

# THE CLINICAL PSYCHOLOGIST



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

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By **Marvin R. Goldfried, PhD, ABPP**  
Stony Brook University  
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### PRESIDENT'S COLUMN

## Results of the Survey of Clinicians' Experiences in using an Empirically Supported Treatment for Panic Disorder

The Society of Clinical Psychology has just completed its first survey of clinicians' experiences in using an empirically supported treatment (EST). The goal of this initiative is to close the gap between practice and research by establishing a mechanism whereby clinicians can have a voice in the research process. It does this by having them make use of their clinical experience to highlight researchable questions and hypotheses that could help improve the effectiveness of our interventions.

By having such a two-way, rather than a one-way bridge between research and practice, it is also our hope that it will encourage practitioners to use research findings in guiding their clinical work. Closing the clinical-research gap is particularly important at this time, as the growing demands for accountability are best met by having both researcher and therapist collaborate in deciding which treatments work.

We began this initiative by focusing on clinicians' experiences in using an EST for the treatment of panic disorder, as it is a clinical problem that they are likely to encounter in their practice, and one for which there exists empirical evidence indicating that treatment is efficacious—although not 100% effective. Although research is underway to determine if other therapies can successfully treat panic, CBT is the only approach at present that has adequate empirical support. However, in order to move from an EST to a treatment that we know works well in practice settings, it is important to know more about the clinical experience of therapists who make use of these interventions. By identifying the obstacles to successful treatment, we can then take steps to overcome these shortcomings.

The items in the survey, which involved patient, therapist, treatment and contextual variables, were generated from open-ended interviews with a group of clinicians who were experienced in using CBT for the treatment of panic, with the goal being to identify those conditions that are likely to influence clinical effectiveness in actual practice. We are most grateful for the time and thought these colleagues put into helping us construct the survey, and would like to thank Dianne Chambless, Steven Fishman, Joann Galst, Alan Goldstein, Steven Gordon, Steven Holland, Philip Levendusky, Barry Lubetkin, Charles Mansuto, Cory Newman, Bethany Teachman, Dina Vivian, and Barry Wolfe for their efforts.

We piloted early versions of the questionnaire, and ended with one that could be complet-

*(continued on page 2)*

## President's Column (*continued*)

ed in approximately 10 minutes. We then announced its availability through postings on listservs, Web sites, and in newsletters of the Society of Clinical Psychology, the APA Division of Psychotherapy, the Society of Counseling Psychology, the Association for Behavioral and Cognitive Therapies, and numerous professional organizations in Canada, the UK, Europe and Australia.

In working on this initiative, I have been fortunate

to have a hard-working committee made up of a group of experienced, motivated and enthusiastic researchers and practitioners who similarly have had an ongoing dedication to closing the gap between practice and research. Our committee includes Louis G. Castonguay (President of the Society for Psychotherapy Research); Marvin R. Goldfried (Past-President of the Society for

*President's Column continued on page 3*

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Psychotherapy Research and President of Division 12); Jeffrey J. Magnavita (President of Division 29--Psychotherapy); Michelle G. Newman (Associate Editor of *Behavior Therapy* and psychotherapy researcher with expertise in anxiety disorders); Linda Sobell (Past-President of AABT and Division 12); and Abraham W. Wolf (Past-President of Division 29). In addition to their motivation and interest, members of the committee have had ongoing experience in working to close the gap between practitioners and researchers, such as Castonguay's role as Co-Chair of the National Research Practice Network; Goldfried's founding of the journal *In Session*, which includes research reviews written for the practicing clinician; Magnavita and Newman serving as Guest Editors for *In Session*; Sobell's collaboration with therapists in designing a therapy manual and research protocol for the treatment of substance abuse (Sobell, 1996); and Wolf's professional dedication to fulfilling the model of the scientist-practitioner. With the assistance of two clinical graduate students at Penn State University—Andrew McAleavey and Lauren Szkodny—we are currently developing surveys that will be sent to clinicians regarding their experiences in implementing two more ESTs: CBT for Generalized Anxiety Disorder and CBT for Social Phobia (Social Anxiety Disorder).

In their response to the panic survey, participants were asked to indicate which of several variables listed under each of the following categories had limited their successful use of CBT in reducing symptoms of panic:

- Patient's symptoms related to panic
- Other patient problems or characteristics
- Patient expectations
- Patient beliefs about panic
- Patient motivation
- Social system (home, work, other)
- Problems/limitations associated with the CBT intervention method
- Therapy relationship issues

The results of the survey have been posted on the Society's Web site ([www.div12.org/panicsurvey](http://www.div12.org/panicsurvey)), and appear as an article in this issue of *The Clinical Psychologist* [American Psychological Association (APA) Division 12 Committee on Building a Two-Way Bridge Between Research and Practice, 2010].

The findings of the survey are both interesting and informative. In some respects, they raise more

questions than they answer. But then again, that was precisely its purpose—to provide the researcher with clinically relevant leads for future investigation. We believe that this initiative is something where everyone benefits—the clinician, the researcher, and certainly the client. It is our hope that this will enable the practicing clinician to have a voice in the research agenda. For the researcher, it points to researchable--and hopefully fundable—hypotheses for investigations that are born out of clinical practice.

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## Current Status and Future Directions of Clinical Psychology in Vietnam: St. John's University Students and Faculty Travel to Vietnam

Randi Pochtar & Mark D. Terjesen, PhD  
St. John's University



This past May, students and faculty from St. John's University's (STJ) graduate programs in Clinical and School psychology travelled to Vietnam to further assist in the development of the profession of applied psychology in that country and to continue the work established in four prior trips (Terjesen & Kassay, 2007; Terjesen, Kassay, & Bolger, 2008; Terjesen, et al., 2010). The aim of the trip was to increase an understanding of current education and mental health practices of children in Vietnam, collaborate on research, discuss current best practices in psychological assessment and intervention, and work on the development of psychological assessment measures in Vietnam. The students took concurrent graduate coursework in Cultural Diversity and Early Intervention services and this trip furthered their knowledge of the role of culture in psychological and educational services.

The country of Vietnam is the thirteenth most populous country in the world with a population of over 89 million (U.S. Census Bureau, 2010). While there is a clear need for mental health services in Vietnam, especially for children, these services are not readily available. That is, mental health care in Vietnam is typically reserved for the more severe mental disorders (i.e., brain injuries depression, epilepsy, schizophrenia, and substance abuse, Schirmer, Cartwright, Montegut, Dreher, & Stovall, 2004). The World Health Organization (2005) reported that only 29 of 64 provinces and cities in Vietnam had psychiatric hospitals; there were only 0.63 psychiatric beds per 10,000 people, 0.32 psychiatrists and 0.06 psychologists per 100,000 people, only one 20-bedded inpatient child psychiatry unit, and 2 child psychiatrists in the entire country.

To meet the growing need for mental health professionals, counseling centers have been set up in some

cities in Vietnam to provide greater access, as well as to offer an opportunity for assistance to those who may not be experiencing pathology that is severe enough to warrant hospitalization (APS, 2007 as cited by Kassay, 2010). These counseling centers operate much like hot-lines and are growing in use and popularity. A survey done by the Applied Psychology Section (APS) of the Hanoi National University of Education (HNUE) (APS, 2007) found that most counseling centers in Hanoi receive between 100 and 250 calls per day.

Not only is there an insufficient number of mental health professionals to meet the needs of the population, the services provided may also not be very advanced in nature (Schirmer, et al., 2004). Moreover, training is often not differentiated from primary health care: "mental health is part of the primary health care system... regular training of primary care professionals is not carried out in the field of mental health... [and] effective psychosocial rehabilitation is still to develop" (World Health Organization, 2005, p. 505). This may be evidenced by the fact that in the aforementioned counseling centers, only 30-40% of counselors reported having a background in psychology (usually an undergraduate degree), and all of those surveyed reported that their ability to provide appropriate counseling services to their clients was hampered by the fact that they lack the practical skills and knowledge to provide these services (APS, 2007 as cited by Kassay, 2010). As such, this lack of formal training in psychological service provision may lead to clients not receiving the best possible care (APS, 2007 as cited by Kassay, 2010).

With a focus on education reform (Ministry of Education and Training [MOET], 2003), it appears that initial efforts to meet the mental health needs of the country are geared towards working with the younger populations. This makes sense given that approximately 33.5% of the population is under 15 years of age and 20% is between 15 and 24 years of age (Bondurant et al., 2003). Kassay (2010) reviewed several studies cited by the APS (2007) supporting the evidence of mental health problems in Vietnam among children and adolescents that warrant intervention. Vietnam has recently witnessed increases in international communication (Ashwill & Thai, 2005), advances in the education system (Ministry of Education and Training [MOET], 2003), and a rapidly growing economy that provides the financial resources to support educational





and social reforms (World Bank, 2007). In concert with the current deficiency of mental health services, it appears that the time is right for communication and collaboration on the development of training possibilities to best meet the educational and mental health needs of the population. Well-trained professionals and formal training for mental health service provision are the necessary missing links to meeting the national mental health needs of the Vietnamese population.

The recognition of the importance of education may be reflected in the fact that Vietnam has recently been described as “A Rising Star on the U.S. Higher Education Scene” (Ashwill, 2010) with many U.S. programs offering different types of services and activities in Vietnam. In the area of applied psychology, Bahr Weiss and colleagues at Vanderbilt University have developed a Ph.D. program in Clinical Psychology for Vietnam National University in Hanoi, that began in the fall of 2008, to train students to “develop and evaluate research-based methods for treating mental health concerns” (Moran, 2007). Similarly, STJ has worked with the faculty at HNUE to establish the first formalized training program in school psychology (Terjesen, et al., 2008) which recently commenced with a summer training of HNUE faculty (Kassay, 2010). The first formal cohort of school psychology students matriculated at HNUE in the fall of 2009.

### Professional Experiences in Vietnam

During our two-week stay in Vietnam, the students and faculty from STJ had numerous opportunities not only to meet with mental health and educational professionals in Vietnam, but also to visit several orphanages, schools, and mental health facilities. The purpose of each visit was twofold: to further our awareness concerning the status of mental health care for children and families in Vietnam while also sharing our knowledge and resources regarding the current best practices in Western mental healthcare.

During their stay in Ho Chi Minh City, the STJ group visited Children’s Hospital #1, the only children’s psychiatric hospital in the city. The STJ students and faculty were struck by the image of hundreds of children and families waiting for hours outside of the hospital in the Vietnam heat to be seen by various doctors. Drs. Mark Terjesen and Samuel Ortiz from STJ met with Dr. Pham Ngoc Thanh regarding the state of mental health care for children and families in Vietnam. They learned about their current practices

for working with students with autism in the hospital and their attempts to reach individuals who would benefit from treatment away from the major cities. The need for continued training and professional development was stressed by Dr. Thanh, as well as measures and systems to assist in accurate diagnosis and treatment planning.

To gain an understanding as to current familial and educational practices in Vietnam, the STJ group had an opportunity to visit a number of orphanages, among them the SOS Village in Hanoi, an alternative orphanage program. This organization focuses on providing long-term care for children who do not have parents to care for them (<http://www.sos-childrensvillages.org>). The SOS community adopts the child and children grow up in a permanent home with a “mother” and several “brothers” and “sisters” until they are independent adults. This system of care struck us as somewhat different than the Western approaches towards orphanages, and the potential positive impact of the development of secure relationships with caring, loving individuals may greatly assist the child.

In addition, the STJ students and faculty visited two orphanages sponsored by the Worldwide Orphans Foundation (WWO), founded in 1997 by Jane Aronson (<http://www.wwo.org>): Tam Binh Orphanage #2 in Ho Chi Minh City and Ba Vi Orphanage outside of the city of Hanoi. Both WWO orphanages visited have early intervention *Hieu Roi Thuong* (HRT) programs, which means “understanding through compassion”, and are based on the concept that every child needs to feel secure with at least one adult caretaker. At Tam Binh #2 and Ba Vi, female volunteers from the community work one-to-one with a child for five hours each day, five days per week. Given the title of “gran-nies,” the volunteers feed, comfort, and engage the children in play (<http://www.wwo.org>).

In conjunction with the faculty at HNUE and WWO, several students are participating in the development and translation of the cognitive scale of the Bayley Scales of Infant Development - III, a measure of functioning in infants and toddlers, for use with the Vietnamese population. This is the first measure of its kind to be officially translated into Vietnamese. Moreover, Pearson, the testing and education company, donated a Bayley assessment kit to WWO for their future use in their development of this infant assessment measure. Each STJ student had the opportunity to demonstrate an administration of the Cognitive

scale of the Bayley to several infants and toddlers for the staff at the orphanage. The children responded positively to the examiners and our first efforts at using this assessment tool with a Vietnamese population were successful and promising. We are hopeful that the development of this measure will allow for ongoing assessments that guide individualized treatment plans for each child.

Clinical psychology students with an interest in autism had the opportunity to meet with several professionals working with families and children with autism including medical doctors, educators, and psychologists. On their first day in Vietnam, the students were visited by Tony Louw, who is an applied behavior analyst for children with autism, and works as a special education teacher at the International School in Ho Chi Minh City. Louw magnified the importance of tailoring one's interventions to meet the cultural needs of the client. As an example, he offered that he has observed that the concept of positive reinforcement is unnatural to Vietnamese parents as their learning is mainly based on punishment, and they are highly concerned with not spoiling their children. He also described some of the struggles he has experienced in his work with families, as there are no Vietnamese

words that are equivalent to some of the English terms we use in explaining concepts such as reinforcement (T. Louw, personal communication, May 19, 2010).

Louw explained to the STJ group that special education in Vietnam is entirely funded by the families who desire and can afford these services, with most services provided privately. Otherwise, children with intellectual disabilities are generally mainstreamed and placed into a single classroom with children of varying disabilities. These schools are typically funded by charities with little reliance on government funding (T. Louw, personal communication, May 19, 2010). Moreover, there are an insufficient number of training opportunities for teachers, and classroom conditions for children with disabilities do not adequately meet their individual educational needs (Center for International Rehabilitation, 2005). Through conversations with several professionals working with these families, it was evident that these individuals are in need of supplementary resources for the assessment, diagnosis, and treatment of autism and other developmental disabilities in Vietnam.

There is limited research on developing countries in general, and more specifically on children and families in Vietnam (D'Antonio & Shin, 2009; Harpham





& Tuan, 2006). While in Hanoi, the STJ group had numerous opportunities to collaborate on several research projects with the faculty in the psychology department at HNUE. The areas of research were varied, involving examining research on psychopathy among adults in both urban and rural settings, as well as research that examined parental functioning, educational behaviors, and child functioning in Vietnam, with data collected from several villages, schools, preschools and daycare centers in Hanoi. Several other doctoral students worked closely alongside faculty members at HNUE in the translation and back-translation of several measures into Vietnamese. The current studies will provide further understanding of the way parenting influences child outcomes in cross-cultural samples. Furthermore, the translation and validation of several measures of parenting affect, beliefs, and behavior will be of value to clinicians in Vietnam.

As a result of this experience, a deepened understanding of the role that culture, resources, and context plays in the delivery of mental health services will serve STJ students when working with children and families different from ourselves within the United States. Furthermore, the long-term collaboration that STJ has developed with the faculty at HNUE will

provide opportunities to continue our understanding of the perceptions and beliefs about child development within the context of a diverse culture, as well as providing the potential to contribute to the future mental health care of children and families in Vietnam. Moreover, our trip to Vietnam is highly representative of the STJ clinical psychology program's scientist-practitioner model of learning. Our experiences in various orphanages, preschools, and mental health facilities will channel the direction of our future research projects each with the aim of providing services to those who are most in need. Concurrently, the research studies conducted in Vietnam help to focus the lens of clinical practice on the areas most needed by Vietnamese families and children.

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### Clinicians' Experiences in using an Empirically Support Treatment (EST) for Panic Disorder: Results of a Survey

American Psychological Association (APA)  
Division 12 Committee on Building a Two-Way  
Bridge Between Research and Practice



As part of its effort to build a two-way bridge between research and practice, the Society of Clinical Psychology recently surveyed therapists about the variables they found to limit the effectiveness of cognitive behavior therapy (CBT) in clinical practice for treating panic disorder—the only current EST. The goal of this initiative was to close the gap between research and practice by providing clinicians with a voice in the research process. In essence, it could allow them to make use of their clinical experience—the context of discovery—to highlight researchable questions and hypotheses that could help improve the effectiveness of our interventions. In having a two-way, rather than a one-way bridge, it is also hoped that it will also encourage practitioners to make use of research findings to guide their clinical work. With growing demands for accountability, it is important for both researcher and therapist to have a collaborative voice in deciding which treatments work.

We began by surveying experiences in the treatment of panic disorder because it is a clinical problem that therapists are likely to encounter in their practice, and one where there exists research findings indicating that it is efficacious—although not 100% effective. The items in the survey, which involved patient, therapist, treatment and contextual variables, were generated from open-ended interviews with a group of clinicians who were experienced in using CBT for the treatment of panic. For their invaluable help in constructing the survey, we thank Dianne Chambless, Steven Fishman, Joann Galst, Alan Goldstein, Steven Gordon, Steven Holland, Philip Leventusky, Barry Lubetkin, Charles Mansuto, Cory Newman, Bethany Teachman, Dina Vivian, and Barry Wolfe.

The next two surveys will focus on the use of ESTs in the treatment of general anxiety disorder, and of social phobia (social anxiety disorder).

Invitations to participate in the current survey were

announced on Web sites, listservs, and in newsletters of numerous professional organizations in the US, Canada, the UK, Europe, and Australia. The survey included the following instructions:

Once a drug has been approved by the Food and Drug Administration (FDA) as a result of clinical trials, practitioners have the opportunity to offer feedback to the FDA on any shortcomings in the use of the drug in clinical practice. The Society of Clinical Psychology, Division 12 of the American Psychological Association, has established a mechanism whereby practicing psychotherapists can report their clinical experiences using empirically supported treatments (ESTs). This is not only an opportunity for clinicians to share their experiences with other therapists, but also to offer information that can encourage researchers to investigate ways of overcoming these limitations.

This questionnaire provides the opportunity for therapists using cognitive-behavior therapy (CBT) in treating panic disorder to share their clinical experiences about those variables they have found to limit the successful reduction of symptomatology. By identifying the obstacles to successful treatment, we can then take steps to overcome these shortcomings.

Your responses, which will be anonymous, will be tallied with those of other therapists and posted on the Division 12 Web site at a later time, with links made to it from other relevant Web sites. The results of the feedback we receive from clinicians will be provided to researchers, in the hope they can investigate ways of overcoming these obstacles.

Participants were asked to indicate which of the items listed under the following categories limited successful symptom reduction: Patient's symptoms related to panic; Other patient problems or characteristics; Patient expectations; Patient beliefs about panic; Patient motivation; Social system (home, work, other); Problems/limitations associated with the CBT intervention method; and Therapy relationship issues. The results of their responses to these questions appear in the Tables appearing below.

## Results of a Survey (*continued*)

We received a total of 326 usable surveys, containing responses to the questions and the necessary demographic information. The median age of respondents was 45 years (25 to 81 years), 52% of whom were female and 86% Caucasian. Fifty-six percent had a PhD in clinical psychology, and the median year of the highest degree was 2000. Experience level varied widely, with 35% having over 20 years of experience, 29% between 10 and 20 years, and the remaining 36 % less than 10 years of experience. Closely paralleling this were the number of panic patients treated: 36% having seen over 51 patients, 28% between 21 and 50, and 36% less than 20 patients. The patients had been seen in varying settings, including outpatient clinic (61%), private practice (54%), counseling centers (10%), and inpatient (3%). The length of treatment varied, from less than 3 months (21%), between 3 and 6 months (49%), 6 months to a year (25%), and over a year (5%). In identifying the degree to which different theoretical orientations guided their work, cognitive (41%) and behavioral (38%) ranked the highest, with psychodynamic (15%), experiential/humanistic (12%), family/systems (11%) and other (12%) playing some role.

The Division 12 committee that has been overseeing this initiative and discussing the findings consists of Louis G. Castonguay: President, Society for Psychotherapy Research; Marvin R. Goldfried (Chair): Past-President, Society for Psychotherapy Research, President, APA Society of Clinical Psychology; Jeffrey J. Magnavita: President, APA Division of Psychotherapy; Michelle G. Newman: Psychotherapy researcher in anxiety disorders, Associate Editor, Behavior Therapy; Linda Sobell: Past-President, of Association for Behavioral and Cognitive Therapies, Past-President, APA Society of Clinical Psychology; and Abraham W. Wolf: Past-President, APA Division of Psychotherapy. The findings of this study, many of which we believe are interesting and important, are presented in the Tables below. Some of results have been discussed by the committee, and a transcription of this discussion appears below:

MARVIN GOLDFRIED: There are a number of interesting points that resulted from our survey of clinicians about their experiences in using cognitive-behavior therapy (CBT)—which is considered an empirically supported treatment for panic disorders. Perhaps we can start by looking at the characteristics of the therapists who participated. As seen by what they indicated to be the orientations that guided their work, approximately 79% of them reported that they

use cognitive and behavioral interventions, but also suggest that they are not doing pure CBT

ABE WOLF: What you mean by “pure CBT?”

GOLDFRIED: Therapy that would be essentially following the CBT manual for the treatment of panic, which is used in clinical trials.

NEWMAN: I think it is likely that therapists interpreted the question more broadly to indicate whether they used only techniques that are based on cognitive and behavioral principles of change (manualized or not) in their treatment of panic disorder.

WOLF: OK.

GOLDFRIED: This is often discussed in the literature, namely that people go beyond what is described in the manual. When we come to the discussion of the experience level of the therapists, we’ll see that there are different cohorts of therapists who do CBT. What do people think about their report that they have an estimated 80% success rate?

WOLF: (laughing). Well, we all like to think that we are very effective in what we do.

JEFFREY MAGNAVITA: And it depends on what you mean by “effective.”

GOLDFRIED: Either total elimination of panic or significant reduction of panic.

MAGNAVITA: In my experience, I often don’t see people who are totally free of panic, but rather are not as adversely affected by it.

WOLF: Yes. Perhaps the panic attacks become less intense and less debilitating.

MAGNAVITA: Yes.

WOLF: So it’s really hard to know what people mean when they talk about being successful with the treatment.

NEWMAN: An 80% success rate, however it is interpreted, is consistent with randomized controlled trials on the efficacy of panic control therapy. So if clinicians’ report of success is accurate, it does say something about the generalizability of this treatment to the real world. In my experience with using panic control therapy with a variety of clients, it is quite helpful in reducing their avoidance and associated symptoms. The goal of the treatment is not to eliminate panic attacks but to eliminate fear and avoidance of panic attacks and associated situations. By doing this, reduction in panic follows.

MAGNAVITA: The question deals specifically with reducing the symptoms of panic disorder, not necessarily the other problems that might be associated with panic.





## Results of a Survey (*continued*)

GOLDFRIED: The question deals with the reduction of panic symptoms, not necessarily “cure.”

WOLF: The other part of what I find interesting is that the respondents reported that 50% of their patients are taking medication. This speaks to the difficulty in doing psychotherapy research these days, as most of the patients seen in actual clinical practice are on medication—especially if they have been referred by a pharmacologist or primary care provider. It’s very rare to see patients that are not currently taking medication for panic disorder.

MAGNAVITA: And we don’t know what other modalities are being used to treat these patients.

GOLDFRIED: This is, no doubt, why it’s difficult to do good effectiveness research, as there are all these other variables that may be operating.

NEWMAN: When patients are taking medications, it makes it very difficult for therapists and CBT techniques to teach the client that they can cope with their panic attacks. These clients are also more likely to attribute any gains to the medication, rather than to something they learned or did.

LINDA SOBELL: Do we know what primary diagnoses were given with these patients?

GOLDFRIED: No, we don’t have information on that.

SOBELL: In subsequent surveys, it would be a good idea to ask whether or not the clinical problem that they are reporting on was the primary diagnosis or not.

MAGNAVITA: Or what percentage of the patient’s with this diagnoses have other diagnoses.

NEWMAN: I think it would be helpful to know how closely therapists follow DSM criteria when making diagnoses and whether they do formal full structured interviews or unstructured interviews. It would also be helpful to know whether therapists routinely

determine primacy of diagnoses and how they make this determination.

WOLF: We do ask about substance abuse and premorbid functioning, and how it affects treatment. This is presented in Table 1.

TABLE 1  
*Other Patient Problems or Characteristics*

Item	Response Rate
Inability to work independently between sessions	71.0%
Unwillingness to give up safety behaviors	65.1%
Chaotic life style	55.9%
Personality disorder(s)	55.2%
Reliance on psychotropic medication	53.4%
Substance abuse	50.0%
Fear of exposure and associated emotional reactions	46.9%
Premorbid functioning is limited	46.0%
Resistance to directiveness of treatment	36.7%
Intellectual/cognitive/introspective limitations	34.9%
Dependency/unassertiveness	33.3%
Depressed mood/mood disorder	32.1%
Perfectionistic/obsessive style	29.6%
Low self-esteem/self-efficacy	21.3%
Negative emotions not recognized	21.3%
Poor interpersonal skills	18.5%
Physical problems	16.7%
Other	12.3%
Low socioeconomic status	7.1%
Diversity issues	2.8%

## *The Clinical Psychologist*

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## Results of a Survey (*continued*)

GOLDFRIED: In Table 2 there's an indication about the problem of CBT not dealing with comorbid problems, which were reported by 37.5% of the respondents.

TABLE 2 <i>Problems/Limitations Associated with the CBT Intervention Method</i>	
Item	Response Rate
Patient's reluctance to eliminate safety behaviors	60.8%
Exposure in vivo has logistical problems	47.5%
Doesn't deal with comorbid problems/symptoms	37.5%
Simulating panic in session is difficult	36.9%
Triggers to panic not evident	29.9%
Strict adherence to CBT protocol	28.6%
Relaxation doesn't work or causes anxiety	27.6%
Absence of guidelines for dealing with resistance/noncompliance	18.9%
Doesn't deal with patient's anger	18.3%
Doesn't deal with fear of interpersonal loss	15.0%
Triggers for panic are not linked to client's past history	10.0%
Doesn't deal with comprehensive or lasting change	9.3%
Current coping skills are not linked to past	8.0%
Other	7.6%

WOLF: One of the things that I think is important is that, in essence, there are different kinds of panic disorders. Some people have panic in the middle of the night, others out of the blue during the day, and so on.

MAGNAVITA: Again, we're also dealing with the very important issue of comorbidity, which makes it more difficult to use CBT for simple symptom reduction.

NEWMAN: Tsao and colleagues (Tsao, Lewin, & Craske, 1998; Tsao, Mystkowski, Zucker, & Craske, 2005) have looked at this within the context of RCTs and they have found a significant impact of CBT for panic disorder on comorbid anxiety disorders. However, we do not really know anything about whether other types of comorbidity interfere with the efficacy of CBT. In addition, we don't know anything about how this plays out in the real world. Most RCTs do exclude substance abuse and dependence.

GOLDFRIED: Table 1, which deals with findings about

other patient problems or characteristics that can undermine treatment, is relevant here. For example, 55.9% report the patient's chaotic life style creates treatment problems. In writing about agoraphobia some years back, Chambless and Goldstein (1982) made a distinction between "simple" and "complex" agoraphobics, depending upon the precipitant of the problem (e.g., a specific, isolated trigger or more pervasive life problems). This was before the notion of comorbidity became popular. So, complexity/comorbidity represents a major part prognostic factor.

MAGNAVITA: Absolutely! And Mark Lenzenweger and his associates (Lenzenweger et al., 2007) have written about how ubiquitous comorbidity is in patients with personality disorders. So it is possible that many patients who are unresponsive to first line treatment protocols are much more complicated and challenging to psychotherapists.

CASTONGUAY: These and other issues endorsed by our participants point the importance of asking clinicians about their day-to-day practice. One thing that is quite clear to me is that some of our findings are consistent with what the empirical literature is telling us. As most of you know, Michelle published two important reviews (chapters in a book that Larry Beutler and I edited) of the literature on principles of change in the treatment of anxiety disorders. One of the reviews focuses on pre-treatment client characteristics and the other provides an integration of client characteristics, technique, and relationship variables. A number of our findings are consistent with her reviews, such as the negative relationship between outcome and symptoms/impairment, as well as personality disorders. Such convergence of information collected via different methods of knowledge acquisition is very reassuring, as it should increase our confidence in the reliability of our current knowledge.

Other findings add to what we know from the empirical literature by providing very detailed information that can help us understand the link (or lack of thereof) between outcome and other client characteristics, such as expectations and beliefs about panic, motivation, and issues related to therapeutic relationship.

Our findings go one step further by providing information that, at least to my knowledge, is not reported in empirical journal articles (while being very complementary to it). Some of this information is specific to the treatment of panic disorder (e.g., unwillingness to give up safety behavior, reliance on



## Results of a Survey (*continued*)

medication, fear of exposure), while other is relevant to all forms of clinical problems (e.g., inability to work independently between sessions, chaotic life style, bad experiences with previous therapy, issues related to social system).

Related to the previous point, our findings regarding problems and limitations of CBT are not likely to be highlighted in peer reviews of RCT trials (and, I would venture to guess in treatment manuals associated with such RCT). Yet they provide important information about how to improve our current gold standard treatment for panic disorders..

GOLDFRIED: In some ways, that may tie into the question of how many sessions people need when being treated for panic disorder. Close to a third of our respondents say they see patients six months or more, which might have to do with the need to deal with these interfering problems. If we look at the findings for the question that asks whether or not more than symptom reduction is needed in working with panic patients, an overwhelming 73 percent indicated “yes.”

SOBELL: In addition to the fact that patients are seen longer in practice than in clinical trials, there are a couple of things in Table 3 dealing with therapy relationship issues that are really striking. That deals with therapist frustration and negative reactions to the patient. There clearly is something happening in this relationship that often does not get discussed in clinical trials.

TABLE 3 <i>Therapy Relationship Issues</i>	
Item	Response Rate
Therapy alliance not strong enough	60.5%
Therapist's frustration with progress	28.7%
Therapist's negative feelings toward patient	28.7%
Distress not sufficiently understood/validated	55.9%
Other	5.1%

CASTONGUAY: This is very much in line with what I mentioned before. Alliance has been linked with outcome in treatment of anxiety disorder, but the quantitative results don't tell us much about the toxic or difficult issues that are involved when the relationship between client and therapist is not good. Our findings address these issues in a way that are very much in line with intensive qualitative analyses that

have been conducted.

MAGNAVITA: Maybe that's what we've been talking about, namely that therapists are trying this first-line treatment for Axis I disorders, but they are actually working with something much more complex. Under such circumstances, therapists may very well have a sense of frustration with therapeutic progress—and, at times, with the patient.

GOLDFRIED: It also may have to do with the fact that the literature gives one the impression that the intervention is straightforward, and that there will not be any problems—which then takes the therapist by surprise. That can be very frustrating, causing therapists to become impatient because the clients are not doing what they are “supposed to be doing. . .”

MAGNAVITA: . . . they're not doing the work. . .

WOLF: . . . right. . .

GOLDFRIED: . . . as a opposed to the intervention not working as well in certain instances.

SOBELL: It's very important to get this information out there to clinicians and researchers. It's not saying that CBT is not working, but rather that there are certain moderators that cause it to be less effective. And this is precisely the kind of thing that really needs to be studied in clinical trials.

CASTONGUAY: I could not agree more! In addition, this has clear implications for training. I remember Bruce Arnow making the point that many people believe that you can be trained in CBT for a specific disorder by attending a workshop at ABCT – and that in a few hours you have attained a minimal level of competence. As Bruce also mentioned, nobody would dare have the same thought about psychodynamic treatments! My view has always been that CBT is complex and requires quite extensive training and supervision in the application of its manuals and beyond; our findings are consistent with this.

GOLDFRIED: Some of these moderating variables seem to be related to general principles associated with success in therapy, such as the nature of the therapy alliance, patient expectations, motivation, and the nature of the therapy alliance (see Tables 3, 4, and 5). And these are the kinds of things that really need to be spelled out very clearly in treatment manuals. We can't simply go along with the assumption that—because somebody is entering therapy—either in a clinical trial in actual clinical practice—that he or she is motivated, has positive expectations, and is able to form a good alliance with the therapist. Without ade-



## Results of a Survey (*continued*)

TABLE 4

*Patient Expectations*

Item	Response Rate
They will be free of all anxiety	58.4%
Therapist will do all the work to make things better	58.0%
They need medication to reduce panic	52.1%
Successful exposure means not having panic/anxiety	44.6%
Pessimism due to disappointment with past therapy	34.4%
Treatment will be brief and easy	29.8%
Symptom reduction is not enough	20.7%
Other	4.6%

TABLE 5

*Patient Motivation*

Item	Response Rate
Minimal motivation at outset	67.1%
Premature termination	66.8%
Motivation decreased as some improvement occurs	34.2%
Motivation decreased when patient learns reasons for having panic	10.8%
Other	6.4%

quate motivation, even the best of treatments won't work; if therapists are not attuned to and aligned with the patient's expectations, there are likely to be problems in the treatment; and if the therapist's directiveness and behavioral assignments are not tempered with empathy and compassion, a rupture in the alliance can occur.

NEWMAN: I think that many of the newer manuals and books on CBT try to provide information about working on the therapeutic alliance, as well as with working with unmotivated or uncooperative clients. However, it isn't easy and there is no simple cookbook for it.

CASTONGUAY: Again our finding can hopefully help newer manuals to do a better job

MAGNAVITA: One of the criteria for entering patients in clinical trials it is that they are indeed motivated—at least at the outset. But we know from clinical experience that this can change over time. However, this is not usually monitored over the course of treat-

ment in clinical trials—which is also true of other important moderating variables.

GOLDFRIED: And those individuals that refuse to be entered into a protocol are sometimes the kinds of individuals that we see in clinical practice. The findings of clinical trials need to be interpreted with this in mind; these are the kind of patients on which we don't have the research data that could help the clinician.

MAGNAVITA: And these may be the more comorbid people.

NEWMAN: I think it would be really interesting to study if those who were screened out of RCTs and/or refused randomization do go on to pursue psychotherapy at all. We assume that they do, but we don't really know. Some of these people may just seek medication because it doesn't require as much effort on their part, and some may decide that they can do the work on their own.

GOLDFRIED: There are also those individuals who drop out of clinical trials—which could be considered treatment failures. These are also the kind of individuals we see in clinical practice. In many ways, the practicing clinician has to deal with more problematic patients than does the therapy researcher.

NEWMAN: Again, I wonder if this is true or if these are the same clients who will drop out of any therapy (RCT or private practice), given that the modal numbers of private practice sessions is one. Also, we assume that people drop out because they don't like the treatment or because the treatment wasn't working, but when asked why they drop most clients report that they just don't have time to schedule regular sessions and/or do homework.

CASTONGUAY: We have to be careful about this.

Researchers at Penn (Barber, DeRubeis) have made very persuasive arguments that some of the patients seen in clinical trials (in downtown Philadelphia, for examples) are very difficult and are those that private practitioners do not see!

WOLF: A lot of this may speak to the issue of adherence—the therapist's adherence to a treatment manual—in contrast to the decisions that clinicians have to make. The practicing therapist may err on the side of not following the treatment manual closely enough, and a fair amount of clinical judgment is required in doing that. That also translates into the question of whether or not therapists are really doing CBT or some variation of it.



## Results of a Survey (continued)

GOLDFRIED: This relates to the question: what is CBT?

Are there different cohorts of therapists, depending on when they were trained or is it their amount of clinical experience? The survey points to some very interesting findings in this regard. As can be seen in Table 6, the extent to which therapists more closely adhere to a CBT protocol seems to be more characteristic of less experienced therapists. Depending

TABLE 6 Please Indicate All Those Aspects of CBT That You Usually Use in Treating Panic:			
	Response Rate		
	Years of Experience		
	< 21 years (N = 211)	> 21 years (N = 115)	p
Psychoeducation about nature of panic	99%	97%	ns
Cognitive restructuring of general beliefs associated with panic	94%	91%	ns
Cognitive restructuring of feared outcomes associated with panic attacks	95%	87%	.009
Cognitive relabeling of sensations triggering panic	84%	87%	ns
Identification of emotional reactions to situations associated with panic	85%	86%	ns
In vivo exposure to travel, open spaces and other agoraphobic situations	80%	70%	.057
Breathing retraining	60%	80%	.000
Simulation of panic sensations within the session	72%	55%	.002
Resolution of stressful conflicts leading to panic (e.g., relationships, work)	47%	74%	.000
Relaxation training	46%	67%	.000
Helping patient understand developmental roots of fears	46%	63%	.006
Mindfulness	45%	54%	ns
Motivational enhancement	29%	35%	ns
Assertiveness training	18%	38%	.000
Communication training	14%	23%	.047
Independence training	7%	15%	.028

upon how you consider it, more experienced therapists can be seen as either diluting a CBT intervention with other procedures, or enhancing its effectiveness by being integrative in nature. And this difference between the more and less experienced individuals may also be a function of which vintage of CBT they learned, and also when they learned CBT in their career—either as their first orientation, or after practicing from within another orientation.

NEWMAN: I think it also speaks to the fact that the accessibility of treatment manuals for a variety of disorders is fairly new. The newer therapists may be those who are more likely to have been introduced to the manuals in their training. If therapists were not introduced to a manual in their training, perhaps they are less likely to use one.

CASTONGUAY: Consistent with the points made by Marv and Michelle, I was struck by how more experienced clinicians are using more traditional behavioral interventions (e.g., assertiveness training) and less CBT-specific interventions to PD.

WOLF: Someone who has been trained in rational emotive therapy and someone who has been trained in CBT can both refer to themselves as “cognitive-behavior therapists,” but can be very different in what they do.

GOLDFRIED: Exactly. As we can see in Table 6 dealing with the breakdown according to whether the therapist is more or less experienced, there are a number of interesting differences in which aspects of CBT are used.

WOLF: It certainly looks like experience is a very relevant moderator.

GOLDFRIED: Absolutely. Although we know that level of experience is playing a role, it is not clear as to why, or as to whether it helps or hinders. But it looks like the less experienced therapist use cognitive restructuring more often—95% as opposed to 87%, which reflects the growing ascendancy of cognitive therapy within CBT. Another practice difference that is a function of experience is the extent to which therapists simulate the sensations of panic within the session— which has been an addition to CBT practice over the years. In speaking to a number of my CBT colleagues who are practitioners, there seems to be a fair amount of variation in their attempt to use this simulation, and also their success in doing so. And while the findings of the survey indicate that younger CBT therapists make greater use of in-session simula-

## Results of a Survey (*continued*)

tion, it is not quite clear as to how much success they have with it.

NEWMAN: It would be important for future surveys if we discriminated between therapists' years of practice of psychotherapy and their experience with using a particular treatment like panic control therapy. I don't believe these are necessarily the same thing, and I think they are important distinctions to understand. Also, as noted by Marv and Linda, interoceptive exposure is a fairly new technique in the scheme of panic treatment, so this may reflect different training. In my own training of therapists, I find that therapists who haven't used interoceptive exposure are reluctant to ask clients to do something that exacerbates their anxiety, and I believe this is probably true of experienced therapists who have not used this technique in the past. However, therapists are more likely to use these techniques and to instill confidence in their patients around the techniques when they believe that this technique is a key to helping clients and when they have seen the long-term positive impact of these techniques.

WOLF: Another difference is that more experienced therapists tend to use relaxation training, more than those with less experience.

NEWMAN: This is also consistent with the possibility that these therapists prefer to use techniques that decrease anxiety as opposed to exposure techniques, which increase anxiety.

GOLDFRIED: And more experienced therapists are more likely to explore those situational conflicts that might be driving the panic.

MAGNAVITA: The triggers of panic.

GOLDFRIED: There is a dramatic difference here, in that 74 per cent of more experienced focus on those stressful factors contributing to the panic, as compared to only 47 per cent of less experienced clinicians.

SOBELL: Why do you think that would be? Is it because there was a greater emphasis in the past on looking at the antecedents of panic than there is now?

WOLF: The answer to that question is very important. It addresses the question of the developmental trajectory of the therapist over time. As we considered earlier, it is a question of whether or not this is the way we as therapists have been trained, and/or how the way our practice has evolved over time. We really can't answer that question from the results of this survey, and it is very definitely an important question

that needs to be researched.

SOBELL: In many ways, it is not surprising to see that finding, as a focus on antecedents of clinical problems was the way I was originally trained in CBT some years ago.

MAGNAVITA: If we think of many of the people in this survey as being integrative in their practice—especially the more experienced ones—there is another difference in experience level, one that was not included in the survey. Based on my experience in training therapists, it is very difficult for beginning therapists to focus on what is happening within the session that might be a sample of the patient's problem, or at least something that is relevant to it—immediacy. This is also more characteristic of a psychodynamic and experiential approach to therapy.

GOLDFRIED: Interesting enough, the results of a multi-site clinical trial in the use of CBT for treating panic found that more experienced therapists tended to be more successful, even though they did not differ from less experienced therapists on the basis of adherence or competence in administering the intervention (Huppert, Bufka, Barlow, Gorman, & Woods, 2001). So, clinically important things may have been happening during the sessions that go beyond what exists in the manual, which can contribute to success. But we don't know exactly what that is.

NEWMAN: This was the finding of an RCT, so perhaps we should also examine the reported success rate of our therapists by level of experience to see whether this effect is replicated in our sample. If we replicate this effect in our sample, this may be due to the ability of more experienced therapists who know well the specific techniques in the manual and their underlying rationales and are more able to apply the treatment more flexibly and more tailored to the individual. Also, a more experienced therapist may be more confident in the efficacy of the techniques and may more readily instill that confidence in their patients. I have seen new therapists and/or those who are experienced with other approaches but just learning CBT introduce a technique reluctantly and apologetically and this almost invariably instills doubt in clients about whether they really want to engage in it.

CASTONGUAY: Another thing that strikes me about possible differences between therapists, which may have an impact on the question that Michelle raised earlier and the points discussed by many of you so far, is that experienced therapists appear to see more



## Results of a Survey (*continued*)

complex cases. I am inferring this, perhaps incorrectly, by their emphasis on issues such as substance abuse, limited premorbid functioning, perfectionistic style, and loss of family member.

MAGNAVITA: It is possible that it is related to more experienced therapists being better able to tolerate the patient's distress level—but we don't know for sure. In many ways, this survey highlights those gaps in knowledge about what we do that is effective. Although we have learned a great deal in recent years, these knowledge gaps continue to exist. As a practicing clinician, I see it as being very important to have research inform us more about what is actually going on that is helpful.

SOBELL: I totally agree. Indeed, I think this is one of the most exciting things that I have seen in my career. It opens up so many questions that we really need to address empirically.

MAGNAVITA: Speaking as a clinician who sits in a room all day working with patients, I find these questions both fascinating and important in helping me know more about what I'm doing. And clearly, these are questions that are relevant to both clinicians and researchers.

GOLDFRIED: That's an interesting point. When we first conceived of having this survey, the thought was that it would be useful in providing clinically-driven hypotheses that would be useful for researchers to investigate. However, it also appears that the findings can be of considerable interest to practitioners, in that they can compare their own experiences to what their colleagues have been doing and experiencing.

MAGNAVITA: A lot of the findings are of really interest for the clinician.

GOLDFRIED: When we talk about differences in clinical experience regarding the limitations of CBT (Table 7), there were six interesting differences. The more experienced therapists don't seem to have as much of a problem in getting the patient to eliminate safety behaviors. So there may be something about experience, or having a greater array of methods, that makes this relatively less of a problem.

WOLF: Perhaps they have a greater tolerance for the problem.

MAGNAVITA: Yes, maybe they get less frustrated.

NEWMAN: Maybe more experienced therapists are more creative in searching for and defining safety behaviors. I have seen some very idiosyncratic safety behaviors in some clients and I have learned over the

years to ask the question in many different ways to get at this issue. Most safety behaviors are subtle and not things you will always find on a typical list. In my mind they include things such as where in the room somebody will sit, internal focus, what they are doing during exposure, etc.

GOLDFRIED: And more experienced therapists seem to have less of a problem in dealing with comorbid

TABLE 7  
*Problems/Limitations Associated with the CBT Intervention*  
Method:

	Response Rate		
	Years of Experience		p
	< 21 years (N = 211)	> 21 years (N = 115)	
Patient's reluctance to eliminate safety behaviors	62%	45%	.004
Exposure in vivo has logistical problems	44%	43%	ns
Doesn't deal with comorbid problems/symptoms	31%	42%	.052
Simulating panic in session is difficult	33%	37%	ns
Triggers to panic not evident	24%	34%	ns
Strict adherence to CBT protocol	23%	32%	.088
Relaxation doesn't work or causes anxiety	22%	32%	.046
Absence of guidelines for dealing with resistance/noncompliance	18%	16%	ns
Doesn't deal with patient's anger	13%	24%	.013
Doesn't deal with fear of interpersonal loss	13%	16%	ns
Triggers for panic are not linked to client's past history	8%	12%	ns
Doesn't deal with comprehensive or lasting change	7%	11%	ns
Current coping skills are not linked to past	5%	12%	.024
Other	9%	4%	ns

## Results of a Survey (*continued*)

issues. Perhaps this is also related to experienced therapists saying they see strict adherence to a CBT protocol as being a limitation in clinical practice.

WOLF: There is also an interesting difference in the more experienced therapist seeing the need to deal with the patient's anger. The less experienced therapists might not identify that as a problem, perhaps because of their adherence to the CBT protocol. More experienced therapists may have a broader conceptualization of aroused states, whether we're dealing with anxiety or anger.

NEWMAN: I do think it may be due to a different definition of aroused states. In my own work with anxiety disorders I would agree that anger is another common expression of arousal.

GOLDFRIED: What is interesting is that there is a two-site clinical trial for treating panic disorder in progress—Penn Medical Center and Cornell Medical Center—where CBT is being compared to a psychodynamic intervention. What is relevant to what we're discussing is that the psychodynamic approach does focus on the possible role of anger in panic disorder—particularly triggered by interpersonal conflict.

WOLF: From a clinical point of view, I see anger as sometimes playing an important role in panic.

GOLDFRIED: If nothing else, it can result in increased panic symptomatology—such as increased heart rate, tension, and hyperventilation.

WOLF: And also anxiety.

MAGNAVITA: It definitely results in an aroused emotional state.

NEWMAN: Yet anger may require some different treatment techniques than the treatment of anxiety. Exposure to anger may only exacerbate the anger.

GOLDFRIED: Another difference that can be seen in Table 7 is that more experienced therapists are more likely to see a limitation of CBT as not linking patients' current coping skills to their past—such as becoming aware of the development roots to current coping.

NEWMAN: Certainly, the manuals do not really focus on the developmental roots to current coping beyond suggesting that clients' first panic attack, their concurrent stress level, how they coped with their first panic attack, and whether or not they developed full-blown panic disorder. The manuals do not focus on clients learning history that may have created their predisposition to panic.

WOLF: In many respects, while CBT views problems as having been learned, it doesn't seem to make as much use of a developmental approach to psychopathology in its interventions. It's very much present-focused.

NEWMAN: Yes, an interesting contradiction. The way I have heard this explained is that what led to the development of a disorder is not necessarily what is currently maintaining the disorder, and it is more important to focus on current maintaining variables. However, this is a theoretical proposition that has not been empirically tested.

GOLDFRIED: Some years ago, Sarason (1979) once pointed out that a limitation of CBT is the failure to recognize that cognitions have histories, and that

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## Results of a Survey (*continued*)

TABLE 8 <i>Patient's Symptoms Related to Panic</i>	
Item	Response Rate
Chronicity	62.4%
Tendency to dissociate	42.3%
PTSD	42.3%
Functional impairment	41.9%
Severity	38.6%
Fainting history	17.4%

TABLE 9 <i>Patient's Beliefs about Panic</i>	
Item	Response Rate
Belief that their fears are realistic	64.0%
Their problems are due to external factors	44.6%
Being anxious is abnormal/dangerous	43.6%
Panic is biologically based	30.1%
Symptom reduction will negatively impact relationships	13.5%
Other	5.5%

TABLE 10 <i>Social System (Home, Work, Other)</i>	
Item	Response Rate
Symptoms/dependency is reinforced/supported	66.0%
Trapped in a dysfunctional home, work, or social situation	62.4%
Stress very high at home, work, or socially	52.5%
Family does not support treatment	46.5%
Social isolation of patient	42.9%
Family is controlling and critical	37.6%
Family members are very anxious	33.7%
Loss of family member, partner, employment	19.8%
Other	2.3%

sometimes knowing about this history can be helpful in an intervention.

WOLFE: I think that's a very important point.

MAGNAVITA: Jeff Young's work talks about that with regard to the historical roots of the maladaptive schemas (1994). And the important things about that is the

period in one's life when the schemas was developed, with the earlier development as creating more problems for intervention.

WOLF: We should also just mention that there was some other interesting finding about those patient symptoms, their beliefs about panic, and very importantly their social system, all of which must be taken into consideration in working with panic patients, as they can undermine treatment effectiveness. These findings are summarized in Tables 8, 9, and 10.

GOLDFRIED: We can certainly go on at greater length about these findings, and will in future conference presentations and in articles. In many respects, the survey has raised as many questions as it has answered. But then again, the purpose of surveying clinicians about their experiences in treating panic was to generate clinically relevant hypotheses for further research.


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## What Clinicians and Researchers Should Know About Sexual Orientation

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 Recent developments in the psychological literature on same-sex sexuality suggest that individuals' self-reported sexual orientation identities may not tell the whole story about their sexual attractions and behaviors. In particular, some people who identify as heterosexual may have some same-sex attractions and/or a history of same-sex sexual behavior (e.g., Savin-Williams, 2006). These people are measurably different from those who do not have any history of same-sex sexuality, particularly in having more positive attitudes toward same-sex sexuality and toward LGBT people (Morales Knight & Hope, 2010; Vrangalova & Savin-Williams, 2010). It is possible that at least some of these people are actively exploring their sexual identity (Worthington, Savoy, Dillon, & Vernaglia, 2008), while others may be better described as holding a stable "mostly heterosexual" identity (Thompson & Morgan, 2008).

Another emerging area of research investigates the ways that sexual attractions and sexual orientation identity can change over the lifetime. Although the bulk of available research evidence suggests that sexual orientation is generally stable over the lifetime, particularly for men, there are some lines of research exploring the ways some people, particularly women, show major changes in attractions, behaviors, and sexual orientation identity over time, a phenomenon sometimes termed "sexual fluidity" (e.g., Diamond, 2007, 2008). A part of the picture of sexual fluidity, especially for women, is that some people are able to have intimate, even passionate, same-sex friendships, some of which may become sexual although both individuals identify as heterosexual (Diamond, 2003; Morgan & Thompson, 2006).

Despite the evidence regarding intermediate identities and sexual fluidity, research suggests also that people tend to follow a sort of "one-drop rule", in that the presence of any same-sex attractions or behaviors in a person's history tends to lead others to classify them

as nonheterosexual (Neighbors, 2000). Researchers and clinicians must be particularly careful to avoid this kind of thinking and recognize that attraction, sexual behavior and sexual orientation identity label may combine in unexpected patterns.

Clinicians and researchers should also be aware that despite the long history of psychology's interest in studying same-sex sexuality, psychologists still do not agree on how best to define sexual orientation (e.g., Chung & Katayama, 1996; Diamond, 2005; Sell, 2007), due in part to lack of a unifying theory. Evidence from evolutionary (e.g., Miller, 2000), biological (see LeVay, 2009, for a review), environmental (see Bohan, 1996, for a review), and social-constructionist (see Bohan, 1996, for a review) lines of research are all fragmentary and contradictory.

This situation leaves researchers and clinicians at a loss as to how best to assess sexual orientation (for a review see Morales Knight, 2010). Some researchers (e.g., Savin-Williams & Ream, 2007) suggest that for research purposes it may be best to treat individuals' self-reported sexual orientation identities as just one piece of the puzzle, and to collect data that reflects the constructs of interest, rather than allowing sexual orientation identity label to stand in for "sexual orientation". For example, researchers interested in mechanisms that drive same-sex attractions should directly query same-sex attraction, rather than assuming that people who identify as LGB have same-sex attractions, or that identified heterosexuals do not have them. The same approach is likely to be helpful for clinicians. Clinicians should assess clients' sexual orientation identity, including identities other than the traditional gay, lesbian, bisexual, and heterosexual identities, but also their comfort and stability in that identity; the way their ethnicities or cultural identities interact with their sexual orientation identities (e.g., Risco, 2008; Zea, Reisen, & Díaz, 2003); their same- and opposite-sex attractions and sexual relationships; and the way all of these have changed, and continue to change, over time.

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### Paul Meehl and Hans Eysenck: The Odd Couple

Donald K. Routh, PhD

 In 1996, Division 12 celebrated the 100th anniversary of the founding of the first psychological clinic in America by naming two recipients of special centennial awards: Paul Meehl and Hans Eysenck. Each was invited to give an address at the meeting of the American Psychological Association in Toronto that year. No one would dispute that both Meehl and Eysenck had brilliant scientific careers. What is also worth noting here is that the two had such contrasting ideas about clinical psychology, including psychopathology, assessment, treatment, and education. As their work shows, clinical psychology in its first century certainly did not speak with one voice. This essay benefited from two recent publications relevant to the lives and work of Meehl and Eysenck: In 2005, Donald R. Peterson, who had received his PhD under Meehl, published *Twelve Years of Correspondence with Paul Meehl: Tough Notes from a Gentle Genius*. Now, in 2010, historian of psychology Roderick Buchanan has published a biography, *Playing with Fire: The Controversial Career of Hans J. Eysenck*. It is fair to say that of the two award recipients, Meehl was more widely admired by colleagues. Eysenck, who treated science as a blood sport, had more detractors.

Paul Meehl championed a categorical view of psychopathology like that of the Diagnostic and Statistical Manuals of the American Psychiatric Association. Meehl was famous for his APA presidential address regarding genetic factors in the etiology of schizophrenia. Throughout his lifetime, Meehl was preoccupied with the development of mathematical criteria (such as his Maxcov-Hitmax procedure) by which categories of psychopathology could be formally identified. Hans Eysenck, in contrast, spent much of his career trying to reduce both psychopathology and personality to dimensions, namely “neuroticism,” introversion-extraversion, and psychoticism. His success in doing so can perhaps be judged by the fact that two of the present “Big Five” factors favored by colleagues for personality assessment (extraversion and emotional stability/neuroticism) correspond to Eysenck’s dimensions.

In the field of clinical assessment, Meehl was famous

for his book on clinical versus statistical prediction, published in 1954. He advocated the replacement of fallible human judgment by use of a desk calculator, noting that a mathematical combination of relevant predictor variables is difficult to beat. Meehl was also one of the architects of the widely used Minnesota Multiphasic Personality Inventory, in particular its “K” scale, which he developed in his dissertation to deal with defensive patient profiles. Eysenck developed various assessment procedures such as the Maudsley Personality Inventory and the Eysenck Personality Questionnaire. Although these procedures are not frequently used in clinical assessment, at least two of the three theoretical dimensions advocated by Eysenck are represented in other assessment procedures such as the internalizing and externalizing dimensions identified by various child behavior checklists.

Paul Meehl not only did a great deal of research, but also engaged in clinical practice during much of his professional life as a psychologist, whereas Eysenck did no hands-on clinical work, confining his activities to research and theory. Specifically, Meehl was formally trained in psychoanalysis and was for a long time a practicing analyst. Seeing a disconnection between his clinical work and his research, however, Meehl ultimately modified his treatment activities in the direction of Albert Ellis’s Rational Emotive Therapy. Eysenck, though he was no therapist himself, is recognized today as one of the founders of the behavior therapy movement. In his famous 1952 article, Eysenck raised questions about whether traditional psychotherapy, including psychoanalysis, had any effect at all, compared to untreated controls. He presented data to suggest that about two thirds of neurotic patients recover in the absence of formal treatment. Thus, Eysenck attacked the Freudians, served as a gadfly to all traditional psychotherapists, and deserves credit for some of the current emphasis on evidence-based therapy that dominates scientific clinical psychology.

Both Paul Meehl and Hans Eysenck were advocates of rigorous scientific training for clinical psychologists. The University of Minnesota, where Meehl himself was trained and where he later served as a faculty member throughout his career, has an enduring reputation for providing this sort of exemplary training. In his later years, Meehl endorsed what he called “second-order relevance,” in other words rather than training the practitioners themselves, concentrating on training scientists

and professors. Similarly, Eysenck developed and then headed for many years a Department of Psychology within the Institute of Psychiatry at the University of London. This Department trained many of the scientific leaders within British clinical psychology as that field emerged after World War II. In this way, Eysenck's Department eclipsed the previous dominance of the psychoanalytic training provided to psychologists by the Tavistock Clinic in London.

In both the United States and Britain, a different type of training of clinical psychologists emerged oriented toward professional practice rather than research. As far back as 1918, clinical psychologist Leta Stetter Hollingworth mentioned the possibility of a Doctor of Psychology degree, and beginning in the 1970s, such professional training programs began to proliferate in this country. At one point, Meehl himself endorsed the concept of PsyD training, using the analogy of physicians he knew personally who had superb clinical skills but no training

or interest in doing research. It was Donald Peterson, Meehl's student, who initiated the first PsyD program at the University of Illinois and went on to become dean of what is perhaps the national flagship PsyD program at Rutgers University. Alas, in the *Twelve Years of Correspondence* book mentioned above, both Peterson and Meehl concluded that the PsyD movement had in many ways been a failure, one that had largely "dumbed down" clinical psychology training. If Eysenck had lived long enough to see the graduates of the new British Doctor of Clinical Psychology programs (funded by the National health system), he might have had a similar criticism of them.

Paul Meehl and Hans Eysenck, controversial though each of them sometimes was, both represented the high scientific possibilities of the first century of clinical psychology. It is thus interesting that they were indeed an "odd couple" in their contrasting views on psychopathology, assessment, treatment, and training. ■■

## DIVISION 12 RISING STAR PROGRAM

### EARLY CAREER OPPORTUNITY—SUMMER 2011

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The APA Society of Clinical Psychology (APA Division 12) offers an annual summer program to recognize and mentor an early career scientist-practitioner in clinical psychology. Each summer, Division 12 finances a post-doctoral summer research experience with a prominent clinical psychologist on a particular subject or theme.

We are pleased to announce that in 2011 an opportunity exists to engage in cutting-edge research on **self-help** at the University of Scranton. A total of 4K and campus lodging will be provided for use as the rising star deems appropriate. The research will build on the existing research program of Dr. John C. Norcross, Professor of Psychology and Distinguished University Fellow. His research seeks to identify evidence-based self-help resources (computer programs, books, autobiographies, movies, websites) for dozens of clinical disorders and life challenges. The position would entail two months of full-time work, during June, July and August of 2011.

Opportunities exist for collaborations with other investigators nationally and internationally, with the chance to build lasting research partnerships. The position will result in coauthored conference presentations, probably publications,

and perhaps a coauthored book. The University of Scranton is a comprehensive university in the Jesuit tradition located in the foothills of the Pocono Mountains, an ideal summer environment.

Nominations should be from a D12 member or a clinical psychologist who is willing to become a member. Nominations must include a CV, one letter of endorsement, and a cover letter outlining interest in and qualifications for the program. Nominees must have earned a doctorate in clinical psychology within the past 10 years. Self-nominations are encouraged.

Previous research experience with self-help, self-administered treatments, or Internet survey methods is particularly welcomed.

Please submit nomination materials electronically to Rising Star Program at [div12apa@comcast.net](mailto:div12apa@comcast.net). The deadline is January 15th. Inquiries should be directed to the Division 12 Central Office at 303-652-3126 or [div12apa@comcast.net](mailto:div12apa@comcast.net)



### Boundary Crossings in Academia

Garnett S. Stokes, PhD and

Jeffrey N. Younggren, PhD



Although there has been a multitude of publications regarding the misuse of power and exploitation of patients in psychotherapy, considerably less focus has been given to exploitation and power misuse in student-faculty relations in academia.

Though there is some evidence that the rates of sexual

relationships between faculty and students are declining (Oberlander & Barnett, 2008), survey research reveals that faculty and students believe that a wide range of possible faculty-student activities and interactions are inappropriate (Birch, Elliott, & Trankel, 2008; Owen & Zwahr-Castro, 2007). The crossing of professional boundaries by faculty in their relationships with their students is potentially problematic for the student, the faculty

***The crossing of professional boundaries by faculty in their relationships with their students is potentially problematic for the student, the faculty member and the university.***

member and the university. Although boundary violations remain the primary cause of claims in the world of professional liability for psychologists (Bennett, et al., 2006), such civil exposure may not be the case in the academic world for a number of reasons.

To start with, academic psychologists are much more professionally diverse with a large number working outside of clinical settings. Many academic psychologists are not licensed to practice and consequently are not subject to oversight by state licensing boards. In addition, not all academic psychologists are members of professional associations, like the APA, that attempt to prescribe standards of professional conduct in the form of Ethics Codes designed to give guidance in this area. Ethics committees of professional associations do not have any authority over non-members. Consequently, the proscriptions regarding inappropriate student faculty interactions that are evident in professional asso-

ciation codes and in state licensing laws do not directly apply to many academic psychologists.

The second problem area is that regulations in academic settings that address faculty-student relationships are frequently not very well defined nor are they explicitly established as university policy. With the exception of sexual misconduct and sexual harassment issues addressed by most universities, guidance about boundary crossings and boundary violations and the potentially destructive impact that these could have on faculty-student interactions is rarely provided (Biaggio, Paget, & Chenoweth, 1997). The consequences of this lack of clear institutional policy regarding inappropriate faculty/student relationships or guidance about managing responsibilities in the teacher-student mentoring relationship are that students remain vulnerable to the power differential that exists between students and faculty.

A student who feels that he or she has been subject to inappropriate conduct or exploitation by a faculty member is sometimes faced with a significant dilemma in reporting the problem. The student often believes that taking any action at all against a faculty member could have significant negative career consequences. Regardless of whether that student is interested in working in an academic setting or in clinical practice, the alienation of a faculty member could impede professional progress. The student who has experienced this type of violation on the part of faculty is thus confronted by a "code of silence" mentality given that saying or doing anything could have dire outcomes. It is this reality that led the Ethics Committee of APA to extend the statute of limitations on complaints made about faculty by their students.

From a university-wide policy perspective, a delicate balance must be struck in the academic setting that protects students from inappropriate conduct on the part of faculty yet is not so paternal and restrictive that it treats students like children who are unable to make adult choices. Interestingly, some universities that have attempted to develop policies to prohibit sexual relationships between faculty and students have met with serious resistance (Bartlett, 2002). Outside of extreme examples such as coercive faculty/student sexual relations, inappropriate conduct on the part of faculty is actually often difficult to define and, consequently, is subject to substantial debate. It is this reality that makes the establish-

ment of university wide policies in this area very difficult because, in the realities of the world, any good policy will likely have a good exception.

In light of this, it falls upon the shoulders of faculty members to constantly be in touch with the power differential that exists in the academic setting. Faculty members confronted by questions about the appropriateness of their relationship with a student should address the following questions:

- Is this boundary crossing necessary?
- Am I remaining objective in my relationship with the student?
- Does this boundary crossing model appropriate respect for the power differential that exists between students and faculty?
- Is the student being exploited in any way by this boundary crossing?

In addition, it falls upon the shoulders of the university leadership to clarify as much as possible the policies that are in place regarding professional boundaries and the potential outcomes that follow inappropriate student/faculty relationships. Universities should:

- Address student grievances in this area in a timely fashion.
- Create policies regarding student/faculty boundary violations that outline as clearly as possible the administration's expectations in this very sensitive area.
- Provide avenues for grievance that protect the student and are sensitive to how vulnerable students can be under such circumstances.
- Provide guidance to faculty about effective mentoring of undergraduate and graduate students and clarification of ethical expectations about faculty-student relationships.

Although professional boundaries in an academic setting may never be regulated with the same clarity that is provided within the therapeutic setting, all universities need to address these important issues. As noted by Ann J. Lane in her 2006 article in *The Chronicle of Higher Education*, "The university should be a safe place in which students can study and learn in ways that help them cope with the adult world they are in the process of joining. Most academics take those responsibilities seriously. Young people may think of themselves as adults. Teachers must honor that sense of self while recognizing that most students are not fully

adult (p.B10)." Faculty must be constantly vigilant to the misuse of their authority and to the potential loss of their objectivity in their relationships with students. It is through this delicate balance that the best interests of all involved are protected.

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### Announcing a Mentorship Program for Students and Early Career Clinical Psychologists

Brian J. Hall, MA

Section Editor's note: *Beginning with this issue, I am the Editor of this column. Indeed, I have big shoes to fill, and would like to thank Dr. George Slavich for his superlative editorial contributions to the Section during the past several years. This column will continue to focus on topics that are important for Graduate Students in the field of clinical psychology. Future articles are open for student contributions and these are encouraged. If you have an idea for a newsletter article you would like to contribute, please contact me at [bhall41@gmail.com](mailto:bhall41@gmail.com).*

— Brian J. Hall, M.A.



#### The Importance of Mentorship in Clinical Psychology

Mentorship is a vital component in the training of clinical psychologists. Generally it is defined as a reciprocal relationship between a senior psychologist (the mentor) and a graduate student or early career psychologist (the junior colleague). The relationship is characterized by guidance, advice, counsel, feedback, and support provided by the mentor for the junior colleague's personal and professional development (Kram, 1985). Further, mentoring serves the function of offering career-related (e.g., how to apply a clinical technique, how to obtain a post-doctoral fellowship) and psychosocial (e.g., role-modeling work life balance) support. Mentoring from a senior psychologist provides assistance to emerging psychologists navigating the shoal waters of early career advancement.

Significant benefits have been quantified regarding engagement in a mentoring relationship. A recent meta-analysis of academic and workplace mentorship demonstrated a positive relationship between mentoring and junior colleagues' increased performance (e.g., scholarly productivity), less withdrawal (e.g., leaving school), greater situational satisfaction/attachment (e.g., job and university satisfaction), less psychological stress/strain (e.g., depression and anxiety), greater quality of interpersonal relations (e.g., peer intimacy),

and increased motivation (e.g., career commitment; Eby, Allen, Evans, Ng, & Dubois, 2008). Another meta-analysis showed that career-related mentorship was related to higher salaries, greater earning potential, promotions, and greater career satisfaction for junior colleagues (Allen, Eby, Poteet, Lentz, & Lima, 2004).

In a summary of the mentorship benefits to clinical psychologist trainees, Johnson (2002) noted that pre-doctoral mentorship is related to developing professional skills, forming a professional identity and gaining confidence, scholarly productivity, developing a professional network, completing the dissertation, and satisfaction in the doctoral program. Mentorship at the post-doctoral level confers more rapid ascendance to positions of disciplinary prestige, willingness to pay it forward by mentoring others, and increased career satisfaction and achievement. He further stated that "a good mentor discerns a protégé's personal and vocational dream, endorses this as realistic, and offers an environment conducive to facilitating this dream."

Clearly, gaining a mentor in the early stages of one's career is associated with many positive outcomes. However, many students do not report participating in a mentoring relationship. A recent survey of 1000 graduate students in clinical psychology indicated that just 66% had mentors in their graduate programs (71% of PhD students, 56% of PsyD students; Clark, Harden, & Johnson, 2000). The majority of students (43%) reported initiating that relationship, 35% were mutually initiated, 14% were assigned by a third party, and just 8% of the relationships were mentor initiated. Once initiated, the majority of the relationships (82%) lasted more than 3 years. The most frequently occurring mentoring functions were direct training, acceptance and support, and role modeling. Satisfaction in the relationships was fairly high; 94% of the sample stated that they believed the relationship was at least moderately important.

#### Division 12 Mentorship Program

Given the importance of establishing a successful mentoring relationship, Section 10 (Graduate Students and Early Career Psychologists) has developed and launched a clinical psychology mentorship program. This program assists students and early career members by pairing them with full members of the Society and by encouraging them to cultivate a mutually beneficial relationship. This provides more senior mem-



bers to “give back” to the society and to foster the development of students they would not otherwise meet. Junior colleagues profit from the expertise of senior members in enhancing their career development. This program primarily provides geographically independent long-distance mentoring opportunities based on matching participants research and/or clinical interests.

### Advantages of Mentorship for Early Career Members

Early Career Members of Division 12 gain access to experience and advice to supplement the information they learn in their graduate and internship programs. 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 a student 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 can provide crucial advice and mentorship during the transition to becoming independent practitioners and practitioner/scientists.

### Application and Matching

Section 10 of Division 12 has created a matching process using two forms: one for interested Graduate Students and Early Career Psychologists, and one for prospective mentors. Questions pertain to the respective research and clinical interests of the student and the mentor and what each hopes to achieve through the mentorship relationship. The forms include a rank order list of four topics of particular interest to the junior member, and expertise of the senior member.

### Guidelines

Mentors will be assigned for six months. After this time, both parties can evaluate the relationship and decide to continue or to be re-matched. This procedure allows a mentor to limit his/her time commitment while also allowing the student to be mentored by more than one person. If either, or both, parties desire to end their match prematurely, the individual(s) would be asked to contact the section to discuss the best way to handle the situation.

The mentoring program’s mission is to provide students with opportunities to gain positive career-related and psychosocial support. For more information on the mentorship program follow this link: <http://www.div12sec10.org/mentorship.htm> or contact the Chair of the Mentorship Program, Brian Hall: [bhall41@gmail.com](mailto:bhall41@gmail.com). Follow this link to access an online application: <http://www.div12.org/mentorship>.

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## BECOME A DIVISION 12 MENTOR!



Section 10 (Graduate Students and Early Career Psychologists) has developed a **Clinical Psychology Mentorship program**. This program assists doctoral student members by pairing them with full members of the Society. We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time

can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit: <http://www.div12sec10.org/mentorship.htm>, and visit <http://www.div12.org/mentorship> to become a mentor today!



### Virtual Environments for Clinical Psychologists

Thomas D. Parsons, PhD

University of Southern California, Institute for Creative Technologies



Simulation technology is coming of age and relevant applications are emerging in clinical psychology. A number of technological advances in computer power, engineering, and artificial intelligence have made virtual environments (VEs) attractive for both research and real-world applications in clinical psychology. In addition to the exponential advances in underlying simulation technologies, there has been a growing body of clinical research into the use of simulation technology for virtual reality exposure therapy, virtual environment-based psychological assessment, and training of clinicians using virtual patients.

#### Virtual Reality Exposure Therapy

Virtual Reality Exposure Therapy (VRET) is a novel tool for systematically exposing clients to specific feared stimuli within a contextually relevant setting. Using VRET, a clinician can immerse a client within a computer-generated simulation or VE that updates in a natural way to the client's head and/or body motion. Typically, VRET researchers follow an emotion-processing model, which holds that fear must be activated through confrontation with threatening stimuli and that new, incompatible information must be added into the emotional network. The amount of research assessing the efficacy of VRET on affective outcomes has increased over the last 10 years as VEs have become less costly, more available, and generally more usable. While much of the research to date has been comprised of uncontrolled designs and open clinical trials, a recent meta-analysis revealed that VRET has good potential as a treatment approach for several specific phobias (i.e. acrophobia, fear of driving, claustrophobia, aviophobia, and arachnophobia; see Parsons and Rizzo, 2008).

#### Virtual Environments for Psychological Assessment

Virtual environments developed for psychological assessment promise enhanced technology and ecological validity. A growing number of VEs are now being

developed and validated that focus on component cognitive processes including: attention processes, spatial abilities, learning and memory, and executive functions. To do this, researchers have developed various VEs such as virtual beaches, caves, fantasy worlds, space stations, and cities filled with skyscrapers, offices, classrooms, homes, and supermarkets. Further, there are a host of aircraft and automobile driving simulations.

Since VEs allow for precise presentation and control of dynamic perceptual stimuli (visual, auditory, olfactory, gustatory, ambulatory, and haptic conditions) that reflect real world environments, they may enhance the ecological validity of assessments through a combination of the veridical control found in laboratory measures and the verisimilitude of the environments that reflect real life situations (Tarr, 2002). Additionally, the enhanced computation power allows for a range of the accurate recording of behavioral responses in a perceptual environment that systematically presents complex stimuli. Such simulation technology appears to be distinctively suited for the development of ecologically valid environments, in which three-dimensional objects are presented in a consistent and precise manner. As a result, clients are able to manipulate three dimensional objects in a virtual world that proffers a range of potential task demands.

#### Training of Clinicians using Virtual Patients

Enabling technologies have evolved and now allow for the design of functional and usable "structural" clinical VEs. As a result, researchers have begun "populating" these environments with virtual representations of humans. These virtual human (VH) representations consist of characters that have realistic appearances, can act like humans, and can express themselves both verbally and non-verbally. Additionally, VHS can listen and understand natural language and see or track limited user interactions with speech or vision systems. Advances in simulated VHS afford the possibility of artificially intelligent VHS that control computer generated bodies and can interact with users through speech and gesture in virtual environments. Advanced VHS are able to engage in rich conversations, recognize nonverbal cues, analyze social and emotional factors and synthesize human communication and nonverbal expressions.

Virtual patients (VPs) are virtual interactive agents who are trained to simulate a particular clinical presentation of a patient with a high degree of consistency and realism. Virtual patients can provide valid, reliable, and applicable representations of live patients. VPs have commonly been used to teach bedside competencies of bioethics, basic patient communication and history taking, clinical decision making, and now for training of clinical psychology students (see Parsons et al., 2008). If this exploratory work continues to show promise, clinical psychologists may see a comprehensive DSM diagnostic trainer that has a diverse library of VPs modeled after each diagnostic category. The VPs would be created to represent a wide range of age, gender and ethnic backgrounds and could be interchangeably loaded with the language and emotional models defined by the criteria specified in any of the DSM disorders.

It is important to note that there are ethical and “best practice” challenges that may exist related to the use of simulation technology for virtual reality exposure therapy, virtual environment-based psychological assessment, and training of clinicians using virtual patients. While simulation technology may not be suitable for all aspects of clinical practice, clinical psychologists may benefit from the advantages found in simulation technology: increased standardization of administration; increased accuracy of timing presentation and response latencies; ease of administration and

data collection; and reliable and randomized presentation of stimuli for repeat administrations. Further, and perhaps more importantly, simulation technology can better replicate the diverse environment in which persons live.

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- Tarr, M. J. & Warren, W. H. (2002). Virtual reality in behavioral neuroscience and beyond. *Nature Neuroscience*, 5, 1089-1093.

**If you are interested in a specific technology topic or would like to contribute a column for a future issue, please contact the column editor Zeeshan Butt, PhD ([z-butt@northwestern.edu](mailto:z-butt@northwestern.edu)). ☐**

## SOCIETY OF CLINICAL PSYCHOLOGY FELLOWSHIP COMMITTEE 2010



On the recommendation of the Society Fellowship Committee, the APA Council has approved the following individuals for Fellowship status, effective January 1, 2011:

### *Initial Fellows:*

James K. Besyner, Ph.D., ABPP • Cheryl A. Boyce, Ph.D. • Glenn R. Caddy, Ph.D. • Eugene J. D'Angelo, Ph.D. • Frank M. Dattilio, Ph.D., ABPP • Marc Hillbrand, Ph.D. • David A. Jobes, Ph.D. • E. David Klonsky, Ph.D. • Radhika Krishnamurthy, Psy.D., ABAP • David F. Tolin, Ph.D., ABPP

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

Martha E. Banks, Ph.D. • Joseph M. Cervantes, Ph.D., ABPP • Lynn H. Collins, Ph.D. • Rosalind S. Dorlen, Psy.D., ABPP • Dan Fishman, Ph.D. • Cheryl A. King, Ph.D., ABPP • William E. Piper, Ph.D. • William S. Pollack, Ph.D., ABPP • Mitchell J. Prinstein, Ph.D. • Abraham W. Wolf, Ph.D.

### *The members of the 2010 Fellowship Committee are:*

Alfred J. Finch, Ph.D., Adlebert H. Jenkins, Ph.D., Nadine J. Kaslow, Ph.D., Gayla Margolin, Ph.D., Carole A. Rayburn, Ph.D., and Linda Craighead, Ph.D., Chair

### The Business Side of Things

April Nesin, PhD



Sometimes one's first exposure to "the business side of things" as a clinical psychologist is during the internship year. For instance, during my internship year, I was at times required to obtain precertification for services, which typically involved providing the patient's insurance company with clinical information. I quickly learned what types of clinical information were most important, to justify my diagnosis, and to be willing to negotiate and advocate for patient care. It was also a tremendous lesson in learning about what I did not know. My program, like most others, did not provide formal training in business-related issues. Though psychologists in academic settings are sometimes faced with business-related issues, perhaps these issues are most germane to psychologists working in primarily clinical settings.

***Though psychologists in academic settings are sometimes faced with business-related issues, perhaps these issues are most germane to psychologists working in primarily clinical settings.***

#### All about insurance panels

What is an insurance panel? Which one(s) should I be on? How do I go about getting on them? These are questions you might find yourself asking when approaching your first clinical position, whether it be in an organization or in private practice. Insurance panels are lists of in-network providers who accept a particular insurance. By "accepting" a client's insurance, you are also agreeing to a particular fee schedule as set out in your contract with the insurance company. At most institutions, these fees are pre-negotiated and there is little that you can do to change them. My primary piece of advice about getting paneled is to ask questions! By this, I mean, you want to be clear what

type of administrative support you have at your job to be able to get this paperwork completed. If you do not have support staff to assist with this task, you should make sure that you have administrative time built into your position up front to be able to get these completed, as they are often time intensive. Also, be sure to poll colleagues locally to see what panels you should prioritize based on information such as the types of insurance that local companies tend to offer and who has the best reimbursement rates. Finally, related to billing and insurance, you will want to be clear when starting your position what your billing responsibilities are and if you will be evaluated based on the amount that you bill or the amount that you collect – as these are often very different numbers.

#### Negotiating service rates.

Is this possible? If so, does the therapist do this or someone in the business office? The negotiation of rates is often completed by the business office at larger institutions, in which case, you will have no control over this issue. In private practice, you may have more leeway in negotiation of reimbursement rates. Again, my advice would be to talk to colleagues in your area to see what has worked for them and what the average reimbursement rates seem to be. Although you may not be able to negotiate rates on an individual basis, if reimbursement rates are an area of interest for you, I would also recommend that you become involved in your state psychological association, as they often have committees that work with insurance companies and state government agencies to lobby for changes to local reimbursement rates and acceptance of billing codes.

#### Billing codes

What are they? What do I need to know about them? Looking back over my training experiences, another topic I wish that I had had exposure to was billing (CPT) codes. These are the codes you use to bill for your services. For instance, the billing code 90801 is what is typically used for a diagnostic interview and is usually reimbursed at a higher rate than a therapy session (90806) because it includes time for you to review records/write your intake report. You need to become familiar with what each of the codes are that you might be using in your practice so that you can gain an understanding of what the code covers and

what types of documentation you are required to have when billing certain codes. This is something that you need to keep up with as changes happen – for instance, over the last couple of years, codes for diagnostic testing have changed in that you are now required to complete your report before you can actually bill for your time. Additionally, there are some CPT codes that are not covered by all insurance companies. For example, in the field of pediatric psychology, newer health and behavior codes are often the most relevant codes to use, however, only a handful of insurance companies are accepting these at this time.

### **Balancing ethics and practical matters**

What if a client's diagnosis is not covered by the insurance company but you believe that the client needs and would benefit from services? What do you do when a client can no longer pay for services but still needs to receive them? In graduate school, we often have the luxury of doing lengthy assessments and giving diagnoses without thought to how this might relate to reimbursement issues. Often in clinical practice, we encounter situations in which what we think might be in the best interest of the client is not necessarily covered by their insurance company (e.g., diagnostic code, number of sessions per week, type of therapy modality). In these cases, it is important to know that you can often talk to the insurance company directly or ask for a peer-to-peer review where you can provide clinical information, explain the circumstance and your rationale for what you are requesting and sometimes, be able to get things approved that may have originally been denied. This is also helpful when clients continue to need services, but they may have reached their maximum benefit for the year.

### **Managing one's own feelings when discussing business matters with clients**

Although during training most of us discussed diagnoses with clients, this was typically in general terms and often not necessarily in the first session. One thing that we should all become more comfortable discussing with our clients are working diagnoses and practical matters such as billing. Clients will receive a copy of the insurance payment including the diagnostic information from their insurance company and therefore it is important that you have discussed this information with them up front so that there is no confusion or surprises! Often discussions related

to diagnoses that we are not sure about or discussing rates of payment, copays, reimbursement, etc. are uncomfortable to have up front, but the more you can work them into your initial intake session, the better your relationship moving forward as these things will be less likely to get in the way of your working relationship down the road.

Overall, while daunting at first, the business side of psychology is manageable and necessary. My biggest piece of advice is to seek information, ask questions, and don't be afraid to ask for help!

**Many thanks to Dr. Nesin for sharing her experiences and offering tips. For questions, comments, or suggestions for future articles please email [csuveg@uga.edu](mailto:csuveg@uga.edu). ☐☐**

## 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](http://www.div12.org/division-12-sections)**



# CALL FOR NOMINATIONS 2011 AWARDS

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The Society for General Psychology, Division One of the American Psychological Association is conducting its Year 2011 awards competition, including the William James Book Award for a recent book that serves to integrate material across psychological subfields or to provide coherence to the diverse subject matter of psychology, the Ernest R. Hilgard Award for a Career Contribution to General Psychology, the George A. Miller Award for an Outstanding Recent Article in General Psychology, and the Arthur W. Staats Lecture for Unifying Psychology, which is an American Psychological Foundation Award managed by the Society. In addition, there is an award for graduate students: The Anne Anastasi General Psychology Graduate Student Award (see below for details).

All nominations and supporting materials for each award must be received on or before February 15, 2011. With the exception of the William James Award, you are encouraged to submit your materials electronically.

There are no restrictions on nominees, and self-nominations as well as nominations by others are encouraged for these awards.

The Society for General Psychology encourages the integration of knowledge across the subfields of psychology and the incorporation of contributions from other disciplines. The Society is looking for creative synthesis, the building of novel conceptual approaches, and a reach for new, integrated wholes. A match between the goals of the Society and the nominated work or person will be an important evaluation criterion. Consequently, for all of these awards, the focus is on the quality of the contribution and the linkages made between diverse fields of psychological theory and research.

Winners will be announced at the annual convention of the American Psychological Association the year of submission. The awardees for the first four awards will be expected to give an invited address at the subsequent APA convention and also to provide a copy of the award presentation for inclusion in the newsletter of the Society (The General Psychologist). These Awardees will receive

a certificate and a cash prize of \$1000 to help defray travel expenses for that convention.

For the William James Book Award, nominations materials should include three copies of the book (dated post-2006 and available in print); the vitae of the author(s) and a one-page statement that explains the strengths of the submission as an integrative work and how it meets criteria established by the Society. The award criteria can be found at [www.apa.org/div1/awards](http://www.apa.org/div1/awards). Textbooks, analytic reviews, biographies, and examples of applications are generally discouraged. Nomination letters and supporting materials should be sent to Dean Keith Simonton, PhD, Department of Psychology, One Shields Avenue, University of California, Davis 95616-8686; [dksimonton@ucdavis.edu](mailto:dksimonton@ucdavis.edu).

For the Ernest R. Hilgard Award, nominations packets should include the candidate's vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award and supporting letters from others who endorse the nomination. Nomination letters and supporting materials should be sent electronically to John D. Hogan, PhD, Psychology Department, St. John's University, 8000 Utopia Parkway, Jamaica, NY 11439 ([hoganjohn@aol.com](mailto:hoganjohn@aol.com)).

For the George A. Miller Award, nominations packets should include four copies of the article being considered (which can be of any length but must be in print and have a post-2006 publication date), vitae of the author(s), and a statement detailing the strength of the candidate article as an outstanding contribution to General Psychology. Nomination letters and supporting materials should be sent electronically to Nancy Felipe Russo, PhD, Department of Psychology, Box 871104, Arizona State University, Tempe, AZ 85287-1104 [NANCY.RUSSO@asu.edu](mailto:NANCY.RUSSO@asu.edu).

The 2012 Arthur W. Staats Lecture for Unifying Psychology is to be awarded in 2011 and given at APA's 2012 annual convention. Nominations materials should

*Continued on next page*



*Continued from previous page*

include the candidate's vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award including evidence that the nominee would give a good lecture. They should be sent electronically to Donald Dewsbury, PhD, Department of Psychology, University of Florida, Gainesville, FL 32611 (dewsbury@ufl.edu).

The Anne Anastasi General Psychology Graduate Student Award is in its second year and some changes are being introduced. This nomination must be submitted electronically to Harold Takooshian, PhD, Psychology-916, Fordham University, New York NY 10023, takoosh@aol.com.

Please send the Following Cover Sheet:

Candidates for the Anne Anastasi General Psychology Graduate Student Award should submit the following:

1. There are 2 levels of the Anastasi Award: Students with 2 years or less of graduate study and those with more than 2 years of graduate study. Circle the one that best applies to you:
  - a. Two years or less of study beyond the baccalaureate.
  - b. More than two years beyond the baccalaureate.
2. I completed my masters' degree in year: \_\_\_\_\_;  
or did not complete \_\_\_\_\_

3. Include:

- a. Name + email:
- b. Institution:
- c. A mentor + email:
- d. Focus of research, title:

II. Send the next three as attachments:

1. Research statement on your past/present/future work (2-3 pages, with limited number of important citations)
2. Your Curriculum Vitae
3. Supporting letter from one mentor, either attached or sent separately

These materials should be sent electronically to the 2011 Chair of the committee, Harold Takooshian, PhD, Psychology-916, Fordham University, New York NY 10023, takoosh@aol.com.

Each of two recipients of this award will receive \$300 and a certificate in 2011. The winner will be decided based on the student's vitae and research plan, plus a supporting letter from the student's advisor.

Requests for further information about Division One Awards may be directed to MaryLou Cheal, PhD, Awards Coordinator, Society for General Psychology, 127 E. Loma Vista Drive, Tempe, AZ 85282 (cheal@asu.edu).

## Postdoctoral research fellowship in the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders (UP) at the Center for Anxiety and Related Disorders at Boston University.


The Center for Anxiety and Related Disorders (CARD) at Boston University invites applications for several post-doctoral research fellowships, available beginning in the summer of 2011, for work on an NIMH-supported project further establishing the efficacy of the UP. Successful candidates will be involved

in both research and clinical responsibilities on this project. Extensive opportunities for manuscript preparation and additional collaborative ongoing research at CARD. The position will provide post-doctoral clinical hours and supervision necessary for licensure. Upon completion of one or two post-doctoral years, promotion to Research Assistant Professor and membership in the faculty of the Clinical Psychology Program at BU may be available. Competitive salary and fringe benefits.

To apply, please send curriculum vita, letters of interest, and the names of three referees to David H. Barlow <dhbarlow@bu.edu>.

### Section II: Society of Clinical Geropsychology

**Brian D. Carpenter, PhD**

 After many long meetings, many long applications, and many long years, Professional Geropsychology was finally granted specialty status by APA Council at the convention in August. Starting with designation as a proficiency in 1997, it's been a long road to specialty status, guided by the passion and commitment of many individuals and groups, including the Council of Professional Geropsychology Training Programs (CoPGTP), Division 20 (Adult Development and Aging), and APA's Committee on Aging (CONA). Specialty status confers further legitimacy to the unique competencies involved in providing services to older adults. Discussions are now underway about whether to pursue ABPP credentialing as the next step in formalizing professional geropsychology.

In other news from the APA convention, a number of awards highlighted the achievements of geropsychologists. The 2010 Committee on Aging (CONA) Award for the Advancement of Psychology and Aging was presented to Jennifer Moye. In the award announcement, CONA noted Dr. Moye's "outstanding contributions to geropsychology aimed at improving the quality of life of older adults through leadership in training of clinical geropsychologists, advocacy for expanded mental health care for veterans, and in translating research to the advancement of science, practice, and public policy, particularly regarding assessment of competency and diminished capacity." Dr. Moye is the editor of three handbooks in the series, *Assessment of Older Adults with Diminished Capacity*. Developed as part of a collaboration between APA and the American Bar Association Commission on Law and Aging, separate handbooks are available for psychologists, judges, and lawyers, and all have been widely adopted around the country and outside the U.S. Dr. Moye is the Director of the Geriatric Mental Health Clinic, VA Boston Healthcare System and Associate Professor of Psychology, Department of Psychiatry, Harvard Medical School.

A number of Section awards were presented at APA by President David Powers. They included the 2010 Student Research Award to Jennifer Kellough, a doctoral student at the University of Southern California, for her work, "Aging and Judgment of Facial Emotion."

The Clinical Mentorship Award went to Michele Karel, training director of the geropsychology track at the Boston VA Healthcare System and Associate Professor of Psychology, Department of Psychiatry, Harvard Medical School. And the M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology award was presented to George Niederehe for his immeasurable contribution guiding geropsychological training and research.

Section II members Cheryl Shigaki and Margie Norris are currently serving on APA's Interdivisional Health Care Committee, and among the issues currently under discussion is the use of the term "medical psychologist," which has emerged in conjunction with prescription privileges offered to psychologists in Louisiana. Questions center on definition of the term and what it might mean for licensing board oversight. Stay tuned.

Deb DiGilio from the Office on Aging advises people to watch for the release of an online Family Caregiver Briefcase for Psychologists in December. Developed by the Presidential Task Force on Caregivers, the briefcase is designed to assist psychologists in assessing and addressing the needs of family caregivers across the lifespan. Topics include common caregiving problems, assessment and intervention strategies and tools, caregiving and interprofessional teams, common ethical issues in caregiving, and the needs of culturally diverse groups.

Also recently released by another task force is a draft of the Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change. The guidelines emphasize, among other topics, the importance of competency with diagnostic criteria, ethical considerations (e.g., informed consent), knowledge regarding components of a comprehensive evaluation, familiarity with standardized assessment tools, and the role of feedback. The public comment period on the guidelines closes on October 20th, with a final version going to the APA Board of Directors for approval in December.

In August the U.S. Department of Health and Human Services announced the latest Graduate Psychology Education grants, which support graduate training programs that prepare students to work with underserved populations, including older adults. This year, \$2.6 million was awarded to 19 accredited health professions schools and other entities, some of which are dedicated to training students in geropsychology. These included the University of Colorado at Colorado Springs (Dan Segal,

PI), Wayne State University (Lori Lackman-Zeman, PI), and the University of Rochester Medical Center (Linda Jayne Alport-Gillis, PI).


“What Psychologists Should Know about Working with Older Adults,” the popular continuing education workshop that has been presented for several years at APA and features a number of members from Section II, continued its successful run at this year’s convention. Due to its popularity, APA has created an on-line version of the course, available at <http://webclients.captus.com/apa/catalog.htm>.

In other CE news, Section II members are now eligible for a 30% discount for offerings provided by Health Forum Online, a provider of online, APA-approved courses, many of which focus on geropsychology.

The Section’s new website is up and running and chock full of useful information. Keep up to date with Section II news, conferences, and members by going to [www.geropsychology.org](http://www.geropsychology.org). Finally, congratulations to our newly-elected officers, President-Elect Erin Emery and Treasurer Norm O’Rourke.

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

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

 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.

The SSCP membership committee has been active, resulting in approximately 30 new student and 30 new full members.

The Division 12 Resolution on evidence-based treatment has been a topic of open discussion on the SSCP listserv, and the Board is currently assembling a final list of suggestions to present to the Division 12 Board for their consideration.


The Academy of Clinical Science and SSCP will host a pre-conference forum at the 2011 APS Convention that will feature two events: 1) psychometric perspectives on diagnostic systems and, 2) training clinical scientists in the dissemination of empirically supported assessment and treatment practices. Speakers for the psychometric perspectives event will be Denny Borsboom, University

of Amsterdam; Lee Anna Clark, Notre Dame; and Tom Widiger, University of Kentucky. Speakers for the dissemination event are being determined.

The SSCP Board is aware of the recent GAO report on fraud in the recruitment and retention of students in professional schools, and is currently discussing the extent to which these issues apply to the psychology programs in these schools, as well as how SSCP should respond.

### Section VII: The Clinical Psychology of Ethnic Minorities


**Wei-Chin Hwang, PhD**

 We are pleased to announce that we had a very successful APA conference! Section VI programming was very well attended and attendees received CEU credits. In addition, we had excellent attendance at the awards ceremony and reception, which demonstrated the importance of recognizing the accomplishments of ethnic minority psychologists. Dr. Hector F. Myers was honored with the Samuel M. Turner MENTOR Award for his outstanding contributions to the training of scientist-practitioners over his long and distinguished career. In addition, Kee Straits was awarded the Dalmas A. Taylor Award for Outstanding Student Research. Thank you to Helen Pratt and Mia Byrn for their excellent service to Section VI.

We are also pleased to announce that membership applications are now online! Thank you to Lynn Peterson for the excellent planning meeting. Membership application, membership data, and funds of the section are now centralized and more streamlined. We are also in the process of moving our financial materials to Lynn.

### Section VII: Clinical Emergencies and Crises

**Marc Hillbrand, PhD**

 Section VII had a successful 2010 APA Convention in San Diego. Section offerings included a workshop on Collaborative Assessment and Management of Suicidality presented by David Jobes. Section VII honored Bruce Bongar with the Section VII Lifetime Contributions Award. He has made numerous seminal contributions to the fields of suicidology and terrorism science, including *The suicidal patient: Clinical and legal*



standards of care (American Psychological Association) and *The psychology of terrorism* (Oxford University Press, co-authored by Brown, Beutler, Zimbardo and Breckenridge). Section VII also recognized Tracey Witte with the Section VII Student Award. She is an early career psychologist with great promise, as her recent paper suggests, Reason for cautious optimism? Two studies suggesting reduced stigma against suicide, co-authored by April Smith and Thomas Joiner.

Section VI I President Michael L. Hendricks has continued the dialog with Division 17 about ways that the two divisions might collaborate on suicide prevention initiatives and using shrinking resources more effectively. Future collaborative endeavors that are envisioned include education, clinical initiatives, prevention, and research. Successful initial discussions with Yu-Wei Wang, Ph.D., and others in a Division 17 Special Interest Group on suicide prevention suggest that this will likely be a profitable path on which to embark.

## Section X: Graduate Students and Early Career Psychologists

**Brian J. Hall, MA**



The Graduate Student and Early Career Psychologist (ECP) Section has several updates to share with the Division. This update will include information about our current officers, our convention programming for this year, the Division 12/Section 10 Mentorship program, and our new website.

### Section officers

The section officers are Arianna Aldridge, M.S., President; Kate Humphreys, Ed.M., M.A., President-Elect; Christopher Cutter, Ph.D., Past-President; Samuel Gontkovsky, Psy.D, Treasurer; Yuliana Gallegos, Secretary; Jon Savant, Communications Chair and Website Manager; and, Brian Hall, M.A., Section 10 Representative to the Board of Directors. George Slavich, Ph.D., a founding member and immediate Past-President, and Rachel Jacobs, Ph.D. past Secretary, have rotated off of the section leadership. We thank them for their contributions to the section.

### Convention programming

In her role as 2010 Convention Program Chair, Arianna Aldridge, M.S. developed several convention programs with graduate student and early career psy-

chologist appeal. The first program was "Applying for a Postdoctoral Fellowship" with Drs. George Slavich, UCLA/UCSF and Christopher Cutter, Yale. The second program, "Applying for a Clinical Research Grant" included two excellent speakers, Dr. Vanessa Malcarne from San Diego State University and the UCSD Moores Cancer Center, and Dr. Niloofar Afari from UCSD and the VA San Diego.

We also honored Daniel Hurley, M.A. with the 2010 Early Career in Clinical Psychology Award for his poster titled "Enhancing Positive Outcomes Through Increasing Savoring the Moment." He is a Doctoral Candidate at Washington State University.

### Mentorship Program Update

The graduate student Mentorship Program launched this year. The program assists graduate students by pairing them with full members of the Society and encourages them to cultivate a mutually beneficial relationship. The focus of the relationship is to enhance students' or young professionals' career development. Our hope is that the Mentorship Program will create connectivity within the Society and continued growth of its membership. For more information on the mentorship program follow this link: <http://www.div12sec10.org/mentorship.htm> or contact Brian J. Hall, M.A., Chair of the Mentorship Program: [bhall41@gmail.com](mailto:bhall41@gmail.com). Follow this link to access an online application: <http://www.div12.org/mentorship>.

### Communications

The Section launched a new website. Please visit us online for updates about the section and more about our activities. <http://www.div12sec10.org/index.htm>. We are currently working to make the Communications Chair position official by adding this to our bylaws. Currently Jon Savant is working on increase the section's web presence through Facebook, developing a monthly blog, a section newsletter, and enhancing the current web-site.

### Membership

Out section membership continues to grow! We now have over 400 graduate students and early career members.

**Visit Division 12's Section web page:**  
**[www.apa.org/divisions/div12/div12.html](http://www.apa.org/divisions/div12/div12.html)**

# APA DIVISION 12 – NOMINATION BALLOT

Dear Division 12 Colleague:

Once again it is time to request your participation in the Division's nomination process. We will be selecting a President-elect, a Treasurer, and one Council Representative. You may enter the names on the ballot of any Division 12 members whom you believe would serve the Division well. Recent officers and committee chairs are listed below.

Thank you for your participation in the nominations and elections process. Ballots must be postmarked on or before Friday, December 3, 2010.

Sincerely yours,  
*Marvin Goldfried, PhD*  
2009 President

## DIVISION 12 BOARD OF DIRECTORS AND STANDING COMMITTEE CHAIRS (2006-2010)

OFFICE	2006	2007	2008	2009	2010
<b>President</b>	Gerald Davison	Marsha Linehan	Irving Weiner	John Norcross	Marvin Goldfried
<b>President-elect</b>	Marsha Linehan	Irving Weiner	John Norcross	Marvin Goldfried	Danny Wedding
<b>Past President</b>	Linda Sobell	Gerald Davison	Marsha Linehan	Irving Weiner	John Norcross
<b>Secretary</b>	Linda Knauss	Linda Knauss	Danny Wedding	Danny Wedding	N/A
<b>Treasurer</b>	Robert Klepac	Robert Klepac	Robert Klepac	David Rudd	David Rudd
<b>APA Council</b>	Barry Hong	Barry Hong	Linda Sobell	Linda Sobell	Deborah King
	Annette Brodsky	Annette Brodsky	Nadine Kaslow	Richard Suinn	Richard Suinn
	Nadine Kaslow	Nadine Kaslow	Larry Beutler	Larry Beutler	Larry Beutler
	Charles Spielberg	Linda Sobell	Lynn Rehm	Lynn Rehm	Lynn Rehm
<b>Member-at-Large</b>		Asuncion Miteria Austria	Asuncion Miteria Austria	Asuncion Miteria Austria	
<b>Section Reps</b>					
<b>2</b>	Deborah King	Deborah King	Deborah King	Deborah King	Brian Carpenter
<b>3</b>	Sheila Woody	E David Klonsky	E. David Klonsky	E. David Klonsky	David Tolin
<b>4</b>	Gloria Gottsegen	Gloria Gottsegen	Gloria Gottsegen	Lynn Collins	Lynn Collins
<b>6</b>	Toy Caldwell-Colbert	Toy Caldwell-Colbert	Toy Caldwell-Colbert	Eduardo Morales	Guillermo Bernal
<b>7</b>	Richard McKeon	Richard McKeon	Marc Hillbrand	Marc Hillbrand	Marc Hillbrand
<b>8</b>	Danny Wedding	Danny Wedding	Ronald Brown	Ronald Brown	Barry Hong
<b>9</b>	Irving Weiner	Norman Abeles	Norman Abeles	Norman Abeles	Norman Abeles
<b>10</b>		Sean Sullivan	Sean Sullivan	Sean Sullivan	Brian Hall

### NOMINATIONS BALLOT POLICIES

1. Nominations may be submitted only by Division 12 full members.
2. The Division 12 member must sign the ballot.
3. Nominations ballots must be completed on or before December 3, 2010.

### ELIGIBILITY REQUIREMENTS

1. Candidates must be Members or Fellows of Division 12.
2. No individual may run simultaneously for more than one elected Division 12 office or Board of Director seat.
3. No individual may simultaneously hold two elected seats on the Board of Directors.
4. No individual may hold the office of President more than once.

BALLOTS MUST BE POSTMARKED ON OR BEFORE **December 3, 2010**

OFFICIAL DIVISION 12 NOMINATIONS BALLOT (Please print or type)

PRESIDENT-ELECT

COUNCIL REPRESENTATIVE

SECRETARY

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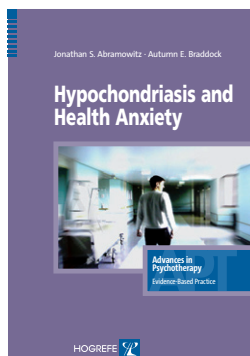
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**SEND THIS BALLOT TO:** Society of Clinical Psychology, P.O. Box 1082, Niwot, CO 80544

# New Releases in 2010

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Gordon J. G. Asmundson, PhD, RD Psych, FRSC, Professor of Psychology, Department of Psychology, University of Regina, Saskatchewan, Canada, Editor-in-Chief, Cognitive Behaviour Therapy

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- 1.3 Epidemiology
- 1.4 Course and Prognosis
- 1.5 Differential Diagnosis
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- 1.7 Diagnostic Procedures and Documentation
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- 4.4 Variants of the Treatment Procedures
- 4.5 Problems in Carrying Out Treatment
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- 4.6 Multicultural Issues

#### 5 Case Vignette

#### 6 Further Readings

#### 7 References

#### 8 Appendices: Tools and Resources

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## In Memoriam: Lynn P. Rehm, PhD, ABPP

Nadine Kaslow, PhD, ABPP



Lynn P. Rehm was born in Chicago in 1941.

After graduating from the University of Southern California, Rehm attended the University of Wisconsin for graduate school, where he was Richard McFall's first doctoral student. After a position at the UCLA-NPI Rehm joined the faculty of the University of Pittsburgh where he became Director of Clinical Training (DCT), which began his longstanding involvement in the Council of University Directors of Clinical Psychology (CUDCP), including a term on the board.

In 1979, Rehm moved to the University of Houston, where he served as DCT and developed the Psychology Research and Service Center, from which he retired in 2009. Past-President of the Houston Psychological Association (HPA) and the Texas Psychological Association (TPA), he was the HPA Psychologist of the Year and won the TPA award for Outstanding Contribution to Science. Upon his retirement, TPA honored him with a Distinguished Lifetime Achievement Award.

Rehm was very involved in APA's Society of Clinical Psychology (Division 12), serving as its President and representing the division on the Council Representative for multiple terms, including at the time of his death. He held APA leadership positions on the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology and the Board of Educational

Affairs. He was President of the International Society of Clinical Psychology and the Division of Clinical and Community Psychology of the International Association of Applied Psychology. In recognition of his many contributions to the division, Rehm received the Florence Halpern Award for Professional Contributions to Clinical Psychology. He chaired the Association of State and Provincial Psychology Boards' (ASPPB) Examination Committee for 10 years and took the lead in the computerization of the Examination for the Examination for the Professional Practice of Psychology (EPPP).

Rehm died in Santa Rosa, California on September 29, 2010 after a brief battle with cancer. His wife, Sue, and daughters, Elizabeth and Sarah, were by his side. Contributions in his honor can be made to the Dr. Lynn Rehm Graduate Scholarship Fund (giving.uh.edu/class) or may be made in his memory to the American Psychological Foundation ([www.apa.org/apf](http://www.apa.org/apf)) or the American Board of Professional Psychology Foundation ([www.abpp.org](http://www.abpp.org)). ■■



## THE SOCIETY OF CLINICAL PSYCHOLOGY

# Support Division 12 with 10 votes

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### **The APA apportionment ballot that determines representation on Council has been mailed.**

Division 12's voice on APA council is critical to advancing the integration of science and practice in psychology. The Society continues to provide many important activities that include advancing evidence-based assessments, relationships, and treatments; promoting multicultural collaboration; offering CE activities; publishing our newsletter, *The Clinical Psychologist*; and sponsoring our flagship journal, *Clinical Psychology: Science and Practice*.

The active involvement and the high esteem in which the Society is held within the APA governance must be maintained. The Society urges those concerned with the integration of science and practice in clinical psychology to allocate votes to Division 12. Our participation in the APA Council is vital.

Best wishes,

Marvin R. Goldfried, Ph.D., ABPP, President  
John Norcross, Ph.D., ABPP, Past President  
Danny Wedding, Ph.D., President-Elect

## 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](mailto: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.**