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# THE CLINICAL PSYCHOLOGIST

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

## CONTENTS



## EDITORIAL



## DIVISION 12 OFFICERS



By Marvin R. Goldfried, PhD, ABPP
Stony Brook University
President, Society of Clinical Psychology

PRESIDENT'S COLUMN

## Building a Two-way Bridge between Practice and Research

Many of us entered graduate school with the fantasy of both practicing therapy and conducting research. Although some in the field have been successful in fulfilling this dream, most of us have tended to go down one of these two paths. Still, I suspect that for many, the desire to make contributions in both realms continues to exist. The Division's initiative of building a two-way bridge between research and practice has been undertaken in the hope of making some of this happen.

**Dissemination of Evidence-Based Treatment**

The future of clinical psychology is clearly in the direction of basing our therapy interventions on empirical evidence. Indeed, graduate students enrolled in clinical programs are increasingly being taught to expect that the interventions they learn about have an empirical underpinning. Still, as noted in the last issue of this newsletter by Stewart and Chambless (2010), an immediate question remains as how to effectively disseminate evidence-based interventions to practitioners who have not had this background. Using their clinical sensitivity to address this question, two graduate students—the future of clinical psychology—have argued that the question is not how researchers can disseminate information about data-based interventions to practitioners. Instead, they pose the question in a more collaborative way:

> How do researchers and clinicians work together to develop efficacious treatments?" ...we the researchers should not be disseminating *onto* the clinicians but rather engaging in dialogues with the professional community as we create new interventions. We believe that if we continue to frame this issue as an "us" versus "them" predicament, we will perpetually be stuck where we are, and, even worse, may continue to grow further polarized rather than closer together (Hershenberg & Malik, 2008, pp. 3-4).

Extending their clinical acumen to this question of dissemination, Hershenberg and Malik go on to suggest:

> To create an environment where application of evidence-based treatments is encouraged and supported, we reference the theme of perceived control....[in that]...clinicians

*(continued on page 2)*

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need to feel that they can successfully deal with a patient's pathology. A primary and reinforcing motivator needs to be in the belief that this new treatment will benefit their client and be consistent with their view of how to ethically conduct therapy; it is then that clinicians may become willing to titrate their intervention accordingly. As such, we believe that evidence-based treatments will only be utilized when the motivation for change comes from within the clinician (Hershenberg & Malik, 2008, p. 6).

And to the extent that clinicians increasingly use evidence-based treatments, they will, in turn, be able

*President's Column continued on page 3*

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## EDITORIAL STAFF

to provide feedback as to how to improve the effectiveness of these interventions in clinical practice.

**Clinical-Research Dialogue at the APA Convention**

To foster a collaborative dialogue between researchers and clinicians, the theme of Division 12's program at the August APA convention in San Diego is "Building a Two-Way Bridge Between Research and Practice." Chris Muran, our Program Chair, has arranged for a number of exciting panels dealing with this theme:

*What the clinician and researcher need from each other?*
Chair: Michelle G. Newman, PhD
Linda F. Campbell, PhD
Hanna Levenson, PhD
Linda C. Sobell, PhD

*Training in Empirically-Supported Treatments and Evidence-Based Practice*
Chair: Hal Arkowitz, PhD
Deborah Drabick, PhD
Charles J. Gelso, PhD
Rachel Hershenberg, MA

*Considering the evidence on therapeutic alliance with regard to practice and training*
Chair: J. Christopher Muran, PhD
Jacques P. Barber, PhD
Louis G. Castonguay, PhD
Armand R. Cerbone PhD

*What Constitutes Effectiveness in psychotherapy? What evidence will help build a bridge between the clinical researcher and the practicing therapist?*
Chair: Barry E. Wolfe, PhD
Daniel B. Fishman, PhD
Steven D. Hollon, PhD
E. David Klonsky, PhD

*Considering Empirically-Supported Treatments versus Evidence-Based Practice*
Chair: Marvin R. Goldfried, PhD
J. Gayle Beck, PhD
E. David Klonsky, PhD
Barry E. Wolfe, PhD

*On Building a Two-Way Bridge between Research and Practice*
Marvin R. Goldfried, PhD

**Survey on the Treatment of Panic Disorder**

As I indicated in my last President's Column, the Division has established an on-line mechanism whereby practicing therapists can provide feedback to researchers about those client and contextual variables that create problems in using empirically supported treatments in clinical practice. We started with surveying therapists on their experiences in using CBT in the treatment of panic disorder, and will later extend our focus to other clinical problems. As of the end of March 2010, over 300 clinicians have taken the survey. Articles describing this initiative will be appearing in the APA *Monitor* and in the *Behavior Therapist*, the newsletter of the Association of Behavioral and Cognitive Therapies (ABCT). Shortly thereafter, links will be made on a number of relevant Web sites and Listservs to the Division 12 Web site, where the findings will be presented.

There are a number of implications in having clinicians report on their experiences with empirically supported treatments, such as offering researchers clinically based hypotheses in need of research; informing clinicians how their experiences compare with their colleagues; and helping beginning therapists understand which of their clinical struggles are also shared by more experienced therapists. This informational feedback also brings us closer to understanding how client and systemic variables can interact with empirically supported treatments, thereby moving us from empirically supported treatments to evidence-based practice—an empirical-clinical standard that can better inform third party payers about the realities of therapy interventions.

**References**

Hershenberg, R., & Malik, J.(2008).Graduate student's view of evidence-based treatment. *The Clinical Psychologist,* 61, 3-6.

Stewart, R. E., & Chambless, D. L. (2010). What do clinicians want? An investigation of EST training desires. *The Clinical Psychologist, 63*, 5-10.

# Minimizing the Risk of Patient-Clinician Violence: A Clinical Primer

**Phillip Kleespies and Diane Bridgeman**

Few challenges facing psychology practitioners are more distressing than the possibility of patient violence toward the clinician. According to national and other large sample surveys, approximately 50% of practicing psychologists have concerns about possible patient violence (Guy, Brown, and Poelstra, 1990); and 15% - 25% have been assaulted at some point in their careers (Arthur, Brende, and Quiroz, 2003; Guy, et el., 1990). Most instances of patient assault have not resulted in serious physical harm or injury; however, the emotional distress for the clinician can be substantial and, at times, more disturbing than any physical injury.

Education and training in the evaluation and management of potentially violent patients is not typically a part of the graduate school curriculum for psychologists. It is nonetheless a real-world issue that many clinicians must deal with, and the outcome can have serious clinical, ethical, and legal consequences for both the patient and the practitioner. Given these potential risks and the high intensity situations in which they can arise, it seems prudent to be prepared with knowledge and a management strategy. To this end, the American Psychological Association's Advisory Committee on Colleague Assistance (ACCA) and Division 12's Section on Clinical Emergencies and Crises (Section VII) have collaborated to produce an informational brochure for clinicians entitled *Minimizing the Risk of Patient Violence in the Workplace*. The brochure offers suggestions for making your office, your sessions, and your practice safer. It also highlights important, evidence-based factors to remember when evaluating for risk and offers suggestions for management based on an analysis of these risk factors. Finally, it provides several resources for those who wish to learn, in greater depth, about evaluating and managing potential or threatened violence, as well as, at times, how the clinician might cope with the emotional aftermath of patient violence.

The conjoint ACCA/Section VII committee that prepared this brochure included Diane Bridgeman, Ph.D. (Co-Chair) (for ACCA), Lynn Bufka, Ph.D., and Dan Galper. Ph.D. (for the APA Practice Directorate), and Phillip Kleespies, Ph.D. (Co-Chair), Dale McNeil, Ph.D., Marc Hillbrand, Ph.D., Robert Yufit, Ph.D., and Justin Hill, Ph.D. (for Section VII). The brochure can be viewed or downloaded by going to a link on the Division 12 web site – www.Div12.org – or by going to a link on the Section VII home page – www.apa.org/divisions/div12/sections/section7

**References**

Arthur, G., Brende, J., and Quiroz, S. (2003). Violence: Incidence and frequency of physical and psychological assaults affecting mental health providers in Georgia. *The Journal of General Psychology,* 130, 22-45.

Guy, J., Brown, C., and Poelstra, P. (1990). Who gets attacked? A national survey of patient violence directed at psychologists in clinical practice. *Professional Psychology: Research and Practice,* 21, 493-495.

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# Biological Bias in National Institute of Mental Health's Consumer Brochures for Psychological Disorders

**Thad R. Leffingwell and**
**Kasey Claborn**
**Oklahoma State University**

The public may benefit from accurate and current information about psychological disorders. Public information serves many critical purposes. Public information can raise awareness of the signs and symptoms of psychological disorders, increasing the likelihood of accurate identification and effective treatment or prevention. Public information can raise hope for sufferers of psychological disorders by offering a sense of understanding or providing education about effective treatment options. Public information can serve to reduce stigma associated with psychological disorders by countering popular myths or misconceptions. Public information can translate science into the public discourse, communicating advances in our understanding or treatment of psychological disorders. In general, public information seeks to influence the popular zeitgeist regarding psychological disorders.

For these reasons, part of the mission of the National Institutes of Mental Health (NIMH) is to educate the public on common psychological disorders. The NIMH is the largest public entity devoted to mental health, providing the vast majority of research funding for scientists studying mental health, supporting over 2000 extramural grants and 500 intramural scientists each year. By virtue of the scientific credibility that the public is likely to attribute to the source, public education materials produced by the NIMH can be safely assumed to carry a great deal of weight with the consumers of that information. Therefore, it is critically important that this information be as accurate, complete, and as free of bias as possible.

The centerpieces of NIMH's public education materials are a series of colorful, brief brochures that are available on a number of the most common psychological disorders. The brochures, published by the Office of Science Policy, Planning, and Communications within NIHM, are geared toward the lay public consumers of health information, including individuals with psychological disorders and their families and caregivers. Each brochure includes, at minimum, a description of the relevant disorder (including DSM-IV symptoms), minimal epidemiological information, basic etiological information, and information regarding treatment options.

Contemporary approaches to understanding the etiology of psychological disorders take a developmental biopsychosocial approach, acknowledging the important contributions of neurobiological, genetic, behavioral, affective, cognitive, social, developmental, and contextual factors that aid in our understanding of psychopathology (Hersen, Turner & Beidel, 2007; Maddux & Winstead, 2005). Increasingly, psychopathology scholars acknowledge that these factors are not competing, mutually exclusive factors but rather they are interrelated and interacting factors.

In addition to the progress made in our understanding of causes of psychopathology, tremendous strides have been made in developing effective treatments (Barlow, 2004; Barlow, 2005; DeRubeis, & Crits-Christoph, 1998). These treatments include psychological treatments and medical advances, including pharmacological options. In many cases, current evidence would suggest either psychological treatments or medical treatments as equally desirable treatment options (Otto & Deveney, 2005). In other cases, combination treatments may be recommended as ideal (Jenike, 1993; Colom & Vieta, 2004; Friedman, Detweiler-Bedell, Leventhal, Horne, Keitner, & Miller, 2004). In a few cases, either psychological treatment or medical treatment is clearly superior, although the differences in expected outcomes are often fairly small (Paris, 2005). See Table 1 for a summary of evidence supporting the use of psychological treatments for a number of disorders.

The purpose of this study was to examine the content of the NIMH brochures to determine if they accurately and comprehensively portray the state of our understanding of the nature, causes, and effective treatments of psychological disorders. We expected to find etiological explanations consistent with a developmental biopsychosocial understanding of disorders and the inclusion of recommendations for all empirically supported treatment options, including both psychological and medical treatments.

*Biological Bias... continued on page 6*

## Method

*Evaluation of Efficacious Psychological Treatments*

In order to evaluate the current status of the evidence for efficacy of psychological treatments, we conducted searches for expert systematic reviews of evidence (in the form of practice guidelines, Cochrane reviews, etc.). The APA Division 12 Empirically Supported Treatment List is issued on the website at http://www.apa.org/divisions/div12/cppi.html. The link for each disorder provides a list of treatments that have met basic scientific standards for effectiveness recommended by the APA Division 12. We accessed the Cochrane Reviews database at http://www.cochrane.org/reviews/index.htm and conducted an advanced search of reviews using a search strategy of (Disorder OR Other Words Related to the Disorder) AND (psychological OR psychosocial OR therapy OR psychotherapy).

The National Guidelines Clearinghouse is resource for evidence-based clinical practice guidelines. We retrieved the practice guidelines at http://www.guideline.gov and performed a "Detailed Search." Then, we entered the disorder in the Disease/Condition field and entered "psychological OR psychosocial OR therapy OR psychotherapy" in the Treatment/Intervention field. We selected "'Treatment" in the Guideline Category Field.

Other reviews were performed through the psychinfo database accessed through the library. We used a search strategy of (Disorder OR Other Words Related to the Disorder) AND (psychological OR psychosocial OR therapy OR psychotherapy) AND (review OR meta) for each disorder.

For each disorder we listed the number of reviews regarding psychological treatments and summarized what the reviews concluded. A summary of our findings can be found it Table 1.

*Analysis of Brochure Content*

Current brochures were downloaded from the NIMH website at http://www.nimh.nih.gov/health/topics/index.shtml. We examined brochures for ten major psychological disorders, including Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), Post-traumatic Stress Disorder (PTSD), Social Anxiety Disorder (SAD), Panic Disorder (PD), Obsessive-Compulsive Disorder (OCD), Borderline Personality Disorder (BPD), Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating Disorder (BED). AN, BN, and BED were each addressed separately within a single brochure about Eating Disorders.

The brochures were analyzed for four different pieces of data: (a) the order in which biological (and/or medical treatment) and psychological (and/or psychological treatment) information was presented; (b) the number of words devoted to biological/medical and psychological treatment information; (c) the nature of etiological explanations provided in the brochures; and (d) the nature of professionals that are recommended for further assistance (e.g., physicians, psychologists, etc.). Biological/medical and psychological information regarding treatment options and etiology were generally distinctively presented in the brochures (typically with headings), which made the coding of this information very straightforward.

## Results

*Status of Evidence for Efficacy of Psychological Treatments*

As can be seen in Table 1, the collective evidence for the efficacy of psychological treatments is very strong. With the exception of bipolar disorder, each of the psychological disorders has one or more treatments meeting APA Division 12's criteria for categorization as an efficacious treatment. Several practice guidelines and systematic reviews for each disorder further conclude that one or more psychological treatment is effective for each psychological disorder.

*Order of presentation of biological/medical vs. psychological treatment information*

In nine of the ten brochures analyzed, information about biological/medical treatment options (most often pharmacotherapy) was presented first. The only brochure to present psychotherapy treatment options first was the brochure for Borderline Personality Disorder, the only personality disorder currently covered by a NIMH brochure.

*Word count for treatment options*

As one index of emphasis, we counted the number of words devoted to descriptions of either medical (typical pharmacotherapy) or psychological treatment options. These word counts can be found in Table 2. Seven of the ten brochures devoted more words to medical treatment options.

*Nature of etiological information*

Five of the nine brochures failed to provide any etiological explanations for the disorder of interest. Of the five that did provide etiological explanations, four

**Table 1. Summary of evidence reviews regarding the efficacy of psychosocial treatments for common psychological disorders.**

| | APA Division 12 EST List | Cochrane Reviews | | Practice Guidelines | | Other Reviews | |
|---|---|---|---|---|---|---|---|
| Disorder | | N | Summary | N | Summary | N | Summary |
| Major Depressive Disorder | Behavior Therapy<br>Cognitive Therapy<br>Interpersonal Therapy<br>Brief Dynamic Therapy<br>Self-Control Therapy<br>Social Problem-Solving Therapy | 2 | Psychosocial and psychological interventions (e.g., CBT and IPT) are an effective treatment option (Dennis & Hodnett, 2007; Wilson, Mottram, & Vassilas, 2008) | 6 | All recommend CBT, IPT, Problem-Solving Therapy and other psychological treatments as effective treatment options | 8 | Conclude that cognitive therapy, CBT, IPT, and other psychological treatments are effective for MDD |
| Bipolar Disorder | | 0 | N/A | 1 | Recommend IPT and CBT in addition to pharmacotherapy and group psychotherapy as effective treatment options | 14 | Conclude that CBT, family therapy, interpersonal and social rhythm therapy, and psychoeducation are effective treatments for bipolar disorder |
| Post-traumatic Stress Disorder | Exposure Treatment for PTSD (PE)<br>EMDR for Civilian PTSD (PE)<br>Stress Inoculation for PTSD (PE) | 1 | Trauma-focused CBT, EMDR, stress management, and group trauma-focused CBT are effective in the treatment of PTSD (Bisson & Andrew, 2007) | 3 | All recommend trauma-focused CBT and other psychological treatments as effective treatment options | 4 | All conclude that trauma-focused CBT and/or EMDR are effective treatments for PTSD |
| Panic Disorder | Cognitive Behavior Therapy<br>Applied relaxation | 1 | Psychotherapy is an effective treatment for Panic Disorder (Furukawa, Watanabe, & Churchill, 2008) | 2 | Both Recommend CBT as an effective treatment option | 10 | Conclude that CBT and relaxation therapy are effective treatments of panic disorder |
| Borderline Personality Disorder | Dialectical Behavior Therapy | 1 | DBT and psychoanalytic day therapy appear to be effective in the treatment of Borderline PD (Binks, Fenton, McCarthy, Lee, Adams, & Duggan, 2007) | 1 | Recommend psychoanalytic therapy and DBT as effective treatment options | 8 | Conclude that psychodynamic psychotherapy and DBT are effective treatments for borderline personality disorder |
| Schizophrenia | Family intervention<br>Social skills training<br>Supported employment | 1 | CBT is a promising intervention in the treatment of schizophrenia (Jones, Cormac, Silveira da Mota Neto, & Campbell, 2007) | 3 | All recommend CBT, family intervention, and social skills training as effective treatment options | 22 | Conclude that social skills training, family treatments, and CBT are effective treatments for schizophrenia |
| Eating Disorders | Cognitive Behavior Therapy<br>Interpersonal Therapy | 2 | CBT and IPT are effective in the treatment of eating disorders (Hay, Bacaltchuk, & Stefano, 2007) | 3 | All recommend CBT, IPT and other psychological interventions as effective treatment options | 21 | Conclude that CBT, IPT and behavior therapy are effective treatments for eating disorders |
| Generalized Anxiety Disorder | Cognitive Behavior Therapy<br>Applied relaxation | 2 | CBT is effective in the treatment of GAD (Hunot, Churchill, Teixeira, & Silva de Lima, 2007; James, Soler, & Weatherall, 2007) | 2 | Recommend CBT, psychodynamic psychotherapy and family therapy as effective in the treatment of GAD | 13 | Conclude that cognitive therapy, relaxation therapy, and CBT are effective treatments for generalized anxiety disorder |
| Obsessive-Compulsive Disorder | Exposure and Response Prevention (ERP)<br>Cognitive Therapy<br>Specific Relax Prevention Program | 2 | CBT is effective in the treatment of OCD (Gava, Barbui, Aguglia, Carlino, Churchill, De Vanna, & McGuire, 2007; O'Kearney, Anstey, & von Sanden, 2007) | 2 | Recommend CBT, Exposure and Response Prevention and other psychological treatment interventions as effective options | 15 | Conclude that CBT, exposure and response prevention are effective treatments for obsessive-compulsive disorder |
| Social Anxiety Disorder | Exposure Treatment<br>Cognitive Behavioral Group Therapy<br>Systematic Desensitization | 0 | N/A | 1 | Recommend CBT as an effective treatment option | 5 | Conclude that CBT and exposure therapy are effective treatments for social anxiety disorder |

Note: WE = Well-established Treatment, PE = Probably Efficacious Treatment

of five provided explanations with a strong biological bias. For example, the brochure for MDD concluded that "Research indicates that depressive illnesses are disorders of the brain." Similarly, brochures for SAD, GAD, and OCD utilized identical language to offer the following explanation: "When chemicals in the brain are not at a certain level, it can cause a person to have [SAD/GAD/OCD]." Further, these explanations pointed to a preferred treatment option by adding: "That is why medications often help with the symptoms because they help the brain to stay at the correct levels." Only the brochure for BPD offered a more balanced, biopsychosocial etiological explanation.

*Nature of health professional recommendations*

Several of the brochures appropriately included information about who individuals might contact for more information or to receive help. Of those, some provided excellent information about the broad range of professionals who may be able to provide assistance (the Depression brochure was particularly outstanding). Unfortunately, brochures for anxiety disorders only directed individuals with concerns to contact "their physician or another health professional" for assistance. While psychologists are technically health professionals, it remains likely that the public interprets that term to include only medical personnel (physicians, nurses, etc.).

**Discussion**

The evidence for the efficacy of psychological treatments for common psychological disorders is strong, as evidence by numerous expert systematic reviews reaching this conclusion. In many cases, the efficacy data is as strong for psychological treatments as for pharmacological treatments, and in some cases is even stronger.

We examined the content of ten different NIMH brochures for potential bias in the presentation of these two perspectives. We found that the brochures were systematically biased toward biological etiologies and medical treatments, although some variability existed across brochures. This bias was demonstrated by a number of factors including (a) the order of presentation, (b) the number of words used to explain each treatment option, (c) the strong biological nature of most etiological descriptions, and (d) the nature of medical professionals that the brochures recommended that consumers contact for more information (physicians vs. psychologists or other mental health professionals). This bias is inconsistent with current scientific findings and biopsychosocial models of etiology and available evidence regarding the relative efficacy of treatments.

The word counts for descriptions of treatment options was particularly surprising to us. Psychosocial treatments can't adequately be described in a few brief sentences. Much more could, and should, be said about the specifics of effective treatments, appropriate treatment professionals, and so-called non-specific factors (e.g., the importance of a good therapeutic relationship).

The observed bias could certainly have important implications. To the extent that the brochures are utilized by the public to gather reliable and objective information, the public will be receiving a slanted message and acquire an incomplete understanding of the nature of psychological disorders. Further, this understanding will likely diminish the awareness of and desirability for known efficacious treatment options, especially psychological treatment.

**References**

Barlow, D. (2004). Psychological treatments. *American Psychologist,* 59, 869-878.

Colom, F. & Vieta, E. (2004). A perspective on the use of psychoeducation, cognitive-behavioral therapy and interpersonal therapy for bipolar patients. *Bipolar Disorders,* 6, 480-486.

DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting and Clinical Psychology,* 66, 37-52.

Friedman, M.A., Detweiler-Bedell, J.B., Leventhal, H.E., Horne, R., Keitner, G. I., Miller, I.W. (2004). Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Science and Practice,* 11, 47-68.

Hersen, M., Turner, S. M., & Beidel, D. C. (2007). *Adult psychopathology and diagnosis (5th Ed.).* Hoboken, NJ: Wiley & Sons.

Jenike, M.A. (1993). Obsessive-compulsive disorder: Efficacy of specific treatments as assessed by controlled trials. *Psychopharmacology Bulletin,* 29, 487-499.

Maddux, J. E. & Winstead, B. A. (2005). *Psychopathology: Foundations for a contemporary understanding.* Mahwah, NJ: Lawrence Erlbaum Associates

Otto, M.W. & Deveney, C. (2005). Cognitive-behavioral therapy and the treatment of panic disorder: Efficacy and strategies. *Journal of Clinical Psychiatry,* 66, 28-32.

Paris, J. (2005). Recent advances in the treatment of borderline personality disorder. *Canadian Journal of Psychiatry,* 50, 435-441.

**Table 2. Summary of content analyses of NIMH brochures.**

| | | | Medical Intervention | | Psychological Intervention | |
|---|---|---|---|---|---|---|
| Disorder | URL[1] | Etiology | Order | Word Count | Order | Word Count |
| Major Depressive Disorder | /depression/nimhdepression.pdf | "Research indicates that depressive illnesses are disorders of the brain." | 1 | 449[2,3,4] | 3[5] | 189[6] |
| Generalized Anxiety Disorder | /nimh_generalizedanxietydisorder.pdf | "When chemicals in the brain are not at a certain level it can cause a person to have GAD. That is why medications often help with the symptoms because they help the brain chemicals stay at the correct levels." | 1 | 76 | 2 | 31 |
| Post-traumatic Stress Disorder | /post-traumatic-stress-disorder-a-real-illness/complete.pdf | None | 1 | 25 | 2 | 36 |
| Social Anxiety Disorder | /nimh_socialphobia_publication.pdf | "When chemicals in the brain are not at a certain level it can cause a person to have social phobia. That is why medications often help with the symptoms because they help the brain chemicals stay at the correct levels." | 1 | 82 | 2 | 33 |
| Panic Disorder | /panic-disorder-a-real-illness/complete.pdf | None | 1 | 19 | 2 | 38 |
| Obsessive-compulsive Disorder | /when-unwanted-thoughts-take-over-obsessive-compulsive-disorder/complete.pdf | "When chemicals in the brain are not at a certain level it may result in OCD. Medications can often help the brain chemicals stay at the correct levels." | 1 | 90 | 2 | 30 |
| Borderline Personality Disorder | /borderline-personality-disorder.shtml | "Researchers believe that BPD results from a combination of individual vulnerability to environmental stress, neglect or abuse as young children, and a series of events that trigger the onset of the disorder as young adults."; "NIMH-funded neuroscience research is revealing brain mechanisms underlying the impulsivity, mood instability, aggression, anger, and negative emotion seen in BPD." | 2 | 40 | 1 | 41 |
| Anorexia Nervosa | eating-disorders/nimheatingdisorders.pdf | None | 1 | 94[7] | 2 | 80 |
| Bulimia Nervosa | eating-disorders/nimheatingdisorders.pdf | None | 1 | 50[7] | 2 | 30 |
| Binge Eating Disorder | eating-disorders/nimheatingdisorders.pdf | None | 1 | 25[7] | 2 | 21 |

1 All URLs begin with "http://www.nimh.nih.gov/health/publications/"

2 An additional 524 words are devoted to the side effects of medication and related FDA warnings.

3 An additional 224 words are devoted to discussing St. John's Wort, an herbal alternative to medicine.

4 An additional 62 words are devoted to electroconvulsive therapy (ECT).

5 Following medication and St. John's Wort

6 80 words are devoted to describing the limitations of psychotherapy alone and recommending combination treatment with medication

7 This brochure includes an additional 207 words devoted to FDA warnings for SSRI medications.

NEW !

# Sexual Violence


*Bill Holcomb*

Volume 17, March 2010, viii + 96 pages
ISBN: 978-0-88937-333-4

**Authoritative, evidence-based guidance on treating sexually coercive and violent men.**

This book presents both a compact summary of the voluminous research on sexual violence and a practical, evidence-based "how-to" treatment guide for mental health practitioners treating men who are sexually coercive and violent toward others. Those needing intervention may be college students, individuals seeking outpatient help, family batterers, or those who sexually abuse women and children. They may have been arrested for sex crimes or be incarcerated or on probation in sex offender treatment program, though most will never have been arrested. This clearly written and well-structured resource will help clinicians deal with all. The book first reviews research on the prevalence of sexually abusive behavior, along with diagnostic issues, assessment strategies, and risk assessment approaches, and then presents current integrated theories on the causes of sexually violent behavior. The primary focus, however, is the specific emotional and behavioral targets of treatment and the therapist skills and strategies that are effective in reducing sexual victimization. Cultural factors that influence treatment are identified and effective prevention programs for sexual violence are also described and evaluated.

## The Author

***Bill Holcomb, PhD, MBA,*** Professor and Program Director for Forensic Services, Alliant University, Fresno, CA, and supervisor of the sex offender program at Coalinga State Hospital, CA

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**www.hogrefe.com**

NEW !

# Elimination Disorders in Children and Adolescents


*Edward R. Christophersen, Patrick C. Friman*

Volume 16, January 2010, vi + 88 pages
ISBN: 978-0-88937-334-1

**A compact, "how-to" manual on effective, evidence-based treatments for enuresis and encopresis.**

The aim of this book is to provide readers with a practical overview of the definitions, characteristics, theories and models, diagnostic and treatment recommendations, and relevant aspects and methods of evidence-based psychosocial treatments for encopresis and enuresis, primarily in children. Although treatments and research for elimination disorders are reviewed in general, particular attention is directed at constipation and encopresis, toileting refusal, and diurnal and nocturnal enuresis due to the high incidence of these conditions in children. Case vignettes, websites, and suggestions for further reading are provided for the interested reader.

## The Authors

***Edward R. Christophersen, PhD,*** Fellow of the American Psychological Association and Honorary Fellow of the American Academy of Pediatrics

***Patrick C. Friman, PhD, ABPP,*** Director of Clinical Services at Boys Town in Omaha, Nebraska and Clinical Professor of Pediatrics at the University of Nebraska School of Medicine.

*"[The authors] have produced a masterful volume... The book is clearly written, yet reviews the relevant research in depth. This book will be a standard reference in the area."*
C. Eugene Walker, PhD

*"This is a strong treatise on evidence-based interventions for two common, but often misunderstood and mistreated childhood disorders... [The authors] have done the field a valuable service with this volume."*
Michael C. Roberts, PhD, ABPP

# Substance Use Problems


*Mitch Earleywine*

Volume 15, 2009, 96 pages
ISBN: 978-0-88937-329-7

Separates the facts from the myths: evidence-based practical guidance on dealing with drug and substance abuse by a leading US expert.

*"Every aspect of the book echoes the best in theory, research and practice that I have learned over my 30-year career in the addiction field. I could not recommend it more highly."*
George A. Parks, PhD

*"The ideal volume for teaching students the issues involved in contemporary treatment of substance abuse problems... a beacon of light, good judgment, and balance in this rapidly changing and contentious field."*
Stanton Peele, PhD

# Suicidal Behavior


*Richard McKeon*

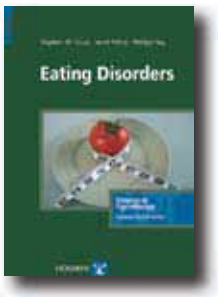
Volume 14, 2009, 108 pages
ISBN: 978-0-88937-327-3

Practice-oriented, evidence-based guidance on assessment, management, and treatment of suicidal behavior – one of the most devastating problems in modern society.

*"This volume is a masterful piece of work, an optimal mixture of a careful review of the literature and personal experiences written in a didactic, user-friendly way. It must be read by anyone dealing with suicidal individuals."*
Béla Buda, MD, PhD, in *Crisis*, Vol. 30

*"An indispensable intellectual guide. I was thrilled to read...*Suicidal Behavior *which spells out,* kurz und klar, *an easily digestible point of view as to what suicide really is. Get this book!"*
Edwin S. Shneidman, PhD

# Eating Disorders

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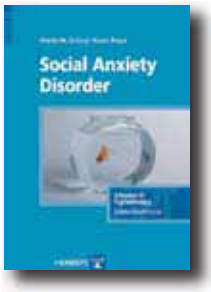


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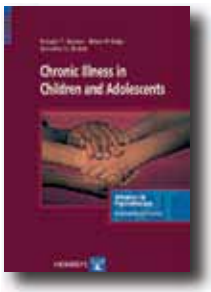


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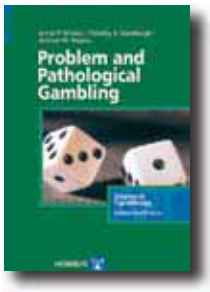


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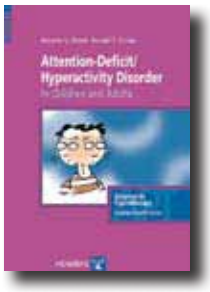


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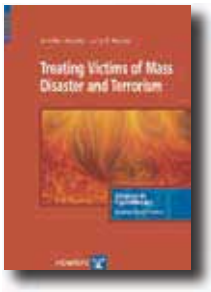


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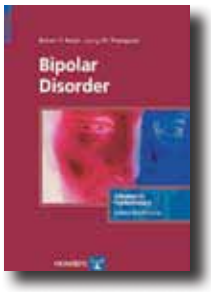


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# *Now* are you done?

Cynthia Suveg, PhD

I am very excited to write my first Early Career Column for *The Clinical Psychologist*. For the past few years I have enjoyed and appreciated insights from Katherine Muller, previous section editor for this column, and hope that I too can provide some helpful information for those of you early on in your careers as Clinical Psychologists. I completed my graduate training at the University of Maine (Developmental Clinical Track), an internship at Geisinger Medical Center in Danville, PA, a postdoctoral fellowship at the Child and Adolescent Anxiety Disorders Clinic at Temple University, and I am currently in my 4th-year as an Assistant Professor at the University of Georgia. I plan to draw on these training and professional experiences as well as those of others to write about timely topics of interest to early-career psychologists in both academic and clinical settings.

***For those not in the field of Clinical Psychology, it can be perplexing that you spend 4-6 years completing coursework and practicum experiences on campus, then a one-year internship, then possibly a 1-3 year postdoctoral position before starting your first job.***

As I considered topics for this first column something my mother said to me when I told her about my job offer from the University of Georgia came to mind, "*Now* are you done?" For those not in the field of Clinical Psychology, it can be perplexing that you spend 4-6 years completing coursework and practicum experiences on campus, then a one-year internship, then possibly a 1-3 year postdoctoral position before starting your first job. Funny how my mother's question suggested that I might actually feel settled, having my first "real" job, as if the major chunk of learning was somehow past me. Yet, when I arrived in a new place 750 miles away from family and friends, I felt anything but settled. So, for this first column I'm going to share some tips for adjusting to your first position post-training.

**Tip 1: Garner a social support network** – *fast!* Many individuals are required or simply choose to move away from family and friends to take a desired position. Starting a new position in an entirely new geographic area can feel quite stressful. Take advantage of social networking opportunities offered through your employer (e.g., meet and greets for new assistant professors or employees). It's also a good idea to meet people who are not associated with your work so also seek out additional opportunities to meet others (e.g., gym, etc.).

**Tip 2: Ask your department head or supervisor for a written copy of your job responsibilities.** A new job can sometimes be overwhelming but learning about expectations early on can help. Some jobs will require some research, teaching, and service. Or, if in a clinical position, you may be required to see a certain number of cases/week. Regardless of your particular job placement, be clear about what is expected of you and keep track of all that you do. Some positions will require a summary of your accomplishments at a later time, such as in an annual or 3rd-year review. For those in academics, it will certainly be required for the tenure review. As time goes on, it will be very easy to forget all that you have done (e.g., community service workshop), so jot it down, even informally, as you do it.

**Tip 3: Don't expect the same work habits that you had as a graduate student/post-doc to work for you in your new position.** You will be balancing many more priorities and tasks, and the luxury of having multiple hours at a stretch to read or write is not as feasible as it was as a graduate student or post-doc. Figure out how to be productive in smaller chunks of time and how to protect those chunks of time. For example, try and keep your door closed for portions of each day, otherwise you might get to the end of the work day and realize that you still have to prep for class the next day. Additionally, try and schedule student and other appointments back-to-back in several "blocks" on certain days/times so that you have more blocks of time to work with on other days.

**Tip 4: Realize that there is no need to reinvent the wheel.** For those who will teach in some capacity, whether it is full- or part-time, it is very easy to spend more time

*Early Career Column continued on page 15*

than you have preparing lectures. To make this task manageable, ask colleagues from your own and other institutions if they are willing to share syllabi and other teaching materials that you can modify into your own (you can then pass yours on later). Incorporate assignments into your courses (e.g., periodic quizzes) that encourage students to keep up with the reading and take responsibility for their own learning. When you are teaching a course for the first time, try not to incorporate too many writing assignments unless you are required to or you will be overloaded with grading. When teaching a course for the second time, don't make too many changes - keep in mind that you can incorporate changes gradually. Also make use of teaching resources that you might have on campus (e.g., such as a Center for Teaching & Learning). Some teaching books that you might find helpful: Becoming a Critically Reflective Teacher (Brookfield; http://www.amazon.com/Becoming-Critically-Reflective-Teacher-Education/dp/0787901318) and Creating Significant Learning Experiences (Fink; http://www.amazon.com/Creating-Significant-Learning-Experiences-Integrated/dp/0787960551).

**Tip 5: Keep in mind that it gets easier.** The transition into a new position will be energizing and exciting but likely stressful at the same time. In fact, you may garner a social support network and be doing all the job responsibilities that are expected of you and still feel stressed. Keep in mind that transitions can be difficult and though general stress management activities help, it might just take some time to really feel settled. Until that time though, exercise, eat well, take time to do an enjoyable activity at least once a week, and keep in mind that it does get easier.

A big thanks to Anne Shaffer and Julie Newman Kingery for offering some of their own tips for this column. Look for future columns devoted entirely to some of the issues raised in this column, such as preparing a course and supervision of students. Feel free to email me with any thoughts or suggestions for future columns at csuveg@uga.edu.

**Donald K. Routh, PhD—Section Editor**

# How Abnormal Psychology and Clinical Psychology got their Link

**Donald K. Routh, PhD**

Abnormal psychology is the scientific study of psychopathology; clinical psychology involves trying to provide help for such difficulties. Although these two domains were conceptually linked from a very early point, they officially became part of the same organization only in 1945, when Division 11 (Abnormal Psychology and Psychotherapy) and Division 12 (Clinical Psychology) of the reorganized American Psychological Association were combined into a single Division 12, initially called the Division of Clinical and Abnormal Psychology.

***The way "clinical psychology" came to Harvard and how it struggled to stay there is particularly interesting. Some new details about this are provided by Eugene Taylor,'s 2009 book,* The Mystery of Personality: A History of Psychodynamic Theories.**

Many (though not all) historians consider Lightner Witmer, who established a psychology clinic at the University of Pennsylvania in 1896, as the founder of clinical psychology. Abnormal psychology has a somewhat different history combining French, American, and other sources. Theodule-Armand Ribot (1839-1916) was among the first to communicate to French colleagues the new psychological research going on in Germany and England. He is also the most likely candidate to be considered the founder of the field of abnormal psychology. During the 1880s, he wrote on disorders of memory, introducing an important concept of retrograde amnesia in which brain damage has greater effects on recent than remote memories (now called "Ribot's Law"). In some of his later writings, he introduced the influential concept of "anhedonia" or the loss of interest in activities that give pleasure, crucial to our contemporary understanding of disorders such as depression. In 1888, Ribot was appointed a professor of psychology at the prestigious College de France. Another influential French figure in the field of abnormal psychology was Pierre Janet, a student of the famous Jean-Martin Charcot; Janet earned doctoral degrees in both psychology and medicine (psychiatry). Among other topics, Janet pioneered in the study of multiple personality disorder.

In the United States, according to historian Eugene Taylor, a "Boston School of Psychopathology" was in existence even before the influence of Freud's work. The influential persons involved included the psychologist William James. A Boston physician named Morton Prince, who played a key role in the development of abnormal psychology in America, was a follower of Pierre Janet and like him wrote on the topic of multiple personality disorder. Prince helped found the American Psychopathological Association. He also founded, in 1906, the *Journal of Abnormal Psychology,* which he later donated to the American Psychological Association. This journal continues to be published today.

The story of the way "clinical psychology" came to Harvard and how it struggled to stay there is particularly interesting. Some new details about this are provided by Eugene Taylor,'s 2009 book, *The Mystery of Personality: A History of Psychodynamic Theories.* Morton Prince thought that psychopathology should be a subject for the Liberal Arts portion of the university, not just the medical school. Accordingly, with the help of funds provided by his brother, a wealthy Boston attorney, Prince offered Harvard University an endowment for a "Psychology Clinic," with the mandate to engage in research rather than clinical treatment. Harvard accepted the offer and in fact initially made Morton Prince its director. However, Harvard did not allow Prince to name his own assistant director but instead in 1927 appointed Henry A. Murray to this position. After Morton Prince died in 1930, Murray became director of this Clinic.

It is interesting that Murray had no formal training in psychology. He came from a wealthy New York family, had earned an undergraduate degree at Harvard, an M.D. from Columbia University, and a Ph.D. in

*History Column continued on page 17*

biochemistry from Cambridge University. Murray's interest in the field of psychopathology stemmed from somewhat atypical sources, namely an interest in the writings of the novelist Herman Melville and those of the Swiss psychiatrist C. G. Jung as well as those of Sigmund Freud. At a certain point, Murray had visited Jung and sailed up and down Lake Zurich with him in order to discuss a love affair he was having with socialite Christiana Morgan, a woman who was not his wife. Jung, who himself had a lengthy extramarital relationship, encouraged similar behavior by Murray. Indeed Christiana Morgan went on to work with Murray as a long-time staffer in the Harvard Psychological Clinic and became a co-author with him of the well-known Thematic Apperception Test. According to historian Eugene Taylor, Harvard's decision to hire Murray as a "clinical psychologist" came about partly because of the machinations of L. J. Henderson, a Harvard chemistry professor in whose laboratory Murray had previously served as a research collaborator.

Several of Murray's colleagues in the psychology program at Harvard such as E. G. Boring, its chairman, and Karl Lashley, an influential researcher in what would now be called neuroscience, developed distinctly negative attitudes about Murray's approaches to psychology. Murray, in turn, had great disdain for conventional research in experimental psychology, which he derided as "ear, nose, and throat" psychology, and preferred to work on what he regarded as far more significant, the study of personality. His main research project, which was funded by the Rockefeller Foundation (courtesy of his long-time friend there, the physician Alan Gregg), concerned the intensive longitudinal study of 50 normal, healthy Harvard undergraduates. In this study, Murray used every imaginable source of information, including in-depth interviews, autobiographical essays, behavioral observations, and newly devised procedures such as the Thematic Apperception Test. This research was presented in the magnum opus of a book by Murray and his colleagues, *Explorations in Personality,* published in 1938. It so happened that Murray came up for promotion later that same year. According to Eugene Taylor, the deliberations regarding Murray's promotion lasted two years, and in the end, the vote was a tie, with Boring, Lashley, and one of the deans on the committee voting against it, and Gordon Allport, Stanley Cobb (from Psychiatry), and another dean voting for it. President James B. Conant broke the tie by favoring the promotion; his decision was no doubt influenced by the fact that the Rockefeller Foundation had agreed to continue supporting Murray's research project if he stayed at Harvard. The animosity between Murray and his colleagues in psychology was sufficiently intense that it influenced the later split between the Psychology Department and a new academic unit known as Social Relations, which included sociology and social anthropology as well as clinical psychology.

Harvard thus served as a model to influence many other universities to appoint faculty researchers in psychopathology, so that by the time the American Psychological Association's reorganization in 1945, both clinical and abnormal psychology were thriving areas of endeavor.

# To Tweet or Not to Tweet, That is the Question

Jeffrey N. Younggren, PhD

I was recently doing a risk management workshop and one of the psychologists in attendance told me about how she communicated with a select group of clients on Twitter. She said she found this to be an "effective way of communicating with them." Then, some days later, I was doing a risk management consult and the psychologist with whom I was speaking said that he had text messaged his patient about a misunderstanding that they had during their treatment session and she responded to him via text messaging. Later, another psychologist mentioned to me about how she used email as a way to communicate with her clients on clinical matters in between their treatment sessions. Finally, I was talking yesterday with a colleague who commented about how a clinical Facebook account was very good way to get information out to a select group of clients.

***Technology offers a great deal to the practitioner and it also creates some very serious risks.***

All of this got me thinking. First, it made me think that I was very out of touch with the technology of today – older people tend to be that way. While I was an avid user of email as a way to communicate with my professional world, this limited form of electronic communication was all I used and that I did not use it as a way to communicate with clients – nope, not at all. In addition, my unused Facebook account was living proof of how I did not use that technology in any clinical way, what-so-ever. Actually, I did not use it at all. So, I asked myself, am I behind or are my technologically savvy colleagues in a risky place? I then recalled an article written by Koocher and Morray (2000) on the topic of telepsychology and electronic modes of communication. In the summary section of that article the authors made seven recommendations that included issues that dealt with confidentiality, informed consent and liability. While we are ten years down the road, I believe that very little has changed and, in fact, things may have become even more complex for those who work in the electronic world.

Technology offers a great deal to the practitioner and it also creates some very serious risks. The first, of these has to do with the loss of confidentiality. While clinicians might find these modes of communication to be both convenient and efficient, they cannot be assured that they are confidential. In fact, communications made with clients through electronic means like Twitter and Facebook are arguably not confidential and are discoverable in legal proceedings. To quote from the Twitter website, "You should be careful about all information that will be made public by Twitter, not just your Tweets (https://twitter.com/privacy)." Thus, if one chooses to use this means as a way to communicate with clients, the client must, at a minimum, both understand and consent to this increased risk that the communications might be seen by others. This requirement not only makes good sense but is also a requirement of professional behavior as set forth in the Ethical Principles of Psychologists and Code of Conduct (4.02 (c), 2002)

Text messaging with clients arguably has more serious confidentiality risks associated with it. While the previously discussed issues also apply here, the problems associated with this mode of communication are even more complex. First, how does the clinician who texts clinical information to a client know that they are in fact even communicating with that client and how does one know if they are communicating with the client at a convenient time when others are not around? In addition, while one might get a response, there is no guarantee that that response is even from the client. Remember, it is just from the phone. Finally, if the text message containing clinical information is sent to the client, is it not possible for others to see the message if the phone is set aside or left somewhere? Clearly confidentiality can be seriously compromised through this mode of communication.

Email communications also have confidentiality risks associated with them and consequently require disclosures in them that outline these issues and what should be done if the email goes to the wrong party. Full disclosure aside, clearly using this medium for the communication of highly confidential information

*Ethics Update continued on page 19*

may be unwise and those who communicate sensitive clinical information this way should consider the use of encryption as a way of reducing risk. While this is not required as part of HIPAA (1996), this security policy would prevent unintended recipients from obtaining access to confidential materials.

Another area of concern related to this type of communication has to do with health care records and record keeping. Clinical information that is shared electronically is arguably a healthcare record and there is a developing view that these materials should be retained in as part of a client's health care records. Not only does this place an increased workload on already busy clinicians but how one makes a record of and stores things like text, Facebook and Twitter messages could prove to be quite problematic.

My final area of concern has to do with the clinical implications of engaging in this type of communication with clients. Is it wise to create the perception on a client's part that his or her psychologist is always available? Is there any empirical evidence that these modes of communication are even helpful or are they potentially destructive? The answers to these questions cannot be found in the research available at this time. While there is some evolving research that shows that treatments conducted through electronic means can be effective, this is an evolving area of study and the implications of creating the previously mentioned types of exchanges with clients remain unknown.

Given the current state of affairs surrounding electronic modes of communicating with clients, those who choose to use electronic communications with clients should take great care in so doing. They must obtain detailed consents from their clients regarding their willingness to compromise confidentiality in exchange for the theoretical benefits that follow this type of communication. From my perspective, that of a risk manager, until more research supports the use of these types of communication in a clinical setting and addresses who is best treated in this fashion, the wise clinician should limit electronic exchanges with clients to administrative matters. So, let's face it, perhaps, at this time, Tweeting is best left to the birds.

**References**

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist,* 57, 1060-1073.

Koocher, Gerald P. & Morray, Elisabeth (2000), The regulation of telepsychology: A survey of state attorneys general, *Professional Psychology: Research and Practice*. Vol 31(5), Oct 2000, 503-508.

Health Insurance Portability and Accountability Act of 1996, Retrieved December 20, 2009 from the Office for Civil Rights, U. S. Department of Health and Human Services web site: http://answers.hhs.gov/questions/3586.

Twitter Privacy Policy, https://twitter.com/privacy.

# (Mental) Health Information Technology

**Zeeshan Butt, PhD**

In February 2009, the House and Senate passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was subsequently signed into law by President Obama as part of the American Recovery and Reinvestment Act (ARRA). The HITECH Act is a $19 billion program to stimulate the adoption and meaningful use of health information technology, with particular attention to electronic health records (EHRs). Simply put, meaningful use of EHR involves electronic capture of health information, which is subsequently used to track clinical conditions, coordinate care, and assess clinical quality. While we are still at an early stage of its implementation, HITECH will likely have significant impact on the work of clinical psychologists.

Underlying the HITECH legislation is the federal government's belief in the value of health information technology (HIT) for improving the delivery and effectiveness of healthcare. HITECH aims to achieve these goals by developing an infrastructure to support the federal HIT policy, an incentive/penalty system related to meaningful use of EHRs, and stronger legislation regarding privacy and security of EHRs. I'll focus in this column on incentives for meaningful use of EHRs and privacy issues relevant to clinical psychologists. David Blumenthal, the National Coordinator for Health Information Technology, has written general overviews of HITECH that provide more information on the provisions for the federal HIT infrastructure for interested readers (Blumenthal, 2009, 2010).

Under HITECH, the government will stimulate the development of a national electronic patient records system through incentives and penalties. In particular, the government will provide states with grants to assist in the development of HIT technology and adoption of EHRs by health care providers – including psychologists – at hospitals, nursing facilities, federally qualified health centers, community mental health agencies and similar entities. Regional centers will also be established in order to assist individual providers with adoption of HIT in their practices. Within ARRA, there are also provisions to provide incentive payments to non-hospital-based physicians who show meaningful use of a certified EHR, in the form of bonus Medicare or Medicaid payments (up to $18,000 in the first year). Such incentives, up for discussion but not currently available to psychologists, will be phased out in 2016. Perhaps it comes as no surprise that there is a stick along with the carrot -- physicians and hospitals will face penalties in their Medicare reimbursement if they do not show meaningful use of EHR by 2015.

The increased focus on expanding the use of EHRs has some concerned regarding the privacy and security of these data. HITECH legislation was written to strengthen the privacy and security of health information above and beyond safeguards put in place under the Health Insurance Portability and Accountability Act (HIPAA). Specifically, HITECH extends HIPAA requirements to previously non-HIPAA covered entities, described as "business associates" of covered entities. For example, health information organization and e-prescribing gateways are now covered under HIPAA when they act on behalf of HIPAA covered entities. Covered entities, and now business associates/vendors, are required to notify patients promptly of any data compromise.

Of particular relevance to practicing clinical psychologists, HITECH preserves patient-psychotherapist privilege as established by Federal law. The new legislation also calls for standards committees to make recommendations for segmenting sensitive health information (e.g. mental health, substance abuse), providing additional protection for such data. A recent survey of a mental health clinicians suggested that data privacy and security concerns may be the biggest obstacles for more widespread implementation of psychiatric EHRs (Salomon et al., 2009). Also subject to study under HITECH is the inclusion of mental health testing records in addition to the current provision under HIPAA for psychotherapy notes, which requires specific patient authorization prior to release. Furthermore, private pay patients may now restrict access of their records to prevent having their information from being shared with insurers for payment or administrative reasons.

The HITECH Act has the potential to significantly alter healthcare delivery. While there are some details of its implementation that are still in development, HITECH will surely have implications for the work of clinical psychologists and other mental health professionals. For those of you doing clinical work, how many are currently charting in an EHR? Have you found it

*Technology Update continued on page 21*

**Donna Rasin-Waters, PhD—Section Editor**

## The Power of Advocacy

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

At the APA Practice Organization State Leadership Conference March 6-9, 2010 appropriately entitled *The Power of Advocacy,* it was made abundantly clear that advocacy should be a core event in our professional lives. In order to advance psychology as a science we need to develop a "culture of advocacy" among our colleagues. As stated frequently at the conference, when we fail to advocate we leave the path of our profession and livelihood to others.

What does it mean to create a culture of advocacy for our profession? Well, there was a lot of talk about a culture of advocacy encompassing "an attitude" and "a habit," and by that it was meant good attitudes and habits among psychologists. There was also much said about developing relationships, something that psychologists already know a tremendous amount about and do quite well. So what are the next steps and how can psychologists begin to shape the future of science and practice? How can we develop this crucial attitude among ourselves and build a culture, an attitude and a habit of advocacy for psychology? Here are some of the highlights and take home messages that I returned with from SLC and would like to share with my Division 12 colleagues:

- We can no longer afford to sit on the sidelines while others shape our profession in terms of science and practice. And to quote one of the keynote speakers, Ron Pollack of Families USA, "We can't stop politics from intervening in the process; "politics is the process."
- Public education is critical to the advocacy efforts of psychology, even if at the very least, to correct the bad information that is sometimes widely disseminated. The APA public education campaign delivers much needed information to the public about mental and behavioral health. We must continue to engage in these activities and widen accessibility regarding information about psychology to include online social networks such as blogs, Twitter, Facebook and numerous other avenues to reach out to the public.
- Constant work with other groups in forming alliances around common issues is crucial as psychology is integrated throughout the healthcare delivery system.
- State-based involvement is fundamental to the application of laws and policies involving psychology that are set by the federal government.

With all that said I hope that each and every division member will consider taking part in some if not all of the above steps in order to build a culture of advocacy. It is then that we will truly experience the power of advocacy.

## Technology Update *(continued from page 20)*

helpful or detrimental in your practice? For those of you not currently using electronic charting, what do you perceive to be the barriers to its implementation? Clinical psychologists should continue to be involved in the roll-out of HITECH, as there will likely be known (and unintended) consequences of meaningful use of EHRs.

*Please feel free to send me a note if you would like to see a specific technology-related topic addressed in a future column or if you have any other related thoughts you'd like to share. I can be reached most easily at z-butt@northwestern.edu.*

**References**

Blumenthal, D. (2009). Stimulating the adoption of health information technology. *The New England Journal of Medicine*, 360, 1477-1479.

Blumenthal, D. (2010). Launching HITECH. *The New England Journal of Medicine,* 362, 382-385.

Salomon, R. M., Blackford, J. U., Rosenbloom, S. T., Seidel, S., Clayton, E. W., Dilts, D. M., & Finder, S. G. (2009). Openness of patients' reporting with use of electronic records: Psychiatric clinicans' views. *Journal of the American Medical Informatics Association,* 17, 54-60.

## Section II: Society of Clinical Geropsychology

**Brian D. Carpenter, PhD**

Recent months have seen some exciting developments in public policy and practice that are likely to have a major impact on geropsychology.

To begin with, the public comment period for proposed changes to DSM-V started, and there's been a great deal of "chatter," as they say, on the Section II listserv about how the diagnostic criteria may or may not be sensitive to aging issues. Section members are formulating an organized response to the Lifespan Study Group, which is seeking input regarding everything from whether the diagnostic criteria adequately capture the phenomena across age groups to the structure and naming of chapters in the text. If you are interested in adding your input, you can do so at www.dsm5.org.

***Health reform legislation has many people excited (or agitated, as the case may be). Politics aside for a moment, the new legislation includes provisions that will, in general, expand the provision of mental health services to older adults.***

Health reform legislation has many people excited (or agitated, as the case may be). Politics aside for a moment, the new legislation includes provisions that will, in general, expand the provision of mental health services to older adults. From the perspective of patients and clients, several programs are planned that will promote integrated interdisciplinary/interprofessional health care in primary care and other settings, where older adults may benefit from easier access to collaborative health services. In addition, there are special grants targeting mental health and substance abuse screening, treatment, and follow up for individuals age 55-64. And family caregivers and other direct care providers are likely to learn more about mental health and dementia as Geriatric Education Centers develop and offer training courses with this new required content.

From the perspective of practitioners and researchers, several initiatives focus on workforce development, opening up education and training opportunities for psychologists interested in geropsychology. For example, the Geriatric Academy Career Awards have been expanded to include psychology faculty, and Geriatric Career Incentive Awards will offer financial support to encourage greater interest in geropsychology among students. All this is very good news for geropsychologists, would-be geropsychologists, and the patients and families with whom they work.

In other Section news, the 2009 Student Research Award was given to Katherine D. Kane from the University of Colorado, Colorado Springs. Katherine's work examined whether depressive symptoms and cognitive dysfunction predicted 12-month, all-cause mortality for new residents in a long-term care facility. You can read the full report on this research in an upcoming issue of *Psychology and Aging*. Congratulations Katherine!

The Section's Cultural Diversity Committee, chaired by Yvette Tazeau, is adding new multicultural resources to the Section's revised website and is preparing several papers for an upcoming special issue of *The Clinical Gerontologist* that will focus on diversity, mental health, and aging.

Finally, Deborah DiGilio from the APA Committee on Aging (CONA) and the Office on Aging has been working with the Task Force to Update the Guidelines for the Evaluation of Dementia and Age-Related Cognitive Decline, whose work is soon to be open for public comment. Deb is also staffing the APA 2010 Presidential Task Force on Caregivers convened by President Carol Goodheart. The Task Force is developing an online "Family Caregiver Briefcase for Psychologists," a resource for psychologists interested in geropsychology.

## Section III: Society for a Science of Clinical Psychology

**David F. Tolin, PhD, ABPP**

**Election Results**

Thomas Ollendick is the President of SSCP; he is joined on the Board by President-Elect Varda Shoham, Past President Howard Garb, Secretary/Treasurer David Smith, At-Large Representatives Kelly Wilson

and Bethany Teachman, Division 12 Representative David Tolin, and Student Representatives Frank Farach and Rebecca Brock.

SSCP heartily congratulates the following five winners of the Dissertation Grant Award for 2010, each of whom received $500 for their research. They are Faith Brozovich (Temple University), Kristen Gainey (University of Iowa), Ashley Johnson (Binghamton University), Lisa Talbot (University of California-Berkeley), and Jennifer Veilleux (University of Illinois-Chicago).

SSCP also wishes to acknowledge Student Representatives Frank Farach and Rebecca Brock, under whose leadership our student listserv has become quite active in the past month, with discussions of the internship process, grantsmanship, and early career development. We also thank Membership Committee chair Doug Mennin, who is reaching out to recruit minority members for the Society.

***The annual Society for a Science of Clinical Psychology Member Meeting will be held at the American Psychological Society conference on May 28.***

In addition to being a section of APA's Division 12, SSCP is also an affiliate of the American Psychological Society (APS). The SSCP Board has been discussing the pros and cons of having a "foot in each camp." This discussion is in the early stages of deliberation, and no decisions have been made. Discussion will continue at our next meeting and likely additional ones throughout the year.

SSCP Program Chair Mitch Prinstein has developed an outstanding program for the APA Annual Convention, including (a) an address by Matthew Nock on suicidal and non-suicidal self-injury, (b) a symposium chaired by Howard Garb on DSM-V, and (c) a panel discussion on ethical issues associated with evidence-based practice chaired by Mitch Prinstein.

The annual SSCP Member Meeting will be held at the APS conference on May 28. Our Distinguished Scientist Address will be delivered by this year's recipient, Tom Widiger. Tom Ollendick will also deliver his SSCP Presidential Address on evidence-based practice.

## Section IV: The Clinical Psychology of Ethnic Minorities

**Wei-Chin Hwang, PhD**

We are excited to announce Section VI programming for the 2010 APA convention. Presentations start off with a 1-hour Presidential Symposium (Program Chair: Cheryl Anne Boyce), which includes talks by Section VI President Guerda Nicolas (Innovations for Mental Health Treatment with Ethnically Diverse Populations), Joseph Trimble (Cultural Resonance, Competence, and Relational Collaboration with Native American Indians), and Guillermo Bernal (Cultural Adaptations and Evidence-Based Treatments for Puerto Rican Youth and Their Families).

Two other symposiums are planned. Symposium #1 (Discussant: Cheryl Anne Boyce), includes talks by Lula Beatty (Working with Special Population Youths and Substance Use Disorders), LeShawndra Price (Developmental Trajectories of Substance Use among African American and Hispanic Youth), Michele Cooley Strickland (Emotion, Behavior, and Substance Use among Diverse Youths), and Tamika Gilreath (Smoking Behaviors among African American Adolescents). Symposium #2 includes a talk by Gail Wyatt on Sexual Health, Trauma and Risk among Couples (Chair: Lewis Wyatt). There will also be a 2-hour Section VI membership meeting and awards presentation (Chair: Guerda Nicolas).

***A new student resource for multicultural professional development is being launched in collaboration with the National Latina/o Psychological Association.***

In addition, a new student resource for multicultural professional development is being launched in collaboration with the National Latina/o Psychological Association. This online tool is a searchable collection of short discussions on student and professional development topics of particular relevance to multicultural psychologists. The site has launched with discussions on perfecting professional writing, research involvement, advice on dealing with "impostor syndrome", and strategies for identifying mentors and

developing mentorship networks. Upcoming entries include discussions of strategies for the completion of successful theses, dissertations on multicultural topics, and interview and negotiation strategies for early career professionals with multicultural expertise. The online tool can be found at: http://multiculturalmentoring.blogspot.com. Suggestions for future topics and inquiries about guest entries are welcome by the blog's editors, Shannon Chavez-Korell (korell@uwm.edu) – Student and Professional Development Coordinator for the NLPA- and I. David Acevedo (david.acevedo@cmich.edu) – Mentorship Chair for Section VI.

The Institute for the Study and Promotion of Race and Culture (ISPRC) at Boston College invites you to join the Institute's tenth annual national Diversity Challenge conference to address issues of racial and ethnic cultural diversity in U.S. society. The Institute was founded in 2000 at Boston College, under the direction of Dr. Janet E. Helms, to promote the assets and address the societal conflicts associated with race and culture in theory and research, mental health practice, education, business, and society at large. For more information, please see http://www.bc.edu/schools/lsoe/isprc/.

Finally, we are also pleased to announce Michi Fu as the new Treasurer. Dr. Fu is a child and family program director for Asian Pacific Family Center, Associate Professor at the California School of Professional Psychology of Alliant International University, and a practicing psychologist. She is a two-time past board member of the Asian American Psychological Association, past Diversity Delegate of the California Psychological Association, and current Member-at-Large of APA's Division 45. She is looking forward to serving APA's Division 12, Section 6 as the Interim Treasurer.

## Section VII: Clinical Emergencies and Crises

**Marc Hillbrand, PhD**

Section VII looks forward to an exciting 2010 APA Convention in San Diego. Section offerings include, among others, a workshop offered by David Jobes, *An Overview to the Collaborative Assessment and Management of Suicide (CAMS),* the Presidential Address by Michael Hendricks, *Suicide Risk in a Transgender Population,* and a program by Bruce Bongar, *The Suicidal Patient: Clinical and Legal Standards of Care.*

Section VII is welcoming new student members, thanks to a collaborative initiative between D12 and its Sections. Student members who are joining Division 12 now get a free membership to one of several Sections during their tenure as students. We encourage them to take advantage of this free membership in Section VII. The Section is a great professional community to foster professional development. Our new student representative is Gina Bruns, who is a clinical doctoral student at The American University in Washington, D.C. Last year's student representative was Kim Van Orden. Both have become involved in an important collaboration between Section VII and the APA's Advisory Committee on Colleague Assistance (ACCA).

***Section VII is welcoming new student members, thanks to a collaborative initiative between D12 and its Sections. Student members who are joining Division 12 now get a free membership to one of several Sections during their tenure as students.***

This collaboration addresses two prevention topics, namely patient-to-psychologist violence and psychologist suicide, and a crisis management topic, namely handling the aftermath of a psychologist suicide. Under the leadership of ACCA chair Diane Bridgeman and Section VII founder Phillip Kleespies, contributors to this project also include Bruce Bongar, Gina Bruns, Lynn Bufka, Daniel Galper, Marc Hillbrand, Dale McNeil, David Rudd, Kim Van Orden and Robert Yufit. One product of these efforts is a pamphlet devoted to patient-to-clinician violence prevention available to clinicians through the ACCA website and with links from the APA and the D12 websites ( http://www.div12.org/blog/minimizing-patient-clinician-violence ).

The psychologist suicide work group has now completed interviews of more than a dozen psychologists who have firsthand experience of dealing with the aftermath of the suicide of a psychologist colleague. The work group is currently studying the implications of this information for both the prevention and "post-

vention" of psychologist suicide. An early report on these findings will be presented at the annual meeting of the American Association of Suicidology.

## Section IX: Assessment

**Norman Abeles, PhD**

I am just in the process of completing a brief article on intellectual disability, The Supreme Court and the Death Penalty. Several years ago in a case called Atkins v Virginia the Supreme court agreed that Intellectual disability (known as mental retardation) should be considered a mitigating factor with regard to the death penalty because it would constitute cruel and unusual punishment and would be in violation of the 8th Amendment to the US Constitution. The case involved in the present paper deals with the question of whether or not attorneys who do not present such evidence are providing ineffective assistance to the defendant. Of course the question of whether or not the defendant met criteria for intellectual disability is also discussed in my paper along with the psychological assessments of several experts. This paper will be discussed at my upcoming presentation at APA in San Diego in August if you would like to obtain more information about this issue. Moving on to DSM V, we note that there is a new syndrome being considered for inclusion. It is called Parental Alienation Syndrome and it begins in childhood and is related to parental conflict. Children may be pulled into a parent's irrational scapegoating of another parent. This syndrome does not apply when physical abuse is present. The American Psychiatric Association is still taking public comments on this proposed syndrome which, if included, will provide more assessment issue for mental health professionals including psychologists.

***Several years ago in a case called Atkins v Virginia the Supreme court agreed that Intellectual disability (known as mental retardation) should be considered a mitigating factor with regard to the death penalty because it would constitute cruel and unusual punishment and would be in violation of the 8th Amendment to the US Constitution.***

Still another interesting topic concerns neuroimaging. There are some individuals who argue that neuroimaging may have impact on the insanity defense. Will such evidence be more difficult to falsify and will neuro-imaging have any impact on jurors asked to decide the question of insanity.Many jurors are skeptical about the insanity defense and even neuroimaging evidence may not seem convincing. Moreover will neuroimaging be perceived as just another rich person's ploy and will this reinforce the perception of jurors that the insanity defense is used primarily by those who can afford such assessments.

Finally some comments on recent actions at APA Council. There was agreement reached by council on creating APA treatment guidelines and the establishment of a Steering Committee and Guidelines Development Panel. A core Values Statement was also adopted and reads as follows:

*Continued pursuit of excellence; knowledge and its applications based upon methods of Science; outstanding service to its members and to society; social justice, diversity and Inclusion; ethical action in all that we do.*

# DIVISION 12 AWARD WINNERS 2010

Award for Distinguished Scientific Contributions to Clinical Psychology presented to **Steven Dennis Hollon, Ph.D.** and **Linda Carter Sobell, Ph.D., ABPP** for distinguished theoretical or empirical contributions to Clinical Psychology throughout their careers.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology presented to **Irving B. Weiner, Ph.D.** for distinguished advances in psychology leading to the understanding or amelioration of important practical problems and outstanding contributions to the general profession of clinical psychology.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology presented to **Armand R. Cerbone, Ph.D.** for remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind.

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology presented to **Jessica Henderson Daniel, Ph.D.** for excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty.

The American Psychological Foundation Theodore Millon Award presented to **Brent W. Roberts, Ph.D.** for outstanding mid-career advances in the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement.

Theodore H. Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology presented to **E. David Klonsky, Ph.D.** for professional accomplishments in clinical psychology. Accomplishments may include promoting the practice of clinical psychology through professional service; innovation in service delivery; novel application of applied research methodologies to professional practice; positive impact on health delivery systems; development of creative educational programs for practice; or other novel or creative activities advancing the service of the profession.

David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology presented to **Bunmi O. Olatunji, Ph.D.** for contributions to the science clinical psychology by a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to science and to practice.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology presented to **Cortney Soderlind Warren, Ph.D.** for an early career psychologist who has made exemplary contributions to diversity within the field. Such contributions can include research, service, practice, training, or any combination thereof.

Distinguished Student Research in Clinical Psychology Award presented to **Rebecca Kathryn McHugh** for exemplary theoretical or empirical contributions to research in clinical psychology.

Distinguished Student Service in Clinical Psychology Award presented to **Emily Engel** for outstanding service contributions to the profession and community.

Distinguished Student Practice in Clinical Psychology Award presented to **Winslow Gerrish** for outstanding clinical practice contributions to the profession.

This year's award ceremony takes place on Friday, August 13, at the 2010 APA Annual Convention. It will be held between 5:00 p.m. - 5:50 p.m. at the San Diego Marriott Hotel and Marina, Marriott Salon 3, and will be followed by the Division 12 Social Hour.

# JOIN A DIVISION 12 SECTION

Division 12 has eight 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.div12.org/division-12-sections

To learn more about the Society of Clinical Psychology, visit our web page:

*www.div12.org*

## 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 sixth edition of the Publication Manual of the American Psychological Association (2010). An electronic copy of a submission in Word format should be sent as an attachment to e-mail. 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 and submissions may be made to the editor at milton.strauss@gmail.com.

**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.**