

THE CLINICAL PSYCHOLOGIST



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

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EDITORIAL

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INVITING AWARD NOMINATIONS

The Society of Clinical Psychology is now inviting nominations for its *five psychologist awards, three early career awards, and three graduate student awards*.
See page 26 for nomination details.



By Danny Wedding, Ph.D.
Professor and
Associate Dean,
Alliant International
University,
San Francisco, CA

PRESIDENT'S COLUMN

Assessing the past, anticipating the future

Trends and ngrams give hints of what is to come in the practice of psychology



I am writing this column from my hotel room in Hong Kong where I have been meeting with local students and faculty from the California School of Professional Psychology (CSPP) Clinical Psychology program. This PsyD program is managed by CSPP faculty and staff who work with colleagues in the continuing professional education program of the City University of Hong Kong. This is the only international doctoral program in clinical psychology run by a U. S. university. As always, I have been impressed by the quality of our students and their enthusiasm for learning as much as possible about their new profession.

CSPP also has masters level training programs in clinical and counseling psychology in Tokyo and Mexico City, and it is a genuine privilege for me to have primary oversight responsibility for these three programs. Many of these students will go on to help shape the practice and profession of psychology – and the public image of psychologists – internationally.

A few years ago Michael Stevens and I surveyed the practice of psychology in 9 regions and 27 different countries (Stevens & Wedding, 2004) and identified six international trends:

1. The growth of psychology as an identified profession
2. Proliferation of psychological specializations
3. Regional revitalization
4. Expansion of psychology in developing countries
5. The profound and continuing feminization of psychology
6. Emergence of contextually sensitive paradigms

More recently, Michael Stevens and Uwe Gielen (2007) have estimated that there are more than a million individuals in the world who identify themselves as psychologists, including 300,000

(continued on page 2)

President's Column (*continued*)

psychologists in Europe, 200,000 in Latin America, and 277,000 in the United States. Of course, capturing these data are complicated by the fact that there are wide differences in the definition of psychology across countries and cultures, and the entry level of education for psychologists in many countries is the bachelor's degree. However, it is clear that the majority of these individuals identify with the professional practice of psychology, and they are enthusiastic about learning more about the clinical psychology in the United States and the work of the Society of Clinical Psychology. I anticipate attending the International Congress of Psychology in Cape Town, South Africa, July 20 – 27, 2012, and I hope to share infor-

mation about the work of Division 12 with psychologists from around the world.

An International Society of Clinical Psychology (ISCP) was founded in 1998 in San Francisco, but the group floundered and is no longer an active international voice for clinical psychology. There likely will be discussions in Cape Town about revitalizing this group.

Of course, I'm interested in the history of clinical psychology as well as its future (especially because I'm teaching a graduate seminar in History and Systems this semester), and I've recently been working with the Google Labs Ngram Viewer as a tool for examining the history of clinical psychology. The Books Engram Viewer

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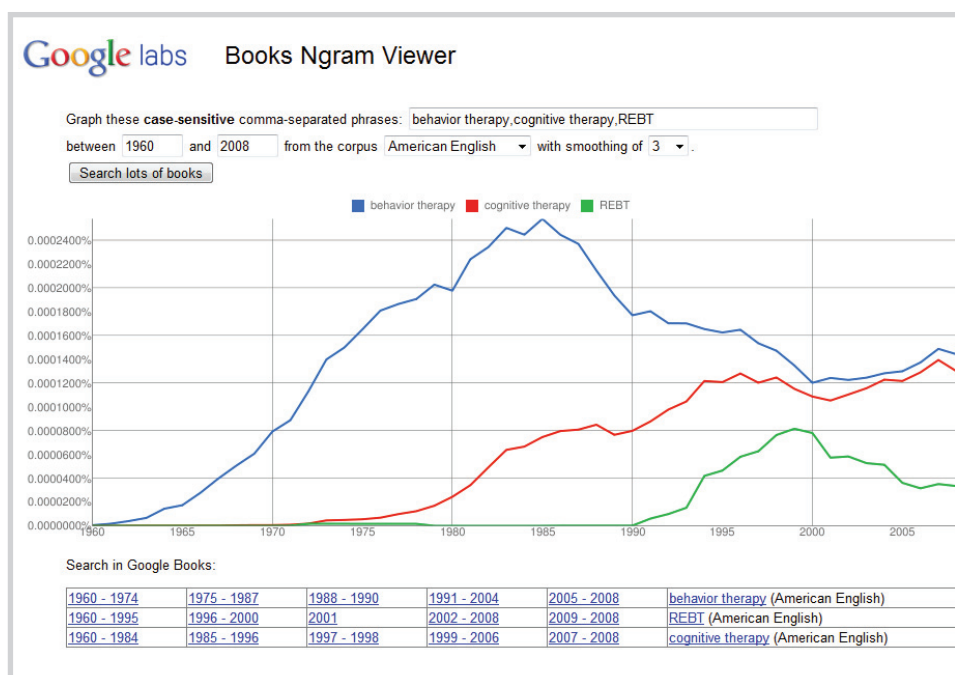
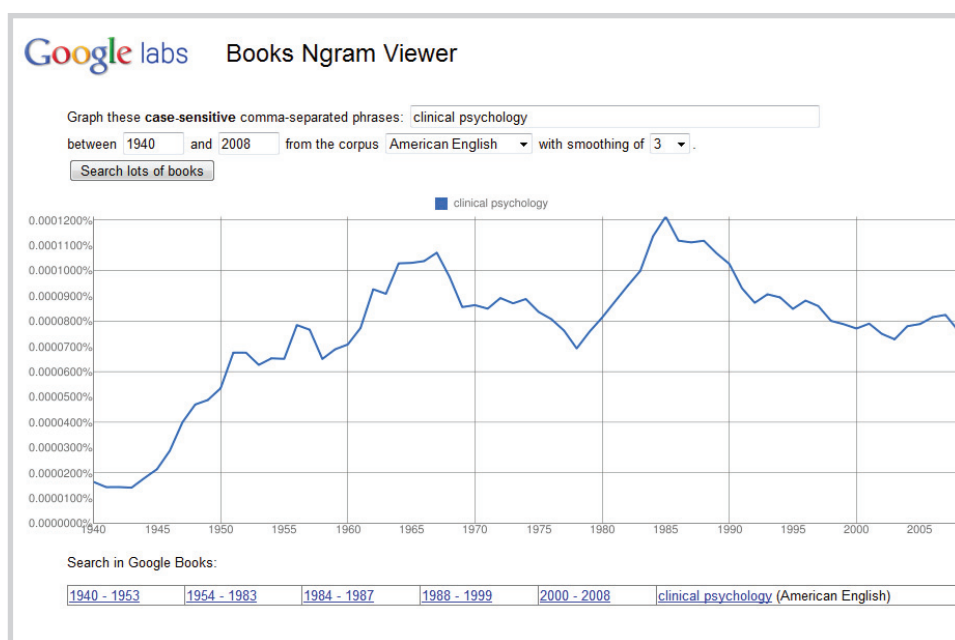
President's Column (continued)

utilizes a Google database of over 5 million books published between 1500 and 2008, and it allows researchers to search for words and phrases over a given time period. Searching on the Ngram site is fascinating—and addicting—and I believe it can provide useful information about social changes over time. For example, a search on the phrase “clinical psychology” clearly demonstrates the dramatic and rapid growth of the field in the years immediately after WWII, with interest apparently peaking around 1985. There has been some diminution of interest since that time, but interest (or at least word usage) appears to have been relatively constant over the past two decades.

A similar analysis can be used to compare and contrast three approaches to therapy: Behavior therapy, cognitive therapy and rational-emotive behavior therapy (REBT). The graphs clearly document the rapid growth of behavior therapy up until 1985, with gradual diminution of interest; in contrast, interest in cognitive therapy has shown a dramatic increase and the actual number of times the term is used may soon surpass usage for the term behavior therapy. The influence of Albert Ellis's decision to change the name of his system from RET to REBT (signifying the importance of behavioral change in the therapy) is seen in the adoption of the REBT acronym after 1990.

Play around with the Ngram tool—I think you'll find it as fascinating as I do.

I am looking forward to seeing many of you at the APA convention August 4-11 in Washington, DC. Barbara Cubic has put together a remarkable Division 12 program, and you'll want to be sure to attend the Society's social hour on Friday after our awards ceremony.



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QUARTERLY SUMMARY OF MEMBER PUBLICATIONS

Milton Strauss, PhD and Guerda Nicolas, PhD—Section Editors

Quarterly Summary of Member Publications



In this first listing of division members' recent publications we are playing "catch up" and including publications from 2010. In subsequent issues, member publications from the previous calendar quarter will be included. Please send information about your recent publications to the TCP editor, milton.strauss@gmail.com. Thank you.

Antony, M.M., & Roemer, L. (2011). *Behavior therapy*. Washington, DC: American Psychological Association.

Antony, M.M., & Barlow, D.H. (Eds.). (2010). *Handbook of assessment and treatment planning for psychological disorders* (2nd ed.). New York, NY: The Guilford Press.

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Barlow, D.H., Ellard, K.K., Fairholme, C.P., Farchione, T.J., Boisseau, C.L. Allen, L.B. & Ehrenreich-May, J. (2011). *The unified protocol for transdiagnostic treatment of emotional disorders: Client workbook*. New York, NY: Oxford University Press.

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Brownell, P. (2010) *Gestalt therapy: A guide to contemporary practice*. New York, NY: Springer Publishing.

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Brownell, P. (2011) Spirituality in gestalt therapy. In T.L. Bar-Yoseph (Ed.) *Gestalt therapy: Advances in theory and practice* (Advancing Theory in Therapy series). New York, NY: Routledge.

Brownell, P. (2011) Evil, sin, and imperfection. In J.H. Ellens (Ed.) *Explaining evil*, Vol. 1: *Definitions, history, and development*. Oxford, England: Praeger/ABC-CLIO.

Greene, B. & Brodbar, D. (Eds.). (2010). *A minyan of women: Family dynamics, Jewish identity and psychotherapy practice*. London & New York: Routledge.

Greene, B. (2010). Riding Trojan Horses From Symbolism To Structural Change: In Feminist Psychology, Context Matters. 2009 Carolyn Wood Sherif Award Address. *Psychology of Women Quarterly*, 34, 443-457.

Kleespies, P., and Hill, J. (2011). Behavioral emergencies and crises. In D. H. Barlow (Ed.): *The Oxford handbook of clinical psychology*. New York: Oxford University Press.

Norcross, J. C., VandenBos, G. R., & Freedheim, D. K. (Eds.). (2011). *History of psychotherapy: Continuity and change* (2nd ed). Washington, DC: American Psychological Association.

Owens, K.M.B., & Antony, M.M. (2011). *Overcoming health anxiety: Letting go of your fear of illness*. Oakland, CA: New Harbinger Publications. ■■

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

ANNOUNCEMENT

Survey on Clinical Experiences in Treating General Anxiety Disorder (GAD)

The Society of Clinical Psychology (Division 12 of the American Psychological Association - APA) and Division 29 of the APA (Psychotherapy) would like to thank those therapists who have completed our surveys of their experiences in using empirically supported treatments (ESTs) as interventions for panic disorder and social anxiety.

We are now conducting a survey of clinical experiences in using CBT to treat general anxiety disorder (GAD), and would very much appreciate your participation. The GAD survey is short; it should take 10 minutes, appears in a popular survey format, and can be found by clicking, using control+click, or copy and pasting the following: <http://www.surveymonkey.com/s/Z8QPRH7>

Much in the way that the Food and Drug Administration (FDA) provides physicians with a method for giving feedback on their experiences in using empirically supported drugs in clinical practice, we have established a procedure for practicing therapists to disseminate their clinical experiences. This is not only an opportunity for clinicians to share their experiences with other therapists, but also can offer clinically based information that researchers may use to investigate ways of improving treatment.

Your responses, which will be anonymous, will be tallied with those of other therapists and posted on the Division 12 and 29 Web sites. By identifying the obstacles to successful treatment, we hope to further establish a two-way bridge between research and practice,

Thank you.

Marvin R. Goldfried, PhD

for Divisions 12 and 29 of the American Psychological Association



CE WORKSHOPS

119TH APA ANNUAL CONVENTION

AUGUST 3, 2011 WASHINGTON, DC



An Introduction to the MMPI-2-RF (Restructured Form)

(This workshop is jointly sponsored by the APA Division 12 Society of Clinical Psychology and the APA Continuing Education Committee.)



CE Credits: 7
Enrollment Limit: 75

Workshop Description

This **INTERMEDIATE** workshop introduces the MMPI-2-RF, a 338-item version of the MMPI-2 published in 2008. Because the core scales that make up the test were first added to the MMPI-2 in 2003, a sizable literature of roughly 100 peer-reviewed papers has already accumulated on the instrument. The workshop begins with an overview of the test and a review of the background leading to its development. It then covers methods used to develop the test, a description of the resulting 50 MMPI-2-RF scales, available data and documentation to guide use of the MMPI-2-RF, and a recommended method for MMPI-2-RF interpretation.

Presenter(s): Yossef S. Ben-Porath, PhD, Kent State University, Kent, OH

Date: Wednesday, August 3, 2011
Time: 8:00 am-3:50 pm
Location: Hyatt Regency Washington (400 New Jersey Ave., NW)

| Fee | Early Bird* | Regular |
|------------|--------------------|----------------|
| Member | \$220 | \$275 |
| Nonmember | \$260 | \$335 |

ENROLLMENT IS NOW OPEN! Visit <http://www.apa.org/convention> or call the CEP Office at 800-374-2721, ext. 5991.

***Early Bird enrollment fee ends June 30, 2011.**
Regular enrollment fee begins July 1 through August 7, 2011.



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CE WORKSHOPS

119TH APA ANNUAL CONVENTION

AUGUST 3, 2011 WASHINGTON, DC



Using Motivational Interviewing Strategies and Techniques to Help Patients Change Risky/Problem Behaviors



(This workshop is jointly sponsored by the APA Division 12 Society of Clinical Psychology and the APA Continuing Education Committee.)

CE Credits: 7
Enrollment Limit: 65

Workshop Description

This **INTERMEDIATE** workshop will teach attendees motivational interviewing (MI) skills to work more effectively with their patients. Initially developed for resistive substance abusers, MI has been adapted to address other health behaviors and conditions (e.g., dual disorders, smoking, diet, physical activity, HIV screening, sexual behavior, diabetes control, gambling, medical adherence, depression). MI is a collection of strategies and techniques from existing models of psychotherapy and behavior change. A key goal is to assist individuals who are ambivalent or low in readiness to change. MI techniques and strategies will be demonstrated using role-play, videotaped clinical vignettes, and case examples. Participants will learn how to use decisional balancing and readiness rulers to evaluate and promote readiness for change.

Presenter(s): *Linda C. Sobell, PhD*, Nova Southeastern University, Ft. Lauderdale, FL

Date: Wednesday, August 3, 2011

Time: 8:00 am-3:50 pm

Location: Hyatt Regency Washington (400 New Jersey Ave., NW)

| Fee | Early Bird* | Regular |
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| Member | \$220 | \$275 |
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Research Findings on Psychotherapist-Client Interactions on the Internet

Keely Kolmes, Psy.D., Private Practice

 Mental health providers and the populations they serve are increasingly spending more time on the Internet and using social media. The heightened visibility of friend networks and access to online postings and interactions are creating new opportunities for psychologists to connect to clients and obtain information about their lives outside of therapy. Clients may also seek information about their providers,

leading to the discovery of either professional or personal information. The impact of the availability of both client and therapist personal information and its effects on the therapeutic relationship has yet to be determined, but it is an issue that we can expect to grow in significance as “digital natives” (Prensky, 2001) enter the field.

The APA Ethics Code (2002) Introduction states that our Ethics Code applies only to our activities when they are part of our scientific, educational, or profes-

sional roles. But social networking sites are making the distinction between personal and professional activities less clear. Pipes, Holstein, and Aguirre (2005) explored the difficulty creating these distinctions, noting that the Ethics Code does little to define personal behavior. Behnke (2008) has acknowledged the challenges of defining “private” in the age of the Internet and the difficulty assessing the impact of events in one’s personal life on one’s work-related activities.

Zur and Donner (2009) have also addressed the blurring of personal and professional behaviors that occurs on the Internet and they acknowledge the types of disclosures that can inadvertently be made on various

networking sites. They note that what clients find about their therapists matters most when therapists deliberately identify themselves as psychologists online, as this makes concrete the distinction between professional and personal activities. They acknowledge that some clients seeking online information about their therapists may be appropriately seeking consumer information, whereas others may engage in online searches that veer into criminal stalking behavior. Their recommendations for therapists using the Internet are that clinicians should remain aware that all of their online postings, blogs, chats, and other interactions may be viewed by clients and will stay archived online forever. They also encourage therapists to search for themselves regularly to determine what clients can discover about them. It is important to remain aware that patients may or may not bring it up in treatment that they have sought or found information about their therapists. But clinicians still need to be prepared for the possibility of this disclosure and they require the skills to manage it clinically if and when clients share that they have found such information.

At the same time, clinicians may accidentally stumble upon client information on the Internet, while others may intentionally seek such information. Kolmes and Taube (in preparation) surveyed 227 providers of psychotherapy services and found that 28% had accidentally discovered information about current clients on the Internet. Forty-eight percent had intentionally sought information on current clients in non-crisis situations without informing their clients that they had done so. Lal and Asay (Martin, 2010) shared that 22% of the 193 clinical psychology graduate students they surveyed had Googled their clients to find information. Lehavot, Barnett, and Powers (2010) found that 27% of student psychotherapists reported seeking out information about a client on the Internet. They acknowledged that searching for client information has the potential both to have negative and positive influences on the clinical relationship. Clearly there are a significant number of clinicians who are using search tools to seek information about those they treat therapeutically.

These instances are inviting new dynamics into the therapy process. Clinicians may wrestle with issues of how and whether to discuss these discoveries with clients. Those who choose not to disclose to clients that they have viewed such material may still

Clinicians should remain aware that all of their online postings, blogs, chats, and other interactions may be viewed by clients and will stay archived online forever.

have to manage the consequences of possessing information obtained indirectly, such as when it is contradictory to what the patient has shared in treatment. Psychologists must also manage other situations such as interactions with current or former clients on social networking sites in which one or the other may intentionally or accidentally invite the other to “connect,” or become “friends.” Other practitioners may discover that they have friends or professional contacts in common. These scenarios raise complex questions about boundaries, multiple roles, and confidentiality.

Barnett (2009) discussed psychologists secretly accessing client information online and seeing photos or other information when looking for information on their clients. He questioned what one may do with this information and acknowledged it as a boundary issue, pointing out that these pursuits violate an implied contract and the public’s trust in psychologists as professionals. He has suggested the need for this sort of circumstance to be integrated into our informed consent forms when we address our obligations to our clients. Some practitioners have heeded this call and incorporated such policies into their practices (Kolmes, 2010).

Hughs (2009) posits that it is not unnecessarily unethical to Google patients. She argues that it should only be done in the interest of promoting patient care and never to satisfy the therapist’s curiosity, but one wonders if that distinction is always clear. One cannot know prior to a Google search whether what will be found will actually promote or detract from a patient’s care. It would seem that no matter what information is discovered, it could wind up being a burden to the clinician who must then decide the significance of the information and what, if anything, should be mentioned to the client about it. What if the information suggests the client has not been honest with the therapist? What if the therapist discovers significant safety issues that haven’t been addressed in the therapy?

The issue of psychologists investigating their own clients and clients seeking and finding information about their clinicians is just starting to be addressed by scholars. It will be interesting to see new data as it emerges and also to see how professional organizations will begin to formally address these issues.


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New Practice Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients

Arthur M. Nezu, Ph.D., ABPP
Drexel University

 The Council of Representatives of APA recently adopted as policy the Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients at its February 2011 meeting. This document officially replaces the 2000 Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients and will have a 10 year effective period. As with other sets of APA guidelines, these are differentiated from “standards,” in that standards are mandatory

and often accompanied by an enforcement process. Rather, these guidelines are being set forth as “aspirational in intent.”

As editor of the diversity column of TCP, I wanted to list these newly adopted guidelines in order for a broader audience (you, members of Division 12), to become more aware of this document, which can be accessed in its entirety on the web at <http://www.apa.org/pi/lgbt/resources/guidelines.aspx>. I have previously remarked that too often such information does not get published in

more mainstreamed venues (Nezu, 2005)—hence, my desire to “broadcast” these guidelines to a “larger” audience.

Because of lack of space for this column, I will be unable to provide detailed information regarding the history, rationale, and need for such guidelines. I only hope that you, the reader, will access the website for a more detailed scrutiny of this important document.

Taking full responsibility for the rationale behind the following statement, this is one of those times, on multiple levels, that I am very proud to be a psychologist!

There are 21 guidelines separated into the following categories: (a) attitudes towards homosexuality and bisexuality; (b) relationships and families; (c) issues of diversity; (d) economic and workplace issues, (e) education and training; and (f) research. The document also has updated literature reviews and resource lists, as well as guidelines regarding several new topics, including religion and spirituality, the difference between gender identity and sexual orientation, HIV/AIDS, and research considerations. The following is a simple listing of the guidelines. I urge you to read them in their entirety.

Attitudes Toward Homosexuality and Bisexuality

Guideline 1. Psychologists strive to understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations in the lives of lesbian, gay, and bisexual people.

Guideline 2. Psychologists understand that lesbian, gay, and bisexual orientations are not mental illnesses.

Guideline 3. Psychologists understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality and that efforts to change sexual orientation have not been shown to be effective or safe.

Guideline 4. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.

Guideline 5. Psychologists strive to recognize the unique experiences of bisexual individuals.

Guideline 6. Psychologists strive to distinguish issues of sexual orientation from those of gender identity when working with lesbian, gay, and bisexual clients.

Relationships and Families

Guideline 7. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships.

I want to list these guidelines in order for a broader audience to become aware of this document. Too often such information does not get published in more mainstreamed venues—hence, my desire to “broadcast” these guidelines to a “larger” audience.

Guideline 8. Psychologists strive to understand the experiences and challenges faced by lesbian, gay, and bisexual parents.

Guideline 9. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related.

Guideline 10. Psychologists strive to understand the ways in which a person's lesbian, gay, or bisexual orientation may have an impact on his or her family of origin and the relationship with that family of origin.

Issues of Diversity

Guideline 11. Psychologists strive to recognize the challenges related to multiple and often conflicting norms, values, and beliefs faced by lesbian, gay, and bisexual members of racial and ethnic minority groups.

Guideline 12. Psychologists are encouraged to consider the influences of religion and spirituality in the lives of lesbian, gay, and bisexual persons.

Guideline 13. Psychologists strive to recognize cohort and age differences among lesbian, gay, and bisexual individuals.

Guideline 14. Psychologists strive to understand the unique problems and risks that exist for lesbian, gay, and bisexual youth.

Guideline 15. Psychologists are encouraged to recognize the particular challenges that lesbian, gay, and bisexual individuals with physical, sensory, and cognitive-emotional disabilities experience.

Guideline 16. Psychologists strive to understand the impact of HIV/AIDS on the lives of lesbian, gay, and bisexual individuals and communities.

Economic and Workplace Issues

Guideline 17. Psychologists are encouraged to consider the impact of socioeconomic status on the psychological well being of lesbian, gay, and bisexual clients.

Guideline 18. Psychologists strive to understand the unique workplace issues that exist for lesbian, gay, and bisexual individuals.

Education and Training


Guideline 19. Psychologists strive to include lesbian, gay, and bisexual issues in professional education and training.

Guideline 20. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.

Research

Guideline 21. In the use and dissemination of research on sexual orientation and related issues, psychologists strive to represent results fully and accurately and to be mindful of the potential misuse or misrepresentation of research findings.

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Three Models for Training Clinical Psychologists: Boulder, Vail and Indiana

Donald K. Routh
University of Miami

 The American Psychological Association's system for accrediting doctoral training in clinical psychology now recognizes at least three different training models, designated as producing "scientist-practitioners," "scholar-practitioners," and "clinical scientists," respectively. Often, such a model corresponds to a historic conference where its concept was discussed and approved by psychologists. As is well known, the conference in Boulder, Colorado in 1949 was the one where the scientist-practitioner model was approved in response to the needs of the new accreditation system. This system came about as a result of the availability of training funds for universities from the Veterans Administration and the National Institute of Mental Health in the aftermath of World War II. The architect of the Boulder conference and of the scientist-practitioner model was David Shakow. At the time, psychotherapy represented a new role for most clinical psychologists. Because of the meager research base concerning the efficacy of such therapies, it was reasoned that those in the profession needed to be actively engaged in research to help validate their work.

The conference in Vail, Colorado, in 1973, endorsed the training of practitioners who were not necessarily expected to be personally engaged in research. It was thought however, that they certainly needed be scholars enough to keep up to date on the research literature relative to their work, hence the designation of this model as one producing scholar-practitioners. The Vail conference recognized the indisputable fact that by that time many clinical psychologists engaged in health service delivery but did no research. Many scholar-practitioner training programs developed that tended to offer a doctor of psychology (PsyD) degree instead of the traditional PhD training endorsed by the Boulder model. Actually, the idea of PsyD training for practitioners emerged long before, in a 1918 talk given by Leta Stetter Hollingworth, a pioneer clinical psychologist and one of the founders of the American Association of Clinical Psychologists in 1917.

The Indiana conference and the clinical scientist model it championed is the least well known of the three. This conference was held at Indiana University, in Bloomington, in 1994, with the title, "Clinical Science in the 21st Century" and was sponsored by Indiana University, the Association for Psychological Science (previously called the American Psychological Society), and the National Institute of Mental Health. The conference led to the formation of the Academy of Psychological Clinical Science the next year, an organization as a coalition of university programs now explicitly engaged in training clinical scientists in psychology. Today these programs exist in most of the major universities in the United States.

The architect of the clinical science model was Richard McFall, a professor at Indiana University, whose work is well described in a recent festschrift, *Psychological Clinical Science: Papers in Honor of Richard M. McFall*, edited by Teresa A. Treat, Richard R. Bootzin, and Timothy Baker and published in New York by the Psychology Press in 2007. In 1991, McFall published "A Manifesto for a Science of Clinical Psychology" in *The Clinical Psychologist*. It had been his presidential address to Section 3 of Division 12, also known as the Society for a Science of Clinical Psychology, and drew wide interest from his colleagues. An interview of Richard McFall by Teresa Treat, recorded on a CD, is included with the above book. There McFall explains that many of the ideas in his Manifesto, though sometimes considered controversial, were simply ones he had imbibed as a doctoral student at Ohio State, sitting at the feet of such distinguished scientifically oriented clinical psychologists as George Kelly, Carl Rogers, and Julian Rotter. Another of his mentors, when he was a junior faculty member at the University of Wisconsin, was Peter Lang, also well known as a scientifically oriented clinical psychologist. In McFall's concept, a psychological clinical scientist is one who is primarily engaged in scientific research, often with colleagues in basic science areas of psychology, related to psychopathology, assessment, or treatment. As such, the clinical scientist is one who devises interventions, evaluates their efficacy, and trains service providers to use them appropriately but is not otherwise involved in service delivery. In McFall's view, the main rationale for clinical psychology training lies in the research skills it

History Column continued on page 18

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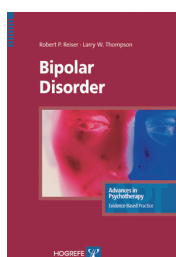
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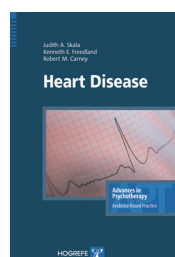
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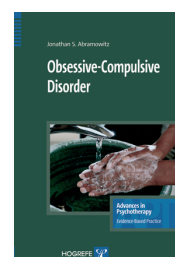
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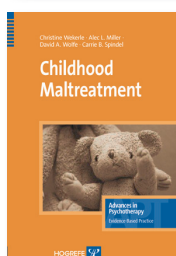
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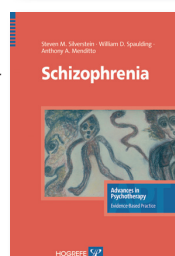
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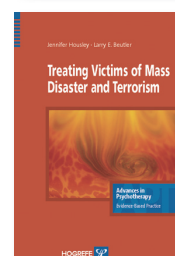
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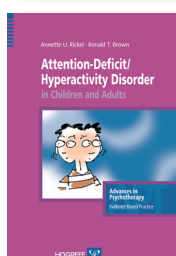
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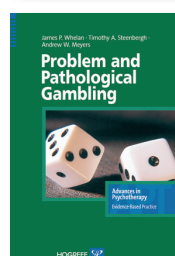
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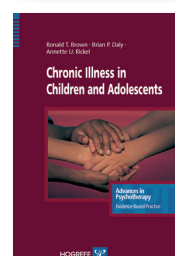
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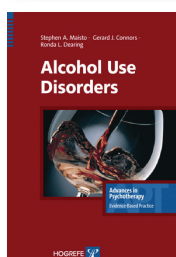
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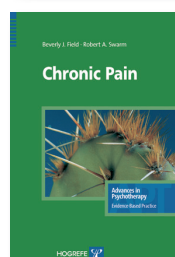
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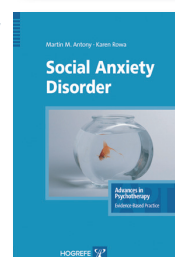
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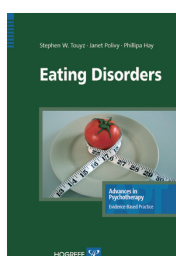
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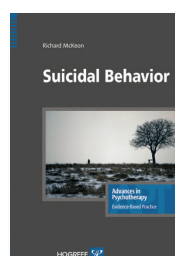
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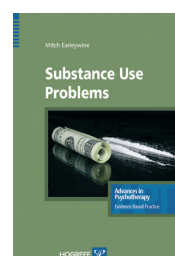
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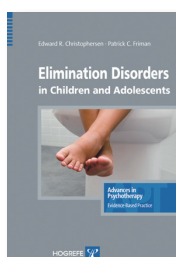
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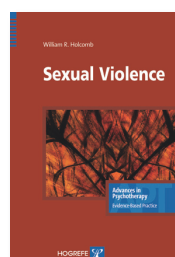
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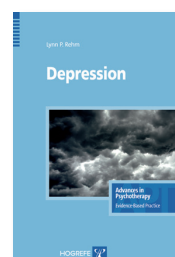
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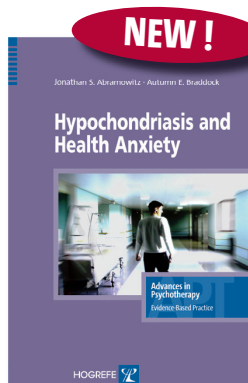
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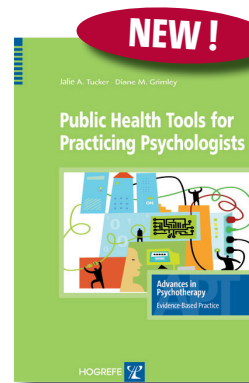
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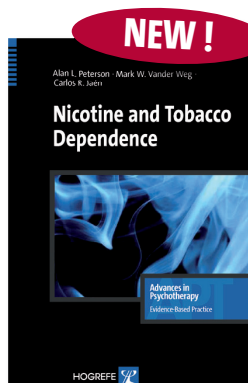
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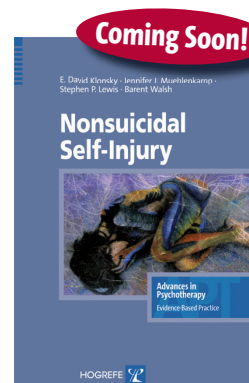
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Decreasing Educational Debt

Cynthia Suveg, Ph.D., University of Georgia

 I recently polled some of the advanced graduate students in the Clinical Psychology program here at the University of Georgia for potential topics for this column. Several students independently requested information on ways to decrease the debt that they compiled during graduate school. Fortunately, the vast majority of students earning doctorate degrees in Clinical Psychology receive some sort of funding and tuition waiver (Norcross, Ellis, & Sayette, 2010). Yet, even with funding and a tuition waiver, approximately 75% of graduates in Clinical Psychology have debt with a median level of \$55,000 (APA Center for Workforce

Studies, 2009). With an overall median starting salary of \$61,111 for all psychology doctorates (APA Center for Workforce Studies, 2009), it is reasonable that recent graduates would be interested in learning about opportunities for loan repayment (please see the APA Center for Workforce Studies reports for debt, salary, and other information specific to subfields of psychology, gender, etc.). In this column,

Even with funding and a tuition waiver, approximately 75% of graduates in Clinical Psychology have debt with a median level of \$55,000.

I will provide information about one loan repayment option - the National Institutes of Health, Loan Repayment Program, which will pay up to \$35,000/year of qualified debt for eligible applicants.

As stated on the NIH LRP website, “The overall purpose of the extramural LRP is the recruitment and retention of highly qualified health professionals as research investigators...” Thus, the NIH LRPs are for “researchers,” defined as individuals who spend at least 50% of their time doing qualified research that takes an average of at least 20 hours per week during each quarterly service period. There are five research areas that qualify: Clinical Research, Pediatric Research, Health Disparities Research, Contraception and Infertility Research, and Clinical Research for Individuals from

Disadvantaged Backgrounds. The specific research topics within each category are broad and if your research falls into one of the categories then you have a reasonable chance to secure an award. For example, 37% and 30% of new applications for Pediatric and Health Disparities Research, respectively were funded in FY 2010 (NIH LRP). Once funded, there are opportunities for renewals if you have remaining debt, which yield even higher success rates (e.g., 63% and 64% of renewal applications for the Pediatric and Health Disparities Research programs were funded in FY 2010). In addition to engagement in qualifying research, there are also other criteria to participate in the NIH LRPs (e.g., US citizenship, debt must be equal to or greater than 20% of your base salary at the time of the award) and they can be found on the NIH LRP website (<http://www.lrp.nih.gov/>). Importantly, funding is awarded in exchange for participation in qualifying research for the term of the award (i.e., two years for first-time awards and one to two years for renewals awards) and individuals who do not complete their term might incur financial penalties.

When preparing your NIH LRP application several pieces of information will be required including but not limited to a biosketch, personal statement, and a research activities statement. All of the required statements essentially demonstrate to NIH that you are able to carry out a research program and that you intend to follow a research career. You will also be required to submit the names of faculty or research mentors who will rate your potential for and commitment to a successful research career. Once funded, if you apply for a renewal you will be required to document evidence of research achievements and your recommender will also be asked to comment on your progress.

The personal statement should describe your career goals. Even if you do not intend on a full-time research position, your essay should evidence a commitment to engaging in at least 50% research in your career. The research statement should describe your current or proposed research project and clearly outline your role and responsibilities in carrying out the research. If first submitting a proposal while on postdoc, then your specific role might be to help carry out your research mentor's projects (e.g., serve as project coordinator, assist in grant writing or data analyses). In such cases, you could clearly describe the projects you will help

with and how they will facilitate your research development. You might also submit your first NIH LRP proposal, or at least a renewal, as a faculty member. You will still be required to clearly articulate a research plan, except in this case, your program or department chair will serve as your supervisor. Regardless of whether you submit the application as a postdoc, faculty member, or independent researcher, you will also need to describe the research environment and the resources available to you to successfully engage in your work.

Though preparation of the application materials can feel daunting, the required documents are probably something that you have already prepared, at least in part, before. For instance, in preparation for internship you likely wrote some about your research experience and future goals. If in a postdoctoral fellowship or academic position, then you may have even written formal research statements that required you to clearly articulate your research program and goals. If you have not yet had to prepare such documents then you will likely

have to sooner or later. Having a draft prepared will be useful at some point (e.g., third-year review as a faculty member). Regardless, for those with educational debt, the benefits of obtaining an NIH LRP award probably far outweigh the amount of effort it takes to complete the required materials. For tips on completing a competitive NIH LRP application go to: http://www.lrp.nih.gov/pdf/0310_1_application_tips.pdf.

This column focused on a loan repayment option for individuals who spend at least 50% of their time engaged in research. However, there are also loan repayment options available for psychologists who work in VAs http://www.va.gov/jobs/hiring_programs.asp and for those who participate in the National Guard (<http://www.nationalguard.com/careers/medical-professional-officer/healthcare-bonuses-and-loans>). Other opportunities for loan repayment and/or forgiveness can be found on the Department of Education's website (www.ed.gov) and APA (www.apa.org).

Please send comments and/or suggestions to csuveg@uga.edu. ☐☐

History Column (*continued from page 12*)

impacts. He argues that the role of service provider in the mental health field is increasingly being taken over by others such as social workers, counselors, and primary-care physicians (the latter group being the ones who prescribe and monitor most of the psychotropic medications taken by patients). For this reason, McFall argues that clinical psychologists who act only as practitioners are a dying breed.

In reflecting personally on the above book and McFall's ideas, I recognize that the doctoral program in which I was trained, at the University of Pittsburgh, would have been well described as a clinical science program. Its major faculty included Peter Lang (one of McFall's own mentors) as well as George Wischner (my advisor), and Arnold Buss. I went to graduate school

thinking that I would return to my own hometown afterwards and "put up a shingle" as a practitioner. At a Departmental party after the first colloquium of the year, some of the more advanced graduate students cornered me to ask why I had come to that school. When I said I wanted to become a therapist in private practice, they dissolved into laughter, telling me that after finishing that program, I would no longer want to do that. This turned out to be true, and in my own decades as a teacher and researcher in clinical psychology, I find that my attitudes were very much those described in McFall's Manifesto. I thus feel like Monsieur Jourdain, the character in Moliere's play, *Le Bourgeois Gentilhomme*, who discovered to his surprise that he had spent his whole life speaking prose. ☐☐



The Clinical Psychologist

Past issues of *The Clinical Psychologist* are available at:
www.div12.org/clinical-psychologist

Donna Rasin-Waters, PhD—Section Editor

Advocacy for Our Profession: The Role of State Psychological Association Membership

Donna Rasin-Waters, PhD

Division 12 Federal Advocacy Coordinator



The American Psychological Association is our voice in Washington, D.C. We are all used to knowing that we can count on APA to concentrate

on legislative, executive and judicial issues that impact psychological science, education and practice. However, how many of us consider the important role the state psychological associations play in these same issues? How many of us belong to our state psychological association?

In a recent meeting for the New York State Psychological Association with our lobbying group New York State United Teachers (NYSUT) I was struck by a comment one of the lobbyists made as he also shook his head: "It's a

real problem that psychologists in your locals are not all affiliated with the state and national or vice versa."

He was commenting on how some of our regional psychological association members do not join the state

organization and also on how some of the national psychological association members do not join the state and so on. Now to understand this analogy one must understand that NYSUT is a federation made up of 1,200 local unions representing 600,000 people in New York's schools, colleges, and healthcare facilities. In addition, NYSUT is also affiliated with the American Federation of Teachers (AFT) and the National Education Association (NEA). Obviously, prior to this federation there was a much less powerful voice among the collection of smaller groups.

Hopefully we can all ponder this as we know that most state psychological associations have a fraction of the total psychologists in the state on their membership rolls. Many psychologists choose membership in either the American Psychological Association or their state psychological association but not always both. One of the most important contributions we can all make to advocacy is joining and becoming active in our state psychological associations in addition to our membership and activities in the APA. Our state lawmakers work on a host of issues that regulate our profession, including overseeing the budget and funding of state human service programs. In addition, our political gains at the national level are enacted in the states.

Therefore, it behooves us all to unite our voices and make them as powerful as they can be. It is especially critical at this time in history when unprecedented changes to the health care system are underway and will inevitably play out in the state budgets and with local insurance carriers. If there was ever a time to heed the call for unity between our state psychological associations and the APA it is now. ■■

I was struck by a comment one of the lobbyists made as he also shook his head: "It's a real problem that psychologists in your locals are not all affiliated with the state and national or vice versa."

BECOME A DIVISION 12 MENTOR

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

a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

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



Internship on the Horizon: Recommendations for a Successful Transition

Amelia Kotte, M.S., Medical University of
South Carolina



Congratulations on matching! In a few months, you will be taking a major step in the advancement of a career toward which you have been investing considerable effort. Internship is a significant experience in our emerging role as professional psychologists, a capstone of our clinical training and the last formal development opportunity we will experience as students.

It presents the opportunity for increased autonomy and adjustment challenges, and therefore requires considerable emotional and practical adaptation. This article aims to aid you toward a smoother transition from graduate student to clinical psychology intern.

Time for a break

Internship can be an even more demanding experience than graduate school. Burnout is a commonly reported phenomenon for both students and interns.

Revitalize now by making

plans to visit a foreign country, a national park, or spending time with loved ones. In short, reward yourself for your achievements thus far and for those to follow.

Moving

Many interns moving across the country decide to ship their books and personal possessions via FedEx or USPS. The cost of truck rentals or moving companies is usually greater than selling personal items and buying new furniture. Depending on whether you are moving with a partner or alone, it might be worthwhile to look for furnished apartments. Your site will usually provide you with a listing of nearby apartments. Additionally, you

may want to contact current interns who will be moving and may be able to extend their lease, or sell you their current belongings at a reasonable price. Take the time to visit your new city one or two months prior to internship to make a more relaxed and better-informed decision about where to live. Get acquainted with the neighborhoods and establish an address where you can ship personal items. A comfortable home environment can make all the difference during this challenging year.

A fish out of water

As with any move, especially when you know few people, it is important you feel at home quickly. Do online research to find your niche. If you are an athlete, research local running or cycling groups. If you enjoy books, theater, or art, look for a local book club, pick up a highly rated city guide, or ask current interns for their recommendations on cultural events. Look to your current intern class for people with whom you have interests in common. Chances are they will be eager to explore their new city with you. Online social networking makes it possible to acquaint yourself with your new intern class prior to starting internship. Creating and joining a Facebook group might help to facilitate connections and get support with the upcoming transition.

Pre-heating the oven

Get to know your internship site and the people with whom you will be working ahead of time. If you have matched to a researched-focused site, call your research mentor, and familiarize yourself with their current projects. Read your mentor's CV, and discuss possibilities of involvement in research activities.

If you know your rotations and the supervisors for those rotations, you may find it helpful to familiarize yourself with rotation schedules, the populations treated, and treatment modalities utilized. Refresh your memory or engage in further reading on therapeutic techniques and assessment protocols.

Contact current interns for an insider's scoop on the culture and philosophy of the site, tips for effective time management, supervisory styles, and objective highlights of their experience.

In the fast track

Finishing dissertation prior to internship has been known to greatly alleviate stress during internship.

***Internship can
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A finished or near-to-complete dissertation translates into higher quality of life. If you cannot complete your dissertation prior to internship, prepare to spend a good portion of your weekends and/or evenings on this project. Many students find it helpful to preemptively set up a defense date a few months in advance, which creates a need for a completion timeline.

Given that this will be a clinical year, it is important for the research-career oriented intern to maintain scholarly productivity. Understandably, between finishing dissertation, looking for a postdoctoral position, completing clinical work, and engaging in self-care, research related activities can quickly become a last priority. Prior to internship, it may be useful to set specific and realistic goals regarding what you would like to accomplish, and to what degree you need to balance the competing demands of the site, to remain competitive in the research sphere.

Additionally, considering that internship is another step towards licensure, it would behoove you to closely monitor your clinical hours. This is especially important as many states are now counting supervised hours accrued during internship towards licensure. Be sure to ask your supervisor to help you understand this process and how to prepare for the EPPP.

Psychology intern, heal thyself

Self-care becomes an important issue during internship especially given the high empathic strain one can experience by working with a greater number of patients, many of whom present with different and more challenging clinical problems. It is well known

that chronic work stress and exhaustion is related to poor performance, higher likelihood of experiencing physical illness and decreased life satisfaction. It is our ethical imperative to tend to ourselves. Set up continuous self-monitoring strategies to attend to your emotional, physical and spiritual needs. Be honest with yourself in documenting your trigger signs – boredom, anger, daydreaming, ending sessions early, arriving late, and fatigue. Familiarize yourself with your site's vacation, sick day and professional leave policy. Plan your conference attendances early, vacation days close to three-day weekends, and space out your time off so that you can ensure continuity of patient care.

As anxiety provoking as the onset of new accountability and professional responsibilities is, this transition can be exciting and fulfilling. It is an opportunity for exploration, developing a new professional network, learning about and enjoying a new place and culture. After the years and efforts you have invested in your career, you are that much closer to realizing your goals of becoming a psychologist, while helping those in need, and contributing to the larger well of scientific knowledge.

Amelia Kotte, M.S. is a doctoral candidate in in the University of California, San Diego/San Diego State University joint program in clinical psychology. Her research interest is in gene-environment interactions in affective disorders. She is currently completing her predoctoral clinical internship with a focus on cognitive behavioral interventions and traumatic stress in the Charleston Consortium at the Medical University of South Carolina. ☐☐

INSTRUCTIONS FOR ADVERTISING IN THE CLINICAL PSYCHOLOGIST

Want-ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of *The Clinical Psychologist*. Ads will be charged at \$2 per line (approximately 40 characters).

Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, phone number, and advertisement to the editor. E-mail is preferred.

For display advertising rates and more details regarding the advertising policy, please contact the editor.

Please note that the editor and the Publication

Committee of Division 12 reserve the right to refuse to publish any advertisement, as per the advertising policy for this publication.

Submission deadlines for advertising and announcements:

SPRING issue: January 3

Spring issue: April 1

Summer Issue: July 1

Fall issue: October 1

Editor: Milton Strauss milton.strauss@gmail.com

Assessment Center: A Data Collection Tool for Clinical Research and Practice

Nan Rothrock, Ph.D., Department of Medical Social Sciences, Feinberg School of Medicine, Northwestern University



A common component of clinical research and practice is the administration of patient-reported outcomes assessing symptoms, function and quality of life. Utilization of technology for capturing patient-reported data offers several advantages over other data collection modalities, including improvements of data quality, integration of a skip logic rather than relying on patients' comprehension of branching

instructions, as well as automated time and date stamping for quality assurance purposes. Accessibility can also be improved through computer-based data collection. For example, font size can be adjusted and other assistive technologies like screen readers can increase participation of participants with low-vision. Integrating sound to read the survey questions aloud can increase accurate understanding from individuals with vary-

ing literacy skills (Hahn et al., 2004). The use of computer-based data collection may also enable real-time scoring of instruments, which improves its utility in clinical scenarios. Finally, computer-administered instruments can utilize selection algorithms to facilitate random or adaptive item administration. For these reasons, there are increasing numbers of available electronic data collection platforms and reasons to use them. Assessment Center is one such software tool.

Assessment Center (www.assessmentcenter.net) was developed in part from the Patient-Reported Outcomes Measurement Information System (PROMIS; www.nihpromis.org) initiative funded by the National

Institutes of Health. PROMIS aims to develop highly reliable and valid measures that are appropriate for use across chronic conditions. PROMIS measures are developed using an Item Response Theory (IRT) framework, a modern measurement approach that enables the creation of large banks of items that can be administered adaptively. That is, after each response, an estimated score and error is calculated. The item that is selected next for administration is one that is targeted to that specific range of the trait being measured. After each subsequent response, the score estimate is adjusted and items that will provide the most information for that given participant are administered. In this way, high measurement precision can be achieved with the administration of very few questions. Assessment Center was developed as an accessible computer platform that can conduct the item scoring and selection necessary for use of Computerized Adaptive Tests (CATs) in clinical research and in clinical practice settings that may benefit from such brief-yet-precise assessment of symptoms.

PROMIS instruments for adult and pediatric populations (short forms, CATs, profiles) are available in many domains of self-reported health including anxiety, depression, anger, psychosocial illness impact, applied cognition, fatigue, pain, physical function, sleep disturbance, social health, social support, and sexual function. As calibrated item banks, they allow efficient, precise, and flexible measurement with demonstrated reliability and construct validity (Cella et al., 2010). PROMIS items don't include attributions about specific conditions or treatments thereby allowing a wide range of respondents to report on their symptoms and functioning. The measures focus on the severity of the symptom or functional ability. For this reason, PROMIS-based assessments may be ideal endpoints for psychological intervention research, which has moved away from primary focus on diagnoses, as well as for endpoint assessment in practice settings.

The creation of Assessment Center benefited from accepted software development methodologies that incorporated user input throughout the development process (Gershon et al., 2010). Thus, the likelihood of inclusion of critical features in a usable and accessible interface was maximized. Assessment Center is a free, online research management tool available for clinical research that enables researchers to create study-spe-

cific websites for capturing participant data securely. Although originally designed for clinical research, Assessment Center can be used for data collection (e.g., monitoring emotional distress over time) in clinical practice. It includes features to support tracking instrument development, monitor study administration, manage data, and store and display results of IRT analyses (e.g., category response function and item information graphs, model fit, scalability indices, and differential item functioning information). Studies can include measures within the Assessment Center library as well as custom instruments created or entered by the researcher. Any PROMIS measure can be downloaded for administration on paper or be included in an online study. Measures completed by others (e.g., clinical information gathered by study staff reviewing medical records) can be entered by the study team to reduce the need for merging data sets at the conclusion of a study. Detailed statistical information and development history about PROMIS items and instruments is available for review within the application. Assessment Center enables customization of items or instruments), real-time scoring, and graphing of individual PROMIS CAT or profile scores. Single timepoint and longitudinal study designs are supported. A researcher can assign a participant to a study arm or a participant can be randomized into one of multiple study arms. Protected health information needed for study management is stored in a secure database that is separate from survey data. Additionally, Assessment Center can present online consent forms for endorsement and capture endorsement data separately from other study survey data. Accrual reports are automated and data exports are updated every 20 minutes. Data exports can readily be imported into a statistical software program. All data collected using Assessment Center is owned and accessible only to the study team. An offline data collection platform can be installed on a computer for collection of data in areas without reliable internet connectivity. Additional information about Assessment Center including a list of instruments in the library, upcoming training workshops, and a user manual are available on the Assessment Center homepage. A customer support team (help@assessmentcenter.net) is also available.

An increasing number of electronic data collection platforms are available. Assessment Center's strengths are its ability to administer and score CATs, inclusion

of all PROMIS measures, features specific to the needs of clinical researchers, and accessibility to the clinical research community. Ongoing development funded by the National Institutes of Health over the next two years will improve system usability, offer additional modes of administration (e.g., smartphone), expand the instrument library, and provide the ability to collect data in Spanish among many other features. The Assessment Center team is enthusiastic about sharing this resource to improve collection of patients' perspectives in clinical research and practice.

Funding for Assessment Center was provided in part by U54 AR 057943 and U01 AR 052177.

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If you have any questions or comments regarding this article, you can reach Dr. Rothrock by e-mail at n-rothrock@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-bbutt@northwestern.edu). ❏

Section III: Society for a Science of Clinical Psychology

David F. Tolin, Ph.D., ABPP



Varda Shoham is 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.

Bunmi Olatunji, Dick Bootzin, and John Kilstrom have agreed to serve on the SSCP External Nominations committee, which is currently seeking nominees for APA's Early Career Award (deadline is June 2011).

Our student representatives Sara Stasik and Rebecca Brock conducted a survey of students' awareness of the SSCP listserv and website, perceived usefulness of the site, and interest in becoming more involved with SSCP. 57 students have responded to the survey to date, almost 50% of whom were not aware of the student listserv or website. Additional results will be publicized after data collection is complete. SSCP is also seeking a Facilitator for the student listserv.

SSCP continues to consult with Division 12 regarding its resolution statement on evidence-based treatment. The discussion has been quite productive, and a revised version is forthcoming.

This Spring's SSCP newsletter, edited by Erika Lawrence, will include an article on the recent STEM conference, Marv Goldfried's article "Closing the gap between research and practice," a Presidential column, and information about the APS conference in May.

During our most recent conference call, the SSCP Board expressed concern about recent "Energy Therapy" offerings from APA-approved continuing education sponsors. An ad hoc committee will be formed to examine this issue more closely.

Section VI: The Clinical Psychology of Ethnic Minorities

Wei-Chin Hwang, PhD



We are pleased to announce that Division 12, Section VI (The Clinical Psychology of Ethnic Minorities) is celebrating its 25th Birthday this year!

Please watch for announcements about celebratory activities at the APA convention, and join us in honoring our founding members at the Section VI business meeting. Section VI was established to:

- Promote research in clinical interventions with American racial and ethnic minority populations;
- Foster sensitivity to cultural, racial, and ethnic issues in the training of all psychologists;
- Increase the quality and accessibility of training opportunities for minority clinical psychologists;
- Enhance the representation of minority psychologists within Division 12 and APA governance; and
- Provide a forum for the exchange of ideas on socio-cultural issues.

Section VI is a great place to exchange ideas, participate in mentoring, and network with others with similar interests. If you have been a member in the past, please update your membership for this year. If you have not been a member, we hope you will consider joining us during this landmark 25th year!

We also invite you to check out our updated website at: www.apa.org/divisions/div12/sections/section6/. You can now join Section VI and pay your annual dues online (\$15 for full members, \$5 for students). Be sure to watch for the launch of our new listserv and check out our new Facebook page: www.facebook.com/home.php#!/pages/Clinical-Psychology-of-Ethnic-Minorities-APA-Division-12-Section-6/190855370947333

Speaking of the convention, we have an outstanding program planned and hope you will check the final schedule for these presentations:

- Culturally Based Prevention and Systems of Care Considerations for American Indian Youth and Families
- Reducing Health Disparities via Psychological Science: Evidence from Community Engaged Investigators
- Addressing Health Disparities through Clinical Interventions in Substance Abuse and Mental Health


One of the great perks of membership is the opportunity to be nominated for Section VI awards. We are currently accepting nominations for the 2011 Dalmas A. Taylor Outstanding Student Research Award and the

Section Updates (*continued*)

2011 Samuel M. Turner Mentor Award. These awards will be given during Convention in Washington, D.C. and the deadline for nominations is May 16, 2011. For detailed award criteria, please visit our website or contact: Karen L. Suyemoto, PhD, Section VI Awards Committee Chair (Karen.suyemoto@umb.edu).

Section VII: The Clinical Emergencies and Crises

Marc Hillbrand, PhD


 Section VII welcomes Kim Van Orden, Ph.D., as the new editor of its newsletter, Behavioral Emergencies Update. Section President Michael Hendricks, Ph.D., and President-Elect Lisa Firestone, Ph.D., have organized a symposium on bullying and suicide at the APA Annual Convention in Washington, DC. The panelists will be Drs. Peter Goldblum, Paul Poteat, Caitlin Ryan, and Dorothy Lamage. The Convention will also be the opportunity to present Lanny Berman, Ph.D., with the Section VII Distinguished Career Award, recognizing his numerous accomplishments in the field of suicide prevention.

Section VII is continuing to explore possible collaborative arrangements with like-minded organizations such as the American Association of Suicidology and the Division 17 special interest work group on suicidality.

The collaborative project between Section VII and the APA Advisory Committee on Colleague Assistance has resulted in the completion of a paper "Psychologist Suicide" co-authored by Phillip Kleespies, Ph.D., Diane Bridgeman, Ph.D., Daniel Galper, Ph.D., Lynn Bufka, Ph.D., Bruce Bongar, Ph.D., Marc Hillbrand, Ph.D., Kim Van Orden, Ph.D., and Robert Yufit, Ph.D., which will appear soon in *Professional Psychology: Research and Practice*. Phil Kleespies will give a presentation on the group's work on psychologist suicide at the upcoming APA Convention.

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.

Significant actions from the APA Council meeting in February 2011 include the following:

1. Council approved the inclusion of diplomate credentials for the American Board of Assessment Psychology (ABAP) in the APA Membership Directory. Inclusion is based on a number of criteria for approving qualified certifying bodies as created by the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPP). These include making publicity available on the certifying body's procedures functions, standards and procedures. The certifying body must maintain a database for the public to view and must make public the procedures necessary for application for credential review and specify the competency assessments specific for assessments. There are other requirements which one can review by looking at the Council action.
2. Council also approved as APA policy the revised Guidelines for Psychological Evaluations in Child Protective Matters.
3. Council approved Guidelines for assessment of and intervention with Persons with Disabilities.
4. Council, on February 18, 2011 adopted the Guidelines for the Assessment of Dementia and Cognitive decline. This was a revision of the 1998 Guidelines which were developed as a presidential initiative when Norman Abeles, PhD was President of APA. ■■

Visit Division 12's
section web page:

www.div12.org/division-12-sections

CALL FOR AWARD NOMINATIONS

*Deadline is **November 1, 2011***

The Society of Clinical Psychology invites nominations for its five psychologist awards, three early career awards, and three graduate student awards. These awards recognize distinguished contributions across the broad spectrum of the discipline, including science, practice, education, diversity, service, and their integration. The Society and the American Psychological Foundation encourage applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

Nominations must include a CV and at least one letter of endorsement. Self-nominations are permitted and should include at least one external endorsement. Candidates can be simultaneously considered for multiple awards, although an individual may receive only one Division 12 award in any given year. No voting members of the Division 12 Board of Directors will be eligible to receive awards from the Division while serving their term.

Please submit nomination materials electronically to Awards Committee Chair at div12apa@comcast.net. The deadline is November 1, 2011. Inquiries should be directed to the Division 12 Central Office at 303-652-3126 or div12apa@comcast.net

SENIOR AWARDS

Award for Distinguished Scientific Contributions to Clinical Psychology

Honors psychologists who have made distinguished theoretical and/or empirical contributions to clinical psychology throughout their careers.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

Honors psychologists who have made distinguished advances in psychology leading to the understanding or amelioration of important practical problems and honors psychologists who have made outstanding contributions to the general profession of clinical psychology.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology

Honors psychologists who have made remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind.

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology

Honors psychologists who display excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty. It will recognize those individuals who have been outstanding in supporting, encouraging and promoting education and training, professional and personal development, and career guidance to junior colleagues.

MID CAREER AWARD

American Psychological Foundation Theodore Millon Award

The American Psychological Foundation (APF) Theodore Millon, Ph.D. Award will be conferred annually to an outstanding mid-career psychologist engaged in advancing the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. A review panel appointed by APA Division 12 will select the recipient upon approval of the APF Trustees. The recipient will receive \$1,000 and a plaque. Nominees should be no less than 8 years and no more than 20 years post doctoral degree.

EARLY CAREER AWARDS

David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology

Given for contributions to the science clinical psychology by a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to science and to practice. Up to \$500 for travel to the APA Convention is awarded.

Theodore Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology (given jointly with APF)

Honors a clinical psychologist for professional accomplishments in clinical psychology. Accomplishments may include promoting the practice of clinical psychology through professional service; innovation in service delivery; novel application of applied research methodologies to professional practice; positive impact on health delivery systems; development of creative educational programs for practice; or other novel or creative activities advancing the service of the profession. Nominees should be no more than seven years post doctoral degree. Amount of the award is \$5000.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology

This award will be conferred annually to an early career psychologist who has made exemplary contributions to diversity within the field. Such contributions can include research, service, practice, training, or any combination thereof. Nominees should be no more than seven years post doctoral degree.

GRADUATE STUDENT AWARDS

Recipients of the Division 12 graduate student awards must be matriculated doctoral students in clinical psychology (including pre-doctoral interns) who are student affiliates of Division 12. Nominations should include a copy of nominee's curriculum vitae and at least one letter of support detailing the nominee's service contributions to the profession and community. Recipients of the awards receive a plaque, a \$200 honorarium contributed jointly by Division 12 and Journal of Clinical Psychology, and a complementary two-year subscription to JCLP. The Division 12 Education & Training Committee will determine the award recipients.

Distinguished Student Research Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made exemplary theoretical or empirical contributions to research in clinical psychology. Clinical research contributions can include quantity, quality, contribution to diversity, and/or innovations in research.

Distinguished Student Practice Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made outstanding clinical practice contributions to the profession. Clinical practice contributions can include breadth and/or depth of practice activities, innovations in service delivery, contribution to diversity, and/or other meritorious contributions.

Distinguished Student Service Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made outstanding service contributions to the profession and community. Service contribution can include development of creative educational programs or other novel activities in the advancement of service, contributions to diversity, working to increase funding for agencies, volunteer time, working on legislation regarding mental health, general mental health advocacy; as initiating outreach to underserved communities or substantive involvement in efforts to do such outreach. ■■



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.