

THE CLINICAL PSYCHOLOGIST



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

CONTENTS

- 1 President's Column
- 4 Accountable Care Organizations and Psychology: Getting on the Invitation List to the Party
- 8 Division 12 Award Winners
- 9 Ethics Update: Do the Right Thing - If Only it Were so Easy
- 11 Diversity Column: Generational Diversity Among Immigrants
- 13 History Column: David Shakow and the Origins of Contemporary Clinical Psychology Training
- 15 Early Career Column: Becoming an Independent Researcher: An Interview with Deborah Drabick
- 21 Federal Advocacy Column: Transformation of the VA Health Care System: National Implementation of Evidence-Based Psychotherapies
- 23 Student Column: Tips on Navigating the APA Convention
- 25 Technology Update: The National Institutes of Health Toolbox for the Assessment of Neurological and Behavioral Function
- 27 Section Updates
- 30 2011 APA Annual Convention: Division 12 Program Summary

EDITORIAL

Editor: Milton Strauss, PhD
Department of Psychology
Case Western Reserve University

Associate Editor: Guerda Nicolas, PhD
Department of Educational and
Psychological Studies
University of Miami



By Danny Wedding,
PhD, MPH
Professor and
Associate Dean,
Alliant International
University,
San Francisco, CA

PRESIDENT'S COLUMN

The Times, They Are A-Changin'

Higher education changed relatively little between the middle ages and the end of the 20th century. Medieval professors stood in front of groups of students and lectured while students listened and took notes . . . *and for much of my career, I stood in front of students and lectured while they listened and took notes.* However, all of this is changing because of technology, and higher education will never be the same.

In short, we have had a long history of bringing *students to knowledge* (in classrooms, libraries, and lecture halls). Increasingly, however, we will be expected to bring *knowledge to students*. This knowledge, packaged in palatable, engaging, and easily digestible modules, will be consumed in students' homes, in parks and cafes, and on beaches,

and our students will master the material at their own pace. If they need a mentor, they will likely turn to online resources rather than come to us.

Despite its long history, the "sage on a stage" model of higher education has never been an especially effective way to train either undergraduate or graduate students. Clinical skills are better taught by "a guide by the side," and psychologists appreciate the power of modeling more than most professionals. However, this guide does not have to be a professor, and he or she does not need to be in the same room – or even the same country – as the student.

Few of us fully appreciate the profound changes that are occurring throughout the world. For example, in 2002 there was a seismic shift in knowledge and a tipping point was reached. In that year, for the first time, "the worldwide digital storage capacity overtook total analog capacity" (University of Southern California, 2011). The ready and ubiquitous availability of digital information on iPhones, iPads, and laptop computers is changing every aspect of our lives – including education.

I have been affected personally by this remarkable revolution in information technology. In 2005, I became editor of *PsycCRITIQUES*, the online continuation of the paper journal *Contemporary Psychology: APA Review of Books*. Bob Sternberg was the last editor of the paper journal, and the lineage of editors included Gardner Lindzey and Janet Taylor Spence and stretched back to E. G. Boring (who founded the journal in 1956).

Initially I was disappointed that the paper journal was being discontinued. Like others of my generation, there was a certain comfort in *holding* information, and I wanted to have the journal in my briefcase, if not in my hands. A web page seemed like a pallid and inadequate substitute.

My disappointment dissipated as soon as I realized that readers could hyperlink from references to primary sources, jumping in seconds to resources that would have taken them hours or days to

(continued on page 2)

President's Column (*continued*)

locate and copy. *Contemporary Psychology* was available to many readers only through libraries, and libraries were closed at night. *PsycCRITIQUES* is available every minute of every day to hundreds of thousands of readers – people who may never have stumbled across the journal in its traditional form.

Although many college professors are whistling in the graveyard, the future is clear. In a world where information is ubiquitous and immediately available, there will be far less need for professors and universities. Increasingly, students will turn to resources like the [Khan Academy](http://www.khanacademy.org) (www.khanacademy.org) for simple explanations of complex phenomena; they will take

free psychology courses from renowned professors at Berkeley, UCLA, and MIT through [Open Culture](http://www.openculture.com/psychology_free_courses) (www.openculture.com/psychology_free_courses); they will have easy access to [lectures by Nobel Laureates](http://www.lindau-nobel.org/WebHome.AxCMS). (www.lindau-nobel.org/WebHome.AxCMS). I suspect they will not want to drive several miles, hunt for a parking space, walk to a classroom, and pay substantial tuition to hear me stand at a lectern and pontificate about the History and Systems of Psychology.

There is currently considerable tension (and more than a little confusion) as the profession tries to set appropri-

DIVISION 12 BOARD OF DIRECTORS

OFFICERS (Executive Committee)

President (2011) Danny Wedding, Ph.D.*
President-elect (2011). J Gayle Beck, Ph.D.*
Past President (2011) Marvin Goldfried, Ph.D.*
Secretary (2011-2013) John C. Linton, Ph.D., ABPP*
Treasurer (2009-2011) M. David Rudd, Ph.D., ABPP*

COUNCIL OF REPRESENTATIVES

Representative (1/09-12/11) Richard M. Suinn, Ph.D.*
Representative (1/10-12/12) Deborah King, Ph.D.*
Representative (1/11-12/13) Larry Beutler, Ph.D., ABPP*
Representative (1/11-12/13/) Irving B. Weiner, Ph.D., ABPP*

MEMBER AT LARGE

Arthur Nezu, Ph.D., ABPP* (2010-12)

EDITORS (Members of the Board without vote)

The Clinical Psychologist:

(2010-14) Milton Strauss, Ph.D. – Ex Officio
Associate Editor (2010-14) Guerda Nicolas, Ph.D.

Clinical Psychology—Science and Practice:

(2010-15) W. Edward Craighead, Ph.D., ABPP

Web Editor: Alexandra Louie – www.endlessquest.net

* = Voting Members of Board

SECTION REPRESENTATIVES TO THE DIVISION 12 BOARD

Section 2: Society of Clinical Geropsychology (2010-12)

Brian D. Carpenter, Ph.D.*

Section 3: Society for a Science of Clinical Psych. (2009-11)

David Tolin, Ph.D.*

Section 4: Clinical Psychology of Women (2011-13)

Elaine Burke, Psy.D.*

Section 6: Clinical Psychology of Ethnic Minorities (2010-12)

Guillermo Bernal, Ph.D.*

Section 7: Emergencies and Crises (2010-12)

Marc Hillbrand, Ph.D.*

Section 8: Assoc. of Psychologists in Academic Health Centers

(2010-12) Barry Hong, Ph.D., ABPP*

Section 9: Assessment Psychology (2011-13)

Norman Abeles, Ph.D., ABPP*

Section 10: Graduate Students and Early Career Psychologists

(2011-13) Brian Hall, M.A.*

* = Voting Members of Board

EDITORIAL STAFF

EDITORS:

Milton Strauss, Ph.D., Editor / Guerda Nicolas, Ph.D., Associate Editor

COLUMN EDITORS:

Early Career Column: Cynthia Suveg, Ph.D., University of Georgia

Ethics Update: Jeffrey Younggren, Ph.D., University of California

Federal Advocacy Column: Donna Rasin-Waters, Ph.D. Independent Practice and VA New York Harbor Healthcare System

History Column: Donald Routh, Ph.D., University of Miami

Student Column: Brian Hall, M.A., Kent State University

Technology Update: Zeeshan Butt, Ph.D., Northwestern University School of Medicine

SECTION UPDATES:

II. Brian D. Carpenter, Ph.D., Washington University in St. Louis

III. David Tolin, Ph.D., Hartford Hospital

VI. Wei-Chin Hwang, Ph.D., Claremont-McKenna College

VII: Marc Hillbrand, Ph.D., Connecticut Valley Hospital

IX. Norman Abeles, Ph.D., ABPP, Michigan State University

X. Brian Hall, M.A., Kent State University

GRAPHIC DESIGN:

Jason Crowtz



ate training guidelines for clinical psychology. This is reflected at the internship level in the recent resolution by the APA Board of Educational Affairs (BEA):

BEA affirms that health service psychologists must be trained in APA/CPA accredited doctoral and APA/CPA accredited internship programs. BEA also affirms that graduation from an APA/CPA accredited doctoral and APA/CPA internship training program must be a prerequisite for licensure for independent practice as health service psychologists.

This resolution is not official APA policy, and it will be hotly debated on the floor of Council. The key problem is that there are simply not enough APA/CPA accredited internships to meet the needs of all our graduates, and there are many high-quality internships (like those approved by the [California Psychology Internship Council](http://www.capic.net) - www.capic.net) that provide excellent training experiences for students while not meeting all of the requirements for APA accreditation (e.g., paying a stipend). The American Psychological Association of Graduate Students (APAGS) has appropriately identified the internship imbalance as an "internship crisis," and the crisis continues to grow. Limiting the number of internships that will lead to licensure or identification as


a health psychologist will only exacerbate this problem.

At the graduate school level, program accreditation is equally contentious. This dilemma is most dramatically illustrated by the 2007 decision of some prestigious training programs to break away from APA accreditation and set up an alternative accreditation mechanism that focuses on clinical science (the [Psychological Clinical Science Accreditation System: PCSAS](http://www.pcsas.org) - www.pcsas.org). It is likely that duplicative accreditation systems will only compound the key question that continues to bedevil our profession: What is the appropriate kind and level of training for a clinical psychologist?

We will debate these issues in the coming months and years, and some of the most spirited debate is likely to occur at the 2011 APA convention in Washington, DC, in early August. I hope those of you attending the meeting will be actively involved in Society of Clinical Psychology activities, including our business meeting, awards ceremony, and social hour.

I'll see you there.

References

- University of Southern California (2011, February 11). How much information is there in the world? *ScienceDaily*. Retrieved June 21, 2011. 

ANNOUNCEMENT

The American Board of Clinical Neuropsychology (ABCN) is pleased to announce that it has now awarded board certification to more than 800 psychologists who specialize in the assessment and treatment of patients with brain disorders. The 800th board-certified neuropsychologist passed the oral examination held during April 2011 at Rush University Medical Center in Chicago. ABCN was incorporated in 1981 and is a member board of the American Board of Professional Psychology (ABPP), the organization that oversees board certification of professional psychologists. ABCN-certified neuropsychologists practice in 49 states and 4 provinces. About 40% provide services to pediatric patients. Similar to board certification in medical specialties, ABCN applicants must document appropriate education and training, and pass written and oral examinations. For applicants trained since 2005, a formal two-year post-doctoral residency is required. A directory of neuropsychologists who are board-certified by ABCN is available online at www.theaacn.org/diplomates/database/view.php.

For more information go to www.theabcn.org or contact ABCN at:

American Board of Clinical Neuropsychology
Department of Psychiatry (F6332, MCHC-6), University of Michigan Health System
1500 East Medical Center Drive, Ann Arbor, MI 48109-0295 [voice: (734) 936-8269; fax: (734) 936-9761]



Accountable Care Organizations and Psychology: Getting on the Invitation List to the Party

Barry A. Hong, PhD, ABPP, APAHC
(Section 8) Division 12 Representative
William Robiner, PhD, ABPP, APAHC
(Section 8) President

An Issue of Relevance to All Practitioners
- **Milton E. Strauss, PhD, Editor**

The changing face of health care administration and organization for Medicaid and Medicare recipients presents both opportunities and challenges for psychology health care providers. Barry Honig, Ph.D. and William Robiner, Ph.D., on behalf of the Section 8, Association of Psychologists in Academic Health Centers, wrote to the administrator of the Centers for Medicare & Medicaid Services for the inclusion of psychologists in Accountable Care Organizations. Their letter is reproduced below, preceded by their analysis of the importance of this matter for the clinical psychology community.



The Accountable Care Organization (ACO) is one of the hot items discussed in an important new health care reform proposal. The idea of ACOs is to integrate physicians, health care providers and hospitals into an entity that shares fiscal and clinical responsibility for patients. In order to keep costs down, the ACO would be awarded a one-time yearly payment for each patient. The ACO would thus be rewarded for efficient and effective health care. Some critics feel this is just a variation of the HMO concept. The specifics of ACOs are still in development.

Earlier this year, the Centers for Medicare and Medicaid Services (CMS) asked for comments about the CMS proposal. Our concern is about Section 3022 of the Affordable Care Act. In its proposed form, psychologists were not included among the listed ACO providers.

In response to the ACO proposal, William Robiner, Ph.D., President of the Association of Psychologists in Academic Health Care Centers (APAHC), Section VIII of Division 12, sent a letter to Dr. Berwick, Director of CMS, requesting that psychologists be included in the list of ACO providers just as physicians, physician assistants, nurse practitioners and clinical nurse spe-

cialists were. We bring attention to this issue and to the APAHC letter to Dr. Berwick as a means to alert and update the membership of the Society of Clinical Psychology (*The letter follows this article*).

No one can tell if the details of the new proposed model of health care will be better than our current health care system, but what seems clear is that psychology was not included in it, certainly not on par with physicians or mid-level clinicians such as nurse practitioners or physician assistants. For decades, psychologists and other health professionals have recognized the influence of psychology on health and the range of psychologists' roles in integrated healthcare. Professional psychology includes training programs at the doctoral and post-doctoral level focused on health psychology and the profession has generated a talented and productive scientific corps of trained psychology researchers in basic and clinical research. But despite their contributions, when it comes to planning for the delivery of efficacious and cost-effective health services, the initial failure to designate psychologists as ACO providers suggests that psychologists have not yet fully made the case of their critical relevance to the healthcare system and have been overlooked by policy makers.

The debate over the new healthcare system and ACOs continues albeit the ultimate extent of reforming the system remains uncertain. Even if ACOs do not evolve as their planners envision, the debate should deliver a strong message to the profession that psychologists' beliefs, views, self-perceptions, and identity as healthcare providers are not necessarily shared by all stakeholders in the health care community in which we think we belong, or by the public.

The ACO model has the potential to drastically change the practice of clinical (health) psychology. In order to be eligible for payment by Medicare/Medicaid or potentially by some insurance companies in the future, psychologists may be required to join an ACO. Within ACOs, psychologists will need to advocate for full status and to be regarded as essential to the process and outcomes of such organizations, as are other health professionals (i.e., physician and mid-level clinicians). Medical staff membership may become very important. If doctoral-level psychologists are not afforded a status that recognizes their diverse and substantive contributions, their responsibilities and privileges will be limited, and their earnings will be

accordingly limited within ACOs (i.e., potentially to levels commensurate with masters-level social workers or counselors). Unless psychologists successfully convince ACOs of the benefits of integrating them fully in clinical, programmatic, and quality assurance endeavors, ACOs will assume they need fewer psychologists. In that scenario, psychologists could be relegated to practice at the margins of the health system as a private fee for service occupation. Responding to our exclusion from the designated list of ACO providers list is the immediate issue for psychologists, but all threats of being marginalized from health care practice should be recognized as the greater vexing concern that they are for practicing psychologists. Psychologists need

to remain vigilant about advocating for their ongoing roles within healthcare. We should not take for granted that our earlier successes in championing our roles within the system will always be sustained. In staking out the roles of psychologists within healthcare, it could be prudent to focus on those services that psychologists are best prepared to deliver.

As medical school faculty members, members of the medical and professional staff at major teaching hospitals, and as board members of APAHC, it is sobering to recognize that health reform offers fertile ground to reprise psychologists' old battles for inclusion despite our profession's years of growth and progress and vast contributions to healthcare. ■■

.....

APAHC Letter to CMS¹

Donald M. Berwick, M.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-1345-P, P.O. Box 8013
Baltimore, MD 21244-8013

RE: Inclusion of Psychologists as ACO Professionals in Accountable Care Organizations

Dear Dr. Berwick,

I am contacting you on behalf of the Association of Psychologists in Academic Health Centers, a national organization of psychologists at medical schools, teaching hospitals, and other health professional schools in academic health centers. This letter is in response to the request of the Centers for Medicare and Medicaid Services (CMS) for input on the proposed rule in Section 3022 of the Affordable Care Act on the Medicare Shared Savings Program: Accountable Care Organizations as published in the *Federal Register* (April 7, 2011). **We urge CMS to add psychologists to the list of "ACO professionals" and "ACO Providers" (p. 19537) and to promote their involvement in ACOs.**

Currently the list of proposed ACO providers includes physicians, physician assistants, nurse practitioners, and clinical nurse specialists. As written, the Act allows the Secretary to designate other groups as eligible. Whereas the currently recognized disciplines are clearly fundamental to the success of ACOs, it is also of utmost importance to recognize that psychologists' contributions to the objectives of the program warrant broadening the current list. Inclusion of psychologists is fully consistent with integrating and enhancing care, increasing the cost-effectiveness of services, and providing care in accord with evidence-based practices. In many instances, psychological services are the only services patients may need. Psychological services can be an invaluable alternative or adjunct to various other clinical interventions (e.g., involving costly medications and procedures). We urge the Secretary to use her discretion to add psychologists to the list of recognized ACO providers.

There are many reasons to include psychologists in ACOs and other healthcare programs as a means of integrating necessary services that comprise or augment healthcare delivery and facilitate positive health outcomes. As doctoral-level practitioners, psychologists are among the most intensively trained mental health

¹ Note letter has been reformatted for *The Clinical Psychologist*



professionals (Robiner, 2006). Psychologists' role in the delivery of health services has been recognized since the 1960s (Schofield, 1969). Psychologists have been included in the Medicare program as clinical providers for two decades and in other private and public programs for much longer periods. Psychologists have more research training than most health care providers, and a long tradition of identifying, respecting, and providing services in accord with empirically supported practices. Such training also equips them to engage substantively in quality enhancement activities. Thousands of psychologists (e.g., members of APAHC and VA psychologists) provide care that is integrated with that of other health professionals in interprofessional teams across the continuum of healthcare settings in this nation and around the world. For example, psychologists provide clinical services in primary care settings and hospitals and serve as members of integrated healthcare teams. Psychologists are recognized as members of medical staff or professional staff of hospitals around the country, including most of the nation's top rated hospitals. Psychologists participate in, and often direct, quality improvement efforts in healthcare institutions. The literature on the roles of psychologists in medical settings and their impact on enhancing health outcomes is robust (e.g., Bluestein & Cubic [2009], Frank, McDaniel, Bray & Heldring [2004], Haas [2004], Peek [2009]). Moreover, in accord with the intent of the Medicare Shared Savings program, the potential savings related to cost offset associated with mental health and behavioral health services is critically important as is evident in the literature (Levant, House, May, & Smith, 2006), including in a meta-analysis of 91 studies (Childes, Lambert, & Hatch, 1999).

The roles and recognized contributions of psychologists have been expanding in the diagnosis, care, and management of medical patients across the spectrum of acute and chronic illness (e.g., diabetes, cancer). The need to address psychological and psychosocial issues is evident to clinical practitioners across disciplines and is an essential feature of medical training (e.g., the requirement of Family Medicine residencies to include behavioral health faculty). Psychologists' lengthy history of collaborating with medical and other professional colleagues reflects their value to multidisciplinary teams in promoting optimal levels of patient care. Health professionals of diverse disciplines value the perspective and knowledge psychologists bring to healthcare as evidenced by the growing body of literature promoting the patient-centered medical home. For example, a recent article based on the National Demonstration Project (Nutting et al., 2011) noted that the:

“...prevalence of mental health and substance abuse issues requires innovative, team-based primary care. The primary care activities required of medical homes have simply outrun the ability of any one discipline to single-handedly provide comprehensive care” (p. 441).

The association of psychological issues and illness and with healthcare is documented in diverse professional and scientific journals including, but not limited to: *The Journal of Clinical Psychology in Medical Settings*; *Health Psychology*, *The Journal of Behavioral Medicine*; *Pediatric Psychology*; *Psycho-Oncology*; *Rehabilitation Psychology*; *General Hospital Psychiatry*; and *Health Affairs*.

Integrating psychological services in the evolving health system is critical due to the clear connection between emotions and behavior on the one hand and health, illness, prevention, and healthcare delivery on the other. Health experts, such as Dr. Steven Schroder of UCSF believe that, “The single greatest opportunity to improve health and reduce premature deaths lies in personal behavior” (Schroder, 2007). Lifestyle and behavioral factors have been estimated to account for nearly 40% of all deaths in the United States (Mokdad, Marks, Stroup, & Gerberding, 2004). In addition, 30% of primary care patients with chronic medical conditions and up to 80% of those with health complexity have mental health comorbidity (Regier et al., 1993; Katon, 2003). Such research also reveals that depressed, medically ill patients are three times more likely than non-depressed patients to adhere poorly to medical recommendations. The necessity of creating systems of care that adequately address these factors is clear. The role of behavior is also evident in the Centers for Disease Control and Prevention (2011) recommendation of regular physical activity as key to health by helping decrease weight, reduce risks for diabetes and cancer, increase bone density and muscle strength, enhance emotional functioning and mental health. Psychologists' focus on and expertise in behavior change generally, and health behavior change specifically, arguably are the most extensive among all health professionals. Engaging this expertise

Accountable care organizations and psychology (continued)

within ACOs is a critical means of providing needed services and coordinating behavioral health and other health services to enhancing adherence and health outcomes.

As an organization of psychologists who currently practice in organized healthcare settings, APAHC recognizes from the research literature as well as from our vast, collective clinical experience that promoting psychological services and integrating them with other organized health services are not only effective means of enhancing outcomes and curbing costs, but are vital to achieving the goals of the Affordable Care Act. **We strongly urge the designation of psychologists as ACO providers and facilitation of psychologists' substantial participation in ACOs to make them more efficacious and cost-effective in delivering quality healthcare.**

Thank you for providing this opportunity to submit comments on the proposed ACO regulations and for your consideration of this request.

Sincerely,

William N. Robiner, PhD, ABPP
President, Association of Psychologists in Academic Health Centers
robin005@umn.edu

References

- Bluestein, D. & Cubic, B. A. (2009). Psychologists and primary care physicians: A training model for creating collaborative relationships. *Journal of Clinical Psychology in Medical Settings*, 16, 101-112.
- Centers for Disease Control and Prevention. <http://www.cdc.gov/physicalactivity/everyone/health/index.html> (retrieved February 26, 2011).
- Centers for Medicare and Medicaid Services (CMS). Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice. *Federal Register* (April 7, 2011), 76 (67).
- Chiles, J.A. Lambert, M. J., & Hatch, A. L. (1999). The impact of psychological interventions on medical cost-offset: A meta-analytic review. *Clinical Psychology: Science and Practice*, 6, 204-219.
- Frank, R. McDaniel, S. H., Bray, J. H., & Heldring, M. (Eds.) (2004). *Primary care psychology*. Washington, DC: American Psychological Association.
- Haas, L. J. (Ed.) (2004). *Handbook of primary care psychology*. New York: Oxford University Press.
- Katon, W. (2003). Clinical and Health Services Relationships between Major Depression, Depressive Symptoms, and General Medical Illness, *Biological Psychiatry*, 54, 216-226.
- Levant, R.F., House, A. T., May, S., & Smith, R. (2006). Cost Offset: Past, Present, and Future. *Psychological Services*, 3, 195-207.
- Mokdad, A.H., Marks, J. S., Stroup, J. S., & Gerberding, J. L. (2004). Actual causes of death in the United States, 2000. *Journal of the American Medical Association*. 291:1238-1245. [Erratum, JAMA 2005;293:293-4, 298.]
- Nutting, P.A., Crabtree, B. F., Miller, W. L., Strange, K. C., Stewart, E., & Jaén, C. (2011). Transforming physician practices to patient-centered medical homes: Lessons from the National Demonstration Project. *Health Affairs*, 30, 439-445.
- Peek, C. J. (2009). Integrating care for persons, not only diseases. *Journal of Clinical Psychology in Medical Settings*, 16, 13-20.
- Regier, D. A. et al. (1993) The de facto US mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50, 85-94.
- Robiner, W. N. (2006). The mental health professions: Workforce Issues and challenges. *Clinical Psychology Review*, 26, 600-625.
- Schofield, W. (1969). The role of psychology in the delivery of health services. *American Psychologist*. 24 565-584.
- Schroeder, S. A. (2007). We can do better — Improving the health of the American people. *New England Journal of Medicine*, 357, 1221-1228.
-



Division 12 Award Winners, 2011



Award for Distinguished Scientific Contributions to Clinical Psychology

presented to *Catherine Lord, Ph.D.* for distinguished theoretical or empirical contributions to Clinical Psychology throughout their careers.

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

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

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


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

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

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

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

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

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

Join us at this year's
Division 12 award
ceremony at the
APA 2011 Annual
Convention!


The Society of Clinical Psychology (Division 12) award ceremony will be held on **Friday, August 5, 2011** at the Renaissance Hotel in Washington, DC from 5:00 p.m. - 5:50 p.m. in Congressional Hall A.

The ceremony will be immediately followed by the Social Hour and Section Poster Showcase.

Do the Right Thing: If Only it Were so Easy

Michael C. Gottlieb, PhD and

Jeffrey N. Younggren, PhD

 We believe that ethics education has unfortunately devoted far too much attention to rule development and rule adherence. The result of this focus has been that students and professionals alike tend to look for concrete answers, to complex and or confusing ethical conundrums which may be better addressed philosophically. When ethical questions arise that would best be addressed conceptually, the students and professionals who have been raised in this tradition struggle to find answers to their dilemmas. In addition, because of this, a perspective has been lost that we feel is vital to properly socializing our graduate students and young professionals into the profession.

One group of experts in the world of psychological ethics has suggested that psychology, based on its ethical principles, espouses a set of values to which we should aspire and that trainers should instill these values in our students, and students should aspire to them as a matter of their personal values as well. (Handelsman, Gottlieb, & Knapp, 2005; Handelsman, Knapp, & Gottlieb, 2009). However, when applied to actual professional conduct and practice, this aspirational, and hopefully internalized, model may not be sufficient to lead psychologists to making the right choices. Evidence for this can be found in the reality that

far too many colleagues are sanctioned by ethics committees or state boards, and when they are, their colleagues many respond with, “What on earth could s/he have been thinking?” The immediate reason for this, which has been consistently supported by the available data, is that knowing what to do when presented with an ethical dilemma does not necessarily translate into doing the right thing (Bernard, Murphy, & Little, 1987; Smith, McGuire, Abbott, & Blau, 1991). This is not a new problem; in fact it is a rather old one, identified by the early Greek philosophers, called “Akrasia” or a condition in which while knowing what it would be best to do, one does something else.

We believe we know one major reason why this problem arises. The work of Kahneman, Tversky

and many others (e.g., Kahneman & Tversky, 1979; Kahneman, 2003; Kahneman & Klein, 2009) has shown how poorly humans perform when they are given inadequate information that is framed in a particular manner and concurrently are under cognitive load, fear of loss, and have interests of their own at stake. (For further reading regarding self-serving bias in such situations, see Bazerman, Morgan, & Loewenstein, 1997). While we would like to think otherwise of ourselves, we frequently dare not, for when we fear a client may file a complaint against us or we may lose an important grant, all of these non-rational processes come in to play and frequently work against sound ethical decision-making. In a forthcoming article, we and our colleagues address this issue and propose some suggestions that may mitigate this problem (Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, In press).

Even if we are right, and we are able to reduce the impact of these processes, we are still left with a fundamental moral problem that when confronted by ethical questions where certain conditions prevail and the answers are not clear or concrete, we too often fail to do the right thing. Given this reality, what then are trainers to do? What changes need to be made to improve up this reality? We would like to propose following:

- We need to teach our aspirational principles not just the Code of Conduct (2010)
- We should model ethical behavior systemically. That is, faculty should model ethical conduct with students, colleagues, and external institutions.
- We must place high expectations on ourselves and our students and do not shirk from enforcing them. For example, students should know that psychology is the only social science discipline that accepts fiduciary obligations for others and as a result, creates higher standards to which we should adhere in the classroom, laboratory and clinic.
- Perhaps even more importantly, we need to actively participate in the creation of the next iteration of the ethics code. The last revision of the APA Ethical Principles and Code of Conduct (2010) was considered by many to be “watered down” when compared to its earlier 1992 revision. Regardless of whether this is true or not, this was a perception held by many; we feel that it is not in the interest of our profession for many of our own to hold such views, and we encourage involvement of all

when the next revision of the code is underway to make clear our commitment to the highest possible, yet reasonable, standards.

- Finally, psychologists should be more reluctant to criticize the work of colleagues. Maybe it is time for us to stop casting stones when others falter. Perhaps we are at a point in the development of our profession when we can stop judging others and honestly say, "There but for the grace of God go I." This change could have two very valuable outcomes. Most immediately it would entail reaching out to colleagues who have erred and support them. But even more importantly, if we do so, they may better learn the error of their ways and teach their lessons to the rest of us.

Michael C. Gottlieb is a forensic and family psychologist in Dallas, Texas and a clinical professor at the University of Texas Health Science Center. Jeffrey N. Younggren is a clinical and forensic psychologist and Clinical Professor, UCLA David Geffen School of Medicine.

References

- American Psychological Association. (2010). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.
- Bazerman, M. H., Morgan, K. P., & Loewenstein, G. (1997). Opinion: The impossibility of auditor independence. *Sloan Management Review*, Summer, 89-94.
- Bernard, J. L., Murphy, M., & Little, M. (1987). The failure of clinical psychologists to apply understood ethical principles. *Professional Psychology: Research and Practice*, 18, 489-491.
- Handelsman, M., Gottlieb, M.C., and Knapp, S. (2005). Acculturation as a framework for training ethical psychologists. *Professional Psychology: Research and Practice*, 36, 59-65.
- Handelsman, M.M., Knapp, S.J., and Gottlieb, M.C. (2009). Positive ethics: Themes and variations. In C. R. Snyder & S.J. Lopez (Eds.) (2nd Ed.) *Oxford Handbook of Positive Psychology* (pp.105-113). New York: Oxford University Press.
- Kahneman, D. (2003). A perspective on judgment and choice: Mapping bounded rationality. *American Psychologist*, 58, 697-720.
- Kahneman, D., & Klein, G. (2009). Conditions for intuitive expertise. *American Psychologist*, 64, 515-526.
- Kahneman, D., & Tversky, A. (1974). Judgment under uncertainty: Heuristics and biases. *Science*, 185, 1124-1131.
- Rogerson, M.D., Gottlieb, M.C., Handelsman, M.M., Knapp, S. & Younggren, J.N. (In press). Non-Rational Processes in Ethical Decision Making. *American Psychologist*.
- Smith, T. S., McGuire, J. M., Abbott, D. W., & Blau, B. I. (1991). Clinical ethical decision making: An investigation of the rationales used to justify doing less than one believes one should. *Professional Psychology: Research and Practice*, 22, 235-239. 

THE CLINICAL PSYCHOLOGIST

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

ISSN: 0009-9244

To subscribe, contact:

Lynn Peterson, Administrative Officer
Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082, USA
Tel: 303-652-3126
Fax: 303-652-2723
E-mail: div12apa@comcast.net

Generational Diversity Among Immigrants

Minsun Lee, MA
Drexel University

Ms. Lee is a doctoral candidate in clinical psychology under my mentorship. I had asked her to contribute to my column specifically addressing her experience as an adult immigrant to this country from Korea. Providing counseling and therapy to “1.5” immigrants requires an understanding of their unique experiences, something Minsun knows about. - AMN



Since 1970, the U.S. immigrant population has grown remarkably. Immigrants account for approximately one in eight U.S. residents. The young immigrant generation, including U.S.-born children of at least one immigrant parent, and those

who arrived by the age of 12, account for one of four Americans under 18 years old (Camarota, 2007). As an immigrant to the U.S. myself, I have had many opportunities to closely observe other immigrants' experiences. As Berry (1997) pointed out, immigration to another country may be one of the most overwhelming life events. The changes that occur to an immigrant involve nearly every area of life, including physical,

psychological, behavioral, and social domains. The adaptation process to a new society, called acculturation, frequently places immigrants at risk for various emotional disturbance and social maladjustment.

One of the interesting observations that I have had since coming to the U.S. is “generational diversity” among immigrants. More specifically, members of each generation appear to experience immigration at different point of their lives, resulting in different levels of acculturation, stress, and vulnerability across generations. Thus, being able to perceive these genera-

tion-specific challenges in immigrants would be essential in implementing optimal therapeutic strategies tailored to each immigrant's diverse needs.

The immigration population includes the first generation, the “1.5 generation,” and a second generation. First generation immigrants refer to those individuals who were foreign-born, but became a naturalized citizen, or someone living permanently in the country without becoming a citizen. Second generation immigrants are those refer who were born in the new country from first generation immigrant parents. The term “1.5 generation” refers to people who immigrate to a new country before or during their early teens.

The first generation immigrants are more likely to be vulnerable to acculturative stress than the other two groups during the acculturation process. They may experience language barriers, loss of social support, and difficulty establishing new social ties, disruptions in family dynamics, and discrimination and non-acceptance by the host culture (Berry, 1997). These difficulties often become the source of emotional distress. For many first generation immigrants, linguistic challenges appear to be at the center of their acculturative stress and psychological problems. Poor language proficiency often becomes an obstacle to building social networks and obtaining a job, leading to lack of confidence in one's ability to function in society. When they decide to stay within their comfort zone, such as their own ethnic community, first generation immigrants may live life in an “island,” isolated from the mainstream culture. The language barrier can also change family dynamics and cause a disconnection between parents and children. Children in immigrant families frequently become translators for their parents, and dependency on their children may induce a feeling of inadequacy from the parents. In cases where children are not proficient in speaking the parents' language, the parents may experience difficulty communicating with their children, potentially resulting in parent-children conflicts.

Part of the conflicts between first-generation parents and second-generation children stems from parents' ambivalence regarding their children's “Americanization.” Many immigrant parents overcome hardships and obstacles to give their children the chance to become American citizens. At the same time, however, parents are often uncomfort-

Being able to perceive generation-specific challenges in immigrants is essential in implementing optimal therapeutic strategies tailored to each immigrant's diverse needs.



able with and anxious about their children's adapting to American attitudes and behaviors. For example, children "becoming American" is often the topic of sermons in Korean churches, in discussions in Ecuadoran hometown associations, and debates in Chinese newspapers (Kasinitz, Mollenkopf, Waters, & Holdaway, 2008).

With their parent's mixed attitude toward their children's Americanization, U.S.-born and raised second-generation immigrants often struggle to balance their parent's values and expectations with more mainstream values and lifestyles. This struggle is reflected in the findings that one of the most common presenting problems in therapy for the second generation of immigrants is parent-child conflict due to their acculturation gap (Lee, Su, & Yoshida, 2005). Although the main task for the first generation is to acculturate to the host culture, enculturation to the culture of family origin is a main challenge to second-generation immigrants. Several studies have found that cultural conflict between children and parents are frequently associated with interpersonal problems, lack of self-confidence and assertiveness, and anxiety and depression (Ahn, Kim, & Park, 2008). Conflicts may arise around topics such as academic achievement, career choice, and dating and marriage. One of my clients who is a second generation of Indian immigrants came to treatment for depression. He stated that he was not successful regarding academic achievement compared to his siblings, which raised his stress level significantly during his childhood and adolescence and may also have contributed to developing low self-esteem.

The 1.5 generation (1.5G) earned the title because they bring with them characteristics from their home country, but continue their assimilation to the new country. These individuals are often bicultural and bilingual and go through both acculturation and enculturation. Although they find it easier to be assimilated into the host culture than people who immigrated as adults, 1.5G individuals sometimes feel they fit in neither society and frequently experience identity confusion. Therefore, the main challenge for this group is to establish their identity and sense of belonging. 1.5G individuals often take the role of a "cultural broker" or bridge between the first and second generations. As youth, they face the challenge of having to learn a second language while being expected to function

academically at grade level at school. In their families, 1.5 G youth often takes the responsibility of handling family matters by communicating with various social systems on behalf of their parents, even though they are at the age in need of parents' care for themselves. Almost without an exception, all of my 1.5G friends have such childhood memories and often talk about how much bravery was needed for them to take an adults' role. Apparently, these role reversals can put additional burden on 1.5 generation individuals who are going through their own acculturation process.

Although each generation of immigrants has its own challenges and struggles at different levels of acculturation, family appears to be the center of both struggle and support across generations. When working with an immigrant population, therefore, it may be important to understand their family values, as well as the unique challenges for each generation in the family. Assisting clients to negotiate the boundaries between the demands of the family and the social expectations from the new culture that the client has internalized is a critical component of psychotherapy.


References

- Ahn, A. J., Kim, B. S. K., & Park, Y. S. (2008). Asian cultural values gap, cognitive flexibility, coping strategies, and parent-child conflicts among Korean Americans. *Cultural Diversity and Ethnic Minority Psychology*, 14, 353-363.
- Camarota, S. A. (2007). Immigrants in the United States, 2007: A profile of America's foreign-born population. Center for Immigration Study.
- Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied psychology: An International Review*, 46, 5-34.
- Kasinitz, P., Mollenkopf, J. H., Waters, M. C., & Holdaway, J. (2008). *Inheriting the city: the children of immigrants come of age*. Boston: Harvard University Press.
- Lee, R. M., Su, J., & Yoshida, E. (2005). Coping with intergenerational family conflict among Asian American college students. ■■

David Shakow and the Origins of Contemporary Clinical Psychology Training¹

David H. Barlow, PhD, ABPP

Center for Anxiety and Related Disorders,
Boston University

 In 1969, David Shakow, widely acclaimed as the father of modern clinical psychology, published a book of his collected papers entitled “Clinical psychology as science and profession: A 40-year odyssey” (Shakow, 1969). At the time, Shakow had recently retired as the first chief of the Laboratory of Psychology in the Intramural Research Program of the National Institute of Mental Health (NIMH). Prior

to that, his career included stints in both departments of psychiatry and psychology in major universities, as well as key leadership positions in prominent clinical settings, including Worcester State Hospital in Massachusetts.

Shakow is one of only two individuals to be honored by the American Psychological Association (APA) over the course of its history with two of its most prestigious awards: the Distinguished Scientific Contribution Award and the Distinguished Professional Contribution Award (Garmezy & Holtzman, 1984). Although he made enormous contributions to

Although he made enormous contributions to our research effort, much of it in the area of schizophrenia, it was Shakow’s conceptualization of the role of modern-day clinical psychology that remains his most enduring legacy.

our research effort, much of it in the area of schizophrenia, it was Shakow’s conceptualization of the role of modern-day clinical psychology that remains his most enduring legacy. He was an early president of the Division (now the Society) of Clinical Psychology of the APA and chaired the very influential Committee

on Training in Clinical Psychology that made its report in 1947 defining the Scientist-Practitioner Model of training, a model that was endorsed, broadened, and deepened at the iconic Boulder Conference in 1949 (Raimy, 1950).

In 1969, Shakow observed, “Present doctoral training . . . calls for a minimum program of four years, one year of which (preferably the third) consists of an internship. On a foundation of basic courses in theoretical clinical and dynamic psychology, practica, clerkships, and internships are organized. The type of training program now generally accepted was initially proposed by the Committee on Training in Clinical Psychology of the APA in its 1947 report, which called for centering clinical training in existing university departments, and the integration of field training units and university programs. (Shakow, 1969, p. 39).” This scheme remains largely in place in 2011, albeit with the internship experience occurring in the last year, often the 5th year now, in many programs.

Shakow also recounted what he called the “phenomenal” growth of clinical psychology in the United States. To take one example, he observed that the number of schools fully accredited by the APA had increased from 30 in 1948 to 55 in 1963. (By comparison, that number had further increased to 226 by 2006 (Grus, 2011)).

Shakow’s 40-year odyssey led him to conclude that (1) science and practice should be integrated and related parts of training in both Ph.D. programs and professional schools, (increasingly true across all models of training (Barlow, 2011)), but (2) that the focus of science in clinical psychology training should be on clinically relevant themes. (In those years, most dissertations focused on basic research, often in animal laboratories). (3) These training experiences should be firmly grounded in academic psychology, but should be fully integrated into front-line practice settings, with increased attention to organized methods for evaluating quality and competence. (See APA’s new initiatives on assessing competencies in training (Grus, 2011)). And (4), the field should be on the forefront of exploring new systems for delivering broad-based psy-

¹ Excerpted and Adapted from: Barlow, D.H. (2011). A prolegomenon to clinical psychology: Two 40-year odysseys. In D.H. Barlow (Ed.), *The Oxford handbook of clinical psychology* (pp. 3-20). New York, NY: Oxford University Press.


chological services. (See new initiatives on dissemination, implementation, and telehealth (Dimeff, Paves, Skutch, & Woodcock, 2011; McHugh & Barlow, 2010)). It is clear that Shakow's vision is coming to fruition.

To achieve these goals, Shakow was a strong advocate of integrating clinical settings fully into doctoral clinical psychology programs. This arrangement was rare in those early years, since hardly any in-house training clinics existed, and sites for clinical practice were few and far between. And when they could be procured, psychologists were often limited to roles of administering routine standardized psychological testing. Nevertheless, Shakow, in 1976, stipulated again a suggestion he had been making for 20 years. "My suggestion is that the university (or professional school) and the field-center training activities be as completely integrated as possible. Integration does not mean sameness, which results in a loss of vigor that comes with having the same point of view . . . The fundamental principal of the plan is that theory and practicum must be constantly associated and tied together, whether in the university or the field station, and that both types of activity—theory and practicum—start with the very beginning of the program. I would suggest as axiomatic: *the greater the degree of integration between theory and practice, and between university and field center, the more effective the program*" (Shakow, 1976, p. 556). On this point, it is clear that Shakow's wisdom has also been recognized, as clinical psychology programs usually conduct most training in captive clinics, often referred to as Psychological Service Centers, and increasingly, specialty clinics focusing on specific areas of psychopathology. Nevertheless, the necessity of completing internships in more fully organized clinical settings, still a requirement of all scientist-practitioner programs, is becoming increasingly problematic. There is an increasing number of applicants for a limited number of internship slots, resulting in a greater number of students each year (over 25% most recently) unable to complete requirements for the PhD or Psy.D degree due to circumstances largely out of their control or that of their clinical psychology doctoral program. Clearly, this is an untenable situation and requires a new look at the admonitions made by Shakow over 40 years ago, recommending control of the entire clinical psychology training experience by the programs with the authority to conduct that training.

Although Shakow had officially retired in 1966, he continued going to work every day where he would

write and supervise research, until he died suddenly one morning in his office, in 1981, at the age of 80 (Garmezy & Holzman, 1984). His legacy lives on.

References


- Barlow, D.H. (2011). A prolegomenon to clinical psychology: Two 40-year odysseys. In D.H. Barlow (Ed.), *The Oxford handbook of clinical psychology* (pp. 3-20). New York, NY: Oxford University Press.
- Dimeff, L. A., Paves, A. P., Skutch, J. M., & Woodcock, E. A. (2011). Shifting paradigms in clinical psychology: How innovative technologies are shaping treatment delivery. In D. H. Barlow (Ed.), *The Oxford handbook of clinical psychology* (pp. 618-648). New York, NY: Oxford University Press.
- Garmezy, N., & Holzman, P. (1984). David Shakow (1901-1981). *American Psychologist*, 39 (6), 698-699.
- Grus, C. L. (2011). Training, credentialing, and new roles in clinical psychology: Emerging trends. In D. H. Barlow (Ed.), *The Oxford Handbook of clinical psychology* (pp.150-168). New York, NY: Oxford University Press.
- McHugh, R. K., & Barlow, D. H. (2010). Disseminations and implementation of evidence-based psychological interventions: A review of current efforts. *American Psychologist*, 65, 73-84.
- Raimy, V. C. (Ed.). (1950). *Training in clinical psychology (Boulder Conference)*. New York: Prentice Hall.
- Shakow, D. (1969). *Clinical psychology as science and profession: A 40-year odyssey*. Chicago: Aldine.
- Shakow, D. (1976). What is clinical psychology? *American Psychologist*, 31, 553-560. 

Visit Division 12's
section web page:

www.div12.org/division-12-sections

Becoming an Independent Researcher: An Interview with Deborah Drabick, Department of Psychology, Temple University

Cynthia Suveg, PhD,
University of Georgia

 For early career psychologists on the academic track, becoming an independent researcher is often of primary concern. One mechanism to facilitate such independence is the Mentored Research Scientist Development Award (K01). The National Institutes of Health states that, “The . . . K01 provides support for a sustained period of ‘protected time’ for intensive research career development under the guidance of an experienced mentor, or sponsor, in the biomedical, behavioral or clinical sciences leading to research independence. The expectation is that through this sustained period of research career development and training, awardees will launch independent research careers and become competitive for new research project grant (R01) funding.” For this column I interviewed Deborah Drabick, an Associate Professor of Psychology at Temple University, who has been successful in securing a K01. Dr. Drabick provides much insight regarding the K award itself and tips on how to secure one.

Cynthia Suveg (CS): What made you decide to apply for a K01 award, as opposed to another type?

Deborah Drabick (DD): Although my graduate training provided me with a lot of training and research opportunities, I realized that I was not as prepared as I would have liked for the direction that I wanted to take with my programmatic work. In particular, I wanted to gain more expertise in neuroscience and advanced statistical modeling techniques. The K01 allowed me to pursue these training areas explicitly and provided me with protected time to do so. Although other K mechanisms also allow for training, I chose the mentored training award so that I could have a more directed set of experiences with experts in the areas for which I sought training.

CS: What position did you hold when you applied for your K award and was it easy to transfer?

DD: I was an assistant professor at Temple University at the time of my application and award. I did not have to transfer the award; however, there were some concerns that if I “bought out” of too many classes, then I would not have enough teaching experience for my tenure evaluation. My department was flexible and supported my application nevertheless.

CS: What are the benefits of having a K award?

DD: The biggest benefits are the opportunities to pursue training and consultation in areas for which you would like to develop expertise. The protected time (i.e., provision of 75% of your salary) makes coursework, consultation, and other training experiences feasible to attain. In addition to salary, the grant provides about \$50,000 per year, which has been very helpful not only for my training and consultation, but also for supporting graduate students, travel, and my own independent research projects that stem from the knowledge acquired through the K training opportunities. There is also ample time for preparing and submitting other grant applications based on pilot data collected.

CS: Are there drawbacks to the K award?

DD: The benefits greatly outweigh any drawbacks in my opinion. However, a few issues come to mind. First, having a “mentored” award may suggest that the individual still requires mentoring, even among individuals who are well past graduate school. At my university, this was never an issue, but I have heard others make this point. A second issue is that the money beyond the salary is less than optimal for funding independent research; of course, this is not the primary objective of the K award, but it becomes increasingly important throughout the duration of the award. A third potential drawback is that, like most research endeavors, the K award requires continual initiative and effort to obtain training and consultation, as well as to develop research projects. Although in my case the grant has been a collaborative endeavor, the K mechanism is much more of an independent award in which the PI seeks out training and develops research with guidance, but it is not conducive to the type of collaborative efforts seen with other grant mechanisms that have multiple principal investigators.

CS: What do you think were key factors in help-

ing you to successfully secure a K award?

DD: I think that my training plan (coursework, consultation, and direct experiences) and choice of mentors and consultants led to my success. The reviewers suggested that the systematic approach to developing expertise in neuroscience and statistical modeling techniques was very strong, and the people whom I asked to be involved with the grant are known for their expertise in these areas, as well as their commitment to mentoring others. I think that the topics addressed were also deemed important for their public health significance, and the links between my programmatic research and the training were clear and compelling to the reviewers.

CS: If an early-career psychologist was thinking about applying for the K award, what factors should they consider when deciding whether this mechanism is right for them?

DD: I think it is important to consider the direction(s) in which you would like to take your programmatic work, and then determine whether there are limitations in your knowledge of specific areas and/or techniques that those knowledgeable in your area would agree are important to know. The next step would be to consider how you would address the potential limitations in your knowledge. Are there gaps in your training that you cannot reasonably

address with workshops or consultations? Would protected time and a systematic training program help you to develop expertise in these areas? Can you justify why these specific areas are integral to your programmatic work and career? The training plan needs to be feasible and compelling, with sufficient detail to allow you to develop the level of expertise that you would need for your programmatic work. Thus, I would think deeply about whether this longer mentored period would be the most practical way to get the training that you need. I also would encourage early-career psychologists to select mentor(s) and consultants carefully. These individuals are very important for your success, and your knowledge of their expertise is just as critical as being realistic about their availability and investment in mentoring.

Thanks to Dr. Drabick for sharing valuable information on the K01 award. For more information on the K01 mechanism in particular, go to: <http://www.grants.nih.gov/grants/guide/pa-files/pa-06-001.html>. Information on all of the types of grant programs offered by NIH can be found at: http://grants.nih.gov/grants/funding/funding_program.htm. Other opportunities for grant funding for early-career psychologist; to read about them go to: (<http://www.apa.org/careers/early-career/funding/index.aspx>). For comments or ideas for future columns, please send an email to csuveg@uga.edu. ■■

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:

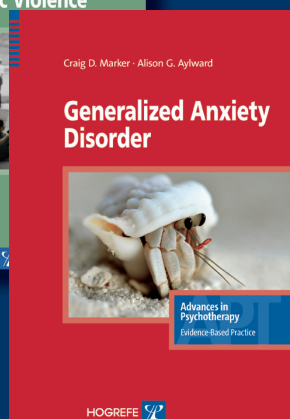
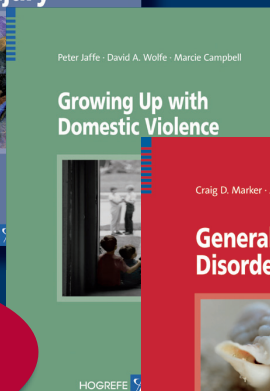
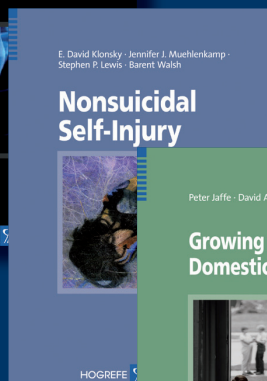
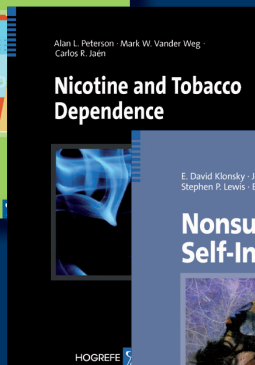
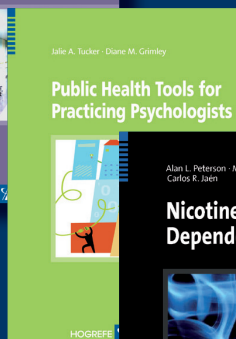
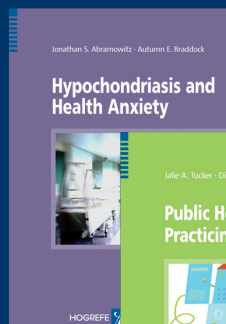
Milton Strauss milton.strauss@gmail.com

Keep Up with the Advances in Psychotherapy Evidence-Based Practice

Developed and edited with the support of the Society of Clinical Psychology (APA Division 12)

Main features of the volumes:

- **Authoritative:** Written and edited by leading authorities
- **Evidence Based:** Proven, effective approaches to each disorder
- **Practice Oriented:** Emphasis on information useful in daily practice
- **Easy to Read:** Tables, illustrations, text boxes, and marginal notes highlight important information
- **Compact:** 80-120 pages
- **Inexpensive:** Less than \$20 each with Series Standing Order



Series Editor:

Danny Wedding

Associate Editors:

*Larry Beutler, Kenneth E. Freedland,
Linda Carter Sobell, David A. Wolfe*

**New titles
in 2011!**

**Advances in
Psychotherapy**
Evidence-Based Practice

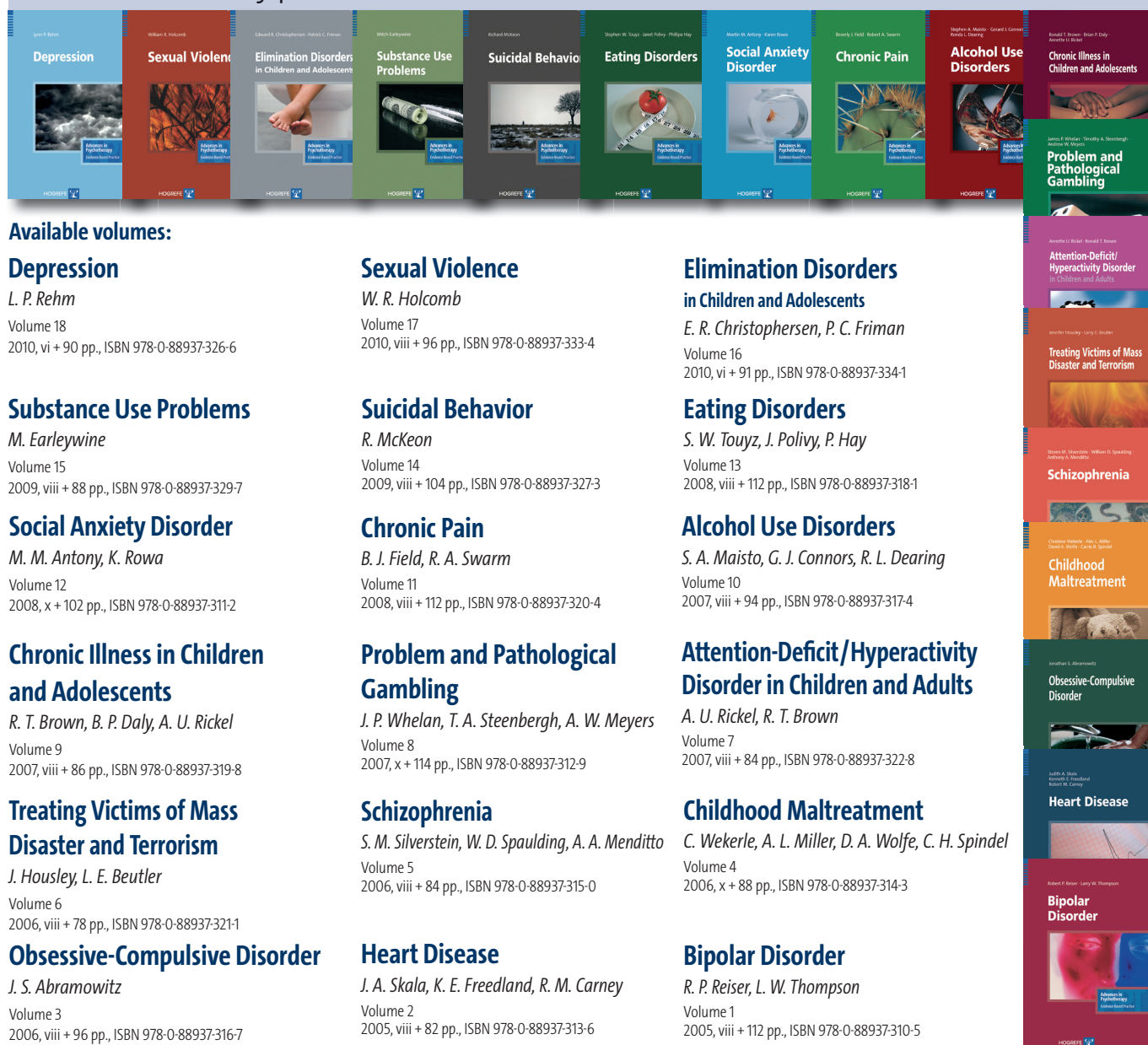
HOGREFE



About the series:

The *Advances in Psychotherapy* series provides therapists and students with practical, evidence-based guidance on the diagnosis and treatment of the most common disorders seen in clinical practice – and does so in a uniquely “reader-friendly” manner. Each book is both a compact “how-to” reference on a particular disorder, for use by professional clinicians in their daily work, and an ideal educational resource for students and for practice-oriented continuing education.

The books all have a similar structure, and each title is a compact and easy-to-follow guide covering all aspects of practice that are relevant in real life. Tables, boxed clinical “pearls,” and marginal notes assist orientation, while checklists for copying and summary boxes provide tools for use in daily practice.



Available volumes:

Depression

L. P. Rehm

Volume 18

2010, vi + 90 pp., ISBN 978-0-88937-326-6

Substance Use Problems

M. Earleywine

Volume 15

2009, viii + 88 pp., ISBN 978-0-88937-329-7

Social Anxiety Disorder

M. M. Antony, K. Rowa

Volume 12

2008, x + 102 pp., ISBN 978-0-88937-311-2

Chronic Illness in Children and Adolescents

R. T. Brown, B. P. Daly, A. U. Rickel

Volume 9

2007, viii + 86 pp., ISBN 978-0-88937-319-8

Treating Victims of Mass Disaster and Terrorism

J. Housley, L. E. Beutler

Volume 6

2006, viii + 78 pp., ISBN 978-0-88937-321-1

Obsessive-Compulsive Disorder

J. S. Abramowitz

Volume 3

2006, viii + 96 pp., ISBN 978-0-88937-316-7

Sexual Violence

W. R. Holcomb

Volume 17

2010, viii + 96 pp., ISBN 978-0-88937-333-4

Suicidal Behavior

R. McKeon

Volume 14

2009, viii + 104 pp., ISBN 978-0-88937-327-3

Chronic Pain

B. J. Field, R. A. Swarm

Volume 11

2008, viii + 112 pp., ISBN 978-0-88937-320-4

Problem and Pathological Gambling

J. P. Whelan, T. A. Steenbergh, A. W. Meyers

Volume 8

2007, x + 114 pp., ISBN 978-0-88937-312-9

Schizophrenia

S. M. Silverstein, W. D. Spaulding, A. A. Menditto

Volume 5

2006, viii + 84 pp., ISBN 978-0-88937-315-0

Heart Disease

J. A. Skala, K. E. Freedland, R. M. Carney

Volume 2

2005, viii + 82 pp., ISBN 978-0-88937-313-6

Elimination Disorders in Children and Adolescents

E. R. Christophersen, P. C. Friman

Volume 16

2010, vi + 91 pp., ISBN 978-0-88937-334-1

Eating Disorders

S. W. Touyz, J. Polivy, P. Hay

Volume 13

2008, viii + 112 pp., ISBN 978-0-88937-318-1

Alcohol Use Disorders

S. A. Maisto, G. J. Connors, R. L. Dearing

Volume 10

2007, viii + 94 pp., ISBN 978-0-88937-317-4

Attention-Deficit/Hyperactivity Disorder in Children and Adults

A. U. Rickel, R. T. Brown

Volume 7

2007, viii + 84 pp., ISBN 978-0-88937-322-8

Childhood Maltreatment

C. Wekerle, A. L. Miller, D. A. Wolfe, C. H. Spindler

Volume 4

2006, x + 88 pp., ISBN 978-0-88937-314-3

Bipolar Disorder

R. P. Reiser, L. W. Thompson

Volume 1

2005, viii + 112 pp., ISBN 978-0-88937-310-5

HOGREFE



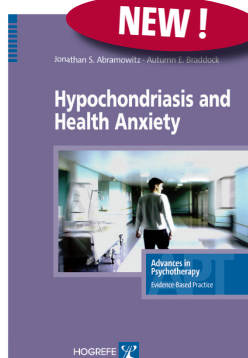
New releases in 2011:

Hypochondriasis and Health Anxiety

by J. S. Abramowitz, A. E. Braddock

Volume 19, 2011, x + 94 pages
ISBN 978-0-88937-325-9

An essential resource for anyone providing services for individuals with somatoform or anxiety disorders



"I highly recommend this book and will use it in training therapists in dealing with this often intransigent problem."

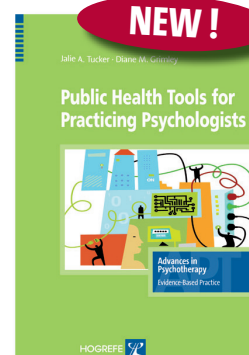
Robert L. Leahy, PhD, Director, American Institute for Cognitive Therapy, New York, NY, Associate Editor, International Journal of Cognitive Therapy, Clinical Professor of Psychology, Department of Psychiatry, Weill-Cornell University Medical College, New York Presbyterian Hospital, New York, NY

Public Health Tools for Practicing Psychologists

by J. A. Tucker, D. M. Grimley

Volume 20, 2011, xii + 84 pages
ISBN 978-0-88937-330-3

Essential public health techniques to make psychological and behavioral health practices more effective.



"This outstanding book lays out the 'how's and why's' in a highly readable fashion. It provides an exciting roadmap for a rewarding career as we face the challenges of the 21st century."

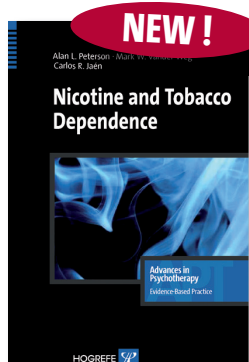
Suzanne Bennett Johnson, PhD, Distinguished Research Professor, Department of Medical Humanities and Social Sciences, Florida State University College of Medicine, Tallahassee, FL

Nicotine and Tobacco Dependence

by A. L. Peterson, M. W. Vander Weg, C. R. Jaén

Volume 21, 2011, x + 94 pages
ISBN 978-0-88937-324-2

How to stop patients and clients smoking – guidance on treatments that work, from leading US authorities.



"A handy compendium of everything a clinician needs to know to assess the degree of tobacco dependence and to decide on the appropriate treatment. Every practice should have this book."

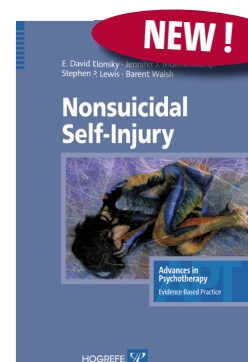
Steven A. Schroeder, MD, Distinguished Professor of Health and Health Care, Department of Medicine, Director, Smoking Cessation Leadership Center, University of California, San Francisco, CA

Nonsuicidal Self-Injury

by E. D. Klonsky, J. J. Muehlenkamp, S. P. Lewis, B. Walsh

Volume 22, 2011, vi + 98 pages
ISBN 978-0-88937-337-2

Practical and expert guidance on how to identify and treat nonsuicidal self-injury – an often misunderstood, but increasingly frequent phenomenon.



"This volume is an extremely valuable resource that summarizes and translates the current science on NSSI to practice. Anyone interested in understanding what psychologists have learned about NSSI, and how to use this knowledge to help reduce self-injury, will want a copy of this excellent book."

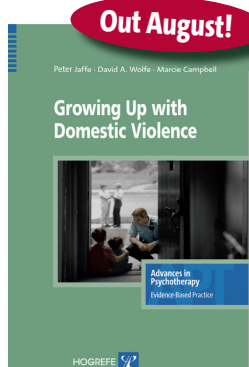
Mitch Prinstein, PhD, Professor and Director of Clinical Psychology, University of North Carolina at Chapel Hill, NC

Growing Up with Domestic Violence

by P. G. Jaffe, D. A. Wolfe, M. Campbell

Volume 23, 2011, viii + 88 pages
ISBN 978-0-88937-336-5

Intimate partner violence (IPV) can have a profound impact on the children – this book shows to recognize these effects and provide effective clinical interventions and preventive measures.



"The authors have created a concise, accessible, and up-to-date guide to research on children exposed to domestic violence and the emerging practices aimed at helping them. A valuable quick read for every practitioner working with children and their families."

Jeffrey L. Edleson, PhD, Director, Minnesota Center Against Violence and Abuse; Professor, School of Social Work, University of Minnesota, Saint Paul, MN

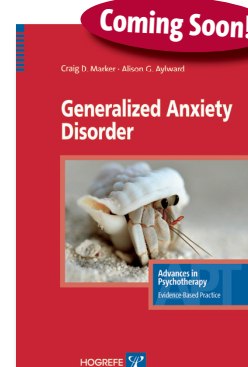
Generalized Anxiety Disorder

by C. D. Marker, A. Aylward

Volume 24, 2011, ca. 90 pages
ISBN 978-0-88937-335-8

A practical book outlining a new, evidence-based treatment protocol for this debilitating and difficult to treat disorder

Generalized anxiety disorder (GAD) is a debilitating disorder that has often proved difficult to treat. Advances in conceptualization, diagnosis, and treatment now allow an empirically supported approach to its diagnosis and treatment. This clear and concise book presents an integrative, up-to-date treatment protocol for GAD. It guides readers through assessment and differential diagnosis, etiological models such as cognitive avoidance, positive beliefs about worry, and intolerance of uncertainty, and treatment techniques. This practical volume is rounded off by case vignettes, handouts, questionnaires, and other useful tools.



HOGREFE



The volumes may be purchased individually or by Series Standing Order (minimum of 4 successive volumes).

The advantages of ordering by Series Standing Order: You will receive each volume automatically as soon as it is released, and only pay the special Series Standing Order price of US \$24.80 – saving US \$5.00 compared to the single-volume price of US \$29.80.

Special prices for members of APA Division 12: APA D12 members can purchase a single volume at US \$24.80, and only pay US \$19.80 per volume by Series Standing Order – saving US \$10 per book!

Order Form (please check a box)

- ☐ I would like to place a Standing Order for the series at the special price of US \$24.80 per volume, starting with volume no.
After a minimum of 4 successive volumes, the Series Standing Order can be cancelled at any time. If you wish to pay by credit card, we will hold the details on file but your card will only be charged when a new volume actually ships.
- ☐ I am an APA Division 12 Member and would like to place a Standing Order for the series at the special D12 Member Price of US \$19.80 per volume, starting with volume no. My APA membership no. is:
- ☐ I would like to order the following single volumes at the regular price of US \$29.80 per volume.
- ☐ I am an APA Division 12 Member and would like to order the following single volumes at the special D12 Member Price of US \$24.80 per volume. My APA membership no. is:

Current Volumes:	Qty.	Price	Total
<input type="checkbox"/> Bipolar Disorder, <i>Reiser, Thompson</i> , ISBN 978-0-88937-310-5 (Vol. 1, 2005)			
<input type="checkbox"/> Heart Disease, <i>Skala et al.</i> , ISBN 978-0-88937-313-6 (Vol. 2, 2005)			
<input type="checkbox"/> Obsessive-Compulsive Disorder, <i>Abramowitz</i> , ISBN 978-0-88937-316-7 (Vol. 3, 2006)			
<input type="checkbox"/> Childhood Maltreatment, <i>Wekerle et al.</i> , ISBN 978-0-88937-314-3 (Vol. 4, 2006)			
<input type="checkbox"/> Schizophrenia, <i>Silverstein et al.</i> , ISBN 978-0-88937-315-0 (Vol. 5, 2006)			
<input type="checkbox"/> Treating Victims of Mass Disaster and Terrorism, <i>Housley, Beutler</i> , ISBN 978-0-88937-321-1 (Vol. 6, 2006)			
<input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder in Children & Adults, <i>Rickel, Brown</i> , ISBN 978-0-88937-322-8 (Vol. 7, 2007)			
<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)			
<input type="checkbox"/> Growing Up with Domestic Violence, <i>Jaffe, Wolfe, Campbell</i> , ISBN 978-0-88937-336-5 (Vol. 23, 2011)			
<input type="checkbox"/> Generalized Anxiety Disorder, <i>Marker, Aylward</i> , ISBN 978-0-88937-335-8 (Vol. 24, 2011)			
Subtotal			
MA residents, please add 6.25% sales tax			
Shipping & handling:			
USA: US \$6.00 per volume (multiple copies: US \$ 1.25 for each further copy)			
Canada: US \$8.00 per volume (multiple copies: US \$2.00 for each further copy)			
South America: US \$10.00 per volume (multiple copies: US \$2.00 for each further copy)			
Total			

Order online at
www.hogrefe.com

[] Check enclosed Charge my: [] VISA [] MC [] AmEx

Card # _____ CVV2/CVC2/CID # _____ Exp. date _____

Cardholder's Name _____ Signature _____

Shipping address:

Name _____

Address _____ City, State, ZIP _____

E-mail _____ Phone _____

HOGREFE



Hogrefe Publishing • 30 Amberwood Parkway • Ashland, OH 44805
Tel: (800) 228-3749 • Fax: (419) 281-6883
E-Mail: customerservice@hogrefe.com



Donna Rasin-Waters, PhD—Editor

Transformation of the VA Health Care System: National Implementation of Evidence-Based Psychotherapies

Bradley E. Karlin, PhD

National Mental Health Director,
Psychotherapy and Psychogeriatrics
Office of Mental Health Services,
VA Central Office

As Health Care Reform begins to roll out in the states we anticipate greater focus on the delivery of evidence-based treatments by practitioners in the coming years. As part of a series of articles aimed at understanding what the future of psychology might look like, I invited Dr. Karlin to write about the VA Initiative aimed at training the mental and behavioral health workforce in evidence-based psychotherapy treatments. It behooves us all to be aware of the developments and successes of large health care delivery systems such as the VA, particularly as the successes translate into cost-savings. Adapting such initiatives into other settings might be one role for psychologists as the system of health care transforms over the next decade.



In 2005, the Department of Veterans Affairs began embarking on an effort to transform its mental health care delivery system to an evidence-based, recovery-oriented system of care (Edwards, 2008). As part of this transformation process, guided by the Comprehensive VHA Mental Health Strategic Plan, VA has expanded its mental health care workforce by over 7,500 staff to the current total of over 21,500 staff. A major focus of this transformation and expansion process has been the dissemination and implementation of evidence-based psychotherapies (EBPs).

Research has consistently shown that mental health providers deliver evidence-based psychological treatments at very low rates, despite their established level of efficacy and recommendation in numerous clinical practice guidelines (Goisman, Warshaw, & Keller, 1999; Rosen et al., 2004). VA sees a significant opportunity to achieve the potential of EBPs and bridge the

science-to-practice gap so that Veterans can have ready access to and receive highly effective treatments for PTSD and other mental health conditions.

In an effort to bring EBPs from the laboratory to the therapy room, VA has developed and implemented several EBP dissemination and implementation initiatives, including national initiatives to disseminate and implement Cognitive Processing Therapy or Prolonged Exposure for PTSD, Cognitive Behavioral Therapy or Acceptance and Commitment Therapy for Depression, and Social Skills Training and Family Psychoeducation for Serious Mental Illness (SMI) throughout the Veterans Health Administration. VA has developed national competency-based, staff-training programs in each of these therapies and has developed adapted protocols and manuals (e.g., Resick, Monson, & Chard, 2007; Wenzel, Brown, & Karlin, 2011), videos, web-based resources, and other materials to support these training efforts. Significantly, the training model for these initiatives involves two key components designed to build skill mastery and promote successful implementation and sustainability: (1) attendance at an in-person, experientially-based workshop, and (2) intensive ongoing, telephone-based clinical consultation on actual therapy cases with a training program consultant who is an expert in the psychotherapy, lasting approximately 6 months. As of June 1, 2004, VA has provided evidence-based psychotherapy training to over 4,300 VA staff. In addition to the centralized training, VHA is developing decentralized training capacity to further expand dissemination and promote sustainability in the field over time.

In addition to training, VHA has developed a number of other mechanisms to promote adoption, implementation, and sustainability of EBPs. VA has developed national policy requiring that all Veterans with PTSD, depression, or SMI have full access to specific EBPs for these conditions and that medical facilities have full capacity to provide these treatments as designed and shown to be effective. In addition, VHA has appointed a Local Evidence-Based Psychotherapy Coordinator at each of its 150+ VA medical centers to serve as a champion for evidence-based psychotherapies at the local level and provide longer-term consultation and clinical infrastructure support, including support for the establishment of clinics with 60-, 90-, or 120-minute weekly sessions.




VA has developed a national evidence-based psychotherapy staff and public awareness campaign. As part of this campaign, the Office of Mental Health Services has developed evidence-based psychotherapy brochures, fact sheets, and posters designed to provide education on and promote awareness of evidence-based psychotherapies among staff and Veterans at VA facilities and community agencies. This is designed to promote requests for evidence-based psychotherapy and asking of questions of patients to their providers (e.g., primary care providers) and other staff that ultimately will promote engagement in treatment. Further, facility Local EBP Coordinators share success stories of Veterans who have successfully participated in EBPs to promote interest and engagement among other Veterans. Additionally, VA has also developed Veteran testimonials about their experiences with EBPs, and many therapists have incorporated these into treatment with patients.

Initial results of national program evaluation efforts implemented into VA's EBP dissemination initiatives indicate significant positive effects on patient and therapist outcomes as a result of EBP training and implementation (Karlin et al., 2010). Significantly, these are outcomes from real-world clinical settings with no exclusion criteria, often involving very complex cases with therapists still in the process of receiving training. Furthermore, program evaluation results have clearly shown that the significant focus on consultation in VA's EBP training model has been essential to establishing clinical competency in EBPs and the ability to deliver these treatments with high fidelity.

VA is committed to sustaining and expanding its evidence-based psychotherapy training and dissemination efforts. As part of expansion efforts planned over the next year and beyond, VA recently developed and launched national competency-based staff training programs in Cognitive Behavioral Therapy for Insomnia, Motivational Interviewing, and Contingency Management for substance use conditions, with addi-

tional training programs under development. It is hoped that VA's efforts to bring evidence-based psychotherapies from the research laboratory to clinical settings nationwide can serve as a model for other health care systems and may help inform debates and ensuing plans for improving health care access, availability, and outcomes in the broader health care environment in this nation.

References

- Goisman, R. M., Warshaw, M., G., & Keller, M. B. (1999). Psychosocial treatment prescriptions for Generalized Anxiety Disorder, Panic Disorder, and Social Phobia, 1991–1996. *American Journal of Psychiatry*, 156, 1819–1821.
- Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., Resick, P. A., & Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, 23, 663–73.
- Resick, P. A., Monson, C.M., & Chard, K.M. (2007). *Cognitive processing therapy: Veteran/military version*. Washington, DC: Department of Veterans Affairs.
- Rosen, C. S., Chow, H. C., Finney, J. F, Greenbaum, M. A., Moos, R. H., Sheikh, J. I., et al. (2004). VA practice patterns and practice guidelines for treating Posttraumatic Stress Disorder. *Journal of Traumatic Stress*, 17, 213–222.
- Wenzel, A., Brown, G. K., & Karlin, B. E. (2011). *Cognitive behavioral therapy for depression in Veterans and Military Servicemembers: Therapist manual*. Washington, DC: U. S. Department of Veterans Affairs. 



The Clinical Psychologist

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

Tips on Navigating the APA Convention

Brian Hall, MA



Attending the annual APA Convention is an excellent way to increase your knowledge about a particular area of interest, expand your professional and social network, and learn new skills that will have lasting benefits long after you have completed graduate school. Each year thousands of graduate students and psychologists attend the annual APA Convention and the Washington D.C. Convention will offer graduate students a wonderful professional development opportunity. But how can you get the most of your experience? Here a few tips.

Get Connected

Network. Professional networking is one of the most important activities one can do at conferences. Many psychologists will be happy to speak with you about your interests, so don't be reticent to introduce yourself. Social hours, coffee breaks, and just waiting for a talk to begin are just a few examples of the many opportunities available to meet people at the Convention. Although you might be tempted to hurry from place to place to gain scholarly information, be sure to focus some of your energy on making professional contacts. If you like to run, check this out instead: <http://www.apa.org/convention/activities/rays-race/index.aspx>

Elevator speech. What would you say to a stranger you are just meeting that summarizes your salient professional characteristics? If you were to meet someone on an elevator, what information could you share by the time you part company? Be prepared with a 1 – 2 minute introduction of yourself. Include the basics: Name, program, year, mentor, and your primary areas of research or clinical interests. Sum up your interests quickly, and focus on the main points to maintain your listener's interest. Engage your audience with an interesting anecdote about yourself to make a lasting impression. Have a question or two in mind for them, too. Make sure to provide others with a chance to share their elevator speech with you.

Business cards. Consider carrying a business card with

you. When making a professional connection, providing a card is a nice way to quickly pass along your contact information. Keep your cards simple and professional. If your school does not provide them, you can easily print your own with perforated cardstock available in most office supply stores. When you receive cards from others, take a moment to write a reminder to yourself about that person, or they may get lost in the shuffle.

Be purposeful. Meeting famous or influential psychologists certainly has appeal, but try to network with a purpose beyond a photo opportunity. Gain access to myriad opportunities for mentorship by becoming involved in leadership or other service roles within the many Division 12 committees. If you meet Danny Wedding, Division 12 President, Kathryn Humphreys, President of Section 10, or other members of the Division 12 leadership, ask them how you can get involved.

Volunteer. Each year, the APA Continuing Education Office recruits students to volunteer one full day to help monitor CE sessions in exchange for free Convention registration. Volunteer opportunities may already be closed for this year, and if so, be sure to contact Marcia Segura in the Continuing Education Office for next year: msegura@apa.org. There may be other opportunities available as well, so be sure to check the APA Convention website <http://www.apa.org/convention/index.aspx> or with the Division 12 Conference Chair.

Attend student oriented events/programs. In addition to attending substantive talks that appeal to your research and clinical interests, seek out programming on professional development topics (e.g., getting a post-doc). These programs feature speakers who are eager to help you grow as a professional. Division 12 is sponsoring several programs that will appeal to students this year (see *Section 10 update, this issue*). The American Psychological Association of Graduate Students (APAGS) has over 30 hours of Convention programming and suite programming tailored to graduate student interests. They also have many social hours for students and volunteer opportunities may still be available.

Follow these links for information regarding APAGS activities:

<http://www.apa.org/apags/programs/convention/index.aspx>



<http://www.apa.org/convention/membership/students.aspx>

Attend Convention Programming

Program booklet. It's huge like a phonebook, but you can navigate it. To narrow the field and to focus on topics that will surely be of interest, some do a targeted search by only looking for Division 12 programs, or programs we co-sponsor with other divisions. You can cast a broader net by thinking of certain topics or people you would like to meet, and use the subject and name index to initiate your search. Of course, you can also just read through the entire Convention program, and highlight programs of interest to you. If you transfer the title, location, and time of the talk to a notepad or calendar, then you can plan your tentative Convention schedule and easily refer to it during the Convention. By checking the APA Convention website, you can scan the list of programs and build your own itinerary electronically. Most of the time, there are several talks co-occurring at once that you would like to see. Put them all in your planner and decide when you get there. Leave the phonebook in your hotel room.

Types of programs. There are many different types of programs available to attend. The most common are symposia, panels, conversation hours, and poster sessions. Attending talks are a great way to gain a broad understanding of a topic of interest. Poster sessions allow for a more in-depth discussion with a researcher. Poster sessions are typically where people cut their teeth presenting at professional conferences. If you have yet to present, check these out to learn what you can expect for your future presentations.

Keep Costs Down

Register before you arrive. It costs about 10 dollars more to register onsite, and the lines are very long to do so.

Take public transportation. Map how to get to your hotel from the airport and take public transportation. Depending on the city and time of arrival, public transport can actually be faster than taking a cab, and it will certainly cost less money. If you want to take a cab, ask someone in the cab line to share it with you.


Stay nearby. Although APA secures competitive rates at the Convention hotels, they may remain expensive options. One can save a lot of money by staying in nearby hotels within walking distance or a short cab/bus ride.

The commute to the Convention can offer a nice way to become familiarized with the host city. Other options such as youth hostels and university dorms, timeshares or weekend apartment rentals, might be viable, and worth checking into. If you plan to attend solo, consider posting to student and division listservs to locate others who would share the room expenses.

Find free food. Most divisions will have social hours and many will provide food to attendees. Given the cost, the food is typically limited, so plan to arrive early.

Stock up on supplies. Need a pen? A notebook? Free demo versions of software? Free text books? Check out the exhibit hall, typically located in the main Convention center.

Most importantly, be sure to have fun!

There are so many exciting things happening at the Convention that there is no way to do them all. Make sure to plan some non-Convention activities like site-seeing and checking out the local cultural events and night-life. Be sure to schedule some down-time for relaxation and try not to overload yourself with Convention programming. Keep a flexible attitude; just because you have a schedule doesn't mean you have to follow it rigidly. Give yourself permission to go with the flow. The more relaxed you are during the Convention, the more you will get out of your experience. 

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

The National Institutes of Health Toolbox for the Assessment of Neurological and Behavioral Function

Richard C. Gershon, PhD, Department of Medical Social Sciences, Feinberg School of Medicine, Northwestern University

Section Editor's Introduction: This issue's Technology Update column summarizes exciting work that has been completed over the past several years by Dr. Gershon's team. As he outlines in his column, the NIH Toolbox has assembled and developed a battery of tests to facilitate assessment of cognitive function, emotional health, motor function, and sensory function of individuals aged 3-85. Originally designed to facilitate comparisons across clinical research studies, the NIH Toolbox assessments have a number of attractive properties related to cost, brevity, and psychometrics that would make them potentially useful adjuncts for direct service providers, as well. - ZB



The National Institutes of Health (NIH) Toolbox for the Assessment of Neurological and Behavioral Function (NIH Toolbox) was designed as a cutting edge, highly automated, standalone measurement tool to provide quick and well-validated assessments of subjects 3-85. Available in both English and Spanish, the tests were originally created for use in longitudinal and/or epidemiologic studies. Created as part of the NIH Blueprint for Neuroscience Research (NIH Blueprint) initiative, the NIH Toolbox also has broad based applicability in various clinical and education settings.

The NIH Blueprint is comprised of the 16 NIH Institutes, Centers and Offices, that conduct and support neuroscience research. The Blueprint leadership sought to identify projects that would have maximum cross-institute benefit. An initial study conducted by the trans-NIH Cognitive and Emotional Health Project (CEHP) Critical Evaluation Study Committee initially identified the need to include measures of cognition and emotional health in all neurological research studies. The additional assessment of Motor

and Sensory functioning were later added to the priority list.

The theoretical foundation of the NIH Toolbox is based upon a broader view of the patient's health – the notion that focus upon optimal functioning and overall health, rather than single disease outcomes, will potentially lead to the discovery of different risk factors and thereby different prevention strategies. The desire to assess these added domains, in addition to primary outcome measures, was of interest and applicability not only to those studying neurological and behavioral function, but also to studies sponsored by scientists in other areas such as cardiovascular research. Focusing on every day functioning and monitoring health rather than identifying illness, loss of ability and disability was so contrary to that which had been tested to date that there were few if any valid and reliable tools which were judged sufficient for the task. Existing tools that assess cohort, longitudinal, and epidemiological neural function, for example, are not uniform and thus cannot be used to effectively compare data across studies. This inability to conduct combined analyses limits the information critical for design strategies to prevent disease and maintain overall health. The NIH Toolbox is designed to provide standard measures of functions to enable comparisons across studies and to make it easier to provide a broader (multi-domain) perspective patient health. The instruments were designed to utilize cutting edge testing methods, including computerized administration and computer adaptive testing (when applicable), be brief, reasonable in cost, and provide strong reliability over time.

To maximize usability, NIH Toolbox design first focused on assessment needs as viewed by potential end users, through the solicitation of expert input regarding specific areas (sub domains) of function to target. In addition, researchers nominated 1,391 existing instruments for potential inclusion. Additional expert insight was gained through two internet-based interviews with NIH funded researchers (N=150 and 143), followed by secondary phone interviews with a subset of the initial pool (N=44). Experts suggested that to be effective the NIH Toolbox needed to be able to be easily administered within 2 hours (30 minutes for individual domain batteries), be simple to score and interpret, comprehensible to subjects with low litera-


cy, accurate across the spectrum of normal function, applicable across diverse populations, and provided at minimal cost. For each targeted domain a thorough literature review was also compiled. In total 47 assessments covering the following four domain areas were developed: Cognitive Function (Executive Function, Episodic Memory, Working Memory, Processing Speed, Vocabulary and Reading); Emotional Health (Negative and Positive Affect, Social Relationships, Stress and Self-Efficacy); Motor Function (Locomotion, Strength, Non-Vestibular Balance, Endurance and Dexterity); and Sensory Function (Vision, Audition, Vestibular Balance, Somatosensation, Taste and Olfaction).

In almost all cases, new instrument development was required due to the general Toolbox guideline that all tests be applicable across the age and ability spectrum, be free of royalties, and be brief. Most individual Toolbox measures can be administered in less than 5 minutes while at the same time maintaining reliability often exceeding longer existing instruments. For some of the motor function and sensory health assessments, custom hardware and materials were created reducing instruments costs by tens of thousands of dollars and materials costs to only a couple of dollars (preexisting taste and olfaction tests typically cost \$15 or more per subject).

Final candidate measures were extensively field-tested and validated against existing “gold standard” assessments across the 3-85 age range, using sample sizes ranging from N=100-7,500 per assessment. A stratified sampling of the U.S. general population will take place this summer and fall at 10 diverse locations to collect normative data in both English and Spanish speaking populations. It is our goal to produce single

year age-based norms for ages 3-17 years, and multi-year age bands through age 85. The breath of NIH Toolbox validation grows exponentially as we collaborate with an ever-increasing number of researchers who wish to validate and in turn apply the NIH Toolbox measures to targeted disease groups. We have also received numerous requests to utilize the full NIH Toolbox or some of its component assessments in clinical practice.

The NIH Toolbox can measure longitudinal data over time and has the flexibility to adapt to ever evolving advances in science and technology. Though developed for use in the United States, the entire battery, of instruments, norms and scoring algorithms can be adapted globally for further translation and normative activities and will be offered to the international research community royalty free. In total, over 254 scientists across 96 academic institutions and the NIH joined forces with testing experts from around the world to build the NIH Toolbox. This unique team of experts has an unparalleled commitment to the structure, continual evolution and maximum use of the tool and looks forward to sharing our validation data and final instruments in late 2012. For further information, please visit our website at <http://www.nihtoolbox.org>.

If you have any questions or comments regarding this article, you can reach Dr. Gershon by e-mail at gershon@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). 

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 www.div12sec10.org/mentorship.htm, and visit www.div12.org/mentorship to become a mentor today!

Section II: Society of Clinical Geropsychology

Brian D. Carpenter, PhD



At the upcoming APA convention, members of the Society of Clinical Geropsychology will be well represented among the many aging-related offerings, including sessions on new diagnostic categories for dementia, prevention of Alzheimer's disease, structure and process in aging families, successful models of integrated care, and a mentoring session on how to build a research career in geropsychology. A full list of gerorelated sessions can be found in the Attachments area of the Section 2 website, www.geropsychology.org.

In other educational initiatives, Committee on Aging (CONA) and Section 2 Members Sara Honn Qualls and Patricia Arean have helped to create a series of videotaped interviews in which they discuss the mental and behavioral health needs of older adults. They outline the critical role psychologists play in treating depression, enhancing medication compliance, and promoting well-being in family caregivers. The videos are part of a campaign sponsored by the Eldercare Workforce Alliance, a coalition of 28 organizations advocating for more federal support to train healthcare providers to address the needs of older adults.

Section 2 members Sara Honn Qualls, Martha Crowther, and Bill Haley contributed to the newly released Family Caregiver Briefcase for Psychologists. Accessible on the APA website, the 160-page Briefcase contains resources that psychologists can use to assist family caregivers through individual and organizational practice, research, teaching, advocacy and community service. The resources are extensive, contemporary, and practical and available at no charge.

Embracing the Internet age once again, APA is encouraging psychologists to add and update psychology-related entries in Wikipedia, the popular, on-line collaborative encyclopedia. Student representatives from the Society of Clinical Geropsychology and sister organizations will be working together to draft a Geropsychology entry. Speaking of students, the cover story of the March issue of *gradPsych* addressed future job prospects for psychologists and highlighted geropsychology, in addition to neuropsychology and industrial/organizational psychology. With the population aging, this is an excellent time for everyone to ramp up their expertise related

to older adults.

On the policy front, in March, key allies in the Senate and House introduced legislation to include psychologists in the Medicare "physician" definition, the first step toward ensuring that psychologists are able to provide Medicare mental health services free of physician supervision requirements. Currently, psychologists are the only doctoral-level providers not included in that definition (in contrast to dentists, podiatrists, optometrists). There is a long way to go to make this a reality, but introducing the legislation was an important first step.

In another initiative, the Institute of Medicine secured congressional support to begin a study on The Mental Health Workforce for Geriatric Populations, the goal of which is to "determine the mental and behavioral health care needs of Americans who are over 65 years of age and make policy recommendations for meeting those needs through a competent and well-trained mental health workforce." Deborah DiGilio from the APA Office on Aging is spearheading efforts to ensure that the important contributions of geropsychologists are recognized in the study.

Finally, as reported previously, Professional Geropsychology gained specialty status in 2010, and a collection of related organizations (i.e., Section 2, the Council of Professional Geropsychology Training Programs (CoPGTP), Division 20 (Adult Development and Aging), and Psychologists in Long Term Care (PLTC)) is exploring the possibility of establishing an ABPP credential for Professional Geropsychology. A recent survey conducted by Victor Molinari, Dan Segal, and Rick Zweig, with assistance from Michele Karel, concluded that there is sufficient interest to pursue next steps in establishing this credential. Stay tuned for further developments.

As always, more news and resources are available on the Society of Clinical Geropsychology's website, www.geropsychology.org.

Section III: Society for a Science of Clinical Psychology

David F. Tolin, PhD, 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.

The SSCP web site (<http://sites.google.com/site/sscpwebsite/>) has been substantially updated, thanks to the efforts of webmaster Frank Farach.

SSCP heartily congratulates Richard Bootzin, who received the SSCP Distinguished Scientist Award at the Annual Meeting of Members on May 27, 2011. SSCP also congratulates member and Past-President David Barlow for receiving the 2012 James McKeen Cattell Award from the Association for Psychological Science (APS). Dr. Barlow was nominated for this award by the SSCP External Nominations Committee. SSCP has also nominated Chris Beevers and David Sparra for the APA Distinguished Scientific Award for Early Career Contribution to Psychology.


Student representatives Sara Stasik and Rebecca Brock have used the results of their recent student survey to guide several initiatives this month. Because nearly half of the student members were unaware of the SSCP listserv, additional invitations were sent out. Membership materials are also being revised to insure that student members are aware of the SSCP website, listserv, and Facebook page. Because the majority of students did not find the listserv to be very helpful, a new *Student Listserv Facilitator* position has been created; student member Kristy Benoit has accepted the position and will take on the considerable task of upgrading the listserv.

The Committee for Promoting Clinical Science, headed by Representative At Large Bethany Teachman, has received several applications for seed grants for teaching clinical science. Winners will be announced at the next Board meeting.

SSCP invites nominations for four positions for the SSCP Executive Board for 2012: President-Elect, Representative to Division 12, Member-At-Large, and Student Representative. Descriptions of the duties of each position are provided below. All terms of office will begin January 1, 2012. Each candidate will be asked to submit a CV and a brief (150-250 words) statement about their qualifications and their interest in running for a position on the SSCP Board. These statements will be provided to members with the election ballot. Submit nominations, including self-nominations, to bolatunji@gmail.com by August 15, 2011.

Section VI: The Clinical Psychology of Ethnic Minorities

Wei-Chin Hwang, PhD

 Welcome to the Section VI update. We are excited that Section VI will have a wonderful series of programs for the 2011 APA convention. During the conference, Section VI will be announcing the Samuel M. Turner Minority Education, Nurturing, Training, Organizational Advocacy, and Research (MENTOR) award winners, as well as the Dalmás A. Taylor Award winner for Outstanding Student Research. The Awards Ceremony will be held during the Section VI Business Meeting on Friday, August 5, from 12-12:50 in Room 102A at the Conference Center. Honorees will also be recognized at a special breakfast Saturday morning from 8 to 10AM in the Division 12 suite in the Grand Hyatt. Special heritage awards for members who have made distinguished contributions in the past will also be given.

Established in 2003, the Samuel M. Turner MENTOR Award honors a psychology faculty member who has demonstrated a commitment to teaching and training clinical psychologists to work more effectively with minority clinical populations as evidenced by significant accomplishments in at least two of the following areas: Education and Professional Development, Nurturing, Training, Organizational advocacy, and Research. This year, we are delighted to be awarding two Samuel M. Turner Mentor Awards to: Jessica Henderson Daniel in recognition of her lifetime achievement of exemplary contributions in these areas and Melanie M. Domenech Rodriguez for her excellent contributions in all of these areas.

The Dalmás A. Taylor Outstanding Student Research Award recognizes a clinical psychology graduate student who has produced exemplary empirical research on the clinical psychology of ethnic minorities. This year's recipient is Ms. LaTrice Montgomery, for her paper titled "Moderators of the Relation between Motivational Enhancement Therapy between Motivational Enhancement Therapy and Outcomes for African Americans: Substance Use and Retention."

We also want to take a moment to recognize the original executive committee from 1985, who included Jorge Montijo, Stanley Sue, Gail Wyatt, and Toni Bernay and Bernadette Gray-Little, co-chairs. In addition, we want to recognize the first elected officers, Gail E. Wyatt, (President) Lillian Comas-Díaz (President-Elect),

Elsie Golil (Secretary), Russell T. Jones (Representative), Samuel Turner (Membership Chair), and Reiko True (Program Chair). Please refer to our website (<http://www.apa.org/divisions/div12/sections/section6/index.htm>) for updates and locations of presentations by Section VI members.

Section IX: Assessment

Norman Abeles, PhD



I am pleased to report on the new Officers for our Section. Yossef BenPoreth is the new President. Paul Arbisi, PhD is President Elect. Virginia Brabender, PhD is Past President. Our Secretary is Ginger Calloway, PhD and our Treasurer through 2011 is Martin Sellbom, PhD Program chair for this year is our President, Yossi Ben Poreth. Membership chair is Dustin Wygant, PhD and the new editor of our Assessment Journal is R. Michael Bagby, PhD. Through 2010 our student representative was Katherine Anne Gifford.

Our membership chair reports that we currently have 87 full members and 25 student affiliates. We also have 7 international members. 89% of our members are APA members. We are continuing our effort to increase our membership.

Of potential interest to our members is a report noted by Ken Pope's list serve regarding a news release from the Canadian Medical Association. This deals with

the topic of "*Genetic Predisposition*". The news release deals specifically with the topic of genetic predisposition in cases involving health problems by employees in worker's compensation cases. Some attorneys may argue that instead of an occupational injury suffered by an employee, the health problem is more likely the result of genetic predisposition rather than occupational injury. This raises the question as to whether or not the deciders of fact have the expertise to evaluate the arguments concerning genetic predisposition. It appears that in many of the cases citing genetic predisposition there were factors involved for which there are non genetic causes. It may be important for psychologists who provide assessments in such legal cases to be familiar with arguments concerning genetic predisposition. An interesting example was provided by Cooper Dreyfuss and Nelkin in 1992 (p.328). The case involved two attorneys both of whom were likely to be disbarred because they had misappropriated their clients' monies. Both appeared before the California Supreme Court. The attorneys did not contest the charges against them. Both attorneys argued that their behavior was the result of having abused alcohol in the hope of mitigating their sentence. One of the attorneys also stated that he had a genetic predisposition to alcoholism. That attorney was permitted to continue his practice but placed on probation. The other attorney was disbarred. Again, all this suggests that assessment psychologists need to be aware that genetic predisposition is perceived by many to be a mitigating factor. ■■

ANNOUNCEMENT

NEW OFFICERS FOR DIVISION 12

The Society of Clinical Psychology has two newly elected officers whose terms will begin January 1, 2012.

Mark B. Sobell, Ph.D., of Nova Southeastern University, has been elected the President-elect Designate. He will begin as President-elect in 2012 and continue for a three-year term including his presidential year and his past presidential year.

Robin B. Jarrett, Ph.D., of the University of Texas Southwestern Medical Center at Dallas, has been elected Treasurer of the Society. She, too, begins a three-year term in 2012.

The Society welcomes them both and thanks all those who participated in the 2011 election process.



DIVISION 12 PROGRAM SUMMARY, 2011

APA Annual Convention 2011: Division 12 Program Summary

Thursday, August 4, 2011

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Symposium (S): Acceptance Commitment Therapy in Veterans Affairs---An Innovative Approach to an Old Problem	8/04 Thu: 8:00 AM - 8:50 AM	Convention Center Room 149A
Symposium (S): Culturally Relevant Discussions of Disordered Eating	8/04 Thu: 8:00 AM - 9:50 AM	Convention Center Room 204A
Business Meeting (N): [Business Meeting]	8/04 Thu: 10:00 AM - 10:50 AM	Renaissance Washington Hotel Meeting Room 15
Poster Session (F): Empirically Supported Clinical Assessments and Interventions--I	8/04 Thu: 10:00 AM - 10:50 AM	Convention Center Halls D and E
Symposium (S): Charting the Development of Personality Pathology Using Genes, Environment, and Basic Personality / Temperament As Our Guides	8/04 Thu: 10:00 AM - 11:50 AM	Convention Center Room 149A
Skill-Building Session (S): The Developing Supervisor---Unique Challenges for Early Career Psychologists in the Supervisory Role	8/04 Thu: 10:00 AM - 11:50 AM	Convention Center Room 154B
Symposium (S): Child Mental Health Problems---Toward a Developmentally Modified Psychiatric Nosology	8/04 Thu: 12:00 PM - 12:50 PM	Convention Center Room 144B
Symposium (S): Mentoring in Clinical Geropsychology	8/04 Thu: 12:00 PM - 12:50 PM	Convention Center Room 148
Business Meeting (N): [Business Meeting]	8/04 Thu: 1:00 PM - 1:50 PM	Renaissance Washington Hotel Meeting Room 15
Invited Address (S): Powell Lawton Award	8/04 Thu: 1:00 PM - 1:50 PM	Convention Center Room 143A
Skill-Building Session (S): Domestic Violence Focused Couples Treatment	8/04 Thu: 1:00 PM - 1:50 PM	Convention Center Room 149A
Conversation Hour (S): Treating People With Serious Mental Illness---Development of New Curriculum and Training Models for Clinical Psychologists	8/04 Thu: 1:00 PM - 1:50 PM	Convention Center Room 209A

Division 12 program summary, 2011 (continued)

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Poster Session (F): Empirically Supported Assessments and Interventions--II	8/04 Thu: 2:00 PM - 2:50 PM	Convention Center Halls D and E
Symposium (S): Realities of Practicum Training---A Survey of Practicum Site Coordinators	8/04 Thu: 2:00 PM - 3:50 PM	Convention Center Room 154A
Symposium (S): Understanding Risk for Suicidal Thoughts and Behaviors Among Ethnic--Racial Minority College Students	8/04 Thu: 2:00 PM - 3:50 PM	Convention Center Room 154B
Symposium (S): National Dissemination and Implementation of Empirically Supported Interventions in the Veterans Affairs Health Care System	8/04 Thu: 3:00 PM - 3:50 PM	Convention Center Room 147A
Conversation Hour (S): Integrated Practice---The Future of Psychology in a Transformed Health Care Delivery System	8/04 Thu: 3:00 PM - 3:50 PM	Convention Center Room 208

Friday, August 5, 2011

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Paper Session (S): The Intersect Between Cultural Issues and Clinical Psychology	8/05 Fri: 8:00 AM - 8:50 AM	Convention Center Room 209A
Symposium (S): Obtaining Postdoctoral Fellowships in Clinical Psychology	8/05 Fri: 8:00 AM - 9:50 AM	Convention Center Room 103B
Symposium (S): How Well Do Existing Measures Assess the Proposed DSM-5 Criteria for Personality Disorders?	8/05 Fri: 8:00 AM - 9:50 AM	Convention Center Room 143A
Symposium (S): Adapting Evidence-Based Practices---Balancing Fit and Fidelity	8/05 Fri: 9:00 AM - 9:50 AM	Convention Center Room 149B
Symposium (S): Answering the Call--- Education, Training, Implementation, and Supervision of Evidence-Based Practice	8/05 Fri: 9:00 AM - 9:50 AM	Convention Center Room 208
Symposium (S): Assessment, Conceptualization, and Classification of Video Game Use---A Balanced Perspective	8/05 Fri: 9:00 AM - 10:50 AM	Convention Center Room 207A
Symposium (S): Addressing Health Disparities Through Clinical Interventions in Substance Abuse and Mental Health	8/05 Fri: 10:00 AM - 10:50 AM	Convention Center Room 154B



Division 12 program summary, 2011 *(continued)*

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Symposium (S): Bridging Science and Practice Through Telehealth-Based Approaches in Mental Health---The Rosalynn Carter Institute for Caregiving Initiative	8/05 Fri: 10:00 AM - 11:50 AM	Convention Center Room 144C
Business Meeting (S): [Business Meeting]	8/05 Fri: 11:00 AM - 11:50 AM	Renaissance Washington Hotel Meeting Room 2
Symposium (S): Academic Career Paths in Clinical Psychology	8/05 Fri: 11:00 AM - 11:50 AM	Convention Center Room 159
Invited Address (S): Tribute to Albert Ellis by Debbie Joffe-Ellis	8/05 Fri: 11:00 AM - 11:50 AM	Convention Center Room 206
Business Meeting (N): [Business Meeting]	8/05 Fri: 12:00 PM - 12:50 PM	Convention Center Room 102A
Poster Session (F): Cultural Diversity Issues and Emerging Opportunities in Clinical Psychology	8/05 Fri: 2:00 PM - 2:50 PM	Convention Center Halls D and E
Presidential Address (S): [Danny Wedding]	8/05 Fri: 4:00 PM - 4:50 PM	Convention Center Room 103B
Symposium (S): Culturally Based Prevention and Systems of Care Considerations for American Indian Youths and Families	8/05 Fri: 4:00 PM - 4:50 PM	Convention Center Room 143A
Symposium (S): Understanding Insurance Regulations in an Age of Accountability---Correct CPT Coding, Audit Triggers, and Strategies for Compliance	8/05 Fri: 4:00 PM - 5:50 PM	Convention Center Room 154A
Symposium (S): Current Developments and Future Directions With Clinical Assessment Instruments	8/05 Fri: 4:00 PM - 5:50 PM	Convention Center Room 202B
Conversation Hour (N): {r} and Award Ceremony{/r}	8/05 Fri: 5:00 PM - 5:50 PM	Renaissance Washington Hotel Congressional Hall A
Social Hour (N): [Social Hour]	8/05 Fri: 6:00 PM - 6:50 PM	Renaissance Washington Hotel Congressional Hall A

Division 12 program summary, 2011 (*continued*)

Saturday, August 6, 2011

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Conversation Hour (N): Conversations and Croissants---Breakfast With Distinguished Division 12 Psychologists	8/06 Sat: 8:00 AM - 8:50 AM	Renaissance Washington Hotel Meeting Rooms 10 and 11
Symposium (S): Dying to Belong--- Interpersonal Predictors of Suicide	8/06 Sat: 8:00 AM - 8:50 AM	Convention Center Room 159
Symposium (S): Training for Integrated Primary Care---Maturing the Partnership Between Psychology and Graduate Medical Education	8/06 Sat: 8:00 AM - 9:50 AM	Convention Center Room 209B
Invited Address (S): [Bagby]	8/06 Sat: 9:00 AM - 9:50 AM	Convention Center Room 101
Paper Session (S): Novel Ways to Evaluate Long-Existing Issues in Clinical Psychology	8/06 Sat: 9:00 AM - 9:50 AM	Convention Center Room 102B
Business Meeting (N): [Business Meeting]	8/06 Sat: 10:00 AM - 10:50 AM	Renaissance Washington Hotel Meeting Room 2
Paper Session (S): Insights Into Suicide	8/06 Sat: 10:00 AM - 10:50 AM	Convention Center Room 208
Symposium (S): Do's and Don'ts of Expert Testimony in Sexual Abuse Cases--- Ethical Issues in Seeking Justice for Women and Children	8/06 Sat: 10:00 AM - 10:50 AM	Convention Center Room 209B
Invited Address (S): [Martin Seligman]	8/06 Sat: 11:00 AM - 11:50 AM	Convention Center East Salon C
Invited Address (S): APAHC 2010 Research and Teaching Award	8/06 Sat: 11:00 AM - 11:50 AM	Convention Center Room 144B
Paper Session (S): Supervision and the Needs of Practicing Psychotherapists	8/06 Sat: 11:00 AM - 11:50 AM	Convention Center Room 149A
Symposium (S): Women and the Military---The Experience, Clinical Concerns, and Implications for Treatment	8/06 Sat: 11:00 AM - 12:50 PM	Convention Center Room 208
Symposium (S): Creating and Finding Postdoctoral Training---APPIC As a Matchmaker	8/06 Sat: 12:00 PM - 1:50 PM	Convention Center Room 103A



Division 12 program summary, 2011 (*continued*)

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Symposium (S): Dissemination of Findings From Clinician to Researcher---Clinical Experiences in Treating for Panic Disorder, Generalized Anxiety Disorder, and Social Phobia	8/06 Sat: 12:00 PM - 1:50 PM	Convention Center Room 143A
Invited Address (S): 2010 APAHC Joe Mattarazo Award	8/06 Sat: 1:00 PM - 1:50 PM	Convention Center Room 154A
Presidential Address (S): [Presidential Address-Section VII]	8/06 Sat: 1:00 PM - 1:50 PM	Convention Center Room 155

Sunday, August 7, 2011

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Paper Session (S): Issues Unique to Primary Care and Nursing Home Settings	8/07 Sun: 8:00 AM - 8:50 AM	Convention Center Room 143B
Business Meeting (N): [Business Meeting]	8/07 Sun: 9:00 AM - 9:50 AM	Grand Hyatt Washington Hotel Latrobe Room
Presidential Address (S): [Erin Emery]	8/07 Sun: 9:00 AM - 9:50 AM	Convention Center Room 156
Symposium (S): Reducing Health Disparities via Psychological Science---Evidence From Community-Engaged Investigators	8/07 Sun: 10:00 AM - 10:50 AM	Convention Center Room 156
Symposium (S): Exploring the Link Between Bullying and Suicide	8/07 Sun: 10:00 AM - 11:50 AM	Convention Center Room 140B
Paper Session (S): Cutting Edge, Empirically Supported Interventions	8/07 Sun: 10:00 AM - 11:50 AM	Convention Center Room 144C
Symposium (S): Eating Disorders Treatment---Bridging the Research/Practice Gap	8/07 Sun: 10:00 AM - 11:50 AM	Convention Center Room 209A
Symposium (S): OCD Spectrum Disorders---Cross-Cutting Research Guiding Future Directions	8/07 Sun: 11:00 AM - 12:50 PM	Convention Center East Overlook Room
Executive Committee Meeting (N): [Executive Committee Meeting]	8/07 Sun: 12:00 PM - 1:50 PM	Grand Hyatt Washington Hotel McPherson Square Room

Division 12 program summary, 2011 (*continued*)

EVENT / TITLE / PEOPLE	DAY / TIME	FACILITY / ROOM
Paper Session (S): Issues in Clinical Psychology Affecting Adolescents and College-Aged Individuals	8/07 Sun: 1:00 PM - 1:50 PM	Convention Center Room 144A
Discussion (S): Effectiveness of Narrowband and Broadband Tools for Mental Health Screening---A Comparison of the PHQ-9 and Health Dynamics Inventory	8/07 Sun: 1:00 PM - 1:50 PM	Convention Center Room 154B

AMERICAN PSYCHOLOGICAL ASSOCIATION DIVISION 12: THE SOCIETY OF CLINICAL PSYCHOLOGY

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

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology

MID CAREER AWARD

American Psychological Foundation Theodore Millon Award

EARLY CAREER AWARDS

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

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

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

GRADUATE STUDENT AWARDS

Distinguished Student Research Award in Clinical Psychology

Distinguished Student Practice Award in Clinical Psychology

Distinguished Student Service Award in Clinical Psychology



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.