

THE CLINICAL PSYCHOLOGIST



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

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By **Danny Wedding, Ph.D.**
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PRESIDENT'S COLUMN

Across borders and boundaries

Looking ahead to transformations and challenges in Clinical Psychology



It is a genuine honor to be given the opportunity to serve as the 2011 President of the Society of Clinical Psychology. Division 12 has always been my APA home, and I have belonged since shortly after I graduated from the clinical program at the University of Hawaii in 1979. My primary mentors were Leonard Ullmann and Tony Marsella, and both encouraged all clinical students to become actively involved with the Division and with the American Psychological Association.

When I defended my master's thesis, Len and I took a one-hour walk around the beautiful Manoa campus so he could formally welcome me to the "community of scholars." Part of our conversation involved what it meant to be a psychologist and the importance of service to the profession.

I am writing this column immediately after chairing the annual board meeting held in Ft. Lauderdale January 6-7. You have an active and engaged board that includes President Elect Gayle Beck, Past President Marvin Goldfried, Secretary John Linton, Treasurer David Rudd, and eight Section Representatives: Brian Carpenter, David Tolin, Elaine Burke, Guillermo Bernal, Marc Hillbrand, Barry Hong, Norman Abeles, and Brian Hall. Our four Council Representatives also attended and participated: Larry Beutler, Richard Sinn, Deborah King and Irving Weiner. It is extremely gratifying to work with such distinguished colleagues.

The Board met to discuss a variety of issues including an aging membership, declining membership (about 5% per year), the loss of a Council seat, and the need to begin preparing the reaccreditation application for the Committee for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP).

The Board provides oversight for the Society's publication committee, and I'm especially proud of the Division's publication record. *Clinical Psychology: Science and Practice* is one of the premier journals in the field with an enviable citation index; *The Clinical Psychologist* is one of the few professional publications I actually read cover to cover; and the Hogrefe/Division 12 book

(continued on page 2)

President's Column (*continued*)

series on *Advances in Psychotherapy: Evidence Based Practice* now has over 20 volumes in print and there are at least a dozen more in the pipeline. I was especially pleased to learn that Wiley makes *Clinical Psychology: Science and Practice* available at low or no cost to 435 libraries in developing countries.

My presidential theme will be **Clinical Psychology Across Borders and Boundaries**. It will allow me to share my interest in international psychology with my clinical colleagues. I also hope to use future columns to discuss the professional school movement, the internship crisis and the ways in which the training of clinical psychologists will be affected by some of the profound

transformations that are occurring in education.

I recently retired (early) from the University of Missouri School of Medicine to take a position as Associate Dean for Management and International Programs in the California School of Professional Psychology (CSPP) at Alliant International University. After three decades training medical students and residents, it is gratifying to be actively involved in training the next generation of clinical psychologists.

Please free to contact me to discuss Society business anytime. I can most easily be reached via email at dwdedding@alliant.edu. I look forward to working with you in the coming year. ☺

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Jason Crowtz



Division 12 Board Meeting: Ft. Lauderdale, FL, January 7-8, 2011



Top row: Brian Hall (Section 10 Rep), Art Nezu (Diversity Chair), Brian Carpenter (Sec 2 Rep), Marc Hillbrand (Sec 7 Rep). Second row: Barry Hong (Sec 8 Rep), John Linton (Secretary), Deborah King (Council rep), Ed Craighead (CPSP Editor), Danny Wedding (President). Third row: Irv Weiner (Council Rep), Marv Goldfried (Past President), Norm Abeles, (Section 9 Rep), Elaine Burke (Sec 4 Rep), Mark Sobell (Host), Gayle Beck (President-elect), Dick Suinn (Council Rep). Bottom: Linda Sobell (Hostess).....Red and R2D2 family members of the Sobells who were welcome at the meeting.



Marv Goldfried being acknowledged
for for his work as a Division 12
President in 2010.

Division 12 Benefits as viewed by Graduate Student and Early Career Members

Tony Cellucci, Sara Bufferd, Jessica Peltan, Kate Humphreys, and John C. Norcross

ABSTRACT

Graduate students and early career psychologists in Division 12 were surveyed regarding influences on their initial membership and the importance of 20 possible membership benefits. Respondents ($N=171$, response rate=24%) indicated that faculty advisors/supervisors and interest in a particular section were the major influences for joining the Society of Clinical Psychology. Respondents rated resources on empirically supported treatments, advocacy for the integration of science and practice, identity as a clinical psychologist, the journal, and opportunities for networking as the most important benefits of membership. The most valued membership benefits of these students and early career psychologists were quite similar to those of full members (Rozell et al., 2010). Analyses indicated that ethnic minority student members were particularly positive about many member benefits and also revealed interesting differences by research interest. The implications of these findings for member recruitment and retention are discussed.



Introduction

Student and early career members represent the future of the Society of Clinical Psychology (APA Division 12). The Society has a relatively large number of graduate student members; approximately 200 new students join the Society each year. But we have been less effective in retaining them as members throughout their early career. For example, in 2010, we had 463 dues-paying student members, but 228 graduate students who paid 2009 dues did not renew in 2010. Given the graying of organized psychology (APA Division Dialogue, 2010), this pattern represents a significant concern. If we were to retain even half of our new graduate student members through the early career period, the future of the Society as representing clinical psychologists would be on a much firmer foundation.

At present, there is limited information on how and

why students affiliate with Division 12 and what they perceive to be the benefits of membership. Consequently, the Society's Membership Committee decided to conduct a study on how student members of the Division perceive the benefits of membership and why they initially joined the Society. This article summarizes our findings and discusses implications for student recruitment and retention in the Division. This study parallels that of Rozell and colleagues (2010) survey of division members.

Method

A survey instrument was constructed by the chair and student members of the Division 12 Membership Committee had three sections. The first section asked for demographics, such as age, gender, ethnicity and geographical location, along with a few questions about what influenced their decision to become a member. The second section asked respondents to rate the 14 membership benefits identified by Rozell et al. (2010) using the same 5-point, Likert-type scale of "importance" with 1=low, 3=moderate, and 5=high. In addition, we added an additional six benefits that committee members believed might prove relevant to graduate student members (i.e., building resume, mentoring, social networking, breakfast conversations at APA convention, opportunities to get involved with committees, and Early Career Status). The third section was directed at lapsed members; it requested reasons for letting their membership lapse and an open-ended question as to what might motivate their rejoining the association.

The instrument was constructed in Survey Monkey, and drafts were reviewed by the Membership Committee, Executive Committee, and the leadership of the student section. The incoming president of the Student Section (10) sent a listserv message informing those subscribed to expect an invitation to participate in the student membership survey. The invitation email and survey link were only sent to the individual emails of identified potential respondents as opposed to the listserv in order to calculate a response rate. The survey invitation was sent at the end of August, 2010 to correspond with the beginning of the fall semester, with two reminder emails sent approximately a week apart.

The invitation with survey link was emailed to 716 potential respondents, consisting of 482 current graduate student members with valid emails, 213 lapsed student members, and 21 early career psychologists (a new membership category defined as less than four years from the

receipt of doctoral degree). Of these, 208 respondents entered the electronic survey (29%). Many more current members ($n=190$) than lapsed members ($n=18$) entered the survey. In sum, 171 respondents (157 current members) completed the survey and rated the membership benefits. The effective response rate was therefore 24% overall, but closer to 30% for paid members. Given only 18 lapsed student members completed the survey, limited data were available about reasons for not renewing and these are not presented here.

Results

Sample Characteristics

Table 1 summarizes the demographics of respondents. Their mean age was 32 years with a range from 21 to 59 years old. Roughly two thirds of the respondents were female. Most of the sample reported their ethnicity as European-Americans (79%), with approximately 20% ethnic/racial minority respondents. The majority of respon-

dents (41%) were in their latter graduate school years but some were post docs (9.6%) or early career psychologists (7.7%). The largest number of respondents reported living in Northeast, Southwest, and Southeast states, with fewer respondents from the South or Northwest.

When asked "how long have you been/were you a member of Division 12?", 56% indicated one year, 23% indicated two years, and 21% three or more years. Few were already licensed to practice psychology (4.3%) but most planned on obtaining licensure (94.2%). The respondents varied substantially as to what percentage of time would be devoted to research in their initial ideal career position: 0-10% (15.9%), 10-25% (36.1%), 25-50% (18.3%), 50-75% (19.7%), and 75-100% (10.1%).

We have no means to systematically compare the characteristics of these respondents to non-respondents. Consequently, it is likely there is some selection bias given the 24% response rate. Clearly, current members were more motivated to respond.

TABLE 1: DESCRIPTION OF RESPONDENTS

Descriptive Characteristic		
Age ¹		32.27 Years (SD 8.7)
Gender	Female	142 (78.8%)
	Male	66 (31.7%)
Ethnicity	European America	164 (78.8%)
	Asian Pacific American	13 (6.3%)
	Other (e.g., multiracial)	13 (6.3%)
	Latino or Hispanic American	11 (5.3%)
	Black American	5 (2.4%)
	Native American	2 (1.0%)
Educational level	1st & 2nd year Graduate school	48 (23.1%)
	3rd year & beyond Graduate school	85 (40.9%)
	Intern	39 (18.8%)
	Post-Doc	20 (9.6%)
	Early Career Status	16 (7.7%)
Current geographical location	US-Northeast	62 (29.8%)
	US-Southwest/Pacific	53 (25.5%)
	US-Southeast	42 (20.2%)
	US-Midwest	26 (12.5%)
	US-South	12 (5.8%)
	US-Northwest	8 (3.8%)
	Outside US	5 (2.4%)
		N=208

¹Two respondents reported "over 40" and "over 50" so these values were used rather than considering their age values missing data.



Influences on Becoming a Student Member

The survey asked, "What influenced your initial decision to become a member of Division 12?" and listed seven choices plus "other," and allowed multiple choices. Table 2 provides the percentage of respondents indicating each source as influential.

TABLE 2: INFLUENCES ON THE INITIAL DECISION TO BECOME A MEMBER OF DIVISION 12

Influence	Frequency	Percent
Advisor or faculty supervisor	90	43.3%
Joined for Section membership	60	28.8%
APAGS	26	12.5%
Peers	25	12.0%
Other (e.g., own interest, journal access, service)	24	11.5%
Website	23	11.1%
APA Solicitation or advertisement	15	7.2%
Convention recruitment	1	0.5%
		N=208

By far, faculty advisors and supervisors were the major influence (43%) on students joining the Society. Many students (29%) were likely to become members because of their interest in a particular section. Student peers and/or APAGS (12%) were also responsible for some memberships. Advertising (7%) and particular convention recruitment (<1%) were rarely influential.

Benefits of Division Membership

The second and major section of the survey asked respondent to rate a list of 20 potential benefits. Analyses indicated that excluding the 18 lapsed members did not affect the overall mean ratings. Thus, Table 3 provides these ratings for all 171 respondents; the table presents for each item the modal rating (in bold), the average rating, and its rank.

In general, respondents were highly positive regarding membership benefits. The modal rating for all items was 3 (moderate importance) or above. The top ranked six items were: Resources on empirically supported treatments, opportunities for networking and involvement, advocacy for integration of science and practice, identity as a clinical psychologist, our Journal, *Clinical Psychology: Science and Practice*, and building resume by joining professional association.

We examined these benefit ratings by gender and ethnicity using independent t-tests. Given the large number of respondents (171) and the large number of possible item comparisons (20 per analysis), we set the statistical significance level a priori at $p < .01$. There were no significant differences by gender. There were a number of significant differences by ethnicity. Ethnic minority students ($n=41$) rated 5 of the 20 potential benefits as more important to them than Caucasian ($n=130$) respondents. Specifically, the ethnic minority students rated educational offerings ($M=3.56$ vs. 2.95 , $t(169)=2.84$, $p=.005$), Division 12 awards ($M=3.44$ vs. 2.76 , $t(169)=3.19$, $p=.002$), mentoring ($M=3.80$ vs. 3.07 , $t(169)=3.29$, $p=.001$), breakfast conversations ($M=3.12$ vs. 2.42 , $t(169)=3.15$, $p=.002$), and early career status ($M=3.71$ vs. 3.14 , $t(169)=2.71$, $p=.007$) as higher in importance.

Inspection of the mean ratings for current members versus those few lapsed student members revealed substantially lower benefit ratings for the latter. Specifically, lapsed students reported that an identity as a clinical psychologist (3.00 vs. 3.85 , $t(169)=2.61$, $p=.010$), a home within APA (2.14 vs. 3.22 , $t(169)=3.33$, $p=.001$), the convention (2.07 vs. 3.02 , $t(169)=2.89$, $p=.004$), the listserv (2.07 vs. 3.22 , $t(169)=3.42$, $p=.001$), awards (1.93 vs. 3.01 , $t(169)=3.28$, $p=.001$) and involvement (2.00 vs. 2.92 , $t(169)=2.62$, $p=.009$) were all less important to them.

Finally, perceived benefits were examined as a function of student and early career members' desired research involvement in their ideal initial career position. The 20 item ratings were analyzed for differences between the five research interest levels using one way ANOVAs and Tukey LSD post hoc testing. There were seven items with significant difference. Student members with the least interest in research involvement (0-10%) were distinguished from all other groups by rating as less important both advocacy for the integration of science and practice ($F(4, 156)=3.73$, $p=.006$) and resources on empirically supported treatments ($F(4,156)=4.63$, $p=.001$). Groups 2 (10-25%) and 3 (25-50%) with some but less than 50% time

Special feature (continued)

TABLE 3: RESPONDENTS' RATINGS OF DIVISION 12 BENEFITS (N = 171)

Item	Low		Moderate		High	Mean Rating	Rank
Resources on empirically supported treatments	2.9%	6.4%	25.1%	25.7%	39.8%	3.93	1
Opportunities for networking and involvement	1.8%	9.9%	24.0%	31.0%	33.3%	3.84	2
Advocacy for integration of science & practice	3.5%	8.8%	22.2%	34.5%	31.0%	3.81	3
Identity as a clinical psychologist	5.3%	8.8%	25.1%	24.6%	31.6%	3.78	4
Our Journal Clinical Psychology: Science and Practice	4.1%	9.9%	28.1%	26.9%	31.0%	3.71	5
Building resume by joining professional association	6.4%	14.6%	25.1%	31.6%	22.2%	3.49	6
Affiliation with a Division 12 section(s)	7.0%	12.9%	35.1%	20.5%	24.6%	3.43	7
Early Career Psychologist Status (new)	8.2%	17.0%	33.3%	22.2%	19.3%	3.27	8
Individual mentoring relationship with senior clinical psychologists	12.9%	13.5%	30.4%	22.8%	20.5%	3.25	9
Our Newsletter, The Clinical Psychologist	7.0%	17.0%	34.5%	28.7%	12.9%	3.23	10
Our Listserv	11.1%	21.1%	28.7%	22.2%	17.0%	3.13	11.5
A home with the APA	13.3%	12.9%	32.7%	28.7%	12.3%	3.13	11.5
Educational offerings (e.g., continuing education)	13.5%	16.4%	32.2%	23.4%	14.6%	3.09	13
Social networking	12.9%	22.8%	28.1%	19.9%	16.4%	3.04	14
Division 12 convention programming	14.0%	20.5%	35.1%	18.1%	12.3%	2.94	15
Division 12 awards and (future) Fellow status	16.4%	17.5%	34.5%	20.5%	11.1%	2.92	16
Opportunities to get involved with committees	17.5%	25.1%	25.1%	19.3%	12.9%	2.85	17
Our Webpage	18.1%	22.2%	33.9%	14.0%	11.7%	2.79	18
Our Book series, Advances in Psychotherapy	22.2%	25.7%	28.1%	18.1%	5.8%	2.6	19
Breakfast conversations with distinguished clinical psychologists at APA convention	28.1%	18.7%	28.7%	15.8%	8.8%	2.58	20

For additional information, please contact Tony Cellucci, PhD., ABPP, East Carolina University, Email: celluccia@ecu.edu.



Special feature continued from page 6

interest in research rated a number of benefits as more important than those with the most (50-75% and 75-100%) research interest. The former groups valued more highly the Division newsletter ($F(4, 156)=3.91, p=.005$), the Division book series ($F(4,156)=3.85, p=.005$), continuing education offerings ($F(4,156)=4.90, p=.001$), and Early Career Status ($F(4,156)=3.76, p=.006$). Those student members who expressed the most interest in a research career (75-100%) rated the importance of building their resume by joining a professional association as least important ($F(4, 156)=4.26, p=.003$).

Discussion

Most graduate students have joined Division 12 due to the influence of faculty advisors or attraction to a specific section. The influence of peers and APAGS account for an additional 25% of the reasons respondents joined. They most value the Society for providing resources on empirically supported treatments, opportunities for networking and involvement, advocacy for the integration of science and practice, the identity as a clinical psychologist, and the *Clinical Psychologist: Science and Practice*.

Comparisons with Rozell et al.'s (2010) survey results of regular Division 12 members are interesting, although caution must be exercised given the different sampling methodologies (online versus mail) and the additional student survey items. Four of the five highest ranked benefits by graduate student members were similarly ranked in the top five by Division 12 psychologists (i.e., advocacy for integration of science and practice, identity as a clinical psychologist, the journal, and resources on empirically supported treatment). The Division's newsletter was ranked somewhat lower by graduate students. Although no statistical analyses were performed, the mean ratings by student members were somewhat higher or similar to those reported by Rozell et al (2010) for regular members. It seems reasonable to conclude that student members are equally, if not more, positive than Division 12 psychologists about the benefits of their membership in the Society of Clinical Psychology.

The survey did not ask respondents which benefits they actually experienced. Inspection of Table 3 suggests that the importance attached to several benefits (e.g., breakfast conversations, committee involvement) may be confounded by the expected low frequency or likelihood of experiencing them. It would be helpful

to know more about how students perceive the benefits ranked lower. Perhaps these could be made more accessible or visible via targeted messages to graduate students and early career members.

Not surprisingly, students whose membership had lapsed were less positive about key membership benefits, although the comparisons must be considered tentative given the small sample size and probable response biases. In addition, ethnic minority student members reported that they attached more importance to many of the listed potential benefits than Caucasian respondents. Many of these benefits suggest a high degree of involvement and interest in being engaged in the Society.

Our survey did not ask the students about their program's training model or theoretical orientation, although the differences in benefit ratings by research interest are intriguing. Those with the least interest in continuing research involvement rated as less important two of the most highly ranked benefits in the overall sample (resources on empirically supported treatments and advocacy for the integration of science and practice). It would be interesting to know if this group is more likely to disaffiliate from the Society in the future. Also, those graduate students expressing moderate research career interests and presumably a scientist-practitioner career direction most valued continuing education offerings, the book series, and the newsletter. It is a useful reminder that the Division is a broad inclusive tent whose members vary in interests and value different benefits (Norcross, 2009).

We extract several take home points from these results related to recruitment and retention of student members. Although there are multiple influences that promote early affiliation with the Society of Clinical Psychology, faculty advisors and supervisors dominate. This finding suggests a call to action for trainers to inform students early in their careers about the Society and its activities. Perhaps advanced students could be recruited as membership ambassadors within training programs or for geographical regions. As sections were the second most influential source of membership, it would be helpful to know which sections generate the most interest. The Membership Committee could work more closely with Division 12 sections to promote membership at the student and early career level.

To a large degree, these graduate students valued most highly the same benefits as member psychologists. It would follow that membership campaigns can be developed around these common themes and particularly Division 12 as the place where science and practice are integrated, the focus of recent presidential initiatives

(Goldfried, 2010; Norcross, 2009). A positive finding is the degree to which ethnic minority students rated most benefits as important to them and, by implication, desire further involvement in the Society. Efforts to involve diverse psychologists and trainees in the Society will strengthen our Division and the profession (Recommendations for Increasing Diversity within APA Division 12, 2007). A final implication for membership planning is that, given the respondents' appreciation of the new Early Career Psychologist member category (ranked 8th out of 20 potential benefits), it is worthwhile to advertise, promote, and grow it. As students mature in their career path, a separate Early Career Psychologist section will no doubt emerge, as these members are currently housed in Section 10, along with the graduate student members.

There were a number of limitations to this survey project. The failure to engage most lapsed student members, a relatively low response rate, and uncertain representativeness of the respondents are probably the three most significant. Nonmember trainees may differ in their interests and the importance they would attach to various membership benefits.

We recommend that this study be repeated at regular intervals. Such future surveys might: 1) target lapsed members separately with a shorter instrument, 2) ask which of the benefits respondents had actually experienced (since several of the activities would have low frequency and thus we are "projecting" interest in many cases), 3) identify which section(s) in the Society spurred their interest, and 4) ask about program training model and future career directions. Of course, a separate study of why more graduate students in clinical psychology did not affiliate with the Society would also prove of interest.

In the meantime, we are reassured that our graduate student members and early career psychologists are generally satisfied with Division benefits, at least as much as our regular members. Nevertheless, we are acutely aware of the proliferations of APA practice divisions and other organizations competing for the attention (and dues) of graduate students. The Membership Committee remains dedicated to listening to our students and early career members, as they literally represent the future of the Society and our discipline.

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How Clinical Psychology linked up with Applied Behavior Analysis

Donald K. Routh
University of Miami



B. F. Skinner was not a clinical psychologist, but his work led to the development of applied behavior analysis, which has considerable clinical relevance. However, applied behavior analysis has only a tenuous link to clinical psychology so far. Skinner's own research, beginning in late 1930s, was carried out largely with rats and pigeons. In the late 1950s and early 1960s, two of his followers, experimental psychologists Sidney Bijou and Donald Baer, working at the Ranier School and the University of Washington, began to apply Skinner's ideas to work with children, including those

with disabilities. In 1968, Baer and some colleagues, then at the University of Kansas, founded the *Journal of Applied Behavior Analysis*, thus formalizing and giving a name to their very successful uses of operant conditioning to help people and not just to study them.

Very few of the persons who became prominent in the field of applied behavior analysis were trained as clinical psychologists. Instead,

Very few of the persons who became prominent in the field of applied behavior analysis were trained as clinical psychologists.

most people in this branch of psychology were trained in experimental or developmental psychology and have now developed their own separate identity as a profession. Many communities are now served by "certified behavior analysts," who have become especially prominent in the treatment of autism and developmental disabilities. Traditional psychotherapy and cognitive behavioral therapy of the types used by most clinical psychologists are successful mainly for people with average or better intellectual development and a certain threshold level of communicative ability. Young children and those with limitations of intellectual and communication skills seem to respond better to operant methods.

I was reminded of these facts rather forcibly in reading a book, published in 2006, *Doing Science and Doing Good: A History of the Bureau of Child Research and the Schiefelbusch Institute for Life Span Studies at the University of Kansas*, edited by Richard L. Schiefelbusch and Stephen R. Schroeder. This describes a highly productive research institute with an annual budget of up to \$22 million. It mainly involves departments of speech pathology, special education, and applied behavior science, with clinical psychology being a relatively minor player. The institute's research demonstrates among other findings the high efficacy of Skinnerian methods for persons with intellectual disabilities. The Department of Special Education at the University of Kansas has been repeatedly ranked first in the United States in recent years.

Looking through the list of the leaders of Division 12 over the years, I can identify only two who were conversant with applied behavior analysis, namely Alan Ross (President, 1969-70) and Logan Wright (President, 1981-82). It is not surprising that both of them focused their clinical activities on children: Alan Ross founded the Section on Clinical Child Psychology in 1962 (now the Division of Clinical Child Psychology), and Logan Wright was among the founders in 1969 of what became the Society of Pediatric Psychology.

Alan Ross received his PhD in clinical psychology from Yale University in 1953 and spent his early career working in child guidance clinics. In 1959 he published a book on the practice of clinical child psychology, an event that led to the founding of the clinical child psychology section three years later. It is interesting that the clinics where Ross worked were of the traditional kind; indeed, his boss at the Pittsburgh Child Guidance Center was a psychoanalytic psychiatrist. His 1959 book accordingly described the field in a rather traditional way. Subsequent to that publication, Ross became a convert to a behavioral approach, though not that developed by Bijou and Baer. Ross soon moved from Pittsburgh to the State University of New York at Stony Brook, where the Department of Psychology was behavioral in its orientation, though (like Ross) not necessarily Skinnerian. At least one graduate student in clinical psychology trained by Ross in his later years at Pittsburgh, Carolyn Schroeder, became highly conversant with applied behavior analysis and went on to use it in her daily clinical work with children and families.

Logan Wright received his PhD in clinical psychology from George Peabody College for Teachers (later part of Vanderbilt University) in 1964. He served as a psychology intern at the University of North Carolina at Chapel Hill, where his principal clinical supervisor was Marilyn Erickson. She was no doubt a major source of Wright's exposure to applied behavior analysis, for she had received her own training in child development and behavior analysis from Donald Baer, Sidney Bijou, and O. Ivar Lovaas at the University of Washington. Wright's subsequent conceptualization of pediatric psychology was thus strongly influenced by a Skinnerian behavioral approach. Some of Wright's subsequent colleagues in pediatric psychology, for example C. Eugene Walker, well known as a trainer of clinical psychology interns and postdoctoral fellows were also influenced by these behavioral methods.

The influence of both Alan Ross and of Logan Wright was in a sense combined in the type of clinical training offered by Carolyn Schroeder. She received her PhD in clinical psychology from the University of Pittsburgh under Alan Ross in 1966 and was soon hired by Marilyn Erickson at the University of North Carolina. Schroeder herself was principally responsible for training an impressive group of behaviorally sophisticated psychologists at North Carolina, including Gary Mesibov, Philip Davidson, and James Mulick. Mesibov

was subsequently a professor at the University of North Carolina, Davidson at the University of Rochester, and Mulick at Ohio State University. It is not incidental that Carolyn Schroeder is married to Stephen R. Schroeder, a Pittsburgh PhD in experimental psychology, who was until recently the director of the institute at the University of Kansas described in the book mentioned above. Those Schroeders are certainly a power couple and, in my opinion, a major source of what has become a vital link between the fields of clinical psychology and applied behavior analysis.

One subsequent president of Division 12, David Barlow, is also an expert in applied behavior analysis and the co-author of an important book on Single-Case designs in research. Such books encouraged the linkage of clinical psychology and behavior analysis, which was generally characterized by the use of such research methods.

According to Michael J. Dougher of the University of New Mexico, in the last two decades a new hybrid field of "clinical behavior analysis" has finally emerged. This applies behavior analytic principles to adult, verbally competent persons with traditional clinical problems such as depression, anxiety, adjustment reactions, marital problems and others. Thus, the present linkage of clinical psychology and applied behavior analysis is even stronger than I had realized. ■■

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What You Don't Know Can Hurt Others: Using the IAT to Promote Cultural Sensitivity

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Drexel University



At the very least, it is a psychologist's ethical responsibility to refrain from unfair discrimination based on one's diverse characteristics (e.g., gender, ethnicity, cultural heritage, sexual orientation) and to seek competency about such areas in order to effectively provide services to such individuals (American Psychological Association, 2002). Beyond that, we are taught to follow recommendations addressing multicultural issues as contained in the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* set forth by the

APA (2003) and perhaps take things further by answering the call from Nezu (2005) to "aver, affirm, and embrace human diversity" (p. 19). The ability to reach these goals partly rests on a psychologist's recognition that "as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are...different from themselves" (APA, 2003, p. 382). This suggests a self-evaluation of one's own multidimensional identity that naturally predisposes one to

biases and assumptions about themselves and others. It could be expected that most psychologists actively evaluate such explicit biases and make conscious efforts to eliminate them. But, what about "nonconscious" prejudices of which psychologists are unaware they have? These too influence behavior.

As a graduate student in clinical psychology, I take personal and professional pride in considering myself, as well as most others in the profession, egalitarian.

It wasn't until I received further education and training in diversity issues, in part by my mentor, Dr. Art Nezu (e.g., Nezu, 2005), that I began to grasp what a true egalitarian perspective encompassed and the limitations of my conscious beliefs in upholding these ideals. I became aware that even subtle, unrecognized information from my social environment influences my perceptions of, and interactions with, others. Efforts to counteract overt biases are unsatisfactory in combating the detriment and pervasiveness of "nonconscious" prejudice. Nezu (2005) likewise identified "unconscious biases against 'out-group' members" (p. 20) as one of three major obstacles to achieving objectives consistent with the profession's egalitarian perspective.

The Implicit Association Test (IAT) has been indicated as very helpful in minimizing such potential "nonconscious" biases by highlighting the discrepancy between conscious and "nonconscious" thoughts regarding various sociocultural variables (e.g., ethnicity, race, gender, age, sexuality, religion, disability). The IAT is a computer-based method of assessing automatic associations that exist outside of conscious awareness and control (Smith & Nosek, 2010). It can be said to "capture" the prejudice that individuals may be unable or unwilling to reveal; these implicit cognitions may be unavailable introspectively or explicitly rejected because they conflict with values or beliefs (Greenwald & Banaji, 1995; Nosek, Greenwald, & Banaji, 2007). The IAT examines implicit cognitions by measuring the strength of concept associations (usually two concept categories and two attribute categories) via stimulus-response reaction time; additionally, explicit cognitions are recorded through self-reported awareness and subjective evaluation of the validity of these associations (Smith & Nosek, 2010).

The IAT procedure involves multiple phases, all of which can be completed within ten minutes. The most important of these phases requires the individual to rapidly sort items (e.g., images of black or white faces and positive- or negative-valenced words) representing four concepts (e.g., black-white, good-bad) using two response options (e.g., the "e" key for black or good, the "i" key for white or bad). Underlying this procedure is the logic that the sorting task should be easier, as indicated by shorter response latency and less frequent errors, when the two concepts that share a response are strongly associated than when they are weakly

Most psychologists actively evaluate explicit biases and make conscious efforts to eliminate them. But what about "nonconscious" prejudices of which psychologists are unaware they have?

associated (Nosek, Greenwald, & Banaji, 2007; Smith & Nosek, 2010). Through a series of trials, a comparison of average response latency between the first combined sorting condition (i.e., containing four concept/attribute categorizations as opposed to only two in the practice trials) and the second reveals relative association strengths between concepts and attributes (Nosek, Greenwald, & Banaji, 2007). Once a task is completed, a description of the degree of the individual's automatic preference is reported (i.e., strong, moderate, slight, or no preference) alongside the percentage of other respondents' scores in each category.

As with any psychological measure, one should take caution in interpreting the results of the IAT (De Houwer, Teige-Mocigemba, Spruyt, & Moor, 2009). Since its development over a decade ago, procedural modifications have been made to reduce the influence of extraneous variables and such improvements are likely to continue (Greenwald, McGhee, & Schwartz, 1998; Nosek, Greenwald, & Banaji, 2007). For a detailed description of the IAT procedure, as well as reports of satisfactory reliability and validity, see Greenwald, Poehlman, Uhlmann, & Banaji (2009) and Nosek, Greenwald, & Banaji (2007). Most noteworthy are findings from a recent meta-analysis suggesting that the predictive validity of IAT measures concerning topics of high social sensitivity (e.g., racial and other intergroup behavior) surpassed that of self-report measures (Greenwald et al., 2009). These findings offer further support for the notion that although many Americans characterize themselves as non-racist, they still harbor "nonconscious", automatic biases about the out-group propagating subtle discriminatory behavior, as observed in microaggressions (Nezu, 2005).

After completing the IAT myself, I found that I fell into this group of "nonconsciously" biased Americans. I participated in nearly every demo test on the IAT website and found myself harboring comparatively negative automatic associations toward only one out-group, individuals with disabilities. I was most uncomfortable with possessing negative associations towards this particular group, which likely led to an avoidance of conscious recognition. Although this result was disheartening because I have always considered myself a compassionate person, my shame was overshadowed by the value of this information. I spent time reflecting on why such results were yielded and realized that my exposure to disabled persons has been extremely limited; I have never had a close relationship with a disabled

person and I have limited knowledge about the experience of those with disabilities, two ways of potentially neutralizing an automatic preference. Whereas I could identify possible cultural factors that might contribute to biases against other out-groups, I had difficulty recalling any environmental influences that might explain my moderate preference for abled persons. This lack of awareness underscores the purpose of the IAT; "nonconscious" biases were brought into consciousness and I was made aware that these automatic associations existed in my memory.

The IAT can serve as a tool for fostering cultural sensitivity in both psychologists and psychology students. The presumed egalitarian perspective of the profession may prevent psychologists from explicitly endorsing, or identifying introspectively, cultural biases that likely exist naturally as a function of being human. By participating in a demo on the IAT website (<https://implicit.harvard.edu/implicit/demo/>), as readers are encouraged to do, psychologists may be made aware of the presence of certain automatic associations after which they can, given motivation and opportunity, take steps towards reducing such biases. Psychology students may also benefit from using the IAT in diversity training. It promotes acknowledgement and acceptance of current biases beyond introspective methods thereby creating open discussion about how such implicit biases may lead to even subtle discriminatory behavior. By effectively addressing both explicit and implicit biases, psychologists and students can make gains towards adapting a culturally sensitive, egalitarian perspective.

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Ethics Issues in Clinical Supervision

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All psychologists and trainees participate in clinical supervision at various points in their careers: each of them as supervisees and many as supervisors (Norcross, Hedges, & Castle, 2002). Clinical supervision is an essential aspect of the professional training and development of all psychologists and it is

described by Goodyear (in Barnett, Cornish, Goodyear, & Lichtenberg, 2007) as our profession's "signature pedagogy" (p. 273). Further, Holloway (1992) describes the provision of clinical supervision to be psychology's "critical teaching method" (p. 177). As such, how supervision is conducted is of great importance. The ethical and effective practice of clinical supervision can have far ranging effects on the training and professional development of the supervisee and it can have a direct impact on the quality of professional services provided to the supervisee's current and future clients.

This brief article addresses several important issues relevant to the ethical and effective provision of clinical supervision.

Supervisor Competence

Supervisors may be experienced psychologists who have sought out this role and who take great pride in training and mentoring junior colleagues or they may be individuals who are assigned this task as one of their required duties at their place of employment.

Regardless, it is hoped that all supervisors take seriously the significant impact their role will play for their supervisees, ensuring that they possess the needed competence to effectively serve in this role. Consistent with Standard 2.01, Boundaries of Competence, of the APA Ethics Code (APA, 2010) supervisors must possess two types of competence; clinical competence in the areas of practice being supervised along with competence in the practice of supervision.

Increasingly, psychologists receive training in the provision of clinical supervision as part of their own training. This typically involves formal course work and supervision of the supervision services they provide. The development of competence as a supervisor goes far beyond merely having participated in supervision as a supervisee. Authors such as Falender and colleagues (2004) assert that supervision is one of professional psychology's core competencies, recommending that it be included in all training programs. Additionally, remaining current with ongoing developments in supervision through reading, and sharpening one's supervision skills by attending continuing education activities and from receiving supervision of one's supervision each can contribute to maintaining and developing one's competence over time (see also Ethics Code Standard 2.03, Maintaining Competence).

Informed Consent

The process of informed consent brings with it several important benefits. Barnett (in Barnett, Wise, Johnson-Greene, & Bucky, 2007) describe these benefits as including the promotion of a collaborative working relationship, increasing autonomy and self-determination, promoting rational decision making, minimizing the risk of exploitation or harm, and promoting openness and sharing. Just as informed consent is essential to the psychotherapy and assessment processes, it is essential to the supervision process.

Supervisees have the right to know at the outset of the supervisory relationship all information relevant to the conduct of the supervision process, expectations, obligations, and the like (See Ethics Code Standard 3.10, Informed Consent). For example, it is likely that supervisees would want to know about the supervisor's approach to supervision, the frequency of meet-

Ethics Update continued on page 19

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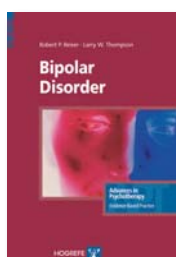
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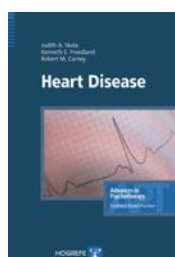
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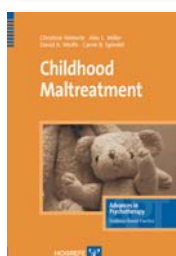
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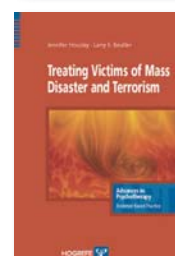
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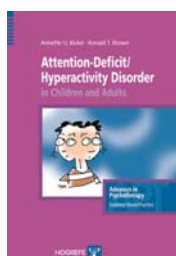
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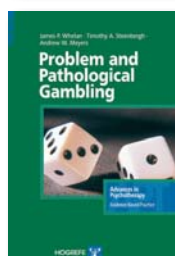
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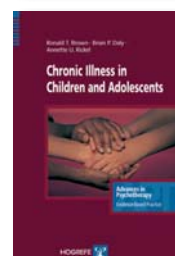
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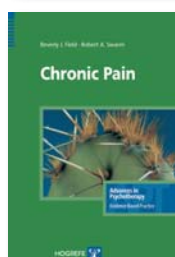
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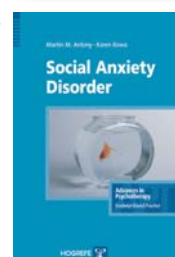
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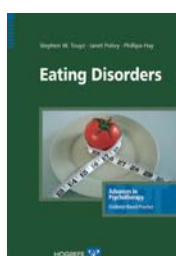
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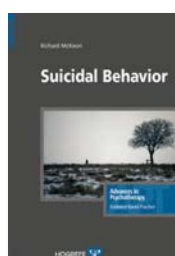
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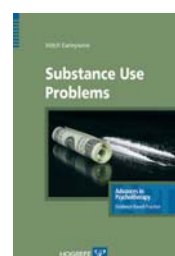
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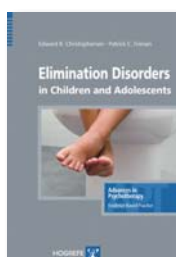
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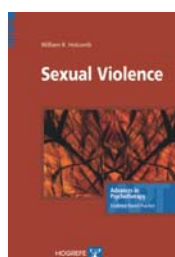
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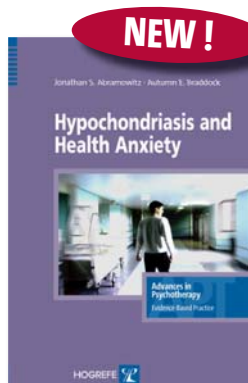
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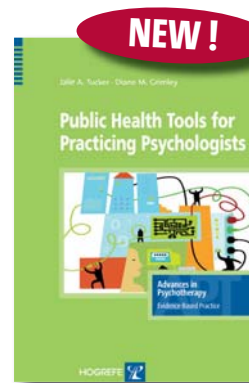
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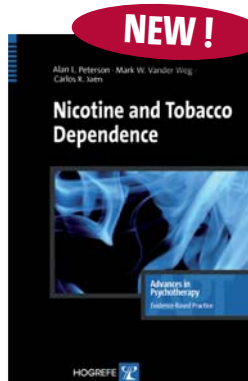
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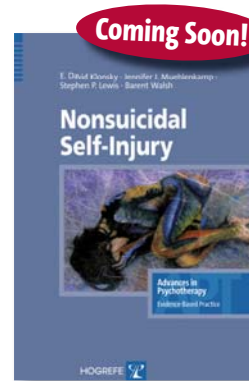
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<input type="checkbox"/> Problem and Pathological Gambling, <i>Whelan et al.</i> , ISBN 978-0-88937-312-9 (Vol. 8, 2007)			
<input type="checkbox"/> Chronic Illness in Children and Adolescents, <i>Brown et al.</i> , ISBN 978-0-88937-319-8 (Vol. 9, 2007)			
<input type="checkbox"/> Alcohol Use Disorders, <i>Maisto et al.</i> , ISBN 978-0-88937-317-4 (Vol. 10, 2007)			
<input type="checkbox"/> Chronic Pain, <i>Field, Swarm</i> , ISBN 978-0-88937-320-4 (Vol. 11, 2008)			
<input type="checkbox"/> Social Anxiety Disorder, <i>Antony, Rowa</i> , ISBN 978-0-88937-311-2 (Vol. 12, 2008)			
<input type="checkbox"/> Eating Disorders, <i>Touyz et al.</i> , ISBN 978-0-88937-318-1 (Vol. 13, 2008)			
<input type="checkbox"/> Suicidal Behavior, <i>McKeon</i> , ISBN 978-0-88937-327-3 (Vol. 14, 2009)			
<input type="checkbox"/> Substance Use Problems, <i>Earleywine</i> , ISBN 978-0-88937-329-7 (Vol. 15, 2009)			
<input type="checkbox"/> Elimination Disorders, <i>Christophersen, Friman</i> , ISBN 978-0-88937-334-1 (Vol. 16, 2010)			
<input type="checkbox"/> Sexual Violence, <i>Holcomb</i> , ISBN 978-0-88937-333-4 (Vol. 17, 2010)			
<input type="checkbox"/> Depression, <i>Rehm</i> , ISBN 978-0-88937-326-6 (Vol. 18, 2010)			
<input type="checkbox"/> Hypochondriasis and Health Anxiety, <i>Abramowitz, Braddock</i> , ISBN 978-0-88937-325-9 (Vol. 19, 2011)			
<input type="checkbox"/> Public Health Tools for Practicing Psychologists, <i>Tucker, Grimley</i> , ISBN 978-0-88937-330-3 (Vol. 20, 2011)			
<input type="checkbox"/> Nicotine and Tobacco Dependence, <i>Peterson, Vander Weg, Jaén</i> , ISBN 978-0-88937-324-2 (Vol. 21, 2011)			
<input type="checkbox"/> Nonsuicidal Self-Injury, <i>Klonsky, Muehlenkamp, Lewis, Walsh</i> , ISBN 978-0-88937-337-2 (Vol. 22, 2011)			
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ings, the limits to the professional relationship, documentation requirements, any fees involved, evaluation standards and procedures and limits to confidentiality, emergency contact information, and other requirements for the successful conduct and completion of the supervision process. It should not be assumed that supervisees will already know this information and it is suggested that the same care go into conducting a timely and thorough informed consent process in supervision just as one would do with one's own clients. Further, it is recommended that this ongoing process occur verbally, but that it is documented as well so that all agreements and expectations can be reviewed over time and so that the potential for misunderstandings can be minimized.

Supervisee Competence

Prior to actually providing supervision of the supervisee's assessment and treatment cases, it is recommended that a careful assessment of the supervisee's training needs occur. It is suggested that supervisors assess each trainee's readiness for the provision of the clinical services to be supervised (See Ethics Code Standard 2.05, Delegation of Work to Others). Rather than assume a supervisee's competence or discover it over time, an assessment from the outset of the supervisory relationship is suggested. This assessment can include a review of the supervisee's transcripts and c.v. to have a clear idea of courses taken and the nature and extent of past training experiences as well as possibly speaking directly with the supervisee's training director. Further, discussing the supervisee's knowledge and skills in areas relevant to the clients to be treated or assessed would be helpful. Then, observing the supervisee initially, before authorizing the supervisee to provide clinical services him or herself, should provide the supervisor with excellent information on the supervisee's ongoing training needs. Based on such observation, any needed remediation can be offered such as through the assignment of readings and the provision of additional training.

Supervision from a Developmental Perspective

Based on the initial assessment of a supervisee's level of competence in relevant areas of practice, the supervisor can determine what type and level of intensity of supervision would be most appropriate for the supervisee. For example, one may begin with having the supervisee observe the supervisor providing a clinical service,

then proceed to providing the service jointly, and then observing the supervisee providing the service. The supervisee can be provided with direct feedback in real time and then the supervisee's clinical work can be analyzed and discussed during supervision sessions. As the supervisee's competence develops, the supervisor's direct involvement in service provision can be reduced and the supervisee can play an increasingly more active role. Direct observation of the supervisee providing clinical services can transition from in-person, to calling in from behind a one-way mirror, to reviewing videotapes of sessions, to reviewing audiotapes of sessions, to the supervisee presenting information verbally in the supervision session (all the while providing the supervisor with documentation of the services provided and discussing the cases during supervision sessions).

Regardless of one's treatment approach or theoretical orientation, or the types of services being provided by supervisees, supervisors have an ethical obligation to provide adequate monitoring and oversight of the services supervisees provide. This helps ensure that supervisees only provide those clinical services that they possess the needed competence to provide effectively (under supervision, not independently), that the level of intensity of supervision is sufficient to support this goal, and that supervisors possess sufficient information needed to provide supervisees with timely and useful feedback to help promote their professional development and to provide feedback to the supervisee's training program. This is consistent with APA Ethics Code Standard 7.06, Assessing Student and Supervisee Performance (APA, 2010).

Supervisor as Role Model

Supervisors serve as important role models to trainees. They offer a firsthand experience of how practicing psychologists act, conduct themselves, and interact with others. The supervisor's level of professionalism, responsiveness and availability, commitment to the supervision process, and commitment to the supervisee's professional growth and development are each important. How issues such as boundaries and multiple relationships, diversity, maintaining confidentiality, demonstrating respect for others, and only practicing within one's areas of competence not only directly impact the value of the supervision being provided, they offer an important model for trainee's to emulate (or not) as they consider their developing professional identity.

Ethics Update (continued)

Note: Exposure to theories and/or methods and/or experience in supervision is required of programs in professional psychology at the pre-doctoral, internship, and post-doctoral level accredited by the APA Commission on Accreditation (see: <http://www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf> and <http://www.apa.org/ed/accreditation/about/policies/implementing-regs.pdf>).

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Get the Postdoctoral Fellowship You Want

Crystal Edler Schiller, M.A.

Doctoral Candidate, The University of Iowa and
Predoctoral Intern, Charleston Consortium,
Medical University of South Carolina



Postdoctoral training in clinical psychology has become the standard rather than the exception, with a diminishing number of doctoral recipients transitioning directly from clinical internships to full-time faculty appointments or clinical positions.

Postdoctoral applicants are encouraged to establish a few key training priorities before applying for positions. Because as Yogi Berra once said, “If you don’t know where you’re going, you might not get there.”

long-term career and training goals. Postdoctoral applicants are encouraged to establish a few key training priorities before applying for positions because, as Yogi Berra said, “If you don’t know where you’re going, you might not get there.” Depending on the type of career sought, proficiencies in the areas of patient care, research, teaching, clinical supervision, and grant writing may be necessary and should be established on your CV. Therefore, specific postdoctoral training goals may include receiving clinical supervision for licen-

In 2007, over half of the psychology doctoral recipients pursued postdoctoral training compared to only 10% of doctoral recipients in 1985 (Wicherski, Michalski, & Kohout, 2009). The 2007 Doctoral Employment Survey identified several key reasons for pursuing postdoctoral study, including focusing on clinical supervision to obtain licensure, becoming more employable, and gaining additional knowledge or skills related to research or clinical practice (Wicherski et al., 2009).

Effective pursuit of postdoctoral training must begin by identifying clear

sure, publishing additional research papers, receiving specific training in a novel research method, providing supervision for trainees, and demonstrating an ability to procure extramural research funding. After identifying your training goals, the next step is to seek available positions or create your own.

As graduate students, we are urged to begin preparing to apply “early;” however, you will likely find yourself doing that by virtue of programmatic milestones in graduate training, and will be laying the groundwork for successfully securing postdoctoral training in several ways. First, by attending conferences, presenting and publishing graduate research projects, and communicating with other clinical researchers, you have already engaged in one of the most important avenues for seeking postdoctoral training: networking. Individuals within your professional network may be able to provide leads for available positions that are not publicly advertised. Second, applying for a clinical internship in the current match system creates ample opportunities to connect with training sites that offer postdoctoral training. Graduate students are wise to consider internship interviews an opportunity to build relationships with future mentors or collaborators. Third, graduate mentors play an important role in establishing your candidacy for a position. Direct contact between your graduate mentor and potential postdoctoral supervisors can be the most effective way to pursue a postdoctoral position. The general principle of “familiarity breeds investment” applies here: the more recognizable and familiar you seem, the more likely you will be to get the position.

Postdoctoral training sites begin formally advertising positions as early as August and continue through December. The application deadlines often begin in September and extend through March, and there are listservs and websites dedicated to postdoctoral position listings. Some of the best websites advertising postdoctoral positions can be found at the end of this article. Most of the time spent on the application process is devoted to finding potential positions. Many of the applications are much less formal than graduate school or internship applications and often include little more than a cover letter, CV, and letters of recommendation. However, this may not be true of all psychology sub-specialties (e.g., neuropsychology) and all postdoctoral positions available, as some students

secure fellowships through a formal matching process (i.e., APPCN or APPIC).

Although established research positions exist, students pursuing research fellowships are well advised to contact researchers whose work they admire. A thorough review of your dissertation's reference section may help to identify potential mentors. It can be intimidating to "cold call" prominent members of your field directly, but this avenue has a high potential payoff. Researchers with grant funding will often be willing to create a postdoctoral position for qualified candidates. Even when they do not have available grant funding, many will provide invaluable career advice and leads for potential positions. You may also consider preparing an individual postdoctoral fellowship application to procure your own funding through agencies such as the National Institute of Health (e.g., F32 award). This option requires significant contributions from both the applicant and the mentor, and therefore, potential mentors should be selected wisely.

Once you've submitted your fellowship applications, the waiting game begins. Judgment of the relative strengths of postdoctoral opportunities should be reserved until after receiving offers because the best opportunity is always the one in hand. If you have multiple offers, several criteria may be considered before accepting a position. As mentioned above, the match of a program's training opportunities with your training and career goals is an obvious primary criterion. Of equal importance, however, is the quality of mentorship and training. Mentorship can be evaluated objectively by asking for a list of previous trainees and their current positions or by speaking to current fellows directly. Training sites should provide a description of planned training experiences and the time allotted for research, training activities, and clinical practice. The relative time spent engaged in each activity is an important consideration in determining the program's match with your training goals. For applicants pursuing research careers, the amount of research funding available, the mentor's record of obtaining grants, data available for publication, and institutional opportunities for long-term career advancement are additional criteria worthy of consideration. For those seeking more clinically oriented positions, the availability of clinical mentorship for expanding your clinical toolbox, strengthening your previous skillset, working with new populations, and

establishing a strong area of clinical expertise may be important considerations.

Quality of life variables, including salary, benefits, and location also contribute to program's relative strength. Although the postdoctoral training period forms the platform for building future career opportunities, student loan repayment begins during this period. Seventy-five percent of graduates with a PhD in clinical psychology report student debt, and the median level of debt is \$55,000 (Wicherski et al., 2009). Postdoctoral salary is therefore an important consideration. In 2007, 92% of postdoctoral fellows received stipends. Median stipends for research and clinical positions were \$38,148 and \$30,000, respectively (Wicherski et al., 2009). In terms of location, family considerations, community resources, expenses associated with relocating, and cost of living should be considered.

Although the process of applying for postdoctoral positions can be daunting so soon after beginning your internship, it is also an exciting time given that your decision will significantly impact the next phase of your career. I hope that this information will be helpful to you. Please send any comments to schiller@musc.edu, and best of luck with your postdoctoral training.

Web Resources

<http://www.appic.org/postdocs/index.html>

<http://www.appcn.org/>


<http://www.apa.org/careers/psycareers/>

<http://www.psychologicalscience.org/index.php/employment>

<http://www.usajobs.opm.gov/>

<http://www2.training.nih.gov/apps/publicForms/postdoctoral/forms/adIndex.aspx>

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Using the Internet for Psychosocial and Behavioral Health Interventions: Considerations for Research and Practice

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Information technology advances over the past decade have opened up a new field of internet supported psychosocial and behavioral health interventions known collectively as “internet interventions” (Ritterband & Tate, 2009). Outcome research

on internet interventions has demonstrated its effectiveness in improving quality of life, managing mental and physical symptoms and changing behaviors for a variety of interventions, including those for physical activity, obesity, substance use, cardiac disease, depression, anxiety and traumatic stress. Other chronic disease areas with increasing use of internet interventions for prevention and symptom management purposes include asthma, diabetes, and cancer.

Such interventions are not just for the young. Older adults are increasingly engaging in online activities ranging from email, watching online videos and surfing the web to participating in social networking sites (e.g., Facebook), online dat-

ing and creating user generated content. With growing use of the internet in both younger and older adults,

internet interventions have the potential to facilitate communication with mental health professionals between clinical visits, self-monitor symptoms on a routine basis, receive tailored, instructional symptom management support and connect participants with one another for information sharing, discussion and encouragement (Ruland et al., 2007); all of which leads to increased engagement in one’s health care.

There are a myriad of internet-supported therapeutic applications, which Barak et al (2009) have categorized into four common sub-types, including: web-based interventions, online counseling and therapy, internet-operated therapeutic software and other online activities, such as use of personal blogs, social networking sites and online support groups. Web-based interventions are mostly self guided tools that are operated through a website to provide prevention or health promotion support through education, awareness-raising and interactive health-based learning experiences. Program content typically focuses on educational or therapeutic topics (e.g., cognitive/behavioral) and often utilizes multimedia, such as pictures, graphics, audio and video. Web-based interventions can be interactive in nature through the use of self monitoring tools, and supportive feedback can be provided (either system automated or human-generated) to offer users information on their progress.

Online counseling and therapy had its start in the mid-1990s and has evolved in tandem with technological advances in non-textual functionalities, such as audio communications and web-cameras. Services can be delivered in individual and group formats, using either synchronous or asynchronous modalities. Advantages to this approach lie in its flexibility in terms of time, space and place for both client and provider. Because several of the explicit and implicit interpersonal dynamics inherent to face-to-face therapy may be less observable online (e.g., nonverbal cues, expression of emotions, minimal encouragers, micro-expressions), both clients and providers need to be mindful that extra efforts may be needed to assure understanding.

Internet-operated therapeutic software capitalizes on advances in artificial intelligence and can include everything from robotic simulations of therapists, 3D virtual gaming environments (e.g., Second Life) to virtual reality. Typically more time, labor and cost intensive for more widespread use, these applications

Internet interventions have the potential to facilitate communication with mental health professionals between clinical visits, self-monitor symptoms on a routine basis, receive tailored, instructional symptom management support and connect participants with one another.

have been shown to be effective in progress monitoring and stages of change assessment, problem solving and decision making, and treating anxiety disorders, pain and substance use through virtual exposure-based methods.

One example of a web-based intervention for people with breast and prostate cancer is called WebChoice (Ruland et al., 2007) and is comprised of assessment, self-management, information and communication components. The assessment component is used for routine symptom monitoring through patient endorsement of a series of single item symptoms dealing with physical issues, pain, thoughts, feelings and social relationships. After being asked how bothersome each symptom is, patients prioritize them in order of self management support needs. Graphic summary reports are produced and are able to be viewed online and printed for use as a communication tool during follow up medical appointments. Each high priority symptom area triggers written management guidelines and recommendations found in the self-management intervention component, which are able to be saved under a “my interventions” area. The information component is a virtual library of updated cancer treatment and support related information. Finally, the communication section is an area where participants can share experiences and post messages to others and ask private questions to a cancer nurse specialist.


Internet intervention benefit from many of the evaluation recommendations from the USDHHS Science Panel on Interactive Communications and Health (Eng, Gustafson, Henderson, Jimison, & Patrick, 1999), which includes formative, process and outcome evaluation models. Evaluation of newly developed systems typically focuses on user interfaces, overall operation, system errors, data security as well as user satisfaction, competence and confidence (Danaher & Seeley, 2009). Recruitment strategies that consider internet related inequities attributed to economics, usability and empowerment help elucidate possible confounds between a program’s effectiveness and an individual’s internet access and efficacy. Finally, examining variable such as exposure and engagement to the internet intervention, including webpage viewing, viewing duration, number of visits provides a quantitative index of utilization.

In sum, the internet offers a dynamic environment from which mental health practitioners and clinical researchers can engage clients and patients across

multiple psychosocial and behavioral health pathways. Similar to “face to face” interventions, those conducted over the internet need to adhere to sound research designs, be grounded in established theoretical models and offer empirically supported treatments. As is expected with any new technology, a challenge and opportunity of this field lies in its state of constant flux, as cutting edge programs will quickly be replaced with next year’s model.

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If you have any questions or comments regarding this article, you can reach Dr. Victorson by e-mail at d-victorson@northwestern.edu. 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). 

Getting Licensed

Cynthia Suveg, PhD



Some clinical psychologists who work in primarily academic settings may forego licensure. Yet, for the vast majority who work in clinical, academic, and/or combined settings, obtaining licensure will be one of the final milestones of becoming an independent professional. Though time consuming and relatively costly, especially for a new professional, the psychologist license is necessary to provide direct services as well as to independently supervise those who are having direct contact with clients. For this reason, it is often beneficial to obtain licensure as soon

as is possible post-graduate training. This article provides some guidance for how to go about obtaining licensure and for things to consider when doing so.

Acquiring a specified number of postdoctoral hours is required for licensure in all states. Go to your state's psychology licensing webpage and familiarize yourself with the rules and regulations so that you can prepare accordingly. Keep in mind that you might relocate

to another state at some point in the future. Therefore, aim to cover requirements that would be acceptable by most states (e.g., relatively high EPPP score) while keeping in mind that there will still be state-specific requirements to meet (e.g., some states require an oral exam whereas others do not). Fortunately, to aid in mobility the ASPPB now has a "Credentials Bank," that stores all information required for licensure (e.g., university transcripts, examination scores). Once practicing for 5 years, and meeting other requirements, mobility becomes even easier because you can attain Professional Qualification in Psychology (CPQ). "The Bank" costs \$200.00 for non-students.

The EPPP is often an anxiety-provoking exam.

With 200 scored questions (175 beginning August 2011) that you must complete within 4 hours and 15 minutes, a hefty price tag (\$450.00), and coverage of domains that might not be in one's area of expertise, such worry is understood. Yet, if you have made it to the EPPP chances are you have already acquired the skills to successfully pass yet one more multiple-choice exam! Given that the EPPP covers eight domains, there will surely be content on the exam that is less familiar to you. However, there are numerous study resources available in both print and on-line through the ASPPB. Though the practice materials can be expensive, they are well worth it if they facilitate a passing score.

Also note that you first must apply to sit for the exam through your local jurisdictional licensing authority. Once you receive approval from your local jurisdiction, then you can register to take the EPPP. After you have sent in your payment for the EPPP, you have just 60 days to actually take the exam. For those juggling postdoctoral fellowships and new positions, finding time to study for the EPPP can be very difficult. Consider studying for a specific period of time. Knowing that you've already paid your money and have a limited time to take the exam might assist you in focusing a limited amount of time to studying and prevent you from drawing out the studying process too long. In combination with the fact that the EPPP will cover some less familiar material to you, consider taking the EPPP as soon out of graduate school as possible, when theories unrelated to your area are most fresh and perhaps your job responsibilities are not yet as intense as they might be once established in your position. The ASPPB recommends a score of 500 (70%) for independent practice and 450 for supervised. Though most states accept this score, the criterion for passing can vary by state.

Some states require that you earn postdoctoral hours before taking the EPPP whereas others do not. Regardless though, everyone will eventually have to acquire postdoctoral hours for licensure. For those who do formal postdoctoral fellowships, acquiring hours for licensure might be fairly easy particularly if you are involved in a range of activities. Much like the APPIC application for internship, some states will require you to break down your supervised postdoctoral hours into categories (e.g., assessment, treatment, supervision). One suggestion is to print off the required postdoc-

A psychologist license is necessary to provide direct services, as well as to independently supervise those who are having direct contact with clients.

toral verification form from your jurisdiction so you see exactly what will be required. Then, you can keep track of each of your activities as you are going along. If you do not do a formal postdoc or if you go straight into an academic position, obtaining hours for licensure might be more challenging. In such cases, think creatively about how to get your hours. For instance, perhaps you have wanted to learn a particular type of group therapy and another licensed faculty member happens to run a group. Ask if you can learn the therapy and get supervision from your licensed colleague. You might also be able to provide clinical supervision of graduate students in your department (which counts as postdoctoral hours) provided that you meet with a licensed faculty member to supervise you and sign off on clinical notes. You can also count so many hours of scholarly work toward licensure. If there are no opportunities within your department to acquire supervised experience, then seek opportunities in the community. There might be practices in the community that will allow you to conduct assessment and/or treatment with supervision

to acquire your hours. Conducting this work helps a busy practice and assists you in getting your hours.

It is probably clear from this post that there are several fees associated with licensure. The fees definitely add up, and can feel daunting for a new professional. Consider whether there are resources available to help offset the fees. For instance, it is oftentimes beneficial for the postdoctoral employer to have you licensed because you can then conduct increased independent work. Because of this, some postdoctoral employers will pay for part or all of your fees. As a new faculty member, you might have start-up funds. Depending on the parameters surrounding the use of start-up funds, you might be able to utilize at least some of those funds for licensure.

For specific information on psychology licensure, go to the Association of State and Provincial Psychology Boards website. The website includes links to the EPPP and to each state's specific licensing boards. Good luck! For comments or suggestions please send an email to csuveg@uga.edu. ☐☐

ANNOUNCEMENT

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

 With the convergence of tough economic times and fractious political dynamics, public policy and advocacy issues seem more and more urgent. The Section's Public Policy Committee, spearheaded for many years by Donna Rasin-Waters, has been very active in recent months. Representatives, including Paula Hartman-Stein, attended the Association for the Advancement of Psychology's Black Tie event honoring congressional champions of psychology. These events are important opportunities for geropsychologists to articulate the importance of aging issues in legislation and regulations. To wit, advocacy continues for sustained Medicare reimbursement for psychological assessment and treatment, and for the inclusion of psychologists into the Medicare physician definition. Finally, the Committee has prepared a survey, soon to go out to the Section membership, to assess current political activity among its members.

Just as APA is finalizing its Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change, a related document was released by the American Medical Association. Their Physician Consortium for Performance Improvement (PCPI) issued a call for public comment on a Dementia Performance Measurement Set, which outlines recommendations for assessment. The development of the measurement set was undertaken without systematic input from psychologists, and so it may not be surprising that it highlighted screening tools (e.g., MMSE, Memory Impairment Screen), with little mention of neuropsychological instruments or evaluation. The American Academy of Clinical Neuropsychology provided a response to the PCPI, and with the public comment period now closed, the final version of the performance set will be unveiled shortly.


As you may have heard, Professional Geropsychology gained specialty status earlier in 2010, and next steps are underway to move the specialty forward. A number of related organizations (Section II, the Council of Professional Geropsychology Training Programs (CoPGTP), Division 20 (Adult Development and Aging), Psychologists in Long Term Care (PLTC), and the APA Committee on Aging (CONA)) are forming a Geropsychology Specialty Council, in order to send a

representative to APA's Council of Specialties. (If the organizations all start to sound the same, they are.) Having an ABPP in Geropsychology is another option, and Rick Zweig, Victor Molinari, and Dan Segal recently surveyed Section members on whether to pursue this opportunity, given the significant time and financial commitments it involves.

As always, you can keep up to date with Section II news, conferences, and members by going to www.geropsychology.org.

Section III: Society for a Science of Clinical Psychology

David F. Tolin, PhD, ABPP

 Varda Shoham is the new President of SSCP; she is joined on the Board by President-Elect Rick Heimberg, Past President Thomas Ollendick, Secretary/Treasurer David Smith, At-Large Representatives Bunmi Olatunji and Bethany Teachman, Division 12 Representative David Tolin, and Student Representatives Sara Stasik and Rebecca Brock. We wish to extend our heartfelt gratitude to our outgoing Board members Howard Garb, Kelly Wilson and Frank Farach.

The largest Section of Division 12, SSCP currently has 558 members. Of these, 445 are professional affiliates, 65 are student affiliates, and 48 are international affiliates.

SSCP congratulates the five winners of the Dissertation Grant Award for 2011. They are Rachel Bender (Temple University), Kristi Benoit (Virginia Tech), Jessica Levinson (University of Pittsburgh), Theresa Morgan (University of Iowa), and Lindsey Stone (Binghamton University).

The Committee for Promoting Clinical Science, formed this year, will give monetary awards (\$3,000 total) to recognize the good efforts of predoctoral, internship, and post-doctoral training programs in their efforts to adopt and utilize evidence-based treatments.


Our website for SSCP's student members (<http://sites.google.com/site/sscpwebsite/students>) contains student-related news, research awards and grant postings, links to professional development websites and online research tools, descriptions of current SSCP student projects, and SSCP membership information.

The SSCP internship directory has been updated and is available on our web site (<http://sites.google.com/>

site/sscpwebsite/). Results were compiled from clinical internship sites during the Spring of 2009. The Directory has been published by SSCP since 1974 as a resource for graduate students and clinical faculty members. The current edition has become a joint effort of SSCP and the Academy of Psychological Clinical Science (APCS). The Directory provides unique information not available elsewhere, including research opportunities and training in empirically supported interventions.

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.

Section VI: The Clinical Psychology of Ethnic Minorities **Wei-Chin Hwang, PhD**


 This year we have a change in officers for Section VI. We are now under the leadership of a new and energetic President, Elizabeth (Beth) Boyd. The following are officers for 2011: Gail E. Wyatt, President-elect; Jawana Ready, Secretary; Louis P. Anderson, Treasurer; Guillermo Bernal, Section VI Representative to Division 12; Cendrine Robinson, Student Representative; April Harris-Britt Membership Chair; David Acevedo-Polakovich, Mentoring Committee Chair; Karen L. Suyemoto, Awards Committee Chair; Cheryl Anne Boyce and Alfiee M. Breland-Noble, Program Committee Co-Chairs; and Wei-Chin Hwang, Division 12 Journal Section VI Editor.

President Boyd's 2011 presidential theme will be "Gathering Our Resources." She hopes to increase membership, establish future goals and directions, and share the individual talent and collective contributions of the section with the rest of Division 12. Program Co-Chairs, Cheryl Boyce and Alfiee Breland-Noble, have put together a wonderful Section VI program for the APA Convention. We will be in touch with the specifics of this program and hope to see many of you there. President Boyd hopes that our members -- both those who have been with us for the long term and those who will join


us -- will help us in gathering our resources and sharing the best that we have in the next APA Convention. She also hopes that the rest of Division 12 will come to section events to learn more about how ethnic minority and cultural issues impact the field of clinical psychology.

Section VI's membership continues to grow. We have a newly updated website and encourage students and professionals to join Section VI and to keep abreast of our Section's activities (<http://www.apa.org/divisions/div12/sections/section6/index.htm>). You can apply for membership using our new online membership application system (<https://www.secure-server-hosting.com/securetran/secureforms/sh200616/Section6FullMember.html>). In addition, new members will have the option of being listed in our professional directory, which identifies professionals who specialize in treating underrepresented racial/ethnic minorities.

Section IX: Assessment 2011 **Norman Abeles, PhD**

 A little known development with regard to assessment takes place in 2011. The Center for Medicare services announced that starting this year if you go to your primary physician and complain of memory problems you will be asked to take a computerized self administered memory test (CST). First published in the Journal of Alzheimer's Disease in April 2010, the CST accurately classified 96% of cognitively impaired individuals in comparison to control participants while the Mini mental (MMSE) exam and the Mini-Cog classified only 71% and 69% respectively. According to its authors the CST shows high sensitivity and specificity and is easy to use.

In other news, Yossef Ben-Porath is the 2011 President of our section. In recently passed bylaws the President will also be the section representative to Division 12 so this is my last column as section representative. Our website is up and improved and I hope you will look at it.

As of December 2010 we had a total membership of 112 including 10 student affiliates, 95 professional affiliates and 7 international affiliates. 

Visit Division 12's Section web page:
www.apa.org/divisions/div12/div12.html

Candidate statements for Treasurer and President

Candidates for President

Adele M. Hayes

Mark B. Sobell



Candidate statement for President: **Adele M. Hayes, PhD**

There has been an exciting proliferation of evidence-based psychosocial treatments (EBPT) that has expanded to include treatments from a range of theoretical orientations. Division 12 has played a key role in developing guidelines to evaluate psychological treatments and consolidate the evidence for clinicians, consumers, and policy makers.

Even with this significant progress, the “science-to-service” gap is wide. It is difficult to disseminate so many different treatments, when in some cases there are more than five EBPTs for a single disorder (e.g. depression), with different treatment manuals for each developmental phase. As we enhance dissemination efforts and provide structures for clinicians to access EBPT training materials, it is clear that further consolidation of the existing knowledge base is in order to improve the usability of these resources. I would be excited to undertake such an initiative if elected Division 12 President.

A look across the set of EBPTs reveals that there are striking similarities in the treatment elements included in the manuals (Chorpita, Daleiden, & Weisz, 2005) and principles of change that are mobilized (Castonguay & Beutler, 2006). The time is right for a concentrated and multifaceted effort to pull together what we know so far about key treatment strategies and principles of change, to expand this knowledge base, and to bridge the child and adult literatures. With such information, community clinicians and our graduate students can be trained to use EBPTs flexibly, considering the diagnoses, specific intervention strategies, change processes, and stage of development relevant to a given person.

I bring expertise in psychotherapy process research and have been active in efforts to promote clinical science and dissemination of evidence-based practice and principles. I completed my graduate training at SUNY Stony Brook with Marvin Goldfried, an early leader in the effort to identify common principles of change across different forms of therapy. I completed my internship/postdoctoral training at Duke University Medical Center and was Associate Director of the Adult Clinical Area at the University of Miami (1992-2004) and Director of Clinical Training (2004-2009) at the University of Delaware (UD), where I am now.

My research focuses on identifying therapist interventions and processes of change that predict outcomes in depression and anxiety disorders, and I have used this research to inform treatment development. I am also conducting an NIMH-funded project on the process of change in Trauma-Focused CBT in the context of a statewide dissemination project and am beginning to study the process of dissemination. Our clinical program at UD is sponsoring an upcoming conference that brings together national leaders in dissemination/implementation science to outline strategies to improve graduate training in this area.

I am an Associate Editor (AE) of *Journal of Consulting and Clinical Psychology*, past AE of *Cognitive Therapy and Research*, past Editor of Society for the Science of Clinical Psychology newsletter, and a member of the Division 12 Committee for Empirically-Supported Treatments (Section Co-Editor: Depression) and Publications Committee. I welcome the opportunity to serve in a leadership role to continue to improve psychological treatments and their accessibility.



Candidate statement for President: **Mark B. Sobell, PhD, ABPP**

I am currently Professor of Psychology at Nova Southeastern University (Florida). I received my Ph.D. from the University of California at Riverside, and previously was on the faculty of Vanderbilt University where I served as Director of Clinical Training prior to joining the University of Toronto and the Addiction

DIVISION 12 CANDIDATE STATEMENTS

Research Foundation where I was Associate Director of the Clinical Institute and oversaw non-medical treatment research. My contributions to the field have centered on treatment research and the blending of science and practice. A longtime Fellow of Divisions 12, 25, 28, and 50, I served as Editor of the *Journal of Consulting and Clinical Psychology* from 2002-2004 and currently am an Associate Editor for that journal and for *Psychology of Addictive Behavior*. In 2002 I received the Distinguished Scientific Contributions to Clinical Psychology Award from Division 12. I have received several other awards, as well, and have published over 250 journal articles and book chapters, and 9 books. I currently serve on the Division 12 Board as Chair of the Publications Committee.

Two issues regarding the future of clinical psychology and the Society of Clinical Psychology (Division 12) are of concern to me. The first involves the integration of practitioners into the development and dissemination of clinical trials, and the second relates to increasing the number of early career psychologists in our division. Both initiatives affect the sustainability and the strength of our Division.

Nearly two decades ago I was involved in a major and effective dissemination project. Part of what I learned was that including stakeholders and practitioners in the development and evaluation of clinical trials can greatly facilitate the adoption of evidence-based approaches. Practitioners involved in our early trials were viewed as early adopters who later successfully influenced their colleagues to adopt the empirically supported treatment approach. Clearly, the consideration and involvement of practitioners in clinical trials will take work and also behavioral changes from the research community. If elected President, I would **appoint a task force on the feasibility of having practitioners become integral partners in the conduct of clinical trials**. This initiative complements the recent presidential initiative of Dr. Goldfried who has set up a mechanism whereby practicing therapists can provide feedback on their experiences using empirically supported treatments.

The second concern I have relates to keeping Division 12's membership base strong. Like most divisions, we have failed to attract significant numbers of young psychologists. To this end, a few years ago the Board created a new section for students and early career psychologists. This was a good first step, but we need to go further and engage in serious efforts to attract early career members to the Division. One such effort I would like to insti-

tute is to revitalize and strengthen our membership by challenging all Fellows and long-term members of the Division to get **just one** new early career psychologist and one student member to join the Division. I would be honored to lead the Society during this critical time for our profession.

Candidates for Treasurer

Michael L. Hendricks

Robin B. Jarrett



Candidate statement for Treasurer:

Michael L. Hendricks, PhD, ABPP

My professional pursuits have been rooted mostly in practice, and have included research, teaching and advocacy. I am a partner at, and the Treasurer of, the Washington Psychological Center, P.C., in D.C. My practice consists of a combination of psychotherapy and psychological and neuropsychological forensic evaluations. I teach graduate coursework in psychopharmacology as an adjunct at The Catholic University of America and have taught many workshops on suicide and homicide risk assessment and the forensic evaluation. I have held adjunct positions at Argosy University and Howard University as well. I have also conducted research at the National Cancer Institute at NIH and Virginia Commonwealth University in suicide risk, HIV dementia, HIV prevention, and health disparities among minority populations. I am a frequent reviewer for *Professional Psychology: Research and Practice*.

My service to psychology spans nearly 20 years and has included serving on the Board of Directors of the American Association of Suicidology (two of those years as its Treasurer), chairing a committee that directed research in HIV prevention for Virginia, and founding co-chair of Division 44's Transgender Task Force. In 2007, I was appointed by the Chief Justice of the Virginia Supreme Court to serve on the Civil Commitment and Future Commitment Reforms Task Forces of Virginia's Mental Health Law Reform Commission, where I have been a major contributor to the re-writing of Virginia's mental health laws. I am currently the Past-President of Section VII—Clinical Emergencies and Crises, the liaison from Division 44 to APA's CLGBTC, and serve on the Finance Committee of Division 44.

Throughout my career, I have brought financial expertise to organizations where I worked and where I served. I look forward to bringing this expertise to Division 12 as its Treasurer.



Candidate statement for Treasurer:

Robin B. Jarrett, PhD

I appreciate the opportunity to serve as Treasurer of American Psychological Association's (APA) Division 12. It is an honor to be nominated and to know that you are taking the time to read this statement. If elected, I will use my skills and judgment to lead and assist our colleagues in making fiscally sound decisions about how your dues are used to advance the field of clinical psychology. I will be guided by any comments you choose to send me by email or telephone and by my past experiences as a principal investigator, collaborator, teacher, mentor, clinician, and administrator. A description of these experiences follows.

My clinical research team is internationally known for examining the effect of psychosocial factors, including intervention, on the course of mood and related disorders. Since its inception, my laboratory has been a training ground for more than 100 associates, ranging from undergraduates to faculty members. Our group's studies range from early investigations on the efficacy of cognitive therapy (CT) in patients with atypical depression to our current investigation on the efficacy of CT for relapse prevention in patients with recurrent major depression. My group has described illness course and identified its predictors, especially those that mark risk, during and after CT. Over the past 22 years, these longitudinal studies have been funded continuously by the National Institute of Mental Health (NIMH), and I have been honored to receive Independent Scientist Award and Mid-Career Investigator Awards. I have been a full member of four NIMH study sections including presently the Interventions Committee for Adult Disorders. I have served on the editorial board of the *Journal of Consulting and Clinical Psychology* since 2004.

At my university, I have held the Elizabeth H. Penn Professorship in Clinical Psychology since 2004. I served on the Institutional Review Board for 13 years. At present, I direct the Conflict of Interest Office and chair the

Conflict of Interest Committee, as I have for 16 years. I serve on the Promotion and Tenure Committee, as I have for 11 years. Most relevant to this nomination, I have served as Treasurer of our university's Faculty and Alumni Center and continue to serve on its Board of Directors. I continue to treat and follow patients and recognize them as the inspiration for our research and our continuous "need to know." For 27 years, I have participated in our medical center's group practice plan which has exposed me to the inherent financial complexities.

I have been an APA member since 1984 and a member of the Association for Behavioral and Cognitive Therapies since I was a student. I was a Fourjay Scholar at the Beck Institute in 2000, and I am a Diplomate and Founding Fellow of the Academy of Cognitive Therapy. In 2007, I graduated from the Hedwig van Ameringen Executive Leadership in Academic Medicine (ELAM) for Women Program. ELAM is the only in-depth national program dedicated to preparing senior women faculty at Schools of medicine, dentistry, and public health for positions of institutional leadership. This fellowship exposed me to standard budgetary practices, as well as focused, collaborative leadership.

I hope that you will find this experience and my long-standing record of service worthy of your vote. 📧

JOIN A DIVISION 12 SECTION

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

To learn more, visit Division 12's Section web page: www.div12.org/division-12-sections

To learn more about the
Society of Clinical Psychology,
visit our web page:
www.div12.org



Instructions to Authors



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

Material to be submitted should conform to the format described in the sixth edition of the Publication Manual of the American Psychological Association (2010). An electronic copy of a submission in Word format should be sent as an attachment to e-mail. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries and submissions may be made to the editor at milton.strauss@gmail.com.

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