

THE CLINICAL PSYCHOLOGIST



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

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**John C. Norcross,
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PRESIDENT'S COLUMN

A Place for All of Us: The Society of Clinical Psychology

John C. Norcross, Ph.D., ABPP



Since its establishment, APA's Division 12 has evidenced a noble tradition of examining its own members and purposes.

E. Lowell Kelly initiated this tradition in 1960 with a seminal study of the entire membership of the APA Division of Clinical Psychology. He mailed a questionnaire to the 2,372 members of Division 12, receiving 1,024 responses, one-sixth of them from women. Kelly's 1960 findings revealed that clinical psychologists were most frequently employed in medical settings where they performed diagnosis, psychotherapy, and administration, primarily with adult patients. His results also demonstrated a decisive shift from diagnostic testing to psychotherapy and the popularity of eclecticism in the late 1950s.

Kelly's aims of discovering Who are we?, Where do we work?, What do we do?, What theories do we embrace?, and What do we think about clinical psychology?, launched a series of similar appraisals over the past 50 years. His study was replicated on the Division 12 membership in 1973 by Garfield and Kurtz, and since 1981, in a series of periodic studies conducted by colleagues and myself. These collective studies have been instrumental in documenting the transformation of the profession, for example, in charting the emergence of cognitive and systems orientations, the steady expansion of independent practice, and the continuation of high career satisfaction. Much of what passes for "common knowledge" and "obvious trends" in clinical psychology was originally identified in these studies.

Conducting these studies over the past three decades enable me to track the pulse of the Division 12 membership as well as inform my presidential initiatives for 2009. In this, my first president's column, I shall elaborate on my dual priorities and offer representative findings from our most recent study of the Division 12 membership (Norcross, Karpiak, & Santoro, 2005).

Toward (More) Inclusiveness

The Society of Clinical Psychology should be an inclusive and welcoming place for clinical psychologists of all theoretical orientations, practice settings, and demographic characteristics. Division 12 is already inclusive in many respects, but we must appreciate it and

(continued on page 2)

President's Column (*continued*)

cultivate it further.

We are theoretically pluralistic, as seen in Figure 1, which summarizes the prevalence of theoretical orientations from 1960 to 2005. Eclecticism/integration (29% of us) remains the modal orientation, with cognitive therapy a close second (28%). Next most popular are psychodynamic at 15% and behavioral at 10%. We are short on adherents of the humanistic orientation,

with only 1% endorsement among the Division 12 membership. Fully 16 theories are represented in the "other" category.

In addition, Division 12 clinical psychologists are employed in every conceivable work setting. Figure 2 displays these historical trends in primary employment settings. In 2005, private practice was the most common employment setting, accounting for 39% of

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the membership. The next most frequent sites were universities (18%), medical schools (8%), and various hospitals and clinics, each averaging about 4% of the membership. Another 15% of psychologists selected "other" as their primary employment setting. Of those Division 12 members not employed full-time in independent practice, 51% provide some clinical services in the private sector on a part-time basis.

The percentage of women in Division 12 has been continually increasing since 1960, from 16% up to the present figure of 36%. By contrast, the percentage of racial/ethnic minorities in Division 12 has slowly climbed; it was only 8% in 2007.

In 2009, we shall implement in the Society plans to (1) enhance its diversity, (2) increase membership, and (3) recruit proponents of all theoretical orientations. Division 12 should be a natural and valued home for a remarkably diverse cadre of clinical psychologists.

Toward Integration

My second presidential initiative is to promote integration, not only between research and practice but also among disparate theoretical orientations. President-elect Marvin Goldfried will carry on the integrative thrust in 2010. Our studies of Division 12 members repeatedly remind us that the modal orientation is integrative and that most of us are engaged in both practice and scholarship.

I intend to make Division 12 a more interpersonally inviting and collaborative organization. I will try to mend fences between the practice and research communities. This initiative continues past-president Irving Weiner's movement toward a more inclusive and ecumenical home for clinical psychologists. Moreover, this initiative converges with our official position (approved

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Figure 1.
Theoretical
Orientations of
Division 12
Psychologists
over the past
45 years

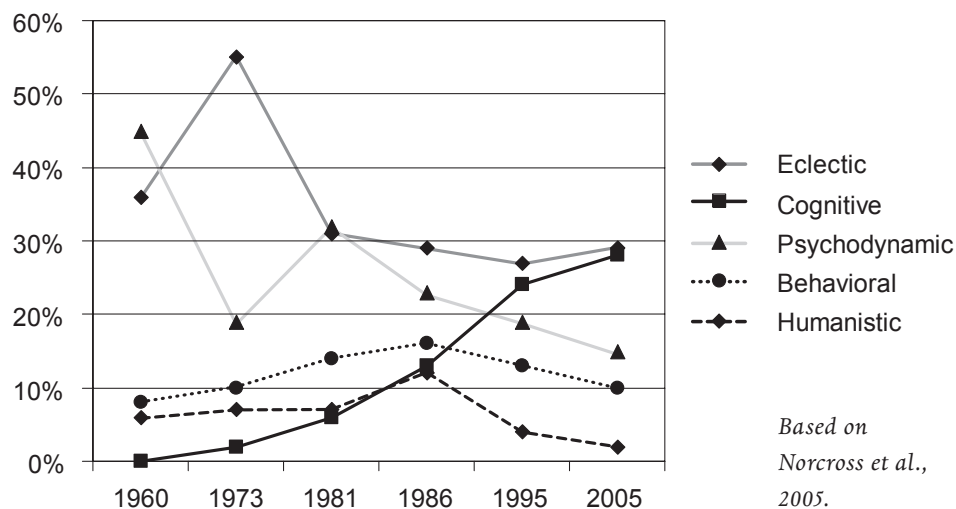
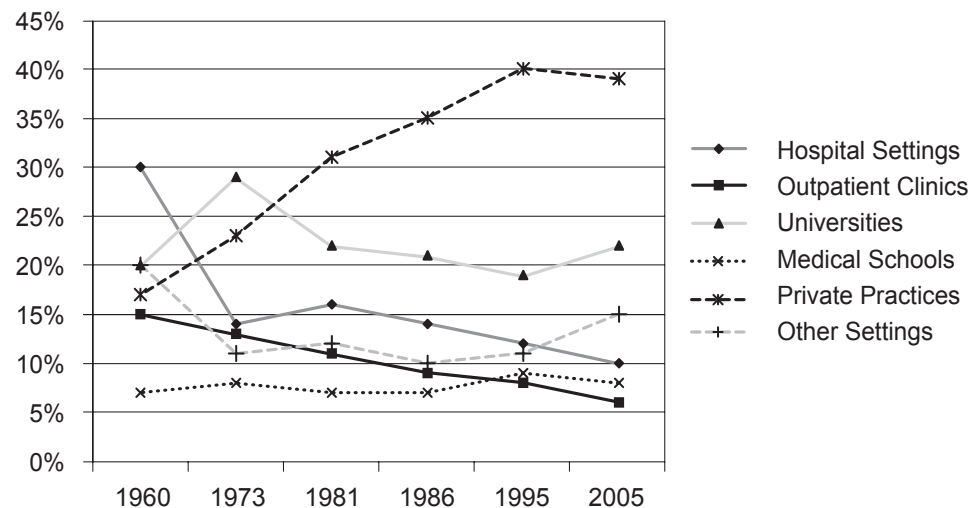



Figure 2.
Primary
Employment
Settings of
Division 12
Psychologists



Online Mental Health: E-therapy

Simon A. Rego, PsyD

 According to the website Metanoia (www.metanoia.org), which includes a section called “E-Therapy: History and Survey”, one of the first demonstrations of the power of the Internet took place during an International Conference on Computer Communications in 1972, when a psychotherapy session was simulated between computers at Stanford and UCLA. In the years that have followed this simulation, the field of e-therapy (i.e., Internet-based therapy) has seen remarkable growth: moving from peer-to-peer on-line support groups, to organized services that provided mental health advice on-line, to fee-based, pay-per-question mental health services, and finally to e-therapy, which aims to establish “longer-term, ongoing helping relationships, communicating only via the Internet”.

Given the continued advancement of Internet-based technologies (e.g., e-mail encryption, videoconferencing, real-time chat, secure web-based messaging services, web cams, etc.), coupled with the ongoing dilemma of providing mental health services to patients in remote locations, we can only expect to see an increase in the use of this modality of treatment – either as a stand-alone therapy

or as a some form of hybrid treatment (e.g., with patients splitting time between office visits and Internet-based sessions). In fact, more than 10 years ago, a nonprofit society called the International Society for Mental Health Online (ISMHO; www.ismho.org) was formed “to promote the understanding, use and development of online communication, information and technology for the international mental health community.”

While e-therapy clearly poses many potential benefits (e.g., reduce wait-lists, cut travel time, improve access), critics have pointed out that it is also not without significant potential risks (e.g., confidentiality, crisis management, legal and jurisdictional issues, etc.). In addition, research on the efficacy and effectiveness of e-therapy is still in its infancy. Interestingly, much of the currently published data on e-therapy appears to be coming from the field of cognitive behavioral therapy (CBT). In fact, a recent study (Mora, Nevid, & Chaplin, 2008) evaluating psychologists’ endorsements of four Internet-based treatment modalities (e-mail, individual chat, group chat, and video conferencing) as either adjunctive or alternative forms of treatment based on a hypothetical case found that cognitive-behaviorally-oriented practitioners more strongly endorsed the use of Internet-based interventions

Internet Column continued on page 5


President’s Column (continued)

unanimously on 6/10/2008) that “The Board commits itself and the Society of Clinical Psychology to collaborate with other organizations containing large numbers of practicing psychologists.”

In 2009, I plan the following Division 12 activities in concert with APA, its practice divisions, and other organizations:


- convening a task force with APA Division 29 (Psychotherapy) on evidence-based psychotherapy relationships
- holding the Winter 2009 Board meeting at APA headquarters in Washington, DC
- cosponsoring the Division 12 Social Hour at the 2009 APA convention with the National Register of Health Service Providers in Psychology
- attending APA directorate functions as a representative of Division 12

- publishing a research study (with Dr. David Klonsky) on the science-practice gap from both sides of the gap – scientists (Division 12 members) and practitioners (former presidents of Division 42) – simultaneously in *The Clinical Psychologist* and *The Independent Practitioner*
- collaborating with APA Division 45 (Society for the Psychological Study of Ethnic Minority Issues) to offer the first three hours of the evidence-based track in James Bray’s Convention Within a Convention at the 2009 APA convention in Toronto

The Society of Clinical Psychology should be a place for all of us – a fully inclusive, integrative, and inviting organization. As is frequently the case, the empirical data have shown us the way. I thank you and the Division 12 governance, in advance, for helping to actualize these goals. 

Psychology in a “Disordered” Economy

Katherine L. Muller, PsyD

 Before sitting down to write this column, I got word that our yearly departmental allowance for conferences was dramatically reduced. Last week, a few of our psychology interns decided to submit CVs for jobs in geographic regions that they would not have initially considered. I’ve been receiving an average of two e-mails a day asking about possible openings for post-docs or jobs at our site (in the past, we’d get maybe two per month). Amidst news of Wall Street lows and housing market slumps, we hear about a decrease in available internship and postdoctoral fellowship slots due to funding cuts. These, my fellow early career psychologists, are the signs of the times.

The American Psychological Association’s recent survey of Americans found that “money” and “the economy” are at the top of the list of stressors for 80% of us (Monitor on Psychology, December 2008). While we listen to clients and help them cope with these stressors, many of us can empathize all too well. What’s a psychologist to do in this economic environment? I did a bit of research, surveyed

psychologist colleagues, and threw in my own two cents to come up with a “career stimulus package” that may be of some assistance.

The Good News

Let’s start with the bright side of this dark economy. Reports in the media from financial and career experts continue to suggest that healthcare, including mental health care, is a secure field to be in (Yahoo! HotJobs, Jobfox.com). Some reports even view the mental health service sector as a growth area, with particular need in geriatric psychology and services for an aging population. Education is also ranked high on the list of “recession-proof” careers. Faculty positions in higher education seem to be particularly secure.

Finding Your Position

Let’s face it: finding a job in a difficult economy is incredibly anxiety-provoking. There are some strategies you can use, however, to maximize your chances of finding a position. Just as a tough economy ups the ante for finding a job, your job hunt may also have to be “kicked up a notch”.

In a climate with few posted job announcements, “cold” calls and introduction e-mails are de rigueur. My colleagues emphasized the need to tai-


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Internet Column (continued)

than psychoanalytically-oriented practitioners.

Examples of current areas of research include the treatment of social phobia over the internet (e.g., Titov, Andrews, & Schwencke, 2008) using a clinician-assisted computerized CBT program (six online lessons, cognitive behavioral homework assignments, email contact with a therapist, and participation in an online discussion forum). Here, researchers have found that the procedure is very acceptable to participants and that the results compared favorably with outcomes reported in benchmarking studies from high-quality face-to-face treatment programs for social phobia. Researchers have also studied a school-based, CBT internet program for depression in adolescents (e.g., O’Kearney, Kang, Gibson, Christensen, & Griffiths, 2007) and an Internet-based CBT program for subthresh-

old depression in people over 50 years (Spek, Cuijpers, Nyklicek, Smits, Riper, Keyzer, & Pop, 2008) – both of which yielded promising results (although the evidence for the long-term results was inconsistent in the study on adolescents). Finally, Greist (2008) discusses a “paradigm-shifting approach that closes the gap to cost-effective real-world delivery of an effective cognitive-behavioral therapy (CBT) program for substance dependence” that he calls computer-based training for cognitive-behavioral therapy or “CBT4CBT”.

Are we really on the verge of a paradigm shift? If so, what does this mean for your practice? Is e-therapy only compatible with CBT? Can e-therapy be regulated? Only time will tell. In the meantime, feel free to send me your comments at: dr.rego@gmail.com. 

lor these cover letters and e-mails to the potential job sites. Don't send a "blast" e-mail to twenty sites with a boilerplate letter. Read up on the site and tell them what programs you'd be "an excellent fit" for. Explain what you can bring to their site that they don't have now. If you have a contact at a site, ask them to make the introduction for you and then send your materials. This increases the likelihood that your CV will be reviewed.

Every person I surveyed and each career website I perused offered this piece of advice: Network, network, network. Review the connections you have and reach out to them. Contact former employers, supervisors, and co-workers to see if they may know of unpublicized openings. One of our former interns got her current faculty position with us this way—she sent an e-mail to us just as a position opened.

Now is the time to go beyond the call of duty.

Join a psychology listserv or bulletin board online (e.g., APA's "Newpsychlist" is tailor-made for early career psychologists; go to www.apa.org). If you are not part of a professional association, join now. Local and regional associations are particularly useful for region-specific position listings.

Keeping Your Position

That old adage about "making yourself indispensable" still applies, even more so in a tough economy. Now is the time to go beyond the call of duty. Finish projects you are currently working on and volunteer for new ones. You may also consider initiating projects based on needs you identify in your workplace. For example, our clinic had to meet certain monthly and annual paperwork deadlines and this had been an area of concern for a long time. I created a tracking form for this paperwork and shared it with all of the staff and trainees, making sure they knew that it was my initiative. Think about the things that have been a source of complaint in your workplace and see if you can be the one to rectify them. You'll be remembered for it.

Think about the specialized skills you bring to the table in your workplace. Make sure that others know that you have these skills (e.g., teaching a course, offering a "brown bag" lunch to talk about your area of interest). If you need to boost your skills, consider taking a workshop or continuing education

course. If your employer, like many, offers Grand Rounds, faculty development programs, or other on-site training, make it a point to go. Not only will you gain new skills, but you will also be seen and strengthen your "in-house" professional network.

There is job security in being a team player. A good attitude is especially important during tough times. If you are going to vent about the workplace, choose your audience carefully. Show your employer how much you like your work. See if you can position yourself to be a morale-booster during this economic crunch. One colleague described organizing weekly "non-business" lunches where clinicians got together to talk about life outside of the workplace and just relax a bit. This engendered lots of positive regard for the organizer.

Supplementing Your Position

Whether you are in a job that is financially stagnant due to the economy (e.g., no raises or bonuses this year, cuts in benefits and reimbursement) or you are still searching for your ideal position (or any position, for that matter), there are some things that you can do to boost your income and build experiences that result in new connections and opportunities. Consider engaging in some form of private practice. This could follow the more traditional model of part-time practice on your own, or becoming an independent contractor for an existing practice. Some employers, especially those in medical or academic settings, allow for part-time faculty practice using your "day job" office space.


Consulting work can be a good choice in a tough economy. You may be able to provide consultation to organizations and other sites outside of the "psychology box". For example, many primary care clinics are now employing part-time psychologists for assessment and brief interventions. Now may also be the time to call local colleges to see if they need adjunct course instructors. These types of positions not only provide some income, but also expand your professional network and CV content for future career endeavors.

Many thanks to my psychologist colleagues for their excellent suggestions and thoughtful advice: Dr. Sharon Spitzer, Dr. Alec Miller, Dr. Kore Nissenson, Dr. Ilyse DiMarco, Dr. Brenda Chabon, and Dr. Simon Rego. What are you doing to cope in this difficult economy? Send me an e-mail about your experiences: kmuller@montefiore.org. ☐

Psychology and Syndromal Diagnosis: Then and Now

Peter E. Nathan
President, 1984

Section Editor's note: Section Editor's note: Now that I have essentially completed my survey of the history of Division 12 and its forbears, I began thinking of what to do for an encore. My solution, as approved by TCP Editor Sanderson, was to ask various former presidents of the Division from a few decades ago to give their own perspectives on the organization or the field. Here is the third one:

 For most of the younger members of Division 12, diagnosis and the diagnostic process have always been part of their professional lives. Most learned the DSM operational criteria as graduate students and routinely use DSM diagnoses in their research, writing, and clinical work. Many of these Division 12 members know that fellow psychologists

were very much involved in the creation of DSM-IV and that as many or more will play important roles in DSM-V. But it hasn't always been this way.

When I received the PhD, now more than 45 years ago, psychologists did personality and intellectual assessments and planned and carried out research. A few also did some diagnosis and psychotherapy, albeit sub rosa, because their legal scope of practice at the time included neither. Since that time, of course, both the work of clinical psychologists and the legal protections for it have changed

dramatically. Every state has a psychology licensing law that describes psychologists' scope of practice, which prominently includes clinical diagnosis among many other activities at which the psychologist of 45 years ago would marvel. How one aspect of this

remarkable change in the scope of psychological practice came about, and my involvement in it, is the focus of this brief narrative.

DSM-I (1952) and DSM-II (1968) were created by small groups of senior psychiatrists based almost entirely on their own clinical experiences. Heavily influenced, respectively, by psychoanalytic and Meyerian concepts, the nomenclatures rested on little or no empirical research. Moreover, few women, members of ethnic or racial minorities, or representatives of other mental health professions than psychiatry helped create these instruments.

Dissatisfaction with what I learned in graduate school about the instruments available then for identifying and labeling psychopathology, including DSM-I, motivated my career-long interest in diagnostic decision-making. That interest was reenergized two years after I completed the PhD, when I began to work in 1964 in the Psychiatry Service at Boston City Hospital. The patients I saw presented typically with a welter of disabling, overlapping, often conflicting symptoms. In trying to develop a way to describe their behavior more systematically, I developed a symptom rating scale and undertook research on the predictive power of specific symptoms. At about the same time, Robert Spitzer, a psychiatrist at Columbia and New York State Psychiatric Institute, began his research on diagnosis that culminated in a number of articles on the coherence of symptoms around diagnoses. Spitzer's research ultimately led to a 1972 article describing the Feighner Criteria and a 1975 article detailing the Research Diagnostic Criteria; both played important roles in the development of DSM-III. My research led to a number of articles on diagnostic reliability and the power of common diagnostic criteria to predict diagnoses, published in the late 1960s and early 1970s, as well as a 1967 book, *Cues, decisions, and diagnoses*, that anticipated DSM-III's branching tree decision model.

In the mid-1970s, I was asked to serve as an APA representative to the group led by Bob Spitzer that was developing DSM-III. As most readers know, DSM-III represented a radical change designed to heighten the reliability of diagnosis. In my role as APA representative, I helped insure that the DSM process would not work against the interests of psychology: When Bob

In a career that by now spans more than 45 years, I have seen psychology develop from a passive observer of the diagnostic enterprise to an active, valued participant in the development of diagnostic theory, research, and practice.

History Column continued on page 8

Spitzer and his psychiatric colleagues considered formal definitions of mental illness for inclusion in the DSM-III manual, the phrase, "Mental disorders are a subset of medical disorders," was proposed. We vigorously opposed this statement because we believed it could be used to limit psychology's role in the diagnostic process. After some back-and-forth, the phrase was dropped.

Although psychology had some input into DSM-III, which appeared in 1980, it tended to be largely informal, based on relationships between the psychiatrist members of the groups responsible for the instrument and individual psychologists. No psychologists were members of the Task Force on Nomenclature and Statistics, the small group ultimately responsible for the instrument, although three (Jean Endicott, Rachel Gittelman, and Theodore Millon) were listed as "consultants" to the Task Force. Five psychologists served on Work Groups designed to consider operational criteria for specific groups of disorders.

In marked contrast, DSM-IV, published in 1994, involved many psychologists, both formally and informally, recognizing a dramatic increase in contributions by psychologists to both syndromal

diagnosis and the development of evidence-based treatments for such common entities as the anxiety and mood disorders. Four psychologists, David Barlow, Ellen Frank, Peter Nathan, and Tom Widiger, who also served the important role of Research Coordinator for the extensive research effort that buttressed DSM-IV, were members of the 25-person Task Force on DSM-IV. These four individuals were also members of Work Groups designed to consider revisions to the operational criteria for the anxiety disorders, the mood disorders, the personality disorders, and the substance-related disorders, respectively. Seven other psychologists were members of other Work Groups. Dozens of psychologists were advisors to the DSM-IV process.

In a career that by now spans more than 45 years, I have seen psychology develop from a passive observer of the diagnostic enterprise to an active, valued participant in the development of diagnostic theory, research, and practice. Psychologists have taken leading roles in the development of DSM-IV and will doubtless do so as well in DSM-V. More importantly, their contributions have helped advance the science of syndromal diagnosis for the benefit of society and our patients. ■■

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Psychology and Society: How Society Shapes Science and Science Shapes Society

George M. Slavich, PhD

 Recent technological advancements have profoundly influenced our understanding of psychological health. Driven by innovations in genetic mapping and functional Magnetic Resonance Imaging, for example, disorders such as major depression are becoming increasingly investigated and discussed along biological lines. The resulting scientific perspective can easily become genetically and neurally deterministic, overemphasizing the role that biology plays in causing psychological disorders and minimizing the contribution of environmental factors to psychological health status.

Biological systems are involved in the onset and clinical course of all psychological disorders, and future work at this level of analysis will surely lead to novel treatments that have the capacity to significantly reduce disability and distress. Notwithstanding this point, though, just how much has the current Zeitgeist shaped research and theory in psychology?

One answer to this question surfaced during a talk I recently attended, given by a well-known geneticist. The talk addressed the role that genes play in risk for major depression, and at the end of the talk, the geneticist revealed what he and his colleagues had found. The PowerPoint slide summarizing their work was titled “Candidate Genes in Depression,” and it was blank! The geneticist’s conclusion: After five years of research into the genetic bases of major depression, his group had found no evidence that candidate genes are associated with elevated risk for the disorder.

Overall, the talk was quite compelling, and if you were to take the conclusion at face value, then you would come away from the presentation thinking that candidate genes are not involved in risk for depression. That’s what I did. But then I realized that the models tested included only genetic factors. Environmental variables, such as exposure to life stress, were omitted, even though genetic risk for depression is known to be conditional upon environmental factors, such

as exposure to both early and recent stress (see Caspi et al., 2003). I asked the presenter about this, and he responded: “There are probably pure genetic effects, pure stress effects, and then some interactive effects.” The answer is fair, I suppose, but unsatisfying. Has the novelty of investigating the genetic bases of psychological disorders rendered all other factors uninteresting or unimportant?

Vignettes like this illustrate how societal changes may shape scientific thinking regarding disorders that we care about. And the effects of a Zeitgeist on science are never limited to only a few investigators. A recent review of research on how variation in the serotonin transporter gene interacts with stress to predict depression demonstrates this point. Specifically, it showed that while great care has generally been taken to determine participants’ genetic risk for depression (as indexed by their 5-HTTLPR status), few investigators carefully assess major life stress, even though stress constitutes half of the interaction term (see Monroe & Reid, 2008). In this case, environmental contributors to psychological health status have not been ignored entirely, but they have taken a backseat to genetic factors, which are much sexier and currently in vogue.

Society thus shapes science, but science also shapes society. Just a few years ago, for example, only geneticists could access their genetic fingerprint. Today, this information is available to anyone who is willing to pay \$399 to 23andMe, a company that uses DNA analyses to genotype and provide to customers a remarkable amount of detailed, personalized feedback. Users are told their propensity for more than 90 health conditions and inherited traits. They can also explore the geographic origins of their genes and are permitted to compare their genomes to those of family and friends who also use the service. The ability to examine your genetic makeup was impossible in 1995 and financially prohibitive in 2005. In 2009, though, the service is not only widely available, but less costly than some visits to the dentist.

As it turns out, The Human Genome Project ushered in not just a new era of scientific exploration, but also a new wave of consumer products. What began as a basic science endeavor quickly evolved into a revolution, at the center of which lies personalized genomics.

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23andMe represents only one example of how science may shape society, but it is a good example. Founded only in 2006, 23andMe's genotyping service was named TIME Magazine's 2008 Invention of the Year. Such attention shows that scientific discoveries, such as those in the fields of genomics and genetics, may profoundly influence societal discussions regarding human health. The potential implications of this are noteworthy. One wonders, for example, if promoting biological explanations over psychosocial ones will lead people to view health status as predetermined, causing them to entertain increasingly radical solutions for unwanted attributes. Will remedies that address our neurobiological and genetic makeup – such as psychiatric medications (for the “faulty brain”) and genetic engineering (for “faulty genes”) – become first-line treatments for various conditions, even when less extreme solutions are available and otherwise sensible?

Reflecting on how society shapes science is useful for budding and seasoned psychologists alike because it adds context and meaning to programs of research and bodies of work. This is particularly true in clinical psychology – a field in which disorders are

not divinely defined but socially constructed based on what society believes is “abnormal” at a given time. Sadness following a relationship break-up is major depression, but sadness following a death is not.

Science also shapes society, and reminders of this help underscore that research can affect how people navigate their lives. This includes influencing how individuals view, and elect to treat, mental health issues. The intended consequences of science are often good, but unintended consequences also exist. Working to understand both is not only the responsible thing to do, but can be quite illuminating, as it reveals the pervasive power of science. ■■

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SOCIETY OF CLINICAL PSYCHOLOGY FELLOWSHIP COMMITTEE 2008

The Society Fellowship Committee, led by Fellowship Chair Carole A. Rayburn, Ph.D., has approved the following individuals for Fellowship status, effective January 1, 2009:

Initial Fellows:

Thomas E. Brown, Ph.D. • Michael Butz, Ph.D. • Kenneth L. Lichstein, Ph.D. • Karen Schmaling, Ph.D.

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

Fellows Who are Already Fellows in Another Division:


Manuel Barrera, Jr., Ph.D. • Robert Colligan, Ph.D. • Richard H. Cox, Ph.D. • Gerald Devins, Ph.D.
Edward A. Dreyfus, Ph.D. • Gary Elkins, Ph.D., ABPP • Charles F. Emery, Ph.D. • Robert Frank, Ph.D.
Meyer D. Glantz, Ph.D. • Robin Gurwitsch, Ph.D. • Carroll W. Hughes, Ph.D. • Robert Hutzell, Ph.D.
Harriette Elizabeth King, Ph.D. • Michael J. Murphy, Ph.D., ABPP • A. Rodney Nurse, Ph.D.
Natalie Porter, Ph.D. • Lisa A. Serbin, Ph.D. • Jeffrey C. Siegel, Ph.D. • Gregory Taylor Smith, Ph.D.

The members of the 2008 Fellowship Committee are:

David Antonuccio, Ph.D., Thomas D. Borkovec, Ph.D., Gerald C. Davison, Ph.D., Alfred J. Finch, Ph.D., Adelbert Jenkins, Ph.D. and Carole A. Rayburn, Ph.D. Chair

Ethical Considerations in Discussing Medications with Clients: Part III

Timothy J. Bruce, PhD

 This column concludes our look at ethical considerations involved in discussing medications with our clients. In Part I of this series, the common roles and responsibilities that non-prescribing mental healthcare providers are routinely asked to assume regarding medication use by their clients were discussed (Bentley & Walsh, 2000). They include educating (e.g., clients and family members about medication use); consulting and collaborating (e.g., with physicians and clients); advocating and assisting (e.g., clients and family members); and monitoring and reporting (e.g., positive and negative effects of the medication on the client). It was noted that consulting, collaborating, monitoring, and reporting responsibilities ask psychologists to form relationships with prescribers, invoking Principle B of the APA Ethical Guidelines (APA, 2002) regarding Fidelity and Responsibility and Standard 3.09, Cooperation With Other Professionals.

Part II of the series discussed the possible conflict introduced when non-prescribers and prescribers have differences of opinion regarding medication use. An example was provided in which a psychologist had a client who on phenelzine sulfate (Nardil) and failing to follow the dietary restrictions. The physician, however, determined that the risk was low and that the Nardil should be continued. The question was posed, “Does this psychologist have an independent ethical duty to warn the client?” The example highlighted the relevance of ethical standards regarding competence (i.e., Standard 2.01), and suggested that unless there was clear evidence that the physician had made an erroneous risk assessment (e.g., misunderstood the severity of the client’s noncompliance), the psychologist should defer to the competence of the physician. It was also noted that documentation of professional work (Standard 6.01), particularly of these potential conflicts, is important.

This brings us to our final issue in this series: informed consent to therapy. Competency standards are obviously invoked whenever psychologists assume the responsibility of educating their clients. One educational responsibility required of psychologists derives from the

guideline to obtain informed consent to therapy: “When obtaining informed consent to therapy...psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers” (APA Ethics Code Standard 10.01A, p. 14-15). A commonly asked question of clients regards other treatment options and selection considerations, including the option of medication. Although standard 10.01A does not specifically guide psychologists to know and discuss available treatment options beyond their own, Standard 10.01b does, but within a context where the therapists is considering the use of “techniques and procedures [that] have not been established...” (brackets inserted; p.15). It states, “psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation (p. 15). But, what if the psychotherapy is “established,” and medication is an alternative option? Medical ethics standards that apply to psychiatry are clearer. They state that, “A psychiatrist shall not withhold information that the patient needs or reasonably could use to make informed treatment decisions, including options for treatment not provided by the psychiatrist” (p. 24, APA, 1998).

Perhaps the strongest push for requiring treatment alternatives to be discussed is coming not from professional organizations, but rather from the courts. Beginning in the early to mid-twentieth century, the decisional rights of patients began to emerge in legal cases against physicians. These culminated in the case of *Canterbury v. Spence* (1972), from which informed consent to medical treatment was judged to be a legal right. *Osheroff v. Chestnut Lodge* (1984) is considered by most to be the landmark case regarding informed consent and mental health treatment alternatives. In 1979, Dr. Rafael Osheroff, an internist, sought treatment for depression and anxiety at Chestnut Lodge Hospital. He received diagnoses of depression and narcissistic personality and underwent psychoanalysis, without psychotropic medication. After seven months of treatment, Dr. Osheroff’s depression remained unresolved upon which he left Chestnut Lodge Hospital and transferred to Silver Hill

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Foundation. There, he responded to treatment involving combined psychotherapy and antidepressant medication. Three years later, Dr. Osheroff sued Chestnut Lodge, alleging that it neglected to inform and provide him pharmacotherapy when it was indicated. In January 1984, the state of Maryland Health Claims Arbitration Board found Chestnut Lodge liable and awarded Dr. Osheroff \$250,000. After subsequent appeals both ways, the case was settled out of court (Malcolm, 1990).

Because *Osheroff v. Chestnut Lodge* (1984) was settled out of court, it left no legal doctrine or precedent. Litteral and Ashford (1995) note, however, that most states have now legislated requirements of informed consent for physicians, including the requirement to discuss alternative treatment options. Although there has been some debate regarding whether these statutes apply to non-prescribing healthcare professionals, some legal scholars have argued that they do (see Appelbaum, Lidz, & Meisel, 1987). More recently, Beahrs and Gutheil (2001) point to cases of liability judgments in arguing that, "Informed consent is in the process of becoming mandatory for psychotherapeutic practice..." (p. 2).

Although current ethical standards for psychologists do not specifically mention the discussion of alternative treatment options such as medications outside the context of using an unestablished therapy, the legal legacy of *Osheroff v. Chestnut Lodge* is cause for thought when psychologists are approached with this question. Recommended reading is Beahrs and Gutheil (2001) who discuss an approach that they believe accommodates relevant clinical, ethical, and legal considerations. It suggests, in part, that clients should understand options, their rationales, methods, and risks and benefits – including no treatment. Therapists who do not feel competent to convey this information recommend to the client alternatives for gaining it. Of course, the question of how we determine what is a viable or established treatment option, a debate also provoked in the context of *Osheroff v. Chestnut Lodge* (see Klerman, 1990, Stone, 1990), is relevant, topical, complex, and beyond the scope of this article.

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Donna Rasin-Waters, PhD—Section Editor

Personalize Your Own Pathway to Advocacy


Donna Rasin-Waters, PhD,
Division 12 Federal Advocacy Coordinator

 We can all thank APA for carving out several pathways to advocate at the federal level for our beloved field of psychology. I hope that each and every division member will find passion for one or more particular way to promote psychology science, practice and education this year, as it is crucial that we all become involved. We are entering a critical time for advocacy with newly elected officials we need to get to know, some well-known champions for psychology who continue to need our support, and multiple opportunities to showcase all that psychology has to offer in scientific research, education and evidenced-based practice. Some recent and exciting editions to advocacy resources are APA webinars that aim to educate psychologists and students of psychology in advocacy, as well as advocacy curriculum available online this spring through the APA Continuing Education Office. (See the recent Government Relations Update, Monitor, January 2009).

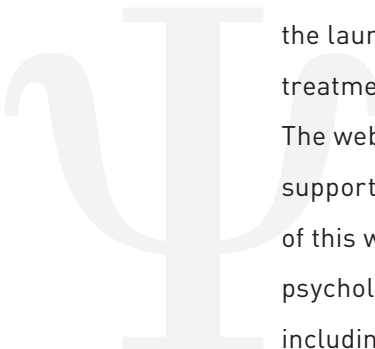
For those who may not be familiar with how federal advocacy is structured in APA, the Government

Relations Office is divided into three directorates: Education, Public Interest and Science, each with a specific agenda. The Education Directorate advocates for policy related to federal funding for psychology education and training, as well as policies related to the utilization and practical application of psychology in education and training, such as federally funded suicide prevention programs on college campuses, as one example. The Public Interest Directorate shapes and consults on federal policy related to a wide range of issues that impact human welfare such as aging, children and adolescents, and lesbian, gay, bisexual and transgender issues, to name just a few. The Science Directorate advocates and advances policy related to psychological science.

In addition, the APA Practice Organization is an affiliate of APA with the mission to promote and enable the practice of psychology through legislative and grassroots efforts for practicing psychologists and consumers.

I highly recommend perusing the many accomplishments in advocacy located on the APA website under Government Relations, educating oneself about advocacy in our field and then choosing your own pathway to action. All politics are local and everyone is needed in the fight to establish a sound position for the future of psychology. (Correspondence can be sent to drasinwaters@aol.com). 

Web Site Launch: www.PsychologicalTreatments.org

 Division 12, the Society of Clinical Psychology, is pleased to announce the launch of a new web site on research-supported psychological treatments. The address of the web site is **PsychologicalTreatments.org**. The web site is an updated, online version of the list of empirically supported treatments first published by Division 12 in 1995. The purpose of this web site is to provide information about effective treatments for psychological disorders. The web site is meant for a wide audience, including the general public, practitioners, researchers, and students.


BOOK RECOMMENDATIONS

Lata K. McGinn, PhD—Section Editor

The Biopsychosocial Formulation Manual: A guide for mental health professionals

Campbell, W. H. & Rohrbaugh, R. M. New York: Routledge (2006).

Recommended by Frank M. Dattilio, Ph.D., ABPP, Department of Psychiatry, Harvard Medical School, Boston, MA

 It has no doubt been said more than once that big gifts often come in small packages. That is clearly the case with the little paperback book on the “Biopsychosocial Model” authored by psychiatrists Campbell and Rohrbaugh. This book is a nicely designed case-formulation manual on the biopsychosocial approach, a concept first introduced in 1977 by George Engel, M.D. in the journal *Science*.

I first learned about the biopsychosocial model many years ago while reviewing a book for the *New England Journal of Medicine*, which described an entire exchange between professionals that centered on Engel’s biopsychosocial approach to medicine. George Engel’s model, heralding a new approach in the seventies, proposed the integration of psychosocial issues into medical practice. The model grew out of Engel’s belief that far too few physicians and mental health professionals aspired to an integration of bio, psycho, and social dynamics in understanding and treating patients. This concept was based on the systems theory, proposing that each system affects and is affected by other systems. The model emphasizes the biological system, which includes anatomical, structural, and molecular substrates of disease and their effects on individual’s biological functioning. The psychosocial system addresses the contributions of developmental factors, motivation, and personality to the individual’s experience of and reactions to illness. This is subsequently followed by the social system, which examines the cultural, environmental, and family influences on the individual’s expression and experiences of illness.

Although the biopsychosocial model is no longer a novel concept, its continued importance in understanding the human condition, cannot be underestimated. The authors of this manual have taken Engel’s

basic approach and compiled it into an excellent little handbook that is appropriate for both trainees and experienced clinicians in the mental health field. The authors, who are practicing and academic psychiatrists, have organized the material in a manner that is extremely efficient and useful to clinicians formulating a solid case conceptualization. The unique format ensures an appropriate emphasis on all three components delineated in Engel’s original model. The book includes sections on biological formulation, psychological formulation, social formulation, differential diagnosis, risk assessment, biopsychosocial treatment plan, and prognosis. The last section affords the reader a case study that outlines proper application of the biopsychosocial formulation model and provides guidelines on how to best implement it. The book also contains appendices that offer psychodynamic perspectives, as well as a psychodiagnostic glossary, and a manual data base. The book is also accompanied by a CD.

Campbell and Rohrbaugh’s “Biopsychosocial Model” is an excellent resource for busy clinicians who need a quick reference to help them develop case conceptualizations for the many arduous cases they encounter during the course of their daily work. It allows clinicians to make accurate assessments in a relatively brief period of time. The evidenced-based assessments provided in each section also helps assure practitioners that they are using interventions that are effective. The writing style is very easy to read and makes for an overall user-friendly manual. This is one of the few books that I find myself wishing that I had authored and should probably be mandatory reading for all interns and residents of psychology and psychiatry. ■■


The Clinical Psychologist

Past issues of
The Clinical Psychologist
are available at:

www.apa.org/divisions/div12/clinpj.html

Section II: Society of Clinical Geropsychology

Deborah A. King, Ph.D.

 Members of the Society of Clinical Geropsychology have worked diligently with Deborah DiGilio, MPH, the Director of the APA Office on Aging and members of the APA Committee on Aging to produce very important resource documents for those interested in aging and mental health. Previously, I reported on developments of Sharon Brehm's 2007 APA Presidential Task Force on Integrative Health Care for an Aging Population which was Co-Chaired by Toni Antonucci, Ph.D., and Antonette Zeiss, Ph.D. The report entitled, "Blueprint for Change: Achieving Integrated Health Care for an Aging Population," was adopted by the APA Council of Representatives and has been disseminated to aging, mental health, and consumer organizations nationwide (<http://www.apa.org/pi/aging/blueprint.html>). Check out the fact sheets developed for policymakers, graduate faculty, training directors, and older adults and their families.

The American Psychological Association (APA)/ American Bar Association (ABA) Working Group has just published and printed "Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists." It is the third in a series of handbooks, the first two of which were for lawyers (2005) and judges (2006). For more information on these and other aging initiatives, visit <http://www.apa.org/pi/aging/homepage.html>.

Also, remember to check out our website at <http://www.geropsych.org/> to join Section 2 or get more information on clinical geropsychology!

Section VII: Clinical Emergencies and Crises

Marc Hillbrand, Ph.D.

 Section VII welcomes Anthony Spirito as President, Michael Hendricks as President-Elect, Lillian Range as Secretary, Kim Van Orden as student representative, and Section founder and first Section President Phillip Kleespies as chair of the Section VII Advisory Board. Section members continue to disseminate


scientific information about violence, suicidality and victimization. Among the books authored by Section VII members are "Behavioral emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization" by Phillip Kleespies (APA Books, 2008), "Suicidal behavior and self-injury" by Richard McKeon (Hogrefe, 2008), and the upcoming "The interpersonal theory of suicide: Guidance for working with suicidal clients" by Thomas Joiner, Kim Van Orden, Tracy Witte and David Rudd (APA Books, January 2009).

Section VII has joined forces with the APA's Advisory Committee on Colleague Assistance (ACCA) to address the topics of patient-to-psychologist violence and psychologist suicide. The collaboration will be on patient-to-psychologist violence prevention as well as advice on how to prevent psychologist suicide and how to handle the aftermath of a psychologist suicide. The former relates to the homicide of New York psychologist Kathryn Faughey. The latter is a longstanding concern of the ACCA, prompted by several psychologists' suicides in recent decades. The co-chairs are Diane Bridgeman, incoming ACCA chair, and Phillip Kleespies. Committee members include Daniel Galper, Marc Hillbrand, Dean Kirkpatrick, Dale McNeil, and Robert Yuffit. The committee will develop two pamphlets for clinicians, one devoted to each topic, along with other resources that will be made available on the ACCA website.

Section VII is continuing to generate resources for clinicians on diversity issues in clinical emergencies. Upcoming documents that will be available on the Section website include a fact sheet on early psychological response to mass disaster, developed by Morgan Van Epp, a fact sheet on minorities and suicidal behavior, developed by Liliana Cordero, and a link to the updated Directory of APPIC Internship sites that offer training in behavioral emergencies (already available).

Section IX: Assessment

Norman Abeles, PhD.

 We have just completed our elections and I am pleased to announce that Virginia Brabender is our newly elected section chairperson. Dr Brabender is Professor of Psychology at Widener University where

she focuses on diagnostic assessments using the Rorschach and other measures and provides supervision and training in assessment. She is also interested in group therapy.

Our new secretary is F. Barton Evans from Bozeman, MT. He is co-author of the 2007 Handbook of Forensic Rorschach assessment and is a forensic psychologist in Bozeman. Congratulations to both and thanks to the individuals who were willing to compete in the elections.

Our newly elected President Elect of APA is Carol Goodheart and we also wish her all the best in these difficult financial times. In other news of our section members, Norman Abeles has just published a chapter on "Supervising Novice Geropsychologists" in Allen Hess (ed) book on Psychotherapy Supervision published by Wiley. In this chapter he points out the importance of assessment supervision in the training of geropsychologists as antecedent to psychotherapy and he notes that the overall purpose of assessment supervision is two fold:

1. To enhance the trainee's clinical proficiency, and
2. to ensure that the services provided are of high quality.

Those of you who are following the work that is going on regarding DSM V may be interested in the dispute concerning transparency. Apparently former editor (of DSM IV) Robert Spitzer wanted the process to be transparent while those in charge of overseeing the revisions prefer secrecy according to an opinion piece by Christopher Lane on the November 16, 2008 Los Angeles Times. Dr. Spitzer had argued that transparency would be helpful to a but others argued that these concerns about confidentiality could negatively influence the integrity of the discussions concerning DSM V revisions. Others have suggested that new disorders that might be listed could have ties to pharmaceutical companies interested in providing treatments for disorders yet to be named. You might be interested in following this debates since it clearly impacts assessments.


In late breaking news Senator Clinton recently introduced legislation to support increased investment in the training and education of health care professionals through the Health Professional and Primary Care Reinvestment Act. This would expand health care training by providing increasing incentives for health professionals working in community settings. It remains to be seen to what extent this will impact assessments by psychologists.

EDITOR'S NOTE:

Welcome to Brian Hall of Section X. This is Section X's first update. Please read below to learn about the activities of this new section – WCS

Section X: Graduate Students and Early Career Psychologists

Brian J. Hall, M.A.

 The Graduate Students and Early Career Psychologist (ECP) Section of Division 12 is dedicated to advancing the needs of students and ECPs within Division 12. Several developments have taken place within the section and each is described in this section update.

As of January, our section leadership includes Christopher J. Cutter, Ph.D., President; George M. Slavich, Ph.D., Past President; Rachel Jacobs, M.A., Secretary; and, Brian J. Hall, M.A., Section 10 Representative to the Board of Directors. Sean Sullivan, Ph.D., the section Past President and one of

JOIN A DIVISION 12 SECTION

Division 12 has seven sections covering specific areas of interest.

- Clinical Geropsychology (Section 2)
- Society for a Science of Clinical Psychology (Section 3)
- Clinical Psychology of Women (Section 4)
- Clinical Psychology of Ethnic Minorities (Section 6)
- Section for Clinical Emergencies and Crises (Section 7)
- Section of the Association of Medical School Psychologists (Section 8)
- Section on Assessment (Section 9)
- Graduate Students and Early Career Psychologists (Section 10)

To learn more, visit Division 12's Section web page:

www.apa.org/divisions/div12/div12.html

Section Updates (*continued*)

the founding members, rotated off of the committee this year. Thanks Sean for all of your hard work in getting this section up and running. At the time of this update, the votes have not yet been tabulated for the President-Elect and Treasurer positions. Updated election results can be found at <http://www.apa.org/divisions/div12/div12G.html>.

The Section has been working to develop a graduate student/ECP Mentorship Program that will begin in 2009. The program will assist students and early career members by pairing them with full members of the Society and by encouraging them to cultivate a mutually beneficial relationship. Junior members will profit from the expertise of senior members in enhancing their career development, and senior members will share knowledge and tap into the younger group's concerns. Our hope is that the Mentorship Program will create connectivity within the Society and continued growth of its membership.

Students can secure information and advice about the field of clinical psychology and discuss training issues that may occur within their training programs. The mentoring program is designed to be informal and non-judgmental, so students may feel freer to ask questions in this relationship than at their university or internship site. For Early Career Psychologists, being paired with Senior Members will provide crucial advice and mentorship during the transition to becoming independent practitioners and scientist practitioners.

Members of the Board of Directors discussed

the program during the September Board meeting in Jacksonville Florida. The Board was unanimously supportive of the idea. Special thanks to Irv Wiener, Ph.D. and John Norcross, Ph.D. for their support and leadership in promoting this program. The Board will convene in Washington D.C. in late January to discuss plans for implementation.

Sam Cawley, a research assistant at the Yale School of Medicine, will develop a new website for the section. The website will contain information about our section and links to resources for graduate students and ECPs. We look forward to having an enhanced web presence in the near future.

In his role as 2008 Convention Program Chair, George M. Slavich, Ph.D. developed convention programming for the 2008 APA Convention in Boston. The section offered two programs for students and ECPs. One was a symposium titled "Navigating the Internship Application Process: Applying, Interviewing and Matching," with George M. Slavich, Ph.D., Joyce P. Chu, Ph.D., James Reid, Ph.D., and Sean Sullivan, Ph.D. (Chair), and the other was an invited talk given by Elizabeth Kensinger, Ph.D., titled "What to do once the Defense is Through: Planning the Career Trajectory that's Right for You." The Section will offer programming in 2009 with a particular focus on research grants and transitioning into academic research positions.

Best wishes to all for a healthy, productive, and prosperous 2009. 🍀

CLINICAL PSYCHOLOGY BROCHURE

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

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

**For more information, contact:
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Email: div12apa@comcast.net**

Please read the statements below, provided by candidates for President-Elect, Council Representative, and Diversity Chair/Member-at-Large. Ballots will be mailed from APA on 4/15/09. Please note that a few candidates who will be listed on the ballot did not submit a statement.

PRESIDENT-ELECT

Ronald T. Brown, Ph.D., ABPP

I am honored to be nominated for President of the Society of Clinical Psychology. Over the past three decades my core values have always included the integration of science and practice in my service on university faculty, service to our profession and the community, and finally in my clinical practice and consultation. I believe that it is of utmost importance to preserve and revere science as a core value of clinical psychology.

Please allow me to review my accomplishments over the past several years. Currently, I serve as Professor at Temple University in the Departments of Psychology and Public Health. I also serve as the Dean of the College of Health Professions at Temple where I manage a budget of approximately \$37,000,000. Thus, I have significant financial management experience which I believe is necessary as part of the leadership of Division 12. In addition, I have been the recipient of grant awards in the amount of \$14,000,000 from the National Institutes of Health that has included research related to children with psychopathology (attention-deficit/hyperactivity disorder), adjustment and adaptation associated with various health conditions, and health promotion. From this program of research, I have published over 250 chapters and peer reviewed articles. In fact, last year, I received the Logan Wright Distinguished Research Award from Division 54 of the American Psychological Association (APA). In addition, I have published 9 books related to childhood psychopathology, the most recent of which was published by the APA in 2008, Psychopharmacological, psychosocial, and combined interventions for childhood disorders: Evidence base, contextual factors, and future directions. In addition, I have served as the Editor of the Journal of Pediatric Psychology and also have served on the editorial boards of 14 peer reviewed journals. I also have served on several study sections of the National Institutes of Health including

the Behavioral Medicine, Outcomes, and Intervention study section for eight years. Finally, over the past several years, I have mentored numerous graduate students and post-doctoral fellows in the aforementioned endeavors and received the Martin P. Levin Award for Distinguished Mentorship from Division 54, Society of Pediatric Psychology of the APA.

My governance experience includes having served as President of Division 54 of the American Psychological Association (APA), having served on Council of APA for six years, having chaired the Board of Scientific Affairs of APA, and I currently serve on the Board of Educational Affairs of the Association. I also hold the diplomate in the American Board of Clinical Health Psychology.

If I am elected to serve as President of the Society of Clinical Psychology, my goals during the Presidential year will be to increase membership, to foster greater collaboration with clinical psychology at the international level, to develop greater collaborations with clinical child psychology and to begin to foster a culture of philanthropy within the Division so that we may provide scholarships to students in clinical training programs that are geared toward training scientists-practitioners. Thank you for your kind support.

Danny Wedding, Ph.D., MPH

I currently direct the Missouri Institute of Mental Health, a research, policy and training center associated with the University of Missouri-Columbia School of Medicine. MIMH has around 110 employees and \$6M budget. NIMH, NIDA and CDC have funded most of my research. I was trained as a clinical psychologist at the University of Hawaii and then completed a postdoctoral year of training at the University of Mississippi Medical Center. I've taught and conducted research in medical schools my entire career except for the two years I spent working for the U. S. Congress, first as a Robert Wood Johnson Health Policy Fellow with Senator Tom Daschle, and then as an APA Science Policy Fellow working for Congressman John Conyers. I was the first psychologist to be selected for the RWJ program; since then, more than a dozen other psychologists have participated as health policy fellows.

I'm currently editing an online journal: PyscCRITIQUES: Contemporary Psychology—APA Review of Books, and I work hard to ensure the most

important books in clinical psychology are reviewed by the most prominent scientists I can recruit. The journal is supported by a blog (<http://psycritiques-blog.apa.org/>) that is designed to serve as a forum for discussion of important, topical issues relevant to the science and practice of psychology. I've published new editions of *Current Psychotherapies*, *Case Studies in Psychotherapy*, and a medical school textbook, *Behavior and Medicine*. My most recent book is *Positive Psychology at the Movies: Using Films to Build Virtues and Character Strengths* (Niemiec & Wedding, 2008).

I previously have worked closely with the Society of Clinical Psychology as the Section Representative from the Association of Psychologists in Academic Health Centers (APAHC) and as your current Secretary; I've now like to serve in a more significant role as your President. I'm especially proud of the series of books I edit for the Society (along with Larry Beutler, Ken Freedland, Linda Sobell and David Wolfe) titled *Advances in Psychotherapy: Evidence Based Practice*. Fourteen volumes have been published to date, six more are currently under contract, and we are projecting approximately at least a dozen more once the first twenty volumes are published. These books generate a significant royalty stream for Division 12; they also provide an important member service by packaging the best available science in small and inexpensive volumes that can be used by our members to obtain continuing education credit.

I received the Heiser Award for Advocacy in Psychology several years ago, and last year received Division One's Ernest Hilgard Award for Lifetime Career Contributions to General Psychology. I enrolled in the University of Hawaii in 1976 so I could study behavior therapy with Leonard Ullmann (recently deceased). I care passionately about our profession, and I have a strong identity as a scientist/ practitioner. Being a clinical psychologist has allowed me to work as a clinician, teacher, researcher and policy wonk. It's been a great run, and I would like to wrap up my career by serving our Division as its President.

COUNCIL REPRESENTATIVE

Deborah A. King, Ph.D.

2009 is a year for change! Our future as a profession and as a Division depends on our ability to attract and retain new members from the diverse ranks

of early career psychologists. Just as important, we must engage seasoned professionals - clinicians and researchers alike - who may question the relevance of Division membership. As your Council Representative, I would actively and visibly advocate for psychology in the 'market place' of health professions. I would work with the larger Association to demonstrate to the public and to policymakers the unique value of psychologists' expert abilities to develop, conduct, and evaluate psychological interventions. Our relevance as a profession requires that we promote the application of evidence-based psychological treatments during this era of daunting economic challenges.

As a Division, it should also be our mission to vigorously promote and advocate for the development of innovative, accessible models of mental health care that reach out to underserved populations, and meet the needs of ethnically, racially, and culturally diverse individuals, families, and communities. I have spent my career mentoring clinical psychology interns and post-doctoral fellows in the Department of Psychiatry at the University of Rochester Medical Center. As Professor of Psychiatry, Director of Clinical Psychology, and for the past 16 years, Director of Psychology Training, I have worked with colleagues from multiple disciplines to bring our training program and clinical services outside the walls of the academic medical center into the communities that we serve. We have established community-partnered programs for frail homebound elders, urban grandmothers raising grandchildren, and communities of color struggling with the ravages of addiction, poverty, and interpersonal violence. As your Council Representative, I would bring this focus on the needs of diverse, underserved populations to my work. Having served as the Section 2 (Geropsychology) representative to the Board for six years, I am eager for a new and broader role. I hope you will honor me with this opportunity.

Radhika Krishnamurthy, Psy.D.

I am truly honored to be given this opportunity to serve Division 12 and represent it on the APA council. I have just completed my term as 2008 president of Division 12's Section IX, Assessment Psychology, a year that brought me great fulfillment in being able to advocate for the role of psychological assessment in clinical psychology practice. I am now eager to broaden my contributions to our Society.

I am a professor of clinical psychology at Florida

Institute of Technology and a licensed psychologist in Florida. I have taught personality and intellectual assessment courses in Florida Tech's Psy.D. program, directed doctoral research, and supervised clinical practica throughout my academic career. I was our Psy.D. program chair and director of clinical training in 2003-2006. I have several scholarly publications that include professional books, book chapters, research articles, and technical test reviews, and have presented numerous papers and symposia in professional conferences including APA and the Society for Personality Assessment (SPA). My recent scholarly writings have been on clinical psychology practice and the development of psychological assessment competency.

Over the last decade, I have also been deeply involved in service to professional organizations and journals. I served on the SPA board for 7 years, have been lead delegate of my school's Psy.D. program to the National Council of Schools and Programs of Professional Psychology (NCSPP) since 2003, and served twice on NCSPP's conference planning committees. I have also served on accreditation site visit teams. I am currently an Associate Editor for the Journal of Personality Assessment and Consulting Editor for Assessment and Psychological Assessment, an APA journal.

My interests in clinical psychology include enhancing the quality of training and practice, supporting diversity, and broadening psychology's role in human welfare. I will bring both thoughtful reflection and action into this position.

Jonathan Weinand, Ph.D.

I am grateful for this opportunity to run for the position of Division 12 Representative. I received my undergraduate training at DePaul University, my doctoral training at Illinois Tech, and completed my residency at the University of Mississippi Medical Center/VA Consortium. After practicing in a medical center-based outpatient clinic for close to twenty years, my interests in clinical training lead to my current position as regional clinical director for a behavior healthcare corporation, where I have the opportunity to put McFall's (1991) second corollary concerning the primacy of application of scientifically sound clinical practice to work in several behavioral health centers.

As a member or chair of various committees at the state, divisional, and national level, I have provided, leadership and direction to the following initia-

tives: development of web technology to significantly increase member recruitment, advocacy for the development of an appropriate committee mechanism to oversee quality assurance of RxP training programs, successfully advocated for a CoA policy concerning institutional public disclosure for doctoral training institutions, and developed a complementary CE website associated with the Division's book series. Most recently I have advanced the use of the competency model and empirically-based training to the professional practice level of education, dissemination and implementation of clinical assessment and treatment practices.

Our membership continues to be pressed by significant funding challenges at the educational, science, and clinical levels of our profession, and we all are worried about our professional futures. The Society will be well-served by looking forward and developing an integrated plan regarding providing high quality, science-based education and training to our membership. Through quality education, research, advocacy and practice, we can work together to assure that the future of behavioral research & healthcare is our future. Please consider supporting my nomination, and my goal to create this better future for our membership.

DIVERSITY CHAIR/ MEMBER-AT-LARGE

Gordon C. Nagayama Hall, Ph.D.

I am pleased to be a candidate for the Diversity Position. I am a Professor of Psychology at the University of Oregon. Previously I was a Professor at Penn State University and Kent State University, and a psychologist at Western State Hospital in Washington state.

Integrating diversity into the mainstream has been a lifelong passion. My graduate work focused on the cultural contexts of personality and psychotherapy, but I began my professional career in work with sexual offenders. I was later able to integrate my interests in cultural diversity. I currently am conducting a research program on empirically-supported and culturally-sensitive interventions as a co-investigator with the NIMH Asian American Center on Disparities Research. My work on diversity has been recognized by Division 12 with the Stanley Sue Award and the Section VI MENTOR Award.

Examples of my leadership towards diversity goals as President of Division 45 include helping establish a Division cultural diversity journal and electing an ethnic minority President of APA. Beyond diversity, we increased Division membership and added a seat on APA Council. Under my editorship, Cultural Diversity and Ethnic Minority Psychology has been added to the ISI citation indexes. I have also addressed broad issues in clinical psychology as an Associate Editor of the Journal of Consulting and Clinical Psychology.

Throughout my career I have made efforts to recruit and retain students and faculty of color. However, diversity means more than changing demographics. Diversity involves considering how well our theories, research, and practice address issues in diverse contexts, and making needed modifications or developing new models to become responsive to these contexts. I hope that clinical psychologists will recognize their responsibility to lead and serve a public that is becoming increasingly diverse. I would be honored to devote my experience to the goals of Division 12.

Arthur M. Nezu, Ph.D., ABPP

I am honored to be running for Member-at-Large for Division 12. Okay, so you ask—who are you and why do you deserve my vote? Some quick background facts: Ph.D. in clinical psychology from SUNY at Stony Brook; presently professor of psychology, medicine, and public health at Drexel University in Philadelphia; Fellow of Division 12 since 1991; editorial board member of Clinical Psychology: Science and Practice

(CP:SP) since 1993; board certified in both clinical psychology and in cognitive and behavioral psychology (ABPP); past president of several professional organizations (e.g., Association for Advancement of Behavior Therapy, World Congress of Cognitive and Behavioral Therapies, American Board of Cognitive and Behavioral Psychology); currently on an NIMH study section for mood and anxiety disorders; co-developer of a Division 12-designated empirically supported clinical intervention (Problem-Solving Therapy for Depression); Asian-American (since birth); recently celebrated my 25th wedding anniversary and the birth of my 3rd grandchild! Hopefully this suggests that I am loyal, persistent, dedicated, hardworking, creative, and sufficiently perspicacious to be an effective Division 12 board member. In addition, for my home department of psychology, I serve as the Coordinator of Diversity Issues, responsible for improving the educational and training components of our doctoral programs, as well as to increase representation and participation of traditionally underrepresented groups in psychology at all levels. I recently ended a term as Chair of the Diversity Committee for the American Board of Professional Psychology, having turned a previous task force into a permanent standing committee. My thoughts, goals, strategies, and visions regarding diversity is best represented in a CP:SP article (2005, vol. 12, pp. 19-24: "Beyond cultural competence: Human diversity and the appositeness of asseverative goals"). Please read it—it's a different perspective. Thanks for your consideration! ☞

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 1st (Winter/Spring Issue – mails in early April)
May 1st (Summer Issue – mails in early July)
September 1st (Fall Issue – mails in early November)

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Society of Clinical Psychology Board of Directors Minutes Division 12 Board of Directors' Meeting September 13-14, 2008 Jacksonville, FL

Present: Norm Abeles, Asuncion Austria, Larry Beutler, Ron Brown, Brian Hall, Marc Hillbrand, Nadine Kaslow, David Klonsky, Eduardo Morales, John Norcross, Lynn Peterson, Linda Sobell, Jon Weinand, Deborah King, Irv Weiner

Absent: Lynn Collins, Robert Klepac, Marsha Linehan, Lynn Rehm, David Rudd, Danny Wedding, Marvin Goldfried

List of motions passed by the Board:

MOTION – Dr. Sobell moved to approve the proposed appointments. Motion carried unanimously.

MOTION – Dr. Abeles moved to approve the Subcommittee on Practitioner-Researcher Collaboration. This motion carried unanimously.

MOTION – Dr. Beutler moved that Division 12 give a total of 1 hour to the Convention within the Convention. This motion carried unanimously.

MOTION – Dr. Norcross moved that the PDIs not be funded in the 2009 preliminary budget. This was agreed upon unanimously. Dr. Klepac wanted to communicate that this is sad for the division. Despite the PDIs flourishing in the past, given the CEs provided by APA and the costs to psychologists, as well as advertising costs, it is no longer feasible to provide these workshops. There is a desire to provide CEs during conference time. As a matter of APA policy, Dr. Belar notes that divisions cannot give CEs within their structured hours. We want to see if this policy can be changed. Dr. Norcross will re-approach Dr. Belar about this. If that fails, the Council Reps can prepare a motion about this for Council. Dr. Norcross will see if Education Directorate or APA gets this money.

MOTION – Dr. Norcross moved to keep student dues

at \$30 for 2009. This motion carried unanimously.

MOTION – Dr. Norcross moved to rescind the previous board decision to increase dues by \$1 per year. This motion carried unanimously. We voted to do this a year ago. Unfortunately, every time we increase the dues by a dollar, we need to redo all our publicity and paperwork, etc. Thus, we may need to wait a few years and increase the dues again. The 2009 dues will be \$61 for members. The \$1 increase also applies to affiliates.


MOTION – Dr. King that the per diem for food be \$75/day (maximum), with receipts for items > \$25. This motion carried unanimously. As a note, the mileage reimbursement is \$0.505 per mile.

MOTION – Dr. Beutler moved that the proposed budget be accepted. This motion passed unanimously. Dr. Morales recommended that a balance sheet be included when we review the budget; he will send Lynn Peterson an example.

MOTION – Dr. King moved that we rename the Outstanding Clinical Educator Award the Toy Caldwell-Colbert Outstanding Clinical Educator Award. This motion carried unanimously. Dr. Austria will inform the family.

MOTION – Dr. Norcross moved that we recommend to Dr. Kendall that Clinical Psychology: Science and Practice publish a special section on evidence-based practice for ethnic minorities. This motion carried unanimously. This builds on the conference that was just held and Dr. Morales will serve as the point person.

MOTION – Dr. Norcross moved that the Guide for Incoming Division 12 Section Representatives be added to the Policy and Procedures Manual. It will be modified to indicate that two written reports per year from sections are requested (one for each in-person meeting) and clarifies that Central Office only needs to be notified of conference calls if their service will be used. This motion carried unanimously.

Respectfully Submitted,
Nadine J. Kaslow, Ph.D. 

Society of Clinical Psychology Board of Directors

Division 12 Board of Directors' Meeting
September 13-14, 2008
Jacksonville, FL

OFFICERS (Executive Committee)

President (2009) John C. Norcross, Ph.D., ABPP*
President-elect (2009) Marvin R. Goldfried, Ph.D.*
Past President (2009) Irving B. Weiner, Ph.D., ABPP *
Secretary (2008-2010) Danny Wedding, Ph.D.*
Treasurer (2009-20011) M. David Rudd, Ph.D.*

COUNCIL OF REPRESENTATIVES

Representative (1/07-12/09) Linda C. Sobell, Ph.D.*
Representative (1/08-12-10) Larry Beutler, Ph.D.*
Representative (1/08-12/10) Lynn P. Rehm, Ph.D.*
Representative (1/09-12/11) Richard M. Suinn, Ph.D.*

MEMBER AT LARGE

Ascuncion M. Austria, Ph.D.* (07-09)

EDITORS (Members of the Board without vote)

The Clinical Psychologist:

(2006-10) William C. Sanderson, Ph.D.

Clinical Psychology: Science and Practice:

(2004-10) Phillip Kendall, Ph.D. ABPP

Web Editor:

(2009-2011) Sammy F. Banawan, Ph.D.

SECTION REPRESENTATIVES TO THE DIVISION 12 BOARD

Section 2: Society of Clinical Geropsychology (07-09)

Deborah A. King, Ph.D.*

Section 3: Society for a Science of Clinical Psych.

(09-11) David Tolin, Ph.D.

Section 4: Clinical Psychology of Women (08-10)

Lynn H. Collins, Ph.D.*

Section 6: Clinical Psychology of Ethnic Minorities

(07-09) Eduardo S. Morales, Ph.D.*

Section 7: Emergencies and Crises (07-09) Marc

Hillbrand, Ph.D.*

Section 8: Assoc. of Psychologists in Academic Health

Centers (07-09) Ronald T. Brown, Ph.D., ABPP*

Section 9: Assessment Psychology (08-10) Norman

Abeles, Ph.D., ABPP*

Section 10: Graduate Students and Early Career
Psychologists (08-10) Brian Hall*

MEMBER AT LARGE

Ascuncion M. Austria, Ph.D.* (07-09)

* = Voting Members of Board

DIVISION 12 CENTRAL OFFICE

Lynn G. Peterson, Administrative Officer
(not Board member)

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Instructions to Authors

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

Material to be submitted should conform to the format described in the Fifth Edition of the Publication Manual of the American Psychological Association (2001). It is preferred that a single electronic copy of a submission be sent as an attachment to e-mail. Alternatively, send four copies of manuscripts along with document file on computer disc 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.

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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.