

THE CLINICAL PSYCHOLOGIST



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

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EDITORIAL

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

PRESIDENT'S COLUMN

Clinical Psychology: Something Rich and Strange¹

I recently have been working with the Division 12 Board of Directors to prepare our petition for clinical psychology recertification as a specialty. This petition will be submitted to the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). I'm deeply grateful to Irv Weiner who wrote the first draft of the petition – Irv writes beautifully, and he appreciates the history of our profession. He is also someone who cares passionately about clinical psychology.

Our petition specifically mentions four model programs that train clinical psychologists: Stony Brook, Utah, Palo Alto University, and the University of Rochester Medical Center. The first two are traditional university based training programs, Palo Alto University is a professional school, and Rochester offers both doctoral level and postdoctoral training (and it is cited as our model for postdoctoral training). Thanks to Marv Goldfried, David Rudd, Larry Beutler and Deb King who graciously agreed to serve as the contact representatives for their respective programs.

Reaccreditation is a serious business, but I'm confident our approval will be a slam dunk for the Society. The APA Division of Clinical Psychology has existed since 1917 (with different names at different times), and we have a proud history as a psychology specialty. Our list of past presidents includes some of the most significant figures in the history of psychology (e.g., Carl Rogers [a three-time President], David Wechsler, George Kelly, and George Albee). Recent well known and highly respected division presidents include David Barlow, Marty Seligman and Marsha Linehan.

Sea-changes

Perhaps the most significant historical change in the field during my 32 year career has been the growing acceptance of the PsyD degree, and the increasing numbers of clinical psychology students trained in PsyD programs. I was trained at the University of Hawaii in the Boulder scientist-practitioner model, and had a deep and unwavering commitment to this model – until 2010 when I was recruited by Morgan Sammons and Russ Newman to serve as the Associate Dean for Management and International Programs for the California School of Professional Psychology (CSPP). Over the past year I have come to know, like and respect CSPP students, and I have a growing appreciation for the myriad contributions they can make to the health care needs of the public. I came late to the party, but I'm here to stay, and I imagine I'll spend the rest

¹ The phrase sea-change comes from Shakespeare's *The Tempest* where he wrote "Full fathom five thy father lies;/ Of his bones are coral made;/ Those are pearls that were his eyes;/ Nothing of him that doth fade/But doth suffer a sea-change/Into something rich and strange."

(continued on page 2)

President's Column (*continued*)

of my career training *practitioners* – professionals who will know, respect and cherish science, but who will identify primarily as *consumers* of research rather than as research scientists.

Another sea change in the profession during my career has been growing appreciation for the relevance of *evidence* to support the work we do, and Division 12 has been at the forefront in promulgating this change. In many ways this dramatic societal change can be directly traced to David Barlow's appointment of Dianne Chambless to head a Division Task Force that published a seminal report on "Training in and Dissemination of Empirically Validated Treatments" in 1993. The Chambless Report,

as it soon came to be known, has had tremendous impact on clinical psychology, and it led to a continued series of division reports and documents including a recent Interdivisional Task Force on Evidence-based Therapy Relationships. The work of this Task Force, comprised of members from Divisions 12 and 29 (Psychotherapy) and chaired by then Division 12 President John Norcross, led to a book (*Psychotherapy Relationships That Work: Evidence-based Responsiveness* [Norcross, 2011]) and a module on the SAMHSA *National Registry of Evidence-based Programs and Practices* [www.nrepp.samhsa.gov/Norcross.aspx].

One excellent way to learn about current research in clinical psychology is to visit the Division's website [www.

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GRAPHIC DESIGN:

Jason Crowtz



div12.org/PsychologicalTreatments/index.html] on evidence supported treatment David Klonsky developed with assistance from some distinguished division members. David, the 2011 recipient of the David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology, lists numerous treatments, evaluates the research support each has received, and provides up to date citations to the relevant science along with information about clinical resources and training opportunities for anyone who wants to learn more about the treatment being described. If you haven't visited David's website, you should – it is an invaluable resource for clinical practitioners and for those of us who educate practitioners.

I'm also proud of the contributions of Division 12 in developing, promoting and supporting the book series *Advances in Psychotherapy: Evidence Based Practice* [www.hogrefe.com/program/advances-in-psychotherapy-evidence-based-practice.html]. I have been privileged to serve as editor for the series since its inception, working with four stalwart Associate Editors: Ken Freedland, Larry Beutler, Linda Sobell and David Wolfe. Twenty-four volumes have been published in the series to date, and two more books are in press (volumes on male and female sexual dysfunction). Royalties from book sales generate a significant revenue stream for the Division; more importantly, these books – written by some of the leading clinical psychologists in the United States and Canada – help busy practitioners keep abreast of new developments in clinical science.

The Globalization of Clinical Psychology

The globalization of the health professions is one of the most exciting changes occurring today. There are now 7 billion people on the planet living in 196 different countries and speaking approximately 6000 languages. (The United Nations predicted that the "Day of 7 Billion" occurred on October 31, 2011.) Approximately 60% of the world's population lives in Asia, and more than a third of these are found in two countries – China and India.

These data underscore the pressing need to ensure that our students are trained to appreciate cultural differences and the ways in which mental illness differs across countries. Anyone interested in the exportation of models of mental illness across borders is encouraged to read Ethan Watters' *Crazy Like Us: The Globalization of the American Psyche*.

Division 12 has members living in 26 different countries, and many of our members lecture or teach courses in other countries. I'm personally responsible for psychology training programs in Tokyo, Hong Kong and Mexico City, and CSPP faculty lecture around the world, but especially in Asia where there is growing interest in clinical psychology as a profession and a science. All of us who work internationally have a responsibility to balance our desire to share the best available Western psychological science with appreciation for cultural differences and the potential failure of our research to generalize to non-Western populations.

2012 Appointment Calendar for Mental Health Professionals

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For nearly 25 years, this 8 1/2 x 11 calendar book has been a "mainstay" among practitioners of all mental health disciplines. It lies flat when open, allowing appointments to be scheduled in 15 minute intervals from 7 a.m. to 8:15 p.m.

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TCP-F11




DSM-5

The new edition of the American Psychiatric Association's Diagnostic and Statistical Manual is scheduled to be released in the spring of 2013, and general information about likely changes can be found at www.dsm5.org. Many professional organizations (e.g., the British Psychological Association and the American Counseling Association) have formally expressed concerns about the proposed changes, and Division 12 will have to decide relatively soon if we want to take an official position on the new manual. Many of our members have been dismayed by the continuing medicalization and stigmatization of normative human experiences like grief or anxiety; likewise, many of us would like to see mental health practitioners in the United States adopt the WHO International Classification of Diseases, the nosology used by almost every other country in the world. It simply doesn't make sense, scientifically or practically, to have two different classification systems for behavioral health disorders. I look forward to the day when we all use the ICD (and the related nosology, the WHO International Classification of Functioning, Disability and Health [ICF]).

Thanks

It has been a genuine pleasure to serve as your President for this past year. I appreciate the good work of our Board, our hard working executive committee and all our members who have stuck with the Division during an economic downturn. I especially appreciate the numerous, largely unseen, and sometimes unappreciated contributions of Lynn Peterson, our Division Administrative Officer. Gayle Beck will do an outstanding job as your President in 2012 (and Mark Sobell in 2013), and I am looking forward to working with Gayle, Mark and the other members of the Board during the coming year.

As I approach retirement, I regard service to Division 12 as one of my most meaningful and rewarding professional contributions. My work with the Society of Clinical Psychology has been a genuine and (almost) unalloyed joy, and I truly believe Carl Rogers and some of the other luminaries I mentioned earlier would be pleased and proud if they could see what the Division has become. Thanks for the opportunity to serve as your 2011 President. 

SOCIETY OF CLINICAL PSYCHOLOGY FELLOWSHIP COMMITTEE 2011



The Society Fellowship Committee, led by Fellowship Chair Carole A. Rayburn, Ph.D., has approved the following individuals for Fellowship status, effective January 1, 2012:

Initial Fellows:

Loring J. Ingraham, Ph.D. • Michelle G. Newman, Ph.D. • Jean L. Kristeller, Ph.D.
Daniel W. McNeil, Ph.D.

We have received word that APA Membership Committee has approved these individuals. Council gave final approval in August.

Fellows Who are Already Fellows in Another Division:

Virginia Brabender, Ph.D., ABPP • Shane S. Bush, Ph.D. • Janet F. Carlson, Ph.D. • Connie C. Duncan, Ph.D. • Bruno Giordani, Ph.D. • Brooke S. G. Molina, Ph.D. • Dolores O. Morris, Ph.D., ABPP • Josephine C. H. Tan, Ph.D., C. Psych. • Timothy J. Trull, Ph.D.

The members of the 2011 Fellowship Committee are:

Nadine J. Kaslow, Ph.D. • Linda Craighead, Ph.D. • Gayla Margolin, Ph.D. • Harriet Aronson, Ph.D. • Milton Shore, Ph.D. • and Carole A. Rayburn, Ph.D.

APA DIVISION 12 – NOMINATION BALLOT

Dear Division 12 Colleague:

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

Thank you for your participation in the nominations and elections process. **Ballots must be postmarked on or before Friday, December 2, 2011.**

Sincerely yours,
Danny Wedding, Ph.D.
 2011 President

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	Annette Brodsky	Nadine Kaslow	Richard Suinn	Richard Suinn	Deborah King
	Nadine Kaslow	Larry Beutler	Larry Beutler	Larry Beutler	Richard Suinn
	Linda Sobell	Lynn Rehm	Lynn Rehm	Lynn Rehm	Irving Weiner
Member-at-Large	Asuncion Miteria Austria	Asuncion Miteria Austria	Asuncion Miteria Austria		
Section Reps					
2	Deborah King	Deborah King	Deborah King	Brian Carpenter	Brian Carpenter
3	E David Klonsky	E. David Klonsky	E. David Klonsky	David Tolin	David Tolin
4	Gloria Gottsegen	Gloria Gottsegen	Lynn Collins	Lynn Collins	Elaine Burke
6	Toy Caldwell-Colbert	Toy Caldwell-Colbert	Eduardo Morales	Guillermo Bernal	Guillermo Bernal
7	Richard McKeon	Marc Hillbrand	Marc Hillbrand	Marc Hillbrand	Marc Hillbrand
8	Danny Wedding	Ronald Brown	Ronald Brown	Barry Hong	Barry Hong
9	Norman Abeles	Norman Abeles	Norman Abeles	Norman Abeles	Norman Abeles
10	Sean Sullivan	Sean Sullivan	Sean Sullivan	Brian Hall	Brian Hall

NOMINATIONS BALLOT POLICIES

1. Nominations may be submitted only by Division 12 full members.
2. The Division 12 member must electronically sign the ballot.
3. Nominations ballots must be completed on or before December 2, 2011.

ELIGIBILITY REQUIREMENTS

1. Candidates must be Members or Fellows of Division 12.
2. No individual may run simultaneously for more than one elected Division 12 office or Board of Director seat.
3. No individual may simultaneously

- hold two elected seats on the Board of Directors.
4. No individual may hold the office of President more than once.

OFFICIAL DIVISION 12 NOMINATIONS BALLOT

PRESIDENT-ELECT

COUNCIL REPRESENTATIVE

Validate with your name: _____

Your signature: _____

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

YOU ALSO MAY MAKE YOUR NOMINATION **ON LINE** AT: www.div12.org/2011-call-nominations



Recent Books and Chapters by Division Members



Ahmed, A. O., Mabe, P.A., & Buckley, P. F. (2011). Recovery in schizophrenia: Perspectives, evidence, and implications. In M.S. Ritsner (Ed.). *Handbook of Schizophrenia Spectrum Disorders (Vol. III): Therapeutic Approaches Comorbidity and Outcomes* (pp 1-22). New York: Springer.

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Tolon, D.F. (2012) *Face Your fears: A proven plan to beat Anxiety, panic, phobias, and obsessions*. New York: Wiley

Young, Gerald (2011). *Development and Causality: Neo-Piagetian perspectives*. New York: Springer SBM.

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Turn out the lights, the party's over: Ethics and end of career considerations

Jeffrey Younggren, Ph.D.
and Joanna Edwards. Psy.D.

 Most people avoid dealing with issues that have to do with the end of their career. This is likely due to a number of things including the fact that these matters are closely tied to dealing with one's own mortality. Nobody likes to think about the reality that we are all getting older, that bad things could happen to us or that we will eventually die. In addition, work is something that is such a vital part of our lives and is something that is ingrained into the fiber of our identities, one within which little thought or instruction is given as to how to extricate ourselves from it. Finally, it is the closing of a major chapter of our lives, one that has been the focus of our training designed to help us become psychologists. Therefore, there is little, if any, time, energy or effort invested in training us how not to be psychologists. That said, it behooves all psychologists to address these possibilities and eventualities in some fashion or another to fulfill their ethical and legal obligations to those that they treat and to those with whom they work. As with most areas of life and business, a little planning put into this area can go a long way in avoiding negative consequences for a psychologist, his or her colleagues and/or his or her clients.

Retirement Issues

When a psychologist retires or considers retirement, a number of issues must be addressed. The first of these deals with the obligations one has to those who are currently in treatment. Clearly, those who are in treatment with the psychologist must be either terminated or transitioned to another professional. Therefore, discussions about potential retirement plans must occur as early as possible to make sure that we are fulfilling our fiduciary obligations to those we treat. If treatment goals can be accomplished by the time of retirement, then the duty of care is completed and the cases are closed. If it cannot be accomplished, the psychologist has to demonstrate a reasonable

attempt on his or her part to transition active cases to other professionals who may be willing to take on the responsibility of care. Referrals to other professionals have to be offered to clients who are currently in treatment. The provision of these referrals avoids any argument that through retirement the psychologist has abandoned them. If the patient belongs to a managed care panel, and since the psychologist likely does not know who is in that carrier's network, the referral needs to be made back to the carrier where the patient can obtain the name of another individual who is a network provider (Younggren & Gottlieb, 2008). In so doing the psychologist has fulfilled their ethical responsibilities to their current clients whether or not the clients choose to follow through on those referrals.

Psychologists who retire must inquire about liability coverage during retirement. While most carriers provide for a free tail (read "free coverage") for those who retire, this is not as simple as it sounds. For example, if you were to retire, you would be covered for any malpractice claims that occur related to services provided before you retired and while you were insured. You are not, however, covered for services that were rendered after retirement. Clarity in this can be found in the following example. If your records were subpoenaed in a legal action after retirement and you were subsequently sued for things that were in those records, you would be covered. However, if you wrote a summary of those records after retirement and were sued for that summary, you might not be covered. This is because the compilation of the information in the summary is not a past act, it is a new act and it occurred after retirement. Therefore, it is the best of interests of those who plan to retire to contact their malpractice carrier to review the coverage benefits after retirement and potential problems areas. Those who retire might consider maintaining their coverage for a while after retirement to reduce the likelihood that these types of coverage problems will occur. It is important to remember that the risk of liability drops with the passage of time and it might be prudent to maintain complete coverage during initial periods of heightened risk.

The maintenance of records can be quite problematic when one retires. If a psychologist has practiced in an institutional setting, the maintenance of records is

rather simple. The institution is the custodian of the record and has the legal obligations to make sure that the records are kept in a fashion that is consistent with both state and federal law. This even applies to group practices where records are maintained centrally by the group and are not kept by the individual professionals who have rendered the service. However, if client's records have been retained and maintained by the individual who is retiring, a plan must be put into place for how those records will be maintained so that others can have access to them. In addition, care must be taken to make sure that they are maintained in a fashion that is consistent with state law. Psychologists who plan on retiring should inform current and certain, potentially vulnerable, old clients about the location of their records and how they could be accessed. If another individual has agreed to take over the responsibility for the records, these same clients need to know of the transfer of their files to another record's custodian and they also need to know how to locate that individual.

Some states have unique requirements that need to be accomplished when a health care professional retires. It is very important for a psychologist who is planning on retiring to contact their state licensing board to make sure that they are aware of any special state level requirements that exist. These might include publication of the plan to retire in a local paper for a definite period of time or notification of the board of individuals who are taking over responsibility for the records of old patients. Sadly, these issues vary from state to state.

Death and Termination Issues

Sometimes things occur that prevent the psychologist from developing and implementing a carefully thought-out retirement transition. Old and young alike need to be aware of the possibility of something happening to them that would abruptly end their ability to provide services to those to whom they owe legal and ethical obligations of care. All psychologists would be well advised to create a plan that would address this possibility so that their professional obligations could be fulfilled in the case of their abrupt death or inability to provide services. Some psychologists choose to do this through the creation of a "professional will" (DeAngelis, 2008). These formally prepared documents identify a "professional executor" who will fulfill the instructions outlined in the professional will. In

addition, the will should outline how to contact that individual. In addition, the will should provide all necessary information regarding where records are kept and how they can be accessed. It should also outline how to contact clients and the plan for how those clients will receive continued necessary care. The plan should address client's records and how they will be handled. Financial issues should also be addressed in the plan to include a discussion regarding how practice finances will be handled and how financial obligations will be fulfilled. Finally the will should include notification plans that will address how state licensing board, insurance carriers and professional organizations should be informed.

When facing the prospect of retirement, the implementation of a carefully thought out retirement plan will help to avoid the possibility that the joys of retirement could be complicated by the pain and agony of litigation or licensing board action. In addition, whether a professional psychologist chooses to go through the formality of creating a professional will or accomplishes the same needs by identifying another professional who agrees to fulfill the professional obligations and duties of the incapacitated professional, all psychologists arguably have an ethical obligation to think about how their practices will be managed and how their professional obligations will be fulfilled in the case of their absence, death or incapacity.

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- Younggren, J. N., & Gottlieb, M. C. (2008). Termination and abandonment: History, risk and risk management. *Professional Psychology: Research and Practice*, 39(5), 498-504.
- Jeffrey Younggren, Ph.D. is a clinical and forensic psychologist in independent practice and clinical professor of psychology in the Department of Psychiatry, David Geffen School of Medicine, UCLA.
- Joanna Edwards, Psy.D., is a clinical psychologist in independent practice. ■■

The Psychological Importance of Subtle Bias

Jordan A. Blenner, Debra A. Hope,
and Richard L. Wiener

Weibling Project for the Psycholegal Study and
Treatment of Discrimination
University of Nebraska-Lincoln

All too often, discrimination, both overt and subtle, are a common experience of individuals of minority or underrepresented populations. In this column, Blenner, Hope, and Wiener describe a project that provides both legal and psychological services to victims of discrimination that occurs in work settings. I am grateful for their contribution to TCP regarding this highly needed program. - AMN

 Well-publicized accounts of hate crimes and bullying demonstrate that bias based race/ethnicity, gender, religion, and sexual orientation continue to be all too common. Such experiences are easily recognized by clinicians as discrimination. Interventions may focus on the sequelae of the traumatic experience and/or support through a legal process. However, mental health providers may be less familiar with the more subtle experiences of discrimination that many clients may face.

A growing body of research indicates that people often express bias against racial and ethnic minorities, women, sexual orientation minorities, older individuals, and the disabled in subtle ways. For example, Dovidio and Gaertner (2000) found that undergraduate research participants recommended African American job applicants with ambiguous-qualifications less frequently and less strongly than they recommended European Americans with the same qualifications. In this example of aversive racism, participants discriminated against African Americans only under ambiguous situations when they could point to legitimate reasons (an ambiguous resumé) to justify their judgments.

Heilman, Wallen, Fuchs, and Tamkins (2004) asked undergraduates to read job summaries and evaluate the competency of female and male employees. For half of the participants the employees were about to

receive their annual performance review, while for the other half, the employees were “top performers” who had already received their reviews. While participants rated male and female “top performers” similarly, they rated unevaluated female employees as less competent than their male counterparts. Like aversive racism, subtle sexism often occurs in ambiguous situations.

The literature also documents subtle displays of bias due to sexual orientation. For example, Hebl, Bigazzi, Foster, Mannix, and Dovidio (2002) had research assistants inquire about jobs in Texas stores. Each applicant wore a hat with the words “Gay and Proud” (stigma-inducing) or “Texan and Proud” (non-stigma-inducing). Applicants did not know which hat they were wearing. Analyses showed that store personnel in the stigmatizing, compared to the non-stigmatizing, condition spoke fewer words to the applicants, engaged in shorter interactions, and that the participants perceived them more negatively. Although employers did not show overt hostility towards the “Gay and Proud” applicants, they still demonstrated a subtle form of disparate treatment evidenced in the strained interactions. These three studies show how modern racism, sexism, and heterosexism can involve very subtle forms of discrimination.

Our Weibling Project (<http://www.unl.edu/psypage/weibling/>) provides legal and psychological services for individuals who believe they have been the target of discrimination, most commonly in employment. Many already have had their cases judged to be “unsubstantiated” by the initial legal process, meaning that disparate treatment that violates the law cannot be proven. Regardless of the legal standard, the psychological impact of the discrimination is substantial. Most clients report difficulty sleeping, dysphoria, crying, anger and relationship problems. They report a loss of confidence in themselves or in a system, that does not recognize their unfair treatment. Often they describe their experiences with the types of subtle incidents of bias as in the studies cited above. At first one might discount these experiences as the client over-interpreting unintended slights. However, when seen against the backdrop of the research literature, a different perspective is worth considering. These smaller experiences combine with many other incidents of being discounted, not heard, not trusted and asked to wait longer than others. The cumulative effect may well have important

psychological consequences that should be considered in case conceptualization and intervention.

In our own work in the Weibling Project, we are re-conceptualizing discrimination as the outcome of both psychological and legal processes. We hope our clinical experience with individuals who believe they are victims of discrimination and our research on the experience and outcome of claims of disparate treatment will eventually inform clinical work more broadly.

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Call for Reviewers: Journal of Latina/o Psychology

The National Latina/o Psychological Association (NLPAA) and the Journals Program of the American Psychological Association (APA) have joined together to launch the *Journal of Latina/o Psychology*, a peer-reviewed journal publishing scholarly writing on research, practice, advocacy, education, and policy relevant to Latino communities.

The *Journal of Latina/o Psychology* will publish empirical, theoretical, methodological, and applied research. The journal will focus on articles that contribute to knowledge of Latina/o psychology through research, methodological innovation, and inquiry; develop and advance theories pertinent to Latinas and Latinos; promote education and training of psychologists to work with Latinas and Latinos; address issues of social justice and advocacy in Latina/o communities; promote the application of research and training to advancement of policy related to Latino individuals and communities; and use quantitative, qualitative, or mixed method approaches. Articles on topics such as immigration and its impact, health and wellness, spirituality, mental health issues, Latina/o identity, and multigenerational families will be of particular interest. The journal will officially begin receiving manuscripts on October 1, 2011. The first issue will be published in Spring 2013.

We are seeking reviewers with expertise in these topics for the journal. We welcome students to serve as co-reviewers of manuscripts. If you are interested in reviewing manuscripts for the *Journal of Latina/o*

Psychology, please send by September 16 a list of 6 or 7 phrases that indicate your areas of expertise and 2 or 3 words that represent your preferred methodologies to:

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Please note that this is a 2 year commitment to serve as a reviewer for the journal. We also welcome ad hoc reviewers who will serve on an "as needed" basis.

About the Editor

Azara L. Santiago-Rivera, PhD, NCC, is the Inaugural Editor of the *Journal of Latina/o Psychology*. Her publications and research interests include multicultural issues in the counseling profession, bilingual therapy, Latinos and depression, and the impact of environmental contamination on the biopsychosocial well-being of Native Americans. She has presented on these topics at major conferences and has published in peer-reviewed journals such as the *Journal of Professional Psychology: Research and Practice*, the *Journal of Counseling and Development*, the *Journal of Community Psychology*, the *Journal of Environment of Psychology*, and *Psychotherapy: Theory, Research, Practice, Training*. She is a Fellow of Divisions 45 and 17 of APA.

Remembering George Kelly

Donald K. Routh, University of Miami

 I have long been an admirer of the work of George Kelly (1905-1967) but now must confess that in my 1994 book on the history of clinical psychology, I misclassified his approach to psychotherapy as “cognitive behavioral.” I am hardly the first one to have trouble placing his work into a conventional category. At the peak of his career in psychology in the 1950s and 1960s everyone seemed to want to claim what he did as their own. One of his own former students said incorrectly that Kelly was a behaviorist. One prominent psychoanalyst thought that Kelly’s approach was fundamentally psychoanalytic. Once when he gave a talk in Poland, he was told that what he was saying agreed well with Marx’s dialectical materialism. Some humanistic psychologists also tried to identify Kelly’s work with their approach.

Upon further investigation, I find that Kelly’s approach to therapy does not at all fit the conventional division of psychological phenomena into cognitive, affective, and behavioral but encompasses all three. He was a true original who seemed to have no identifiable academic or clinical parentage. His educational history in Kansas, Scotland, at the University of Iowa, where he obtained his PhD in 1931, cut across various fields, from physics to engineering to sociology and education as well as psychology.

In his first academic position in psychology, Kelly taught at Ft. Hays, Kansas State College. It was there he was first responsible for doing psychotherapy, and in effect he seems to have taught himself how to do so beginning at that time. He continued this by developing a statewide program of traveling clinics in Kansas.

Kelly considered each psychotherapy client to be a scientist and experimenter, like himself. Thus, the client dealt with life by uniquely “construing” or making sense out of persons and events in the environment, noting in what way they resembled each other and in what way they were different, in order to try to predict future events. If these predictions were not working out, the client experienced this non-confirmation as

a threat and as a sign that some new way of construing events might be needed. The therapist could be helpful, first of all, by trying to understand the client’s constructs and by raising questions about the ones that did not seem to be working and about how they might be modified. Thus, the therapist was not so much a source of advice as a colleague who was perhaps more experienced in using scientific methods in the area of interpersonal relations.

Therapeutic change would take place when the client re-construed events, behaved in a new way as a means of carrying out an experiment, and then was able to evaluate the results of this. Thus, the client’s behavior, rather than being seen as the outcome of treatment, expressed the experimental question the client posed to the environment to see what would then happen.

Kelly did not wish to be considered a behaviorist because his therapy did not make use of the principles of reinforcement nor of the prediction that the client would keep on doing what had been reinforced in the past. Instead, he thought psychologists should view their clients as being just as able as scientists are to come up with original hypotheses to direct what they do. He also did not care for the use of actuarial predictions which again lead to the expectation that the future will repeat past experience, again denying the possibility of creative scientific hypotheses by the client directing new behaviors as experiments. Kelly did not like official psychiatric classification systems because they lumped together people with widely disparate systems of personal constructs and were thus not helpful to the therapist.

In 1946, on the basis of his growing reputation, Kelly was appointed professor and director of clinical psychology training at Ohio State University. There he was a successor to Carl Rogers and a part of one of one of the strongest scientifically oriented clinical psychology PhD programs of its time. In 1957, he served as president of the APA Division of Clinical Psychology. In 1965, two years before his death, he began to occupy an endowed chair at Brandeis University.

Kelly’s most famous book, *The Psychology of Personal Constructs*, presenting his approach to psychotherapy, was published in two volumes in 1955. During his lifetime he also published some transcripts of psychotherapy sessions, as Carl Rogers had also done, and was also

responsible for a well-known assessment procedure called the Repertory Grid Test. After his death, Kelly's fame continued, especially in Great Britain and British Commonwealth countries such as Australia, where his approach was adopted by prominent clinical psychologists such as the late psychologists Don Bannister and Fay Fransella. A *Journal of Constructivist Psychology* and an electronic publication, *Personal Construct: Theory and Practice*, continue, and international conferences have been convened on Kelly's work. There is a special institute devoted to his approach at the University of

Hertfordshire in England. Doctoral students in clinical psychology may receive this type of training there.

Thus, psychotherapy as conceived within Kelly's system continues, and in recent years has been supported by formal clinical trials of its effectiveness. A review of a half century of work on Personal Construct Psychology by Australian psychologist Beverly Walker and British Psychologist David Winter appeared in the *Annual Review of Psychology* in 2007. It concluded that Personal Construct Psychology could probably anticipate another half century of elaboration. ■■

ANNOUNCEMENT

Enhancements to ABCN examination procedures

The American Board of Clinical Neuropsychology (ABCN) is pleased to announce two enhancements to its examination procedures. First, starting in 2012, the ABCN written examination will be administered exclusively through Prometric testing centers (www.prometric.com). The final group administration of the written examination will be held in conjunction with the 2011 National Academy of Neuropsychology conference. Starting in 2012, Prometric will administer the written examination four times per year, each for a window of two weeks. The time windows during 2012 will be March 1-17, June 1-16, September 1-15, and December 1-15. Examinations will be administered electronically at Prometric testing centers in the USA and Canada.

A second enhancement is that the schedule of oral examinations is being expanded to three times per year. During 2012 the oral examination dates will be April 20-21, August 17-18, and November 16-17. The location for the oral examinations will continue at Rush University Medical Center in Chicago. The additional examination dates are needed to accommodate the increasing numbers of candidates for ABCN certification.

ABCN is changing to electronic test administration in order to minimize travel requirements. Most candidates will be able to access a Prometric testing center conveniently. The expanded examination schedules will allow greater flexibility in choosing examination dates. The electronic test administration will also offer a higher level of confidentiality for candidates.

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. The steps required for ABCN certification are to document education and training, pass the written examination, submit two sample reports for peer review and approval, and pass an oral examination covering clinical knowledge, professional practice, and ethical judgment. For applicants trained since 2005, training must include a formal two-year post-doctoral residency. 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:

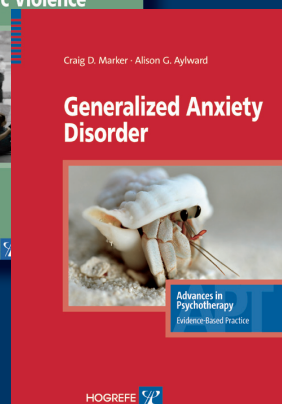
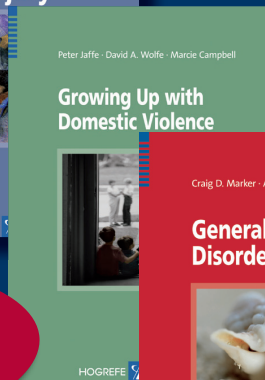
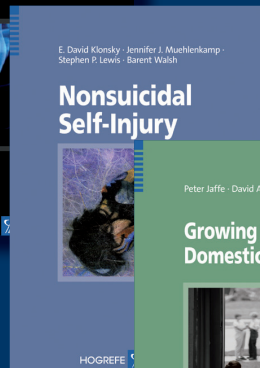
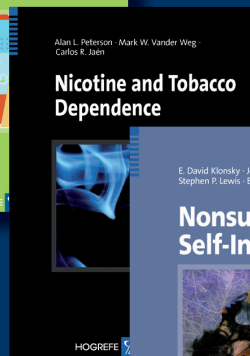
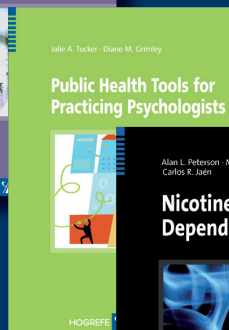
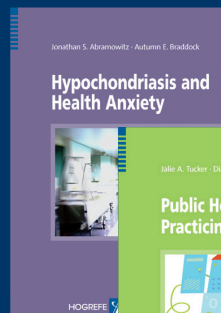
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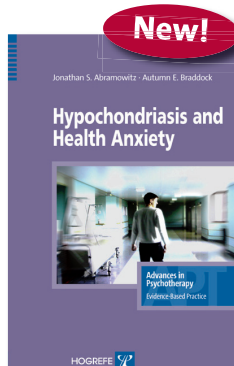
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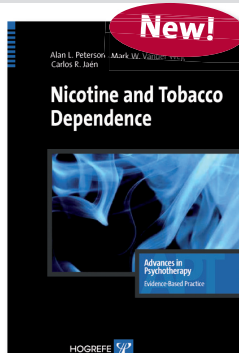
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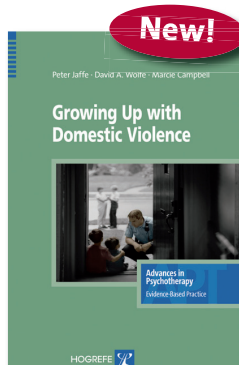
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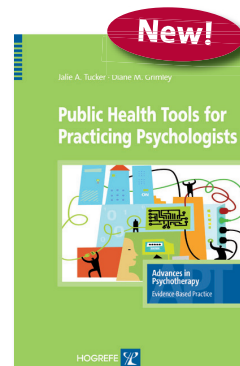
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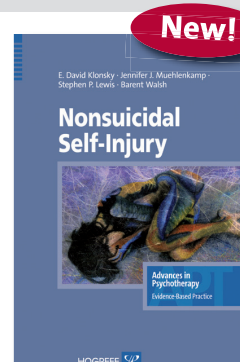
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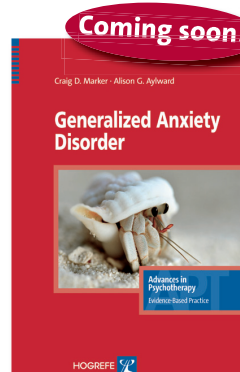
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Early career considerations in independent practice

Alyssa G. Clark, Ph.D.

 There are many potential career paths for clinical psychologists, including independent practice. Although graduate school and post-graduate training provide us with the therapeutic skills for working with clients, we are not necessarily provided with guidance in regard to managing a business. Additionally, as opposed to the up-close view of faculty life we witness in graduate school, we may not have had the opportunity to see the work routine of independent practitioners, including attending to business issues, client concerns, professional development, and prevention of isolation (given the often solitary nature of practice work). Although I cannot address all of the many issues related to beginning a practice in this column, I will highlight key concerns that have been salient in my early career.

Choosing how to structure an independent practice is one of the first major decisions many encounter. The decision of whether to start out on your own or participate in a group practice is not easy, as there are benefits to each model. Joining a pre-existing practice, or forming a new practice with colleagues, provides a built in support network for consultation and referral. However, if the finances are shared, there will be less autonomy in terms of hours and client-load, as the understandable focus must be on equity, often in terms of billable hours. The autonomy inherent in building an entire business from the ground up is appealing, but cultivating a professional support system will require greater conscious and concerted effort. Many practitioners choose a hybrid of these models, working in a group environment (i.e., sharing a physical space with other practitioners), while maintaining independent businesses in legally and financially.

When considering the independent practice route, another salient concern is building and maintaining a sufficient client base. Many factors contribute to the challenges in doing so, including your willingness to join insurance panels, the relative number of mental health professionals in your area, whether you have a specialty niche, and your own business savvy. There are also larger, sometimes unpredictable, forces at work,

such as the overall economic climate that will impact the ability of people to afford therapy. It is important to have a sense of how other psychologists in your area, preferably those who have had a successful practice for many years, maintain their client base. What are their referral sources? Frequent sources are other mental health professionals, physicians, schools, colleges and universities, and insurance panels. What professional networking opportunities have aided in building relationships with these referral sources? In addition to state or regional associations, there may be additional psychological or other relevant associations in your specific town or city. What are effective or necessary ways to market your practice? Thinking creatively about how to make your presence known is a good investment of your time, such as offering workshops to physicians or other referral sources or simply taking people out to lunch. How important is joining insurance panels in terms of maintaining a viable practice in your area? If you do decide to join panels, it is important to find out which insurance companies have the greatest prevalence in your area. Are there particular times of year that are busier or slower in terms of referral volume? The answer to this question will help you gauge times of year when you may want to take on “extra” clients in preparation for times when referral volume may be low.


As a final point, I want to emphasize the importance of getting to know psychologists in your community. Ideally cultivation of a professional network begins before you officially open your business. Seek mentorship from those who have met the challenges of independent practice successfully. The practice climate and landscape, including business relationships among practitioners and the relative over- or under-abundance of psychotherapists, may differ based on locale. Experienced colleagues will be your best bet in terms of getting an accurate sense of these issues. Further, helpful colleagues can ease a variety of start-up concerns through advice and example, addressing issues such as initial paperwork, organization of your billing process, and general time management. After you are up and running, a professional support network is key for maintaining the quality of your work (and life). Even if you are practicing alongside others, many psychologists find that working in independent practice can be isolating. You may only have a moment to exchange a quick greeting with colleagues between clients. Given the intense nature of our work, it is impor-

Donna Rasin-Waters, Ph.D.—Editor

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

By Donna Rasin-Waters, Ph.D.

Division 12 Federal Advocacy Coordinator

 The American Psychological Association is our voice in Washington, D.C. We are all used to knowing that we can count on APA to concentrate on legislative, executive and judicial issues that impact psychological science, education and practice. However, how many of us consider the important role the state psychological associations play in these same issues? How many of us belong to our state psychological associations?

In a recent meeting for the New York State Psychological Association with our lobbying group NYSUT I was struck by a comment one of the lobbyists made as he also shook his head: “It’s a real problem that psychologists in your locals are not all affiliated with the state and national or vice versa.”

He was commenting on how some of our regional psychological association members do not join the state organization and also on how some of the national psychological association members do not join the state and so on. Now to understand this analogy one must understand that NYSUT is a federation

made up of 1,200 local unions representing 600,000 people in New York’s schools, colleges, and healthcare facilities. In addition, NYSUT is also affiliated with the American Federation of Teachers (AFT) and the National Education Association (NEA). Obviously, prior to this federation there was a much less powerful voice among the collection of smaller groups.

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

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

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tant to carve out a set time for consultation, such as a weekly meeting to discuss cases or business concerns.


Consultation with colleagues also promotes continued skill building and professional growth. Given the hectic daily pace in independent practice, it can be difficult to find the time to stay updated on recent research or newer therapeutic and assessment methods. Although attending continuing education workshops or conferences provides a context for new learning, discussions with colleagues can also be helpful in sharing new information. This can happen in the context of discussing cases, or through book clubs or similar events. In considering consultation, it is beneficial to maintain relationships

with psychologists working in research or academics, rather than narrowing your network to only psychologists engaged in similar work. As a practicing psychologist, this is helpful in terms of both updating my sense of current research and maintaining the research skills that I no longer use on a daily basis. As importantly, keeping our connections across career domains aids in bridging the practice-research divide!

Alyssa Clark received her Ph.D. in Clinical/Community Psychology from the University of Illinois at Urbana-Champaign. She is currently in independent practice in Athens, GA. ■■

Strategies for Publishing in Graduate School

Kathryn L. Humphreys, M.A., Ed.M.

 Graduate students in clinical psychology have many expectations thrust upon them. They are expected to gain a sufficient number of clinical hours with depth and breadth in varied age groups, patient populations, and treatment orientations. Courses are required for the particular program as well as for licensure requirements. In addition, and particularly for those in more research-oriented PhD programs, there is an expectation to develop an active research program as demonstrated by presentations at conferences and in publications in peer-reviewed journals. Sometimes working toward a PhD in clinical psychology feels like working towards two PhDs, one for clinical practice and the other for clinical research, as we hurry between class and our practicum site, supervision and running research participants. The task of analyzing and writing up research for publication is often easily pushed to the end of the to-do list given the lack of immediate gratification for each stage of the process, and the discouraging process of rejection, revision, and resubmission. Given that there are only 24 hours in one day, how can one maximize their ability to publish in graduate school?

Where to start

Find data - An ideal project starts with a question, and sometimes collecting your own data is the only way to answer it. Beginning a new data collection project requires a great deal of thought, planning, and effort. Many universities will provide assistance in subject recruitment by providing a pool of undergraduates willing to participate in return for course credit. Finding a dedicated research assistant or two as well as the mentorship of an advisor to walk you through the IRB process is essential. If collecting your own data is not in your future, you can seek out data that has previously been collected. For example, many established professors will have existing datasets from prior projects that may be able to answer new questions. There are also many datasets that are available to the public (see www.data.gov/catalog). In cases where you did not design the data collection, your research question will need to be guided by the available data. In either case, a

careful search of the literature should be conducted prior to beginning the project to ensure that your findings will be unique and help to fill a gap in the literature.

Collaborate - Graduate students are not expected to be the sole author on their projects. Start by finding an advisor whose research interests you. Ask if you can help out with a current project by writing a literature review or running analyses. Often times large projects have a central question intended to be addressed, in which the principal investigator is the lead author. There is room for additional collaborators to be included on the list who help to make the project become a reality. In addition, secondary projects that stem from the data collected during the project may be available for further scrutiny. After the major project is submitted, seek out lead authorship on follow-up projects that complement the main findings. This way, you will be familiar with the project and have the ability to gain the trust and support of your advisor. For example, if the main project provides the descriptive information of the topic of interest, a follow-up project could explore potential mediators and moderators of the effects.

Write a review article - No new data is required for writing a review paper or meta-analysis. A clear and thorough review of your topic of interest may be well received in journals that specialize in review articles.

Next steps

If you find yourself staring at a blank page, consider writing a draft of your methods and results sections first. These are relatively easy sections to write, and can help to ward off procrastination. Also, having your findings and figures laid out on paper can provide clarity on the “story” of your project. Seeing the figures and being able to discuss the major findings with your advisor, classmates, and friends (if they are the patient type) can help to clarify the main point of the project. Next, sketch out an introduction outline that starts with a broad overview of the area and becomes more and more specific, leading up to the main question your project can answer. Writing the discussion can require quite a bit of reading about how your findings fit into the broader literature. Be sure to link it up to similar research and explain how the present project adds to the knowledge base while acknowledging limitations and potential future directions.

Behavioral Intervention Technologies (BITs): Harnessing Wireless and Web-based Technologies to Deliver Care

David C. Mohr, Ph.D.

Northwestern University



Behavioral Intervention Technologies (BITs) is a broad term for interventions that integrate information and communications media with psychological theory and science aimed at promoting physical and mental health. The rapid development of information and communications technologies has opened tremendous opportunities for clinical psychology to develop new intervention paradigms that can potentially overcome access barriers, expand the purview of clinical psychology to include a population-based public health perspective, and extend care from the clinic office into the patient's environment. The purpose of this article is to provide a brief overview of two of the most common BITs: web-based interventions and mHealth interventions.

Web-based interventions commonly provide a combination of didactic materials and exercises or tools derived from evidence based treatment models. These

interventions can vary on a wide variety of dimensions, including the degree to which they are static or interactive programs, the degree of tailoring or personalization, the use of multimedia, the degree to which site is engaging, how patients progress through the site (e.g. expectations of login frequency, whether all site content is immediately accessible, or if content is rolled out contingent upon other factors such time from start of intervention, or completion of tasks), whether or not they are supported by a therapist or coach, and so on. Moodgym (<http://www.moodgym.com.au/welcome>) is one example of a freely-available site.

Standalone web-based interventions have produced a wide range of outcomes, from small or non-significant to very substantial improvements. Poor efficacy is often associated with non-adherence (e.g. low number of logins) or attrition (which can range from extremely high, >95% for standalone depression sites, to minimal). This variability may be due in part to how research participants are selected; websites that are open to entire populations may produce high rates of initial access, with low return rates after one or two visits, which could suggest that attrition is a byproduct of easy access and broad reach. Poor site design can also contribute to higher attrition and poor outcomes. It is also possible that sites designed based on principals of face-to-face interventions do not adequately harness the benefits of the technology and/or

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After a draft of the paper is written, think about the paper from the perspective of a reviewer. What issues might they have and can you address them now? How can you “sell” your paper by playing up the relative strengths of your method, population, or question? Get feedback from others by presenting the findings at a lab meeting or asking someone you respect read your draft and provide constructive criticism. We can always improve our writing. Following edits, look for a journal that publishes similar projects as a guide and review papers from their recent issue and their “guide to authors” section to ensure you submit your manuscript in the correct style. Journal choice is important. While the top-tier journals are ideal, be realistic about the impact of your paper and what type of audience is likely to be most interested in findings (a broad scientific audience or other specialists in

your research area).

Finally, when the reviews come in, be willing to accept that the reviewers may want changes. If the changes desired are substantial, it may be cause for rejection. While rejection is always disappointing, your paper will likely to find a home somewhere, perhaps a journal with a different core audience or focus. Move quickly on addressing reviewers' comments if you have been asked for a resubmission. If your paper was not accepted, it is a great time to re-read the paper and take note of feedback provided by the reviewers. Months can be wasted letting a paper that only needs a few tweaks collect dust. Perseverance can indeed be the difference in getting your work published, and considering how much work it takes to get a paper to that stage in the process, following through on getting the paper accepted is well worth the effort. ■■

do not conform to how people use the technologies.

In general, human support via periodic e-mail or brief phone contact improves adherence and outcomes for web-based treatments, although this may vary depending on the patient population, disorder, and the quality, usability and utility of the program. Outcomes of coach or therapist-supported internet treatments can be moderate to large for depression and anxiety (Andersson & Cuijpers, 2009; Cuijpers et al., 2009), weight-loss, and a variety of other problems, sometimes approaching effect-sizes seen in traditional face-to-face treatments. We have posited that human support enhances adherence through “supportive accountability,” a process in which patients know that their activity on the site is being monitored by a person who will review their activity and provide support at defined time intervals (Mohr, Cuijpers, & Lehman, 2011).

Mobile Interventions use wireless technologies to provide a ubiquitous connection between a care system and the patient. A growing number of studies are investigating mobile systems that provide treatment tools that can be accessed anywhere and send reminders via text messaging to support patient behaviors related to a variety of treatment targets, including diet, exercise, smoking cessation, mood disorders, schizophrenia, and medication adherence. Querying users through their phones can allow text messages to be sent that are tailored to the immediate needs or state of the user. Smartphones also allow access to the internet, supporting interventions that integrate mobile and web-based intervention programs. A growing area of research uses sensors to identify patient states without input from the patient to allow just-in-time intervention. Much of this work uses external sensors to monitor physiological factors related to targets of behavioral interventions such as cardiovascular markers of stress, physical activity, alcohol consumption, or glucose (Goodwin, Velicer, & Intille, 2008). Other investigators, including our lab, are seeking to continuously analyze sensors such as GPS, Bluetooth, accelerometers, sound, etc., and, using datamining techniques, to create individualized prediction models that can infer patient states such as location, activity, social context, and mood (Burns et al., 2011).

Our work harnessing mobile technologies has taught us that existing behavioral and psychological theories are inadequate to inform and optimize the development of BITs. We do not yet fully understand how people utilize mobile and web-based technolo-

gies, nor how these activities can interact with human change processes.

Dissemination has become an important issue as BITs are developed and validated. Support for the efficacy and cost-effectiveness of web-based interventions has prompted a number of countries (including the United Kingdom, the Netherlands, the Scandinavian countries, and Australia) to begin integrating web-based interventions into their national healthcare systems. While the US does not yet have an integrated healthcare system that can take advantage of the cost savings accrued through BITs, closed healthcare systems such as HMOs and the VA have become increasingly interested in harnessing such technologies.

BITs are also being developed and disseminated through commercial ventures. For example, online and mobile weight-loss programs have become a profitable and competitive area of business. Private industry can play a valuable and positive role, given its capacity to develop and disseminate these tools. However, while commercial ventures regularly employ rigorous product testing, they often do not evaluate the tools' efficacy, which can lead to products that may be attractive but ineffective or even harmful. The FDA has created draft regulations and requirements for mobile health applications that may cover some behavioral health apps. Future solutions will likely also include clearinghouses where consumers can obtain information about BITs. One such site, Beacon (<http://www.beacon.anu.edu.au/>), maintained by the Australian National University, provides information on the evidence base for web-based and mobile interventions.

While mobile and online BITs have received much attention in research, there are many other technologies and media that are being harnessed in the service of psychological and behavioral intervention, including immersive virtual reality, online virtual worlds, social media, and serious gaming. This is a rapidly growing area of research with enormous potential to augment and extend care.

In summary, BITs research is an emerging area that integrates many disciplines, including psychological science, computer science and engineering. A new generation of researchers will be required who have skills across a number of these areas. As BITs are integrated into the healthcare system, there will be a demand for professionals who can implement and manage these systems. Clinical psychology

has an opportunity to take a leadership role in BITs research and education. Northwestern University has made a strong commitment to supporting growth in this area by establishing the Center for Behavioral Intervention Technologies (www.cbits.northwestern.edu). We invite you to visit our website, and welcome your thoughts and comments.

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If you have any questions or comments regarding this article, you can reach Dr. Mohr by e-mail at d-mohr@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). ❏

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Section II: Society of Clinical Geropsychology

Brian D. Carpenter, Ph.D.

 Once again the APA convention included plentiful offerings for researchers and clinicians interested in older adults. Selected highlights included a panel discussion on new diagnostic categories for dementia, a plenary session on reducing Alzheimer's risk by Margy Gatz, another plenary on aging family structure and process by Sara Qualls, a mentoring session on building a research career in neuro- and geropsychology, and a boisterous social hour cosponsored by Section 2 and Division 20. Successful continuing education opportunities included the annual What Psychologists Should Know About Working with Older Adults, presented by Merla Arnold, Lee Hyer, Peter Lichtenberg, and Margie Norris. Interpersonal Psychotherapy for Depressed Older Adults was offered by Gregory Hinrichsen and Marie-Genevieve Iselin. And Douglas Powell presented a session on Empirically Based Strategies for Maximizing the Intellectual Capabilities of Older Adults.

The Section's Student Research Award went to Sheri Gibson from the University of Colorado, Colorado Springs, for her paper, "Assessing Knowledge of Elder Financial Abuse: A First Step in Enhancing Prosecutions." This year's recipient of the Distinguished Clinical Mentorship Award is Forrest Scogin at the University of Alabama. And the M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology was presented to David Guttman from Northwestern University. Nominations are still open for this year's Clinical Mentorship and Lawton award and may be submitted by December 1st to David Coon, david.w.coon@asu.edu.

As Professional Geropsychology moves forward as a newly recognized practice specialty, 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. With assistance from Dan Segal, Rick Zweig, and Michele Karel, Victor Molinari coordinated a survey to members of the 4 organizations on whether to pursue the credential. Results of the survey suggested

that a large percentage of respondents (89%) believed that petitioning for ABPP status was worthwhile, and a slim majority (54%), heavily weighted toward early career professionals, said they were likely to take the ABPP exam. A spirited discussion has followed on the Section 2 listserv, with diverse opinions on the benefits and risks of creating an ABPP for the specialty, though consensus appears to be emerging to move ahead with the process. Next steps include an initial application to the ABPP Board of Trustees and submission of an implementation plan that would include credentialing examination materials and a plan for the initial exams.

Three psychologists have been appointed to serve on the panel guiding the Institute of Medicine's 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. Deborah DiGilio in the APA Office on Aging reported that her office submitted a white paper, *Psychology's Role in Addressing the Mental and Behavioral Health Needs of the Geriatric Population*. APA also submitted a Health Care Workforce Data Collection Form to provide information on psychology and geropsychology.

Advocacy continues in the Office on Aging for geropsychology grants in the education programs adopted in President Obama's *Patient Protection and Affordable Care Act*. Psychologists are now eligible for 3 of the 4 federal grant programs: Geriatric Education Centers, Geriatric Academic Career Awards, Geriatric Career Incentive Awards, that latter specifically for graduate students.


In recent policy and practice news of interest, Medicare has proposed to add alcohol screening and behavioral counseling, and screening for depression, to the comprehensive package of preventive services covered by Medicare. Under the new proposals, Medicare would cover an annual alcohol misuse screening by a beneficiary's primary care provider. The benefit would also include four behavioral counseling sessions per year if a beneficiary screens positive for alcohol misuse. Medicare would also cover an annual screening for depression in primary care settings that offer staff-assisted depression care, so beneficiaries can receive an accurate diagnosis, effective treatment, and follow-up. The Centers for Medicare &

Medicaid Services will issue final coverage decisions later this year.

Finally, if you're looking for an informative brochure on geropsychology opportunities, check out, *Geropsychology: It's Your Future*, published by the Office on Aging and available at <http://www.apa.org/pi/aging/geropsychology.pdf>. It describes educational, research, and practice opportunities, and provides links to key geropsychology guidelines and career development resources. It's a great, concise resource to share with colleagues and students.

Section III: Society for a Science of Clinical Psychology

David F. Tolin, Ph.D., ABPP

 Varda Shoham is President of SSCP; she is joined on the Board by President-Elect Rick Heimberg, Past President Thomas Ollendick, Secretary/Treasurer David Smith, At-Large Representatives Bunmi Olatunji and Bethany Teachman, Division 12 Representative David Tolin, and Student Representatives Sara Stasik and Rebecca Brock. We will hold elections for President-Elect, Member at Large, Student Representatives, and Division 12 Representative this Fall; nominations are now closed.

SSCP is seeking nominations for its annual Distinguished Scientist Award and Dissertation Award. These awards will be presented at the Annual Meeting of Members at the APS convention next Spring.

We are also seeking a replacement for our newsletter Editor, Erika Lawrence. Past issues of the newsletter can be found at <http://sites.google.com/site/sscpwebsite/newsletters-1>.

We had a record-breaking number of SSCP student posters at this year's APS Convention. We heartily congratulate the following winners, who received a \$200 prize and APS membership:

A Meta-Analysis of Component Controlled Trials of CBT for Anxiety Disorders

Sacha Brown, Daniel F. Hill, Jonathon C. Gable, Liam P. Porter, W. Jake Jacobs - University of Arizona

Paradoxical Cardiovascular Effects of Adaptive Emotion Regulation Strategies in Generalized Anxiety Disorder

Amelia Aldao, Douglas S. Mennin - Yale University

In addition, six more posters were recognized for distinguished contributions, and received a \$100 prize and APS membership. They are:

A Meta-Analytic Review of Mood-Congruent Implicit Memory in Depressed Mood

Melinda Gaddy, Rick E. Ingram - University of Kansas

Depressed and Anxious Persons Inhibit Positive Information: Three Subliminal Perception Studies

E. Samuel Winer, Daniel Cervone - University of Illinois at Chicago

Emotional Go/No-Go Task Predicts Trait Aggression

Katherine G. Denny, Matthias Siemer - University of Miami

High Negative Affectivity and Attenuated Neuroendocrine Reactivity in Women with Borderline Personality

Lori N. Scott & Kenneth N. Levy - Pennsylvania State University, Douglas A. Granger, Johns Hopkins University

Is Reassurance Seeking Specific to Depression?


Nehjla Mashal, Lisa Wang, Richard E. Zinbarg - Northwestern University

Reciprocal Relationship Between Peer Relational Victimization and Depression in Early Adolescence

Elissa J. Hamlat, Angelo S. Boccia, Jonathan P. Stange, Lauren B. Alloy - Temple University

Section VI: The Clinical Psychology of Ethnic Minorities

Wei-Chin Hwang, Ph.D.

 We are pleased to announce that Section VI had a very successful 25th Anniversary celebration at APA Convention in Washington, DC. At our Business Meeting, the founders of the Section were honored with Presidential awards. We were excited that several of the founders were able to attend, and that Mrs. Samuel Turner was able to come and accept her late husband's award. We would also like to congratulate Melanie M. Domenech Rodriguez and Jessica Henderson Daniel for their accomplishments and receipt of the Samuel M. Turner MENTOR Award, as well

as LaTrice Montgomery who received the Dalmas A. Taylor Outstanding Student Research Award.

Over the past few months, a number of issues have arisen that may be of particular interest to Section VI members. First, *Psychology Today* published an article in May claiming that Black women are less attractive than other women. Although the article was taken down the next day, the fact that such a poor excuse for an empirical study would be published in the first place is deplorable. Allowing “junk science” that simply supports existing prejudices and racist ideas hurts all of clinical psychology. It was easy to spot the racial bias beneath this so-called “study” in the sweeping generalizations and seriously flawed methodology. This begs the question why *Psychology Today* would allow itself to be a partner in distributing such unscientific material to its readership. *Psychology Today* apologized for the article several weeks later and last week (four months later) the author, Satoshi Kanazawa, finally apologized to his employer, the London School of Economics. However, his apology was insufficient, made only to his employer and not to the thousands of women he hurt and offended or the countless number of readers he misled with his “science.” As clinical psychologists, we know well the impact that this kind of painful event can have on the development of healthy identity in young women. It is our shared problem when these things occur, and our shared responsibility to prevent them.


The second issue of particular relevance to us was the study commissioned by NIH-finding that Black scientists are less likely than White scientists to receive NIH research dollars (e.g., a 10% point gap between Black and White researchers in winning R01 grants). This kind of discrepancy greatly affects the understanding of cultural issues in mental and public health, development of culturally responsive prevention and intervention programs, retention and success of ethnic minority faculty who are striving to fund their research, as well as recruitment and training opportunities for ethnic minority students. APA is working with a number of other organizations and professional associations to formulate a coordinated response. This is another issue that affects us all and we encourage our members and all psychologists to respond to NIH directly. The Director of the Office of Extramural Research has opened the blog where people can openly discuss the topic. <http://nexus.od.nih.gov/all/2011/08/18/new-nih-study-on-diversity/>

These are the kinds of issues that led to the formation of Section VI and make this section relevant 25 years later.

By bringing our voices and talents together, we play a critical role in making clinical psychology a leader in advocating for equity and justice.

Section VIII: The Association of Psychologists in Academic Health Centers

Barry A. Hong, Ph.D., FAACP

 The *Journal of Clinical Psychology in Medical Settings*, the journal of Section VIII, has significantly increased its impact factor from 0.683 to 1.506 under the leadership of Dr. Barbara Cubic. JCPMS continues to highlight the research and work of clinical psychologists in health centers and in the practice of medicine. A Special Issue of JCPMS edited by Dr. Barbara Melamed has been published (June, 2011) entitled “Strengthening Our Soldiers (SOS) and Their Families.” A good deal of media attention has been given to Dr. Albert Rizzo’s article about the use of “clinical virtual reality” in the treatment of PTSD for military personnel. The article reviews the military efforts with this technology and intervention. This special issue will highlight clinical psychology’s efforts to address the wartime problems of our soldiers and their families.

Dr. Susan McDaniel, Associate Chair of the Department of Family Medicine and Director of the Institute for the Family at the University of Rochester School of Medicine, received the Society of Teachers of Family Medicine Recognition Award this year (2011). Dr. McDaniel is a longtime member of Section VIII. Congratulations to Susan for being such an exemplary psychologist that even the physicians in family medicine recognize her contributions to their field and her educational efforts with their residents, teaching faculty and practitioners.

The work of representatives in the Council of Academic Societies of the AAMC has also been very fruitful. The Association is very well represented by Dr. Patrick Smith who is the Associate Dean of Faculty Affairs at the University of Mississippi and by Dr. Cynthia Belar, from the Educational Directorate of the APA. It was cited by both of our representatives the importance of teaching health centers (THC’s). Dr. Belar gave emphasis that within the AAMC work being done on inter-professional education. Inter-personal education is one of the building blocks for better integrated multi-disciplinary patient care. She cited that there are strong

implications for psychologists in academic health centers with this particular project.

Division 12 members may also be interested in a recently published article by Dr. Bill Robiner, President of APAHC, entitled "Hospital Privileges for Psychologists in the Era of Competencies and Increased Accountability" which was published in the *Journal of Clinical Psychology in Medical Settings*, December of 2010. Bill points out many issues that are affecting hospital privileges will have direct bearing on psychology membership in hospitals. Much of this is led by reforms and new standards required by the Joint Commission. These new standards will make it more difficult for psychologists to maintain privileges at community hospitals as well as make it difficult for physicians who do not use hospitals on a regular basis.

Finally, at APA, Dr. Steve Breckler, Science Director of the APA, met with the Research Committee of APAHC chaired by Dr. Gerry Leventhal to discuss work force issues for psychologists in academic health centers. Data will be jointly gathered with the help of the AAMC Workforce group for the mutual benefits of APA, AAMC and APAHC.

Section IX: Assessment

Norman Abeles, Ph.D.



Here is an update on our officers. Paul Arbisi, PhD, a clinical psychologist at the Minneapolis VA is the new President Elect. Ginger Calloway, PhD a clinical psychologist in independent practice in Raleigh, NC is our new secretary. Yossef Ben-Poreth, PhD continues as our President. Our Journal Editor is Michael Bagby, PhD. He is Director of Clinical Research at the Toronto, Canada Center for Addiction and Mental Health. He also holds an appointment as a Professor in the Department of Psychiatry and Institute of Medical Sciences at the University of Toronto.

In other assessment news there is considerable discussion among researchers concerning the prediction of the presence of Alzheimer's disease (AD). There are now biomarkers for AD which may be useful in predicting AD long before there are any symptoms. While the sensitivity and specificity of these markers are likely not fully established they have been recommended it might be helpful for the development of treatments for AD even though there are currently no effective treatments for this disease. It may also help eventual caregivers get

prepared for the onset of symptoms for their loved ones. Early diagnosis of other disease like high blood pressure can help the prevention of strokes and heart attacks. However there is as yet no effective treatment for AD. Some wonder if patients really want to know about an untreatable disease when there are no symptoms. In addition the testing for biomarkers can cost several thousand dollars. The Alzheimer's Association recommended the use of molecular and structural biomarkers. Some researchers argue that using these criteria may be helpful in the search for effective treatments. The ethical dilemma for the individual is whether or not knowing that one has the potential for AD is helpful to the individual especially when one has no symptoms.

Another interesting assessment issue is described in a proposed decision memo for screening for depression in Adults by the Center for Medicare services (CMS). That memo states that screening for depression is necessary for the early detection of depression for individuals enrolled for Medicare benefits. CMS proposed to pay for such screening by primary care physicians aided by nurses and physician assistants. Screening tests include the Hamilton Depression Rating Scale, The Beck Depression Inventory, the Zung Self-Assessment Depression scale, The Center for Epidemiological Studies Depression Scale, the geriatric Depression Scale, The General Health Questionnaire the Patient Health Questionnaire and the Cornell Scale for depression in dementia. ■■

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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.

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