to FGAs and while it remains undetermined whether SGAs can perform as well as clozapine (Freedman, 2005). Although the SGA's lowered risk for movement disorders and better efficacy with negative symptoms have supported their first-line status, it remains unclear whether the SGA effect on negative symptoms is direct or indirect (e.g., antidepressant; Tollefson & Sanger, 1997). And although less prone to produce extrapyramidal effects, some SGAs may cause significant metabolic problems including weight gain, type 2 diabetes, and hypercholesterolemia (Henderson, Cagliero, Copeland, 2005). Lastly, the most widely used SGAs are not off patent yet, and consequently, are significantly more expensive than their FGA counterparts leading some to question



their relative overall value and making them potentially unaffordable to individuals without prescription benefits. With this backdrop, CATIE was designed to compare the clinical effectiveness of SGAs with an FGA. The primary outcome measure was discontinuation of treatment for any cause, which was seen as an important clinical endpoint that reflects both clinician and patient judgements about efficacy and tolerability. Additional measures included positive and negative symptoms and side effects.

Overall results of CATIE confirmed an adherence problem well known in community settings. Of the 1432 participants, 1061 (74%) discontinued treatment before the end of 18-month first phase of the study. Even the best performing medication group, olanzapine, had only 36 percent of members adherent at 18 months. Olanzapine did outperform the FGA, perphenazine, which had a 25 percent adherence rate, but the other SGA groups did not achieve this relative advantage, with adherence rates ranging from 18-24 percent.

***“Will results of CATIE open the door to questions regarding best practice recommendations?”***

ful treatment, rehospitalization rates, and the speed of symptom improvement. The caveat is that olanzapine produced significantly more metabolic side effects than other drugs, had more dropouts due to metabolic side effects, and had highest rate of dropouts due to side effects of all groups. For example, 30 percent of patients receiving olanzapine gained more than 7 percent of their body weight, compared to 7-16 percent of those receiving the other medications. Blood glucose, cholesterol, and triglyceride levels showed comparable problems. The FGA, which was chosen to reduce movement side effects, did not produce significantly more of these than did the SGAs, but it did have more participants discontinue due to movement side effects than any of the other groups.

Will results of CATIE open the door to questions regarding best practice recommendations? For example, should olanzapine be specifically recommended as the first-line treatment option? Should FGAs be elevated in treatment algorithms, in consideration of their lower costs and comparable performance to most SGAs? Should strategies to improve adherence be built in to any pharmacotherapeutic intervention for schizophrenia, and what should they be?

Olanzapine's relative advantage over other study medications was evident on other measures as well, including the duration of successful

Will CATIE open the door to an expanded or more integral role for psychology in the treatment of schizophrenia? Some of the problems evident in CATIE are behavioral or have been responsive to behavioral interventions. Examples include treatment engagement and adherence, management of diabetes, and relapse prevention. Policymakers have been calling for the improved dissemination of evidence-based practices (e.g., SAMHSA, 2003). Will those that are emerging such as family psychoeducation and assertive community treatment (Drake, Mueser, Torrey, et al., 2000) have a more receptive audience?

Time will tell if advances in psychopharmacology, psychosocial interventions, or better integration of the two will occur and improve the status of schizophrenia treatment. The need for improvement is evident in the results of this study. CATIE clearly opened the door to that fact. □

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# BOOK RECOMMENDATIONS COLUMN

Lata K. McGinn, PhD — Section Editor


Greetings. As its newly appointed section editor, I am pleased to introduce the Book Recommendation column to our readers. In contrast to traditional book reviews where the books are chosen by the editor and the reviews typically consist of a detailed critical overview of the book, the book recommendation column invites members of the division to offer books that they believe are exceptional reads, with a brief paragraph explaining the reasons for their selection. The member's name will be listed along with their recommendation. Recommended books must be relevant to clinical psychology but can include professional texts or those written for the general audience. We plan to mainly focus on relatively recent publications with the exception of classic works in the field. Please note that authors or editors may not recommend their own books. I am pleased to introduce our first column with a book recommended by Dr. Martin Seligman. I encourage the members at large and members of the board to submit their recommendations. Contributions may be sent to me via email at [Lmcginn@acom.yu.edu](mailto:Lmcginn@acom.yu.edu).

## **The Paradox of Choice: Why More is Less (2005)**

**Barry Schwartz**

**Harper Collins, NY**

**Submitted by Martin E.P. Seligman, PhD**

 There is an epidemic of depression in every wealthy nation in the world. Depression has increased by tenfold over the last fifty years and it has greened. Fifty years ago the mean age of first onset for depression was 29.5 years, now it has fallen to about age 15. Since depression recurs for about the half its victims every three years or so, this much younger onset adds up to an ocean of additional tears. This is the only order-of-magnitude change in the epidemiology of mental illness in my lifetime and no one has satisfactorily explained it. Barry Schwartz, a distinguished professor of psychology from Swarthmore College, in his provocative book "Paradox of Choice," suggests that too much choice as is found in all wealthy nations may be at the heart of modern demoralization.

Most economic theories suggest that the justi-

fication for increasing wealth increases human choice, which ultimately creates "freedom" and resulting happiness. According to Schwartz, increasing choice actually increases well being up to a certain point. Schwartz's argument, beautifully documented and gracefully written, suggests that a bewildering array of choices, beyond some small number of options, actually decreases our freedom and increases passivity and demoralization. He also argues that people who look for the very best, the Platonic ideal, in what they choose may be more prone to become depressed (maximizers) than those who are satisfied with making "good enough" choices (satisficers). So the gigantic number of choices available to our youth, and our responses to them, may be key ingredients in the epidemic of depression.

Schwartz is asking the right questions and he points us in the direction of a better understanding of the epidemic of depression in our kids. The book has one shortcoming. What do we do? How do we turn the juggernaut of more and more choice around in an economy that runs on choice?□

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## SECTION UPDATES

### Section II:

#### Clinical Geropsychology

Deborah King, Ph.D.

There is a lot happening in Section 2! 2005 President Barry Edelstein's initiative on education and training, led by Erin Emery, included a survey of graduate and internship geropsychology training offerings. Results will be used to develop standardized curriculum guidelines and training materials. Geropsychologists in Australia and Canada may join the effort.

Preparations are underway for a National Conference on Training in Professional Geropsychology, June 8-11th, 2006 in Colorado Springs. This Conference, planned by Division 12, Section 2 and Division 20, will result in aspirational educational models at all levels of training.

The Public Policy Committee, co-chaired by Donna Rasin-Waters and Peter Kanaris, continues to promote a broader understanding of psychology by posting psychologists' profiles on a national media platform.

Finally, two new committees, the Diversity Committee led by Angela Lau and the Mentorship Committee led by Amy Fiske, are hard at work. Visit our website at <http://www.geropsych.org/> for more information!

### Section III:

#### Society for a Science of Clinical Psychology

Sheila Woody, Ph.D.

SSCP aims to promote scientific principles in training, practice and public policy relevant to clinical psychology. We sponsor programming at the APA and APS annual meetings. We also present awards for outstanding student posters at APA and APS, dissertation awards, and an annual award for Distinguished Scientist Award (which recognized Richard J. McNally in 2005). SSCP supports two listserves, SSCPNet for all members and a listserve just for students. The SSCP Directory of Clinical Psychology Internships, edited by Horan and Blanchard, is available free online and describes research-based internship opportunities. Clinical Science, the SSCP newsletter, announces award winners, outlines special SSCP initiatives, and engages in commentary about issues facing our field. The most recent issue describes the controversy around public debate on the topic of prescription privileges from the perspective of two recent SSCP Presidents. For more information on current activities in SSCP, award recipients, listserves, the Clinical Science newsletter, or the *Directory of Clinical Psychology Internships*, go to the SSCP website at [www.sscpweb.org](http://www.sscpweb.org).

### Section VI:

#### The Clinical Psychology of Ethnic Minorities

Anabel Bejarano, Ph.D.

Section VI had a busy and productive year under the leadership of its president, Asuncion Miteria Austria. Dr. Austria guided members with a presidential theme of "Advancing the Present, Preparing the Future: Valuing Our Strengths". In keeping with this theme, we held the first ever Section VI Presidential Awards session at the 2005 APA Convention to acknowledge distinguished psychologists of color in the areas of science, education, practice, public interest and leadership. We also developed a mentorship program for psychologists of color at all phases of training. Our incoming president for 2006, Steven James, will focus our members on increasing awareness about mixed-race issues, an area not sufficiently attended to given the changing demographics within the U.S. We encourage everyone to visit our website at <http://www.apa.org/divisions/div12/sections/section6/> to learn more about our section and consider becoming a member.

### Section VII:

#### Emergencies and Crises

Richard T. McKeon, PhD

Section VII had another active year as it endeavors to serve the needs of psychologists to respond to behavioral emergencies and crises. At APA's 2005 Annual Convention in Washington, D.C., the section sponsored a full day continuing education workshop on behavioral emergencies with adults, and will be featuring another full day continuing education program in 2006 in New Orleans entitled "Behavioral Emergencies with Adolescents: Suicide Risk, Violence Risk, Self-Harm, Victimization". The section has also expanded the resources on its website, including an informational flyer entitled "Understanding when your child may be suicidal and ways to help" as well as one entitled "Management of Mental Health Emergencies".

In 2005, the section awarded Marsha Linehan our Section VII Career Achievement Award for her many and enduring contributions to the study of suicidal and self-injurious behavior. Laura Guy received the Section VII Graduate Student Research Award for her excellent meta-analysis of the findings on predicting violence with the Hare Psychopathy Checklist.

Phil Kleespies, founder of the section, has been appointed an Associate Editor for the Association of Psychology Postdoctoral and Internship Centers (APPIC) newsletter, and has facilitated the development of a semi-annual column on behavioral emergencies.

As a result of our most recent elections, Alec Miller is now President, David Rudd is President-elect,



and Kate Comtois is Secretary.

Finally, we have an excellent program scheduled for the APA Convention in New Orleans. In addition to the previously mentioned full day conference workshop on behavioral emergencies with adolescents, we will have a symposium on "Common Risk Factors for Different Forms of Violence" with Phil Kleespies, Lanny Berman, and Dean Kilpatrick as presenters, and David Rudd as a discussant. Particularly timely will be an "Update on the FDA Warnings About Antidepressants and Suicide in Children and Adults", with Kelly Posner, of Columbia University, Chair of FDA Suicidal Classification Project. This will be an important opportunity to hear about this extremely important topic with relevance for all practicing psychologists. In addition, Alec Miller will be giving the section's Presidential Address.

### **Section VIII:**

#### **Association of Psychologists in Academic Health Centers**

##### **Danny Wedding, Ph.D.**

The big news from Section VIII is that we have changed our name from the Association of Medical School Psychologists (AMSP) to the Association of Psychologists in Academic Health Centers (APAHC). The Board unanimously agreed to change the name to make sure that it was clear that all psychologists who work in Academic Health Centers (e.g., medical schools, teaching hospitals, dental schools, schools of allied health or health professions, or schools of public health) are welcome as members of the Association.

We are also searching for a new editor for the Association's journal, the *Journal of Clinical Psychology in Medical Settings*. Founding editor Ron Rozensky will be stepping down as editor after twelve years of service. During those twelve years, the journal's stature has increased dramatically, and everyone in APAHC is proud of the high standards Ron set and maintained. Jack Carr is chairing the APAHC JCPMS Editor Search Committee; nominations can be sent directly to Jack ([jcarr@u.washington.edu](mailto:jcarr@u.washington.edu)), or to any member of the search committee (Sharon Berry, Nadine Kaslow, Jerry Leventhal, and Ron Rozensky).

The results of the most recent APAHC election have been announced. Our new officers, starting January 1, 2006, are John Linton (President Elect), Patrick Smith (Treasurer) and Lisa Opiari-Arrigan (Member at Large). Congratulations to all three new Board members.

We truly appreciate the good work of Rick Seime (Past President), Steve Tovian (Treasurer) and Carl Zimet (Member at Large), all of whom will be rotating off the Board. Jerry Leventhal will continue to serve the Association as our Past President, and Cheryl

King, our new President, will assume responsibility for leading APAHC.

APAHC will be presenting a tribute to Ivan Mensh at the New Orleans APA convention. Ivan was one of the original founders of our group, and he served as an invaluable role model and mentor for many of us trying to make our way in a medical school environment. We are also planning a national conference for 2007, although the date and venue have not yet been finalized.

### **Section IX:**

#### **Assessment**

##### **Norman Abeles, Ph.D.**

Our assessment section has had a successful year. At the APA convention Janet Matthews, PhD, our current president, organized a presidential panel titled "Training Students for Assessment of Special Populations." The graduate student presentations included papers on Training in the assessment of Traumatic Brain Injury; Training in the assessment of children with Autism Spectrum Disorders, and training in the assessment of adult learning disability/ADHD Disorders.

Section IX also presented a 2 hour symposium with presentations by David Lachar, PhD on "Evaluating test result accuracy in the assessment of students; Norman Abeles, PhD presented on "Coaching clients to take psychological and neuropsychological tests in forensic settings-an update"; Robert Archer, PhD discussed "Assessing adolescents in forensic settings, and Irving Weiner, PhD gave a presentation on "Projective assessment in forensic settings".

Two lifetime awards were presented. One was presented to David Lachar, PhD for enduring contribution to training in assessment psychology and the other was presented to Norman Abeles, PhD for enduring contribution to education in assessment psychology. Previous award winners included Charles Golden, PhD, Alan Raphael, PhD, Irving Weiner, PhD and Janet Matthews, PhD.

David Lachar, our current Treasurer is the incoming President of our section and Robert Archer, PhD is President-Elect Designate. Steve Smith, PhD is our new Treasurer-designate. Our continuing student representative is Jessica Foley who has already recruited 29 new student members to our section. Irving Weiner, PhD is spearheading a membership campaign for additional section members.


In other business Section IX collaborated on a reply to a motion by the APA Board of Professional Affairs and on an ad hoc forensic assessment committee. Several Section IX members who are ABAP (American Board of Assessment Psychology) participated in the ABAP examination process. □



From the Editor: This is a new section I have added. I will solicit articles that provide a brief focus on a range of topics. Given the evidence-based treatment efforts of Division 12, I thought an update on Principles of Change would be of interest to members. –WCS

## Principles of change in psychotherapy: Empirically based guidelines for clinical practice

Louis G. Castonguay, PhD and Larry Beutler, PhD

 As an attempt to delineate and integrate what we know about numerous variables that contribute to change in psychotherapy, the Division 12/ North American Society for Psychotherapy Research (NASPR) sponsored a Task Force on empirically based principles of change. This initiative was build on two previous Task Forces, one that focused on empirically supported treatments (Division 12, see Chambless & Ollendick, 2001) and the other addressing empirically-supported therapeutic relationship (Division 29, see Norcross, 2002). The findings of the present Task Force were recently reported in a book published by Oxford University Press (Castonguay & Beutler, 2006).

The Task Force was guided by three overarching goals. First, it was aimed at providing a challenge to false dichotomies (e.g., techniques VS relationship, treatment approaches Vs therapist effects) that frequently prevail in current discussions about what makes psychotherapy effective. We set up to meet this challenge by simultaneously reviewing (and thus reporting within one single volume) the contribution of three set of variables (i.e., participants characteristics, relationships variables, and technical factors) that have not only been shown to be related to outcome but that more than likely operate in constant interaction in clinical practice. Second, we wanted to foster the translation of research-based evidence into principles of change that could serve as helpful guidelines to clinicians without being tied to a particular jargons or theoretical models. Third, we elect to examine the

role of therapeutic variables and identify principles of change for four clusters of clinical problems frequently encounter by clinicians: dysphoric, anxiety, personality, substance use disorders.

The members of the Task included respected psychotherapy researchers (see list of Task Force members below) that were asked to work in pairs (with the exception of one work group that involved three individuals) to review the empirical evidence related to one type of therapeutic factor for one particular problem area. Efforts were also make to join together researchers who were associated with contrasting theoretical orientations (e.g., cognitive-behavioral and psychodynamic; radical behaviorism and experiential) in order to cover the literature from broad perspectives.

Reflecting the structure of the Task Force, our book is divided into four main sections (one for each problem area covered). In addition of including a chapter for each of the three specific type of therapeutic variables targeted, each section includes a chapter aimed at integrating (into a cohesive and comprehensive set clinical guidelines) the principles of change related to participant characteristic, relationship factors, and technical procedures. As a complementary effort to integrate the massive empirical literature examined, the concluding chapter of the book identified principles of change that are common to the treatment of at least to two of the clinical problems covered by the Task force, and those who appears to be unique to the treatment of one of these specific disorders. Delineated in this final chapter are 61 "Research Informed Principles" (26 common and 35 unique) that can be used to help clinicians of different theoretical orientations to plan and deliver treatments that are consistent with contemporary research findings. □

### Task Force Members

#### *Dysphoric Disorders*

Participant Factors  
Larry E. Beutler and Sidney J. Blatt

Relationship Factors  
Louis G. Castonguay and Enrico E. Jones

Treatment Factors  
William C. Follette and Leslie S. Greenberg

#### *Anxiety Disorders*

Participant Factors  
Michelle G. Newman and Paul Crits-Christoph

Relationship Factors  
William B. Stiles and Barry E. Wolfe

#### Treatment Factors

Sheila R. Woody and Thomas H. Ollendick

#### *Personality Disorders*

Participant Factors  
Héctor Fernández-Alvarez,  
John F. Clarkin, and Kenneth L. Critchfield

Relationship Factors  
Lorna Smith Benjamin and Jacques P. Barber

Treatment Factors  
Marsha M. Linehan and Gerald C. Davison

#### *Substance Use Disorders*

Participant Factors  
David A. F. Haaga and Sharon M. Hall

Relationship Factors  
Jay Lebow and Rudolf Moos

#### Treatment Factors

Barbara S. McCrady and Peter E. Nathan

### References

- Castonguay, L.G., & Beutler, L.E. (2006). (Eds), Principles of therapeutic change that work. New York: Oxford University Press.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685-716.

# DIVISION 12 ELECTIONS CANDIDATE STATEMENTS

Ballots will be mailed to members

## PRESIDENT ELECT

### **Linda K. Knauss, Ph.D., ABPP**

Linda K. Knauss received her doctorate in Clinical Psychology in 1981 from Temple University. She is Director of Internship Training and an Associate Professor at Widener University. She is also a state and nationally certified school psychologist and has a private practice specializing in children, adolescents and families. She holds a diplomate in Clinical Psychology and is a Fellow of the Academy of Clinical Psychology. Currently she is the Secretary of Division 12, and the APA representative from Pennsylvania. She has held many leadership positions at the regional, state, and national levels including: President of Section IV of Division 12, Clinical Psychology of Women; Mentoring Award Chair of Section IV; Chair of the APA Child and Adolescent Caucus; Executive Committee of the APA Caucus of State, Provincial, and Territorial Representatives; President of the Pennsylvania Psychological Association, Pennsylvania Psychological Foundation, and Philadelphia Society of Clinical Psychologists.

Dr. Knauss received the Pennsylvania Psychological Association Distinguished Service Award, and Ethics Educator Award as well as the Outstanding Service Award from Widener University. She has numerous publications and presentations in the area of ethics and professional issues, supervision, and the treatment of children and adolescents.

Science, practice, education, and training are all important issues to the Society of Clinical Psychologists. We must be responsive to the needs and interests of the wide variety of clinical psychologists, especially new professionals and students. Responding to the political and economic events of the time requires an aggressively proactive legislative agenda. We must continue to advocate for quality care for the public by encouraging innovative solutions to policies that adversely affect the delivery of psychological services. This includes encouraging more funding for research, providing job opportunities for new professionals, and meeting the mental health needs of children, families, and underserved populations.

It is critical that research and science provide the basis for therapeutic interventions. In addition, diversity and multicultural competence need to be an integral part of not only the work, but the thinking of clinical psychologists. As a director of training and APA site visitor for many years, I am committed to high quality clinical training. I will bring to the position

of Division 12 President professional commitment, a background of administrative leadership, and an atmosphere of collaboration. I would be honored to serve as President of the Society of Clinical Psychology.

### **Kenneth Sher, PhD**

I am Professor of Psychological Sciences at the University of Missouri-Columbia. A licensed psychologist and health service provider in Missouri, I have been actively engaged in professional and public service throughout my career. At the Federal level, I serve on the National Advisory Council on Alcohol and Alcoholism and NIAAA's Extramural Advisory Board. I have provided extensive service to several professional societies; with respect to APA, I have served on APA's Committee on Scientific Awards and as associate editor of two of its journals (*Journal of Abnormal Psychology* and *Psychological Bulletin*). Within the Division, I recently served as President of Section III – the Society for a Science of Clinical Psychology. I have published extensively in the area of the psychology of addiction and I currently hold a MERIT award to continue my research on the predictors and course of alcohol involvement, direct a combined predoctoral and postdoctoral NIH training grant, and direct the MU component of the Midwest Alcoholism Research Center.

I am interested in running for president-elect of Division 12 because I believe there are serious problems with APA and that "if you're not part of the solution, you're part of the problem." A clear indicator of APA's "problems" is that fact that many clinical psychologists of diverse orientations (and including clinicians, educators, and researchers) are not members of APA and find APA irrelevant and, in some cases, antagonistic to their professional needs. Whatever the reasons (and they are undoubtedly many), the lack of interest by many clinical psychologists in the APA overall and in the Division is a serious issue because it limits our ability to speak with a strong voice (even with the additional harmonics of dissenting minority opinions) to the larger profession, policy makers, and the public at large. We can be more effective in advancing issues of common interest with respect to service provision, education, and research if the Division were viewed as representing the diverse discipline of clinical psychology with broad support from the profession. For example, a particularly important issue concerns the future of prescribing authority for psychologists. As prescribing authority proliferates across multiple states, we need to be vigilant in insuring

## **DIVISION 12 SPONSORED CONTINUING EDUCATION WORKSHOPS**

will be offered this year in New Orleans, LA, at the Sheraton Centre Toronto Hotel,  
August 9, 2006, just prior to the APA Convention.

### **Full-day Workshops, Wednesday, August 9 7CE Credits**

**A. Second Annual Military Clinical Psychology  
Symposium: Posttraumatic  
Stress Disorder-Innovations in Research  
and Practice**

Matt Friedman, MD, LCDR Gary Hoyt,  
Ph.D., Steven Southwick, MD, Andy Morgan,  
MD, LTCOL Rick Campise, Ph.D., COL Tom  
Williams, Ph.D., Ann Rasmusson, MD, CAPT  
Morgan Sammons, Ph.D., Heidi Kraft, Ph.D.

**B. Recent Developments in MMPI-2 Interpreta-  
tion: The Restructured Clinical Scales and  
Non-K-Corrected Profile**

Yossef S. Ben-Porath, Ph.D.

**C. Treating Victims of mass Trauma and Terrorism**

Larry E. Beutler, Ph.D.

**D. Movies and Mental Illness: Using Films to  
Understand Psychopathology**

Danny Wedding, Ph.D.

**E. Surviving the Politics of Academia: How to  
Get Tenure and Promotion**

Helen D. Pratt, Ph.D.

**F. Dialectical Behavior Therapy for Borderline  
personality Disorder**

Anthony P. DuBose, Psy.D.

**G. Psychological Interventions for patients with  
heart Disease**

Judith A. Skala, RN, Ph.D., and  
Kenneth E. Freedland, Ph.D.

**H. Diagnosis and treatment of Obsessive-  
Compulsive Disorder**

Jonathan Abramowitz, Ph.D.

**I. Advances in Evidence-based Treatment for  
Bipolar Disorder**

Robert Reiser, Ph.D.

**Members \$170 full day  
Non-members \$190 full day**

**Students  
Members \$95 full day  
Non-members \$115 full day**  
*Limit of 10 Student Spaces Per Workshop*

Contact : Lynn Peterson

NOTE: CE also offered by Division 12 at specified sessions during the APA Convention.

Contact Central Office below for more information.

**INFORMATION:** Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082.

Tel. (303) 652-3126 Fax (303) 652-2723 [www.apa.org/division/div12/homepage](http://www.apa.org/division/div12/homepage)



## **DIVISION 12 ELECTIONS CANDIDATE STATEMENTS (cont.)**

that the quality of training and certification is something that all clinical psychologists can take pride in, regardless of their feelings of whether the prescribing authority is good for the profession. Another timely issue concerns the nature of what constitutes “evidence” for evidence-based practice. I believe the issue of “evidence” is important for all of our activities (practice, education, research, policy) because it gets at the heart of accountability to the diverse constituencies we serve. In deciding what constitutes “evidence” for our various activities we need to be respectful of each other’s perspectives and understand differences in the “state-of-the-art” for establishing evidence across different activities. At the same time, we need to be rigorous and intellectually honest in evaluating the effectiveness of our activities. Doing so can only make us better at what we do and help build the trust of those we serve and support our profession.

### **Danny Wedding, PhD, MPH.**

I’m a clinical psychologist trained in an APA approved program at the University of Hawaii. Following my internship at Hawaii State Hospital, I completed a post-doctoral fellowship in clinical neuropsychology and behavioral medicine at the University of Mississippi Medical Center. Following this, I spent a decade working at two medical schools, East Tennessee State University and Marshall University.

I left Marshall to spend a year as the first psychologist ever selected to participate in the Robert Wood Johnson Health Policy Fellowship Program; three months of this program were devoted to an orientation by the Institute of Medicine; the next nine months were spent working on the personal staff of Senator Tom Daschle as a health policy legislative assistant. I subsequently gave up tenure at Marshall to spend a second year on the Hill working as an APA Congressional Science Fellow on the Staff of the House Government Operations Committee.

I returned to academia in 1991 to become the Director of the Missouri Institute of Mental Health (MIMH), a mental health research, training and policy center associated with the School of Medicine at the University of Missouri – Columbia. In this position I also serve as a tenured Professor of Psychiatry. I spent my 1999 sabbatical as a Fulbright Senior Scholar teaching psychotherapy to psychiatry residents at the Chiang Mai University School of Medicine (Thailand).

I’m a Past President of the Missouri Psychological Association (MOPA) and have served as the Missouri

Representative to the APA Council of Representatives. I’m a charter member and Past President of the Association of Psychologists in Academic Health Centers (APAHC; Section VIII of the Society of Clinical Psychology), and I’m currently the Section VIII representative to Division 12. I’m a Fellow of Divisions 1 (General), 12 (Clinical), 38 (Health Psychology) and 52 (International Psychology).

Most of my professional writing has been in the areas of neuropsychology and psychotherapy. My books, many coauthored or coedited, include *Current Psychotherapies*, *Movies And Mental Illness*, *Behavior And Medicine*, *Case Studies in Psychotherapy*, *Screening for Brain Impairment*, *The Neuropsychology Handbook*, *Clinical and Behavioral Neuropsychology* and the *Handbook of International Psychology*. I’m also the current editor for *PsycCRITIQUES: Contemporary Psychology—APA Review of Books*.

I take particular pride in planning, implementing and editing the book series titled *Advances in Psychotherapy—Evidence Based Practice*. My Associate Editors for the series are Linda Sobell, Larry Beutler, Ken Freedland and David Wolfe. This series of books, published through a collaborative agreement between the Society of Clinical Psychology and Hogrefe & Huber, will include a minimum of 20 books. The series and the associated online CE program will generate at least \$10,000 for Division 12 and possibly much more.

I’m deeply committed to the Scientist/Practitioner model of training and I believe in training students to evaluate patients and shape their practice based on the best available evidence. I have been a member of Division 12 for over two decades, and I am honored to have been nominated to be President of the Society.

### **Irving B. Weiner, Ph.D., ABPP, ABAP**

I view the presidency of the Society of Clinical Psychology as an opportunity to promote the breadth and diversity that characterize Division 12. Our division is concerned with science and practice; with assessment and intervention; with psychological disorder and positive personal growth; with treatments that work and relationships that heal; with cognitive-behavioral, psychodynamic-interpersonal, and humanistic-existential perspectives; and with persons of all ages, of both genders, from all sociocultural backgrounds. It is from this breadth and diversity, together with the talents of our productive and distinguished membership, that Division 12 derives its strength and appeal.



## ***DIVISION 12 ELECTIONS CANDIDATE STATEMENTS (cont.)***

As your president, I would strive to bolster the division's broad scope and enhance its attractiveness as a professional home for all clinical psychologists, whatever their theoretical preferences and special areas of interest. Regarding my qualifications, I am a University of Michigan Ph.D. in Clinical Psychology and a lifelong academic scientist-practitioner. I am an ABPP Diplomate in clinical and in forensic psychology, a Diplomate of the American Board of Assessment Psychology, and have maintained a part-time practice in psychotherapy, psychological assessment, and forensic consultation throughout most of my career.

I have been Professor of Psychiatry and Head of the Division of Psychology at the University of Rochester Medical Center; Professor of Psychology, Department Chair, and Dean of Graduate Studies and Research at Case Western Reserve University; Professor of Psychology and Vice President for Academic Affairs at the University of Denver and at Fairleigh Dickinson University; and Professor of Psychiatry and Director of Psychological Services at the University of South Florida Psychiatry Center, where I continue currently as Affiliate Professor. The scope of my scholarship is reflected in the books I have written on psychotherapy, psychopathology, psychological assessment, clinical methods, forensic psychology, and child and adolescent development and in my serving as Editor-in-Chief of Wiley's 12-volume *Handbook of Psychology*.

I am a Division 12 Fellow, a Fellow of Divisions 5, 39, 42, and 53, and a member of Divisions 41 and 52. In Division 12, I have represented Section IX (Assessment Psychology) on the Board of Directors and served on the Fellows Committee, the Nominating Committee, and the Finance Committee. I am familiar with Division 12 operations, with the issues facing clinical psychology, and with administrative responsibility, having been a medical school division head, an internship and postdoctoral training director, a department chair, and a university graduate dean and chief academic officer.

To promote the strengths and appeal of Division 12, I would work to ensure that all of its many voices are heard. I would implement increased communication from the president's office to the membership and endeavor to meet our members' needs and interests through expanded division services. These efforts will be designed to retain the enthusiasm and participation of current division members and to foster the recruitment of new members as well. From a vibrant and involved membership will come the continued leadership role of

Division 12 in shaping education, training, research, service delivery, and public policy in clinical psychology.

### **Council Representative**

#### **Larry C. James, Ph.D., ABPP**

It is with great pleasure that I have the opportunity to run for the Division 12 Council of Representatives. I have been a member of Division 12 for many years, hold an ABPP in Clinical Psychology and I am a fellow of Division 12. I do believe that I have the experience and background to serve our division as the council representative. I have served on the APA Board of Professional Affairs, Committee on Professional Practice and also served on the Board of Directors for Division 38 as the Chair of the Clinical Practice Committee. Currently, I am the President of the American Board of Health Psychology. Over the past twenty years I have been active in the education and training of clinical psychologists. Most noticeably, I have served in many and varied leadership capacities that would benefit our division. Serving as the Chief Psychologist at the Pentagon during the 9-11 response has provided me with the leadership experiences needed to better serve our division. My position as a leader of psychologists in government and public service has allowed me to be the Chair of the Psychology Department at Walter Reed Army Medical Center and direct the mental health care for the entire prison system in Iraq. Together, my career of public and government service, background in research & training, and being at the fore front of health service delivery have qualified me to serve as the division council representative. I will work tirelessly to represent our division at council and expand the opportunities for clinical psychology.

#### **Deborah King, Ph.D.**

I am delighted and honored to be running for APA Council representing the Society of Clinical Psychology (Division 12). I have served on the Division 12 Board since 2002 as the Clinical Geropsychology (Section II) Representative. As a member of the Division's Finance and Nominations Committees, I have witnessed the fiscal challenges arising in part from declining membership in APA and its Divisions. I believe that the future of our Society depends on our ability to attract and retain a diversity of new members from the ranks of those entering the field. I also believe that we owe it to those future generations to more clearly define the 'value added' of our field, especially our expert ability to develop, conduct and evaluate psychological interventions.

## ***DIVISION 12 ELECTIONS CANDIDATE STATEMENTS (cont.)***

As Associate Professor of Psychiatry at the University of Rochester Medical Center and Director of Training of our accredited Doctoral Internship and Postdoctoral Programs, I have worked tirelessly to integrate evidence-based treatments into our training and clinical care. As the Director of a HRSA-funded Graduate Psychology Education (GPE) Program, I developed an innovative training model focused on accessible, culturally-responsive care to underserved elders in community centers, social service agencies and primary care offices. This experience impressed upon me the importance of integrated models of care delivery, as well as the urgent need for more research on the effectiveness of these interventions.

If elected as your Council Representative, I would continue to vigorously pursue the advancement of evidence-based practice and training. Having had 15 years of experience recruiting and mentoring young professionals as Training Director, I would work hard to enhance the Society's initiatives to bring in new members. I would also work within APA and beyond to restore funding for programs such as GPE that support the development of future generations of psychologists. To pursue these and other Society initiatives, I ask for your support.

### **Linda Carter Sobell, Ph.D., ABPP**

As Past-President of the Society for Clinical Psychology (Division 12), I would be honored to continue to serve the Division as its Council Representative. During my presidency, we were able to implement several important initiatives that I would like to continue to advocate

for on council. The first was to establish a sustained effort on recruitment, retention, equitable representation, and involvement of culturally diverse groups in psychology. The second was to reach out and create sustained, viable, and meaningful involvement in APA for graduate students and early career psychologists. With the Board and members' support last year, we created a Committee on Diversity and a Member-at-Large position that chairs the committee and is a voting Board member. We also established a new section, "Graduate Students and Early Career Psychologists," to increase membership in those areas. Lastly, consistent with my 30-year career, a blending of science and practice, I will advocate for the integration of science and practice and our section's goals as well as an overall strong division to represent the interests of clinical psychology now and in the future.

I am presently at Nova Southeastern University's Center for Psychological Studies as Professor and Associate Director of Clinical Training. Before that, I was at the University of Toronto and Vanderbilt University. I have long been involved in clinical training, internship programs, and supervision of clinical doctoral students. I have received several awards, including APA's Division 28 Brady/Schuster award, Harvard's Norman Zinberg Memorial Award, and the Betty Ford award from the Association for Medical Education and Research in Substance Abuse. Lastly, I was president of the Association for Advancement of Behavior Therapy, am a fellow in 4 divisions of APA, on 8 editorial boards, and have published over 250 articles/book chapters, and 6 books. □

## **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):**

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# ABBREVIATED MINUTES

## Society of Clinical Psychology Board of Directors Conference Call October 27, 2005

### Minutes – June 25-26, 2005

**MOTION:** To approve the minutes

**ACTION:** Passed unanimously

### 2006 Meeting Year Update

The February 2006 meeting will be held in conjunction with the Immigration Conference. The conference will take place on Thursday, February 2, 2006. The Board will meet February 3-5, 2006. The meeting will be held at the Holiday Inn in San Antonio, Texas. The second meeting of the Board in 2006 will be on June 10-11, 2006 at the Doubletree Suites in Santa Monica, California. The third meeting of the Board in 2006 will be by conference call in October, 2006.

### President-elect Report

Dr. Marsha Linehan has appointed Dr. Alec Miller at Montefiore Medical Center/Albert Einstein College of Medicine as the Program Chair for 2007.

### Treasurer's Report

An issue was raised of how to handle financial requests throughout the year. The Finance Committee has added a new line item to the budget for requests for external events. In the 2006 budget \$2,000 has been allocated. The recommendation of the Finance Committee is to limit the amount of money per request up to \$500. However, the Multicultural Summit, which is a bi-annual event will be a separate line item. If unexpected financial requests come up during the year that exceed the \$2,000 in the budget, these requests would have to be considered by the Board to spend more than the \$2,000 already in the budget.

Financial requests will also be considered three times during the year, one month before each Board meeting. In this way, all of the requests during a particular time period can be considered rather than funding the requests in the order they are received. Due dates for financial requests will be January 1, May 1, and September 1 each year. One third of the funds can be used during each period. In this way, the Board will know what to expect and when to expect requests in order to make pro-active decisions.

A request was made by Section II, Geropsychology for funding for a National Training Conference on Geropsychology that is being developed jointly by Division 12/Section II and Division 20. The conference is expected to cost \$60,000 to \$70,000. Funds to support the conference are being solicited from a variety of organizations including other APA Divisions. Grants are also being sought. Board members indicated that Geropsychology is very important.

**MOTION:** To allocate \$500 for the National Training Conference on Geropsychology.

**ACTION:** Passed unanimously.

### 2006 Budget

A discussion of the 2006 budget resulted in the following motions:

**MOTION:** Raise the stipend of the editor of TCP to \$4,000.

**ACTION:** Passed unanimously

**MOTION:** To increase Section allocations from \$400 to \$500.

**ACTION:** Passed unanimously.

This will change the total allocation for Sections from \$3,200 to \$4,000.

**MOTION:** To approve the budget as amended.

**ACTION:** Passed unanimously

### Awards

A discussion was held on whether award winners should give talks at the APA Convention. In 2005, all of these presentations had 20 or less attendees. One option would be to have a longer awards ceremony and give award winners the opportunity to speak briefly at the awards ceremony. In this way the Division would gain five hours of program time at the convention.

**MOTION:** To dispense with award winner presentations at the APA Convention and have a longer awards ceremony.

**ACTION:** Passed unanimously

### The Clinical Psychologist

Dr. Gerald Davison will be writing a new type of column as President. His column will be about the Evidence Based Task Force Report and he will invite responses from readers in an effort to make the newsletter more interactive.

### Hogrefe and Huber

The book series currently has 12 books planned. A brochure will be sent to members soon. Hogrefe and Huber will have a booth at the AABT Conference. Negotiations are in process for CE for the book series.

### Finance Committee

**MOTION:** to allocate funding for Dr. Robert Klepac to go to Colorado for one day to review the Blackwell contract.

**ACTION:** Passed unanimously

### Education and Training Committee

The committee has been very active and will give a comprehensive report in February 2006. The focus has been on student financial issues. A program is being considered to inform students of the amount of potential debt that is involved in graduate education. The committee will also be asked to address the Accreditation Summit Report at the next Board meeting.

### Section Membership

The Division By-laws state that 50% of Section members must be fellows or members of the Division (not student members). The Sections need to let Lynn Peterson know if new Section members are Division 12 members. She does not verify Division 12 membership. This will be discussed further at the Board meeting in February, 2006.

Respectfully submitted,

Linda Knauss, Ph.D., Secretary

## Instructions to Authors



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

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

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

## THE CLINICAL PSYCHOLOGIST

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