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EDITORIAL

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By J. Gayle Beck, Ph.D., University of Memphis, TN

PRESIDENT'S COLUMN

The dog days of summer – and our horizons

As I look out my window at the crepe myrtles blooming on a beautiful Wednesday afternoon, it seems like summer has set its teeth into all of us. Everyone is a bit laconic in their speech and deeds, as if somehow expending energy is not for this season. The Society, however, is on the move. We are in the midst of a major revision of our web site and have begun Society-wide dialog about the design of **new member benefits** for you (including an active continuing education program which would provide free CE to members). Moreover, we have re-structured and re-focused several committees, with the aim of **engaging you,** our members, to a greater extent. And we are working on new ways to **encourage new members,** particularly among early career professionals.

In this column, rather than talk (er, write), I am soliciting your input – I want to listen to you, our members, rather than describe what has transpired or what we have done. I welcome your input on several issues in particular:

- How could the Society engage its membership to a greater extent?
- Are there needs that the Society could help to fill, by way of increased member benefits?
- Considering continuing education, are there specific topics that you would like to learn more about?
- Do you have a preference for how CE is delivered to you by the Society? Some individuals prefer readings (followed by a short test), others prefer webinars, and yet others prefer to listen to pre-recorded talks or workshops. Each of these medium have specific technical requirements. Which do you prefer? Why?
- How can the Society's website be more useful to you? Are there resources that you would like to see added to the website?
- If you were a newcomer in the field of clinical psychology, what would attract you to the Society of Clinical Psychology?

So, even though it's the Dog Days of summer, this is actually a time of tremendous development within the Society. Your input matters more than you perhaps realize. Please email your thoughts and ideas to me at jgbeck@memphis.edu. I am all ears!

New list serve policy on research requests

Previously, the Society list serve was open for members to post solicitation for research participation. In June, the Board of Directors was asked to examine this issue. In particular, the

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Society's practice was in violation of APA's policy, which prohibits solicitation of research participants via an APA-sponsored list-serve; this policy is based on the fact that this type of participant recruitment results in sample bias. The Board of Directors felt that the APA policy was sound and thus, revised our operating policy.

New leaders elected

In mid-June, we learned the results of the 2012 elections. I am pleased to announce the evolving leadership team for the Society:

President-Elect: David Tolin, Ph.D.

Member at Large: Cheryl Boyce, Ph.D.

Council Representative:: Danny Wedding, Ph.D.

We were quite fortunate to have a strong slate of candidates in this election. Thank you all for your willingness to serve the Society.

And a **heads up** – the Call for Nominations will come out in early October. If you are interested in participating in the Society leadership, please consider this opportunity. Self nominations are welcome.

Our thanks to Hogrefe!

Once again, Hogrefe Publishing has generously provided sponsorship for the Society social hour at the

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GRAPHIC DESIGN

Jason Crowtz

Annual Convention, as well as copies of the Society's book series for specific award winners. We have benefitted greatly from our partnership with Hogrefe and express our gratitude to this publishing house for their continued generosity. And additional thanks to Danny Wedding, who has ably served as the Editor of this series.

On the horizon…

Initiatives that are in progress but not quite ready for prime time include:

- Our new website. We have recently selected our new web editor (Damion J. Grasso, Ph.D., University of Connecticut Health Center). Welcome to our publications team!! Now that many of the technical details have been ironed out with our web designer, we will be relying on Damion to move us forward. Look for a more attractive site, which will be easier to navigate, updated more frequently, and provide useful tools and resources about Clinical Psychology.
- Direct Member benefits on the website, accessible via a Members only section. Again, this is another work in progress.
- Our continuing education program – WE REALLY NEED YOUR INPUT HERE! Feel free to send your answers to the questions that I raised earlier. Any and all additional thoughts and ideas are welcome.

Again, I value your input on these emerging activities. This is your Society – your involvement is essential as we aim for new horizons.

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ON BECOMING A FELLOW OF THE SOCIETY OF CLINICAL PSYCHOLOGY

The Society of Clinical Psychology, APA Division 12, welcomes within its membership psychologists who are interested in and who identify with the field of clinical psychology---its practice, research, service, and/or missions. Besides being an esteemed member of Division 12, there are within our Society those who should be considered to be nominated and elected to fellow status. Many such members have not taken steps to apply for fellow status. Sometimes this is due to extreme modesty in evaluating one's own achievements, intimidation by the thought of the application process and being reviewed by peers, modesty in asking others for endorsement, or simply time constraints. Yet becoming a fellow of Division 12 holds many rewards and benefits well worth applying and focusing on successful election to fellow status.

There are two categories of fellow status: initial fellows and previous fellows. Initial fellows are those who have not yet been elected to fellow status in any APA division and need to apply for this in the division. Endorsements by three fellows are required. Current fellows are usually willing to mentor the initial applicant through the process and thus make it more user-friendly. Previous fellows are those who, having been fellowed by another division, can state how their work and experiences also qualify them to become fellows of Division 12. All members who are not yet Division 12 fellows or fellows of any other division need to consider applying for fellow status in Division 12. All who are current fellows are encouraged to give a helping hand to deserving potential fellows who might otherwise be overlooked: Nominate others who should be recognized for their outstanding and unusual clinical research, practice, or services.

What are the benefits and rewards of becoming a fellow of the Society of Clinical Psychology? The deserved recognition, appreciation, and greater visibility of one's research, practices, and service by one's peers are highly important to most of us. Research can certainly be disseminated without being a fellow, but having one's work seen in the light of becoming a fellow within the Society of Clinical Psychology burns a far brighter and visible light on one's accomplishments and achievements. Often the more modest members within our Society feel overlooked and even isolated by the lack of colleagues recognizing and appreciating one's work and nominating him or her for fellow status.

The networking and cross-research connections may be much increased when members become fellows. Collegiality is usually increased as fellows more identify with the field and their contributions to clinical psychology. Greater opportunities to share what one has done in clinical psychology usually come with fellow status. Often more opportunities to enter divisional offices come after one is fellowed. Fellows are often more sought for mentors of peers and early career psychologists, as well as in teaching and advisor capacities. Fellows have often been cited and referenced before being fellowed but may find even more of such citations and references after their fellow status has been achieved.

Sometimes our members overlook Division 12 sectional interest groups, such as sections on children, women's issues, ethnic minority issues, and research. Special achievement within these groups may well merit fellow nomination and election. Further, opportunities for intra- and interdivisional interests may foster new opportunities and challenges for research, practice, and publication. Our Society has more abundant and untapped talents and skills than we have sufficiently appreciated and that need to be acknowledged.

The greater collegiality and sense of appreciation by peers in adding deserving fellows to the Division enhances division cohesiveness and solidarity and contributes to the strength of the field of clinical psychology itself. Look in the mirror and at your colleagues and nominate the worthy for fellows!

—Carole A. Rayburn, Ph.D. Fellows Chair, Division 12

The Strong African American Families (SAAF) Program: Bridging the Science to Practice Gap in Prevention Science

Christina Grange, Ph.D. and Gene Brody, Ph.D.
Department of Psychology
University of Georgia

A challenge for prevention science and clinical research is the effective translation of programs and interventions from research trials to tools useful in practice. While significant advances have been made in the development and testing of family-focused prevention programs, challenges in selecting and implementing programs at the local level can be a barrier to translation efforts and ultimately contribute to the lack of adoption and sustainability over time (Mitchell, Florin, & Stevenson, 2002). The Strong African American Families (SAAF) program is one example of how interventions developed in the context of research can be translated into programs used by agencies communities across the country.

SAAF is a family-centered prevention intervention for rural youth. It is designed to capitalize on naturally occurring protective processes that buffered African American youth from poverty and other hardships in rural communities. Clinical research trails conducted by the Center for Family Research (CFR) at the University of Georgia support SAAF's efficacy for preventing risk behavior, particularly substance use among African American youth (Brody et al., 2004). Since the efficacy trial, dissemination efforts have been initiated to increase program access and usability. Key elements of the SAAF dissemination model are highlighted below to indicate possible strategies for the dissemination of evidence-based prevention programs (EBPPs).

SAAF Development

SAAF's mission is to strengthen family relationships, parenting processes, and youth competencies in a manner that will reduce youth risk behavior. Research indicates that the rates of substance use among African American youth in rural communities is approaching, and in some cases surpassing, the rates of those in urban communities (Kogan, Berkel, Chen, Brody, & Murry, 2006). SAAF was developed as a multi-session, family-centered program to prevent such substance use and other risk behaviors among African American youth. In total, SAAF is developed so that youth and caregivers each receive 14 hours of prevention training across seven program sessions (Murry & Brody, 2004).

SAAF Dissemination Components

SAAF's Core Values

SAAF's Core Values are shared and modeled during training so that facilitators can infuse them into subsequent implementations with families. These values are consistent with recommendations from the American Psychological Association's (APA) Task Force on Resilience and Strength in Black Children indicating that meaningful considerations of the strengths of African American families should take into account their cultural integrity, as well as their unique experiences as an involuntary ethnic group in the United States (American Psychological Association, 2008). These values include operating from a (1) strength orientation, (2) demonstrating collectivism, (3) having ownership, and (4) recognizing the need for social justice. Operating from a Strength Orientation involves recognizing that people are not dominated by their problems. All families can benefit from opportunities to develop new competencies or enhancing existing skills. Collectivism reflects the unity present in a shared purpose and the benefits of working together to foster healthy families and communities. SAAF recognizes the benefits that participants get from sharing with and learning from one another. Ownership emphasizes that the lived experiences of African American families are relevant and valuable. Each facilitator's and participant's contribution is important for a successful group experience. The final Core Value is Social Justice emphasizing that we live in a society that presents unequal opportunities and that access to opportunities is too often affected by factors such as race, gender and class. SAAF provides a place to share experiences related this injustice, acknowledges the historical and current effects of injustice on African American communities, and facilitates problem-solving to avoid being limited by related barriers.

Working with Community Agencies

The CFR recognizes that effective dissemination of SAAF involves partnering with agencies across the country and supporting their efforts to build relationships with other agencies and organizations in their communities. Research efforts have illuminated the benefit of partnering with local organizations or agencies to recruit and implement family-centered programs (Murry & Brody, 2004). Community resources are often sparse so partnering to bring EBPPs to families can maximize all resources – human, structural, and financial. For example, in Pennsylvania a university community outreach office adopted SAAF and later partnered with a local community agency to implement SAAF in a context where other services where already being provided for young girls and their mothers. To support these types of relationships and many other components of successful implementation, the partnership between the CFR Dissemination Office and SAAF site is critical.

SAAF Facilitator Training

It is recommended that EBPP training initiatives have clear criteria that guide program adoption, develop strategies for evaluating the training, integrate cognitive and interpersonal skills, and provide the opportunity for behavioral rehearsal (Elliott & Mihalic, 2004). SAAF three-day training integrates these elements with the goal of building competencies that will allow for implementation fidelity. Equally important are the relationships among training participants and trainers that will support future implementation efforts. Training participants are encouraged to ask questions and make contributions that can help trainers know how to adapt training components to be most relevant to the context in which the program will be used. Trainings involve role plays and hands-on exercises that parallel program activities. On the third day of training, participants simulate the facilitation experience by leading specific curriculum activities while the trainer and other facilitators act as program participants. Doing so allows training participants to work through their anxieties and curriculum complexities with the goal of ultimately implementing with fidelity and comfort. After each training, participants complete trainer evaluations and a general training evaluation to support continuous quality improvement efforts.

Recruitment and Engagement

SAAF dissemination efforts stress the value of effective recruitment and engagement strategies. The following approaches have successfully been used in CFR research trials and are shared with SAAF sites to support implementation efforts.

Community Liaisons

SAAF's retention rate of over 85% is attributable to the establishment of a community liaison network (Murry & Brody, 2004). Community Liaisons (CLs) are residents of the communities in which targeted families live. SAAF sites are strongly encouraged to integrate a community liaison system allowing for the CL to serve as the link between agencies and targeted communities. In a Georgia community that adopted SAAF, this system was implemented with success when a mother, and previous SAAF participant, served as the CL. Her success in getting families to attend SAAF sessions was largely due to the fact that she was a respected and trusted community member.

Communication

USPS mail, phone calls, home visits, and electronic communication (texting, emails, and social media) are all methods that can (1) help keep potential participants abreast of program activities and (2) let them know that their attendance is valued by the host agency. Host agencies might also consider providing a program brochure to describe program sessions. When testing SAAF, reminder calls and post-cards were helpful in keeping families engaged, particularly given the stress and multiple responsibilities facing many caregivers. As technology evolves some SAAF sites use texting and social media to keep families engaged. Finally, planned home visits can also be opportunities for families to learn about SAAF and develop rapport with program staff.

Technical Assistance

Technical assistance is provided throughout all phases of a site's experience with SAAF – from initially exploring the program through efforts to sustain the program. To start, agencies are given a Readiness for Adoption Survey to assess their ability to implement SAAF successfully and maintain programming over time. Through the process of training preparation, the CFR Dissemination Office is in close communication with agencies and provides a SAAF Site Resource Manual to guide training preparation as well as future implementation efforts. Post-training TA continues

to be available to support systems for recruitment, implementation, and sustainability.

Conclusions

The experience with SAAF suggests that dissemination is not an easy process. However, given the potential benefits to communities and the resources invested in determining program efficacy, it is a necessary one. As intervention research efforts continue to develop, dissemination should be an early consideration. This increases the likelihood of getting EBPPs programs to communities and families across the country.

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For further inform please contact cgrange@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:
Winter issue: January 3
Spring issue: April 1
Summer issue: July 1
Fall issue: October 1

Editor:
Milton Strauss *milton.strauss@gmail.com*

Psychology & the New MCAT

Barry Hong, Ph.D., ABPP
Washington University School of Medicine

In 2015 medical student applicants will be taking the new revised Medical College Admission Test (MCAT). The MCAT exam has been in use since 1928 and the current version (fifth revision) has not been modified since 1991. This "high stakes exam" has been a major factor in determining an applicant's readiness for medical school. Almost 80,000 tests are administered annually. The current changes reflect topical changes in medicine as well as changes in the perceived qualities desired in physicians. In addition to the traditional areas of biology, physics and chemistry, questions will reflect newer areas of study such as cell and molecular biology, genetics and genomics. What will be surprising to medical school applicants and to pre-med advisors is an added emphasis on psychology, behavioral science, statistics and research design. The new MCAT will consist of four parts assessing knowledge in 1) biological and biochemical foundations of living systems, 2) chemical and physical foundations of biological systems, 3) psychological, social and biological foundations of behavior and 4) critical analysis and reasoning skills. Psychology and behavioral science will receive as much attention as biology/biochemistry. These major test sections correspond to the knowledge and skill base that physicians need, and excellent physicians will be the ones who can integrate each of these areas in their practice of medicine.

The preliminary work and input to the MCAT Revision Committee (MR5) was comprehensive and exhaustive. The diverse 21-member committee included deans, educational affairs, student affairs, undergraduate faculty, premed advisors, and two psychologists (a neuroscientist and a clinical psychologist-myself), which was meant to insure that the new MCAT would be a valid, balanced and comprehensive test.

The information and data which drove the recommendations came not only from MR5 but also from undergraduate and medical school faculty, basic and clinical faculty, medical students and residents. Input from other sources including the AAMC—Howard Hughes Medical Institute report on the Scientific Foundations for future physicians, the AAMC Behavioral and Social Sciences Expert Panel, the AAMC Holistic Review Project, and the 2004 Institute of Medicine report - which recommend that behavioral and social science be enhanced in the medical school curriculum were considered. All of this information was supplemented by data gained through 2,700 surveys of medical students, residents, medical faculty and administrators, asking what they believed to be essential areas of medical education. Thus, there was an overwhelming amount of data and information supporting the new changes in the MCAT.

The new MCAT will measure critical analysis and reasoning skills. These are skills not unique to medicine, but fundamental skills for many professionals and educated individuals. With knowledge increasing at a rapid rate, physicians will need to carefully evaluate new information and scientific data. How to think logically, rationally, empirically and systematically about issues and problems will be measured in this section of the examination. Passages which evaluate these skills will come from diverse offerings in ethics, scientific studies, cross-cultural studies as well as the news/public media.

The focus of these MCAT changes has been not the accumulation of additional knowledge, but in contrast, the integration of all areas which influence health and illness behavior. There has been a mistaken notion that the psychology/behavioral science part of MCAT will measure personality and psychopathology; however, psychological concepts such as altruism, cooperativeness and extroversion will not be measured. This section of MCAT will measure knowledge and the integration of biology with social science and psychology.

The new MCAT will be a more comprehensive examination evaluating knowledge and skills across a diverse set of areas. It will be a historical change from previous MCAT exams, but hopefully a better exam. It will not be sufficient to be well prepared in the natural and physical science only. The new MCAT will continue to be a major factor for students considering application to medical school. In its new structure, it will give admission committees additional input about the academic preparedness of potential students and about their abilities to consider more holistically

their patients and the greater society. The challenges confronting present-day medicine will go far beyond conversations held in physician examination rooms, but will be addressed in the application of medicine in the community and society. In this context, ethics, public good and human values will be important variables to consider.

The importance of the inclusion of psychology and behavioral science on the MCAT cannot be minimized. Students who aspire to a career in medicine or any health profession will be alerted to the fact that psychosocial/cultural issues matter. The new MCAT will "raise" the level of undergraduate psychology education, as knowledge of the scientific aspects of psychology will be needed by pre-med students. This may raise the level of scientific psychology instruction in many colleges and universities. Indirectly, the MCAT will help raise the awareness that psychological science is a foundational, essential aspect of health care. The new MCAT may have a ripple effect as more of society appreciates the input of psychology to health and illness.

For those of us in the psychology community, we can strive to ensure that future physicians get the needed background and input from our discipline. These are lofty goals but worthy of our best efforts and engagement.

Note: Dr. Barry Hong has been a member of the twenty-one member MR5 Committee since 2008, representing clinical faculty members in medical schools. His membership on the committee is ongoing. He was the previous representative of the Association of Psychologists in Academic Health Centers (APAHC) to the Council of Academic Societies (CAS) of the AAMC and has served on various AAMC committees. Dr. Hong is Professor of Psychiatry, Internal Medicine and Psychology at the Washington University School of Medicine in St. Louis and the Vice-Chair for Clinical Affairs in the Department of Psychiatry.

This article was adapted from the APAHC newsletter, Grand Rounds (2012, Spring).

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!

Edgar A. Doll as a Clinical Psychology Leader

Donald K. Routh, Ph.D., University of Miami

These days Edgar A. Doll is remembered mainly as the author of the Vineland Social Maturity Scale, an interview-based measure of what is now labeled as Adaptive Behavior. In his day he was considered one of the main leaders of the relatively new field of clinical psychology. He was co-chair of the Clinical Psychology Section of the American Psychological Assocation (APA) in 1932-33 and chair of the Section in 1933-34. In 1938-39 and 1939-40 he was vice president (chair) of the Clinical Section of the American Association for Applied Psychology. In 1945-46 he served as the first president of the new Division 12 (Clinical Psychology) of the American Psychological Association. In addition, during these years he also presided over other major organizations in the field, including the American Orthopsychiatric Association and the American Association on Mental Deficiency.

Because of Doll's influence, for many years the official clinical definition of mental deficiency in the United States required both low IQ and impaired adaptive behavior.

Doll was born in 1889. He earned his bachelor's degree from Cornell and a masters degree in pedagogy from New York University. He was one of the early persons to serve as a psychology intern at the Vineland School in New Jersey, the first institution to initiate such internships in 1908. Doll was the first person to state that training in clinical psychology should require not only a PhD but an internship.

At Vineland his mentor was psychologist Herbert Goddard, the research director at Vineland and the person who first had the Binet test translated into English and demonstrated its validity in diagnosing mental deficiency. Doll received his PhD in psychology from Princeton University in 1920, in a collaborative arrangement which permitted Goddard to supervise his dissertation. Doll's research examined IQ scores in the Vineland population and concluded that in contrast to the claims of colleagues such as Lewis Terman, IQ scores could not be considered to be constant over time.

Doll served for many years as the research director at the Vineland School, and it was there that he developed his Social Maturity Scale. This scale was based on the interviews of parents or other persons who knew the individual well who described what the person characteristically did, in contrast to the IQ test, which is based on direct observation of performance on standardized tasks. Its subscales included communication skills, general self-help ability, locomotion skills, occupation skills, self-direction, self-help eating, self-help dressing, and socialization skills. Doll used this Scale to document systematic differences in social competence between persons with intellectual disability who required institutional placement and others with the same IQ levels who were able to live outside institutional walls. Indeed, because of Doll's influence, for many years the official clinical definition of mental deficiency in the United States required both low IQ and impaired adaptive behavior. In recent years, Sara Sparrow and her colleagues at Yale standardized and published a revised version of Doll's work under the title of the Vineland Adaptive Behavior Scales. Newer measures of adaptive behavior have proved to be important in the assessment of intellectual disability but also of other conditions such as autism spectrum disorders, which involve notable deficits in social competence.

Doll's career illustrates how much clinical psychology changed over its first century of existence. In the early years of the field before World War II, clinical psychologists spent much of their time in assessment activities, particularly with children. Like Doll, many of them were regarded as experts in the assessment and management of intellectual disability. Beginning in the postwar era, the field changed its focus toward work with adults and became much more occupied with intervention, including psychotherapy as well as behavior and cognitive therapy.

Behavioral Intervention Technologies to Support the Health and Development of LGBT Youth

Brian Mustanski, Ph.D., Department of Medical Social Sciences, IMPACT LGBT Health and Development Program, Northwestern University and

Michelle Burns, Ph.D., Department of Preventive Medicine, Center for Behavioral Intervention Technologies, Northwestern University

Multiple health disparities indicate critical need for intervention research with lesbian, gay, bisexual, and transgender (LGBT) youth. For example, LGB youth experience greater depressive and bulimic symptoms, and higher rates of substance use and suicidality, than heterosexual youth (IOM, 2011). The prevalence of HIV in young men who have sex with men (YMSM) is alarming, and convenience samples also suggest high rates of HIV and substance use among young transgender women (IOM, 2011).

Research supports a minority stress model to explain health disparities among sexual minority people through exposure to stigma-generated stressors. Indeed, LGB youth are at higher risk for physical and sexual abuse, peer victimization, and homelessness than heterosexual youth (IOM, 2011). Unfortunately, LGBT youth also face difficulties when accessing healthcare. General barriers can include lack of knowledge about available resources, inadequate insurance, transportation difficulties, and concerns that parents may discover use of particular services. LGBT youth face additional barriers such as reluctance to disclose sexual orientation, and related health issues, to providers due to anticipated discrimination. Many providers are also inadequately trained in LGBT health issues (IOM, 2011).

Online and mobile resources can address these barriers by delivering tailored health information and interventions directly to LGBT youth. Adolescents and young people maintain the highest online presence of any age group, and about 1/3 of online youth use the Internet to find health information (Lenhart, Purcell, Smith, & Zickuhr, 2010). Such resources may be especially beneficial for LGBT youth, who are more likely to seek health information online than heterosexual youth (Mustanski, Lyons, & Garcia, 2011; Ybarra, 2012). They also use the internet to explore their identity, forge romantic relationships, and connect to the larger gay community (Mustanski, Lyons, et al., 2011). For many LGBT youth, the Internet allows privacy and anonymity, permitting increased control over information seeking and disclosure than traditional offline settings. The Internet can also act as a bridge to offline resources that would otherwise be unknown or unutilized (DeHaan, Kuper, Magee, Bigelow, & Mustanski, 2012).

Behavioral Intervention Technologies (BITs) use communication technologies to improve health outcomes by targeting behaviors, cognitions, and emotions. Web-based BITs can provide multimedia didactics, skill-building exercises, feedback, and self-management tools (e.g., behavior tracking). Mobile BITs employ handheld devices and mobile phones to intervene as patients complete daily activities in their own environments, and can tailor intervention to patients' current states. BITs also include telemedicine, internet support groups, virtual worlds, and games (Burns & Mohr, in press).

For example, *Keep It Up!* (KIU!) is a web-based BIT we developed to prevent HIV among YMSM, who are recruited by clinic staff upon a negative HIV test result. Recruitment was linked to HIV testing to reach more diverse YMSM and build greater prevention into HIV testing and counseling. Most web-based HIV behavioral studies of MSM have substantially under-enrolled racial minorities. Our experience with minority YMSM suggested face-to-face recruitment by trusted HIV clinic staff could facilitate enrollment, even when the intervention was subsequently delivered online. Indeed, there were no racial differences in willingness to participate (Du Bois, Johnson, & Mustanski, 2011). KIU! used mixed delivery modalities (actor and lay videos, games, quizzes, a virtual bar, etc.) to educate about HIV transmission, motivate risk reduction behaviors, and provide skills for effective prevention. A pilot RCT demonstrated KIU!'s feasibility, acceptability, safety, and efficacy at reduc-

ing unprotected sex relative to an active control arm (Mustanski, Garofalo, Monahan, Gratzer, & Andrews, Under Review).

We are also developing a web and mobile phone intervention for anxiety and depressive disorders among YMSM. First, constructs from minority stress theory are being evaluated as longitudinal predictors of anxiety and depression in YMSM. The intervention website will teach cognitive behavioral therapy (CBT) techniques, which will then be applied to YMSM-specific predictors of anxiety and depression revealed by the longitudinal analysis. The phone application will translate CBT into YMSM's daily lives. Several times daily, the phone will prompt youth to report their emotions and contextual states. Youth can discover emotional triggers by graphing states against one another (e.g., sadness by location). The phone will provide outreach when youth report or anticipate distress, suggesting coping strategies tailored to the particular emotion(s) and intensity.

The potential and pitfalls of online recruitment for diverse and "hidden populations" have been a perennial focus of this method. As mentioned, racial diversity in most online samples has been disappointing, although mobile devises may help eliminate this digital divide (Lenhart et al., 2010). It is critical that researchers carefully consider the most appropriate recruitment channel for BITs, including offline sources. It's also critical that researchers plan for ethical issues related to BITs. For example, if items ask about suicidal ideation, is there a plan for timely response? Similar issues arise in face-to-face treatment, where clinical emergencies most often occur after hours.

One of the keys to a successful BIT is to use novel approaches that cannot be accomplished offline, and there is enormous potential for these diverse technologies to overcome access barriers and reduce health disparities. Only a handful of BITs have yet been developed for LGBT youth, suggesting this research area is ripe for expansion and innovation.

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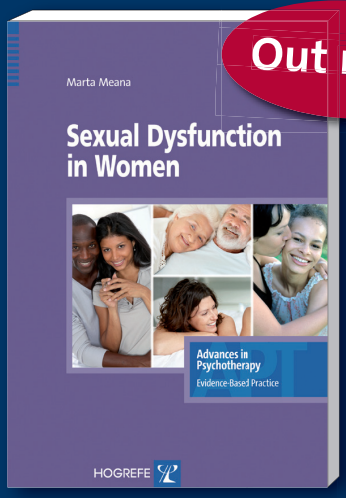

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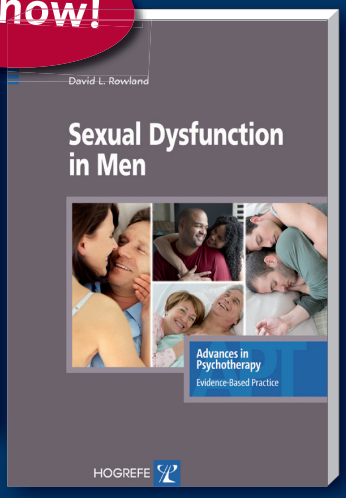

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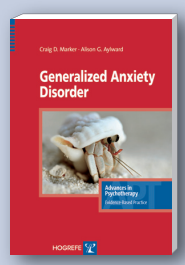

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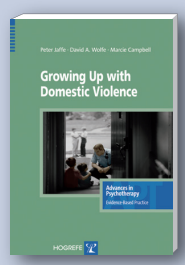

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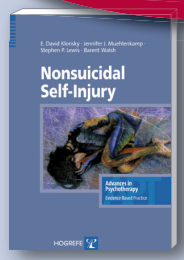

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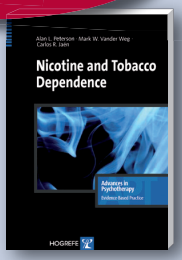

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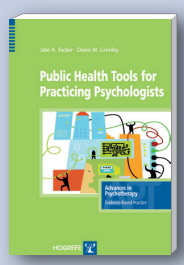

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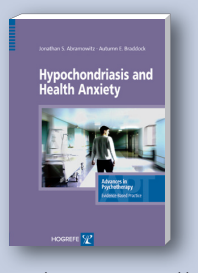

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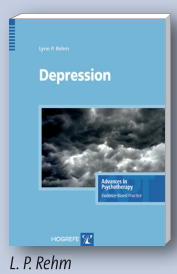

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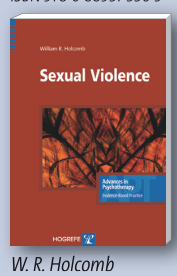

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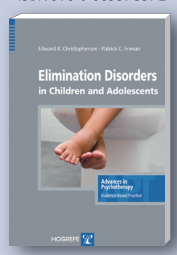

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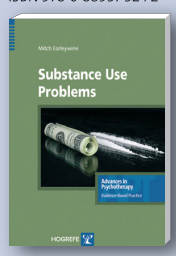

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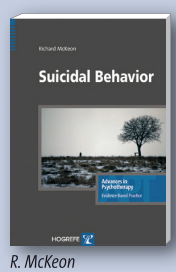

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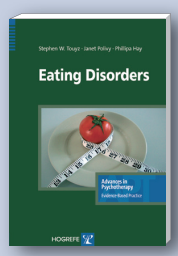

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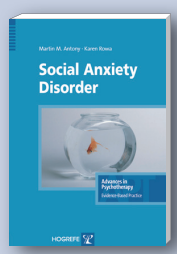

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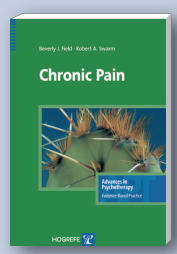

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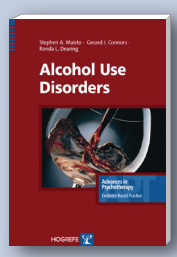

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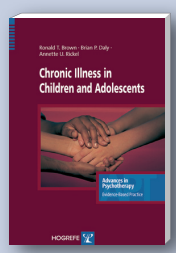

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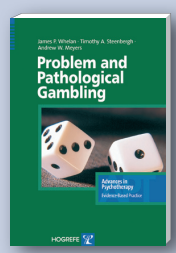

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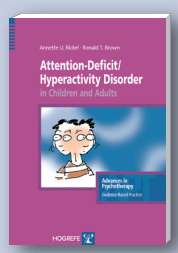

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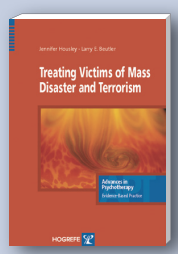

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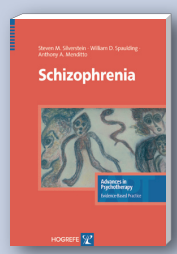

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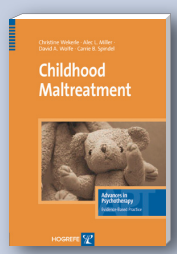

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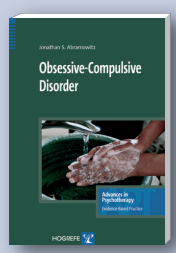

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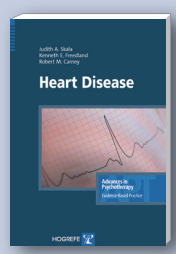

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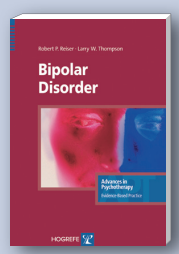

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How Social Cognitive Career Theory Can Influence Career Development in Clinical Psychology

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

Undergraduates regularly ask me and my fellow graduate students about how to improve their chances of obtaining entry into graduate school. However, getting in is just the first of many steps towards reaching a fulltime position in clinical psychology. In research-oriented programs, graduates student often internally debate the merits of an academic or research career versus one that emphasizes clinical practice. In practice-oriented programs, the possibilities within a clinical career provide a vast array of career options. While opinions often change across the course of graduate school as to what path fits best, especially as students are presented with numerous options beyond simply what their professors have chosen to pursue, there are frameworks available to help to match individuals to the best career fit. Social cognitive career theory (SCCT) (Lent, Brown, & Hackett, 1994) is a framework that identifies both cognitive-person variables and environmental variables as essential components to understanding career development. These can also be used to help individuals to identify which career paths are likely to be appropriate for meeting one's goals while also matching individual strengths.

Cognitive-person variables include goals (e.g., to become a practicing clinician), self-efficacy (e.g., feelings of one's own competence), and outcome expectations (e.g., following the attainment of a goal, you enjoy having obtained it). Environmental variables include demographic factors (e.g., sex, ethnicity), institutional support (e.g., career support from one's home institution), social support (e.g., supportive mentors and family members), and barriers. Such barriers may be both real and perceived. For example, the ability to be hired for a tenure-track position at a research university may be hampered without proper research training, yet where that threshold lies may vary based on the particular applicant and search committee.

Both cognitive-person factors and environmental factors are important in career development, and also can interact with one another. As we learned in Psychology 101, individuals differ in important ways, including how much they seek out new experiences in their environment. Those who are temperamentally less inclined to attempt new activities or apply for a training position that is relatively uncharted are likely to have fewer learning experiences without challenging themselves. The greater array of learning experiences we have, the more opportunities we have to develop a sense of self-efficacy, to test whether obtaining a goal was really what we desired, and, most obviously, to see whether we enjoy what we were doing in that experience. For example, my graduate program had forged ties to a training hospital across the city, but no students had yet applied to the child and adolescent trauma placement. Although there were training opportunities in which I knew much more about the day-to-day procedures and population, I took a small risk and applied for the trauma clinic. This experience opened my eyes to a range of careers I had not known existed – working as a clinician and researcher in a community hospital. My supervisors perform several of the same activities as my professors in the psychology department (e.g., supervise students, write empirical and theoretical articles, run treatment trials), yet had an entirely different work structure and outlook on career trajectory. It was refreshing to learn about new opportunities, and I enjoyed the opportunity to provide treatment to a population different from those in the home department clinic.

While it is important to gain a variety of experiences and learn about the multiple career options one has as a clinical psychologist, SSCT also emphasizes that we are not simply receptacles of information. We interpret information with our own biases. For example, if a treasured mentor did not value a particular psychotherapy orientation, we may be less open to seeking out that training or less invested during a placement with an emphasis in that particular orientation, despite the possibility of it being a personally good fit. In order to combat the potential negative biases, students should be open to recognizing the factors that may influence our decisions. In addition, personal interest in career prestige, a desire for flexibility in time commitment, and the values we have for people and activities outside

of our career will also affect both career interests and career goals.

In addition, establishing suitable career goals also requires the ability to successfully manage that career. Someone without any training in neuroscience should not expect to be the director of a neuroimaging institute. Similarly, if one's goal is to be a child psychologist in a community setting, experience working with children, and especially one in which was both personally rewarding and there was a degree of objective success (e.g., supervisor's positive appraisals of one's work) in a similar setting and population would bode well for continued success in such a career. Thus, while both interest and experience is not sufficient, actual likelihood of success is important to obtain. Students may receive feedback and appraisals of success both in direct manners (e.g., grades, progress reports from one's academic advisor or clinical supervisor), and indirectly (e.g., interactions with clients, professors, other students). Although receiving negative feedback can certainly be unpleasant, if accurate, it may be essential information for gathering information on what career goals are likely to be more or less a good option in the long run.

In sum, career development in any field is multifactorial. In clinical psychology, the gift and challenge is that the career options are seemingly limitless. In order to increase your odds of finding a path that is the right fit, gaining several experiences, being aware of one's own biases, and remaining realistic about the possibility for success in any particular position are likely to each contribution to career match.

Reference:

Lent, R. W., Brown, S. D., & Hackett, G. (1994). Toward a unifying social cognitive theory of career and academic interest, choice, and performance. *Journal of Vocational Behavior,* 45, 79-122.

VISIT THE SOCIETY OF CLINICAL PSYCHOLOGY AT THE 2012 APA ANNUAL CONVENTION

The 120th American Psychological Association Annual Convention will take place Aug. 2–5, 2012, at the Orange County Convention Center in Orlando, Florida. The convention will feature internationally known presenters on topics and programs highlighting the latest research findings. Programs and sessions will cover issues such as immigration, racism, eating disorders, clinical practice, social networking and psychotherapy.

For more information on the convention and the activities of the Society of Clinical Psychology, contact Lynn Peterson, Division 12 Central Office (Tel: 303-652-3126, E-mail: div12apa@comcast.net).

Is Administration for You?

Cynthia Suveg, Ph.D.

Recently the Clinical program here at UGA underwent the APA reaccreditation process. I was astounded at the necessary preparations. Though all faculty and graduate students contributed in some way to the process, the vast majority of the work was completed by Drs. Steve Miller and Joan Jackson, who served as outgoing and incoming Director of Clinical Training, respectively during the time of the reaccreditation process. To that point in time, I had never really considered what it might be like to serve in an administrative role, though many faculty members do so in some capacity at some point during their careers. My observations of Drs. Jackson and Miller during the reaccreditation process peaked my interest and I asked them a few questions about serving in an administrative role. Here is what they had to share.

"Skills in effectively working with others for a common good, are important, and a realization that, given faculty governance, you may need to work towards group goals that you do not 100% agree with."

What are your primary responsibilities as DCT?

Dr. Joan Joackson: The DCT is, broadly speaking, responsible for ensuring that the program's curriculum is implemented, monitored, and modified as needed. The DCT needs to be familiar with accreditation standards and licensure laws as well as university-level requirements in order to ensure that the design of the curriculum is appropriate and meets the needs of students. A substantial part of the DCT job is concerned with the evaluation of student outcomes, both proximal and distal, and with using these data to inform the direction of the program. The DCT must be aware of employment opportunities available to clinical psychologists and the competencies students need to be prepared for these jobs. The DCT represents the program to external entities including its accrediting bodies and the internship and postdoctoral programs its students attend.

What skills and/or qualities do you think are necessary for a DCT? Are there skills beyond those that are learned in our training that are desirable or necessary?

Dr. Steve Miller: In regard to skills, if not direct administrative experience, a strong interest in wanting to develop administrative skills is necessary. These include the ability to work with and take the perspective of others, effective communication abilities, and ability to recognize and maintain fairness and integrity in dealing with both faculty and students. DCT's will have to deal at some level with budgets, teaching or supervision loads, salary, retention, hiring processes, space allocation issues, contractual relationships, student stipends, admission decisions, student performance, and of course DCT's are responsible for demonstrating the quality of the training experience. Thus, organizational skills are a must to have or to learn. Skills in effectively working with others for a common good, are important, and a realization that, given faculty governance, you may need to work towards group goals that you do not 100% agree with. Everyone comes to the table with either more or less of these skills, but a willingness to develop them if not already there is more important than actually already having all these skills in hand.

The qualities necessary to be an effective DCT are harder to pin down, but a sense of service, an ability to be self-reinforced by maintaining and improving your program, rather than say your research accomplishments, are likely important. I think having a genuine interest in the successful development of ALL the students is very important, as well as genuinely being interested in the wellbeing of your fellow faculty. Other important qualities include patience, thoughtfulness, being a good listener, and being able to, at the end of the day, make a decision and live with it.

What are the advantages to serving in the DCT role? What are the challenges?

Dr. Joan Jackson: One of the greatest rewards of being a DCT is playing a role in students' socialization into the profession of clinical psychology. The DCT is in a position not only to structure a program that will meet students' training needs but she or he also typically

plays a major role in advising students individually on matters ranging from selecting their courses to selecting and securing their internship. The satisfaction that comes from seeing students pursuing successful, productive careers is the ultimate reward.

Perhaps the biggest challenge of the DCT role is maintaining awareness of relevant changes in professional and regulatory standards and in the evolving health care environment in which our students train and ultimately seek employment. Finding ways to keep what works in our programs while adapting to new demands is a constant challenge.

"The DCT is a significant administrative role (i.e., it will consume time you normally set aside for research and teaching). Since teaching is usually a much more prescribed time in most programs, this will almost always negatively impact your research time, and thus your research productivity. Do not go into serving as DCT thinking otherwise."

At what stage of professional development do you think someone is best suited to serve as DCT? What advice would you give someone who is considering this role?

Dr. Steve Miller: A couple critical things to have done before one can devote the time and energy to being a DCT include initial tenure and promotion to Associate Professor status in the typical academic environment (e.g., a clinical PhD program). While there is nothing "magical" about tenure/promotion, the psychological effects of pre-tenure angst combined with the very real needs of focusing on research productivity and teaching skills in those early years are not conducive to the role and responsibilities in a DCT position. Additionally, a DCT is quite often the "program" director or head, and thus has some promotion, hiring, job tasking, etc. responsibilities which are simply not possible when one is supervising persons who have influence on your T & P (A caution, this can also sometimes occur to an attenuated extent with Associate Professor level DCTs if a program has a large number of Full Professors or those who are particularly difficult). I also think it is helpful to have been around long enough to have followed a few student classes through their complete training as a clinical faculty member, so as to have a solid idea of what the program does at all stages to train the students. This perspective I found very helpful in my own ability as a DCT to effect appropriate change, and to know what is likely to need changing, and what is likely to not need it.

My advice for starting out would be to appreciate that the DCT is a significant administrative role (i.e., it will consume time you normally set aside for research and teaching). Since teaching is usually a much more prescribed time in most programs, this will almost always negatively impact your research time, and thus your research productivity. Do not go into serving as DCT thinking otherwise. Once the above is recognized, and one still wants to do this, there are a few basic things to attend to: adequate "credit" for the administrative duties explicitly set out, additional administrative support (administrative assistant, associate DCT) explicitly provided, salary supplement provided if possible (the DCT role becomes a 12 month job, not conducive with a typical 10-month academic pay system), and buy in from the rest of the faculty, which is particularly important because these positions have more responsibility than authority, hence you need the cooperation of your faculty.

Many thanks to Drs. Miller and Jackson for sharing their experiences on serving as a DCT (and for their superb service to our Clinical Program at UGA)! For questions or ideas for future columns send an email to csuveg@uga.edu.

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Donna Rasin-Waters, Ph.D.—Editor

Educating Stakeholders About the Affordable Care Act

By Donna Rasin-Waters, Ph.D.
Division 12 Federal Advocacy Coordinator

As states adopt the Affordable Care Act (ACA), practicing psychologists will need to understand and adapt to new systems of healthcare delivery. Psychologists will need to be visible partners in care delivery in order to be included in reform. One way to gain visibility is to provide outreach and education. Thus I suggest that psychologists take action and reach out to stakeholders. Here are a few ideas:

One is to meet with insurance companies to educate and advocate for following:

- screening and assessment that adds value and impacts treatment planning;
- psychotherapy and behavioral health techniques that can be utilized effectively and efficiently in the new system;
- reimbursement under the new system, including the health and behavior codes and an ability to provide same day assessment, psychotherapy and health psychology services in integrated care settings;
- and as reform shifts reimbursement from fee-for-service to payment based on performance, it will be important to advocate for documentation and quantification systems that are pragmatic for practicing psychologists and add value to patient care.

Our educational outreach and advocacy for psychology should also include interdisciplinary partners in care. It is critical for medical doctors, nurses and other specialty professions to understand the medical benefits of psychological intervention and treatment. A listener friendly presentation about the vital services psychologists offer patients is a wonderful way to advocate for the field.

Let us not forget consumer outreach and education about psychological services. The most effective advocacy can be driven by consumer groups who understand the benefits of doctoral level assessment, intervention and treatment options. A critical element to the ACA is health literacy, patient participation and responsibility. Therefore, educating patients and families about psychological science and best practices is a natural next step in health reform.

All politics is local. As the ACA implementation moves forward, get involved in your state psychological association. Many of the activities listed above are already occurring in your state association. Take an active role in such activities. In addition, pay the American Psychological Association practice assessment fee. The fee assists with projects related to the needs of practitioners and the APA Practice Organization is actively involved in strategies to assist with health reform in your state.

Dr. Rasin-Waters, Division 12 Federal Advocacy Coordinator, can be reached at drrasinwaters@aol.com and followed on Twitter @rasinwaters.

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Section VI: Psychology of Ethnic Minorities

Gail Wyatt, Ph.D., Editor

A Call for Mentoring in Health Disparities Research

Gail E. Wyatt, Ph.D., President
Alfiee M. Breland-Noble, Ph.D., MHSc.
Cheryl A. Boyce, Ph.D.
— Co-Program Chairs, 2012

Recent data provided by a landmark paper in Science (Ginther et al, 2011) on federal funding and racial/ethnic disparities found a woeful underrepresentation of people of color among the ranks of those receiving what some consider to be the "gold standard" and hallmark of independent biomedical research funding, the R01. Of the many concerns purported as contributing to this established disparity was the disturbingly high proportion (up to 60%) of un-scored applications received by African American and other researchers of color on initial application submissions. This 60% figure compares to just a 30% chance of receiving an unscored application among white investigators. Given the importance of resubmission of any grant application to have a strong chance of funding in today's fiscal climate, it is troubling to note the disproportionately high numbers of racially diverse researchers (including African Americans) who choose to not resubmit applications after their initial submissions.

In response to these and other findings from the Science report, NIH's Advisory Committee to the Director (ACD) Workgroup on Diversity in the Biomedical Workforce has identified a series of specific interventions necessary for addressing the disparities in research funding between white researchers and researchers of color (NIH, 2012; http://acd.od.nih.gov/dbr.htm). In particular, they point to the need for mentoring opportunities for racially diverse investigators, mechanisms for addressing the "leaky pipeline" present among diverse investigators and most importantly, the need to address any potential biases that may be seeping into the grant review process at the peer review level. Recognizing these issues in health disparities research, the President of the Clinical Psychology of Ethnic Minorities Section of Division 12 (Division 12, Section VI) has initiated a special award to recognize those who have persevered through the many obstacles facing racially diverse investigators in the pursuit of rigorous health disparities research with the 2012 Presidential Awards for Health Disparities Research Mentoring TEAMS (Together Everyone Advances Minority Science). These new awards recognize the hard work of diverse mentor and mentee teams working together to achieve a scientific product (i.e. poster, journal, chapter, symposium, etc.).

The section will also continue to recognize individual achievements with the Dalmas A. Taylor Outstanding Student Research Award and the Samuel M. Turner MENTOR Award. However, the new award will highlight the bidirectional process between mentor and mentee(s) and "TEAMSwork" that we have long recognized as crucial for research career success. At this APA convention program this year, program co-chairs Alfiee Breland-Noble and Cheryl Anne Boyce have assembled an ambitious and informative program including continuing education credits eligible to meet the diversity requirements of many state licensure boards. A collaborative session with Society for the Psychological Study of Ethnic Minority Issues (APA Division 45) will provide background and a discussion on the disparities in obtained research grant funding and racially diverse investigators. In addition, the presidential symposium will identify: "Successful Strategies for Diversity and Health Disparities Research in Addiction and Mental Health." This session will highlight the principal investigators of three NIH health disparities research centers focused on Asian Americans (Nolan Zane, UC-Davis); Hispanic/Latino populations (Margartia Alegria, Cambridge Health Alliance/Harvard University) and African Americans (Gail E. Wyatt, UCLA) with Dr. Yonette Thomas from Howard University as the discussant. We will also support a new partnership to promote mentoring in the form of a joint session hosted by our section and APAGS entitled "Food for Thought"; an early morning student session on research grants organized by our very own student representatives Jennifer Hsia (USD) and Cendrine Robinson (UHSUS).

Finally, two members of our section, Guillermo Bernal, PhD, University of Puerto Rico, Rio Piedras Campus, San Juan, P.R. and Melanie M. Domenech Rodríguez, PhD, Utah State University, Logan, Utah

will be leading a pre-conference 4 unit CE training entitled, "Cultural Adaptation of Psychotherapy -- Tools for Practice and Research". The Clinical Psychology of Ethnic Minorities (Division 12, Section VI) looks forward to your participation in planned sessions at APA 2012 convention. We also look forward to partnerships for continuing efforts in mentoring and health disparities to serve the clinical psychology needs of this diverse nation.

Section VII Clinical Emergencies and Crises

Marc Hillbrand, Ph.D., Editor

A Request for Suggestions of Resources on Suicide Risk Assessment and Suicide Risk Management for The Division 12 Clinician Toolkit

Marc Hillbrand, Ph.D., Connecticut Valley Hospital

Year after year, a succession of Division 12 Presidents has called on the D12 Sections to develop ways to share their knowledge with the membership at large. Hidden treasures within D12 are the Sections that consist of communities of clinical psychologists with common professional interests. Some Sections focus on specific clinical populations such as women (Section IV Clinical Psychology of Women), the elderly (Section II Clinical Geropsychology), and ethnic minorities (Section VI Clinical Psychology of Ethnic Minorities). Others are organized around a philosophy of clinical psychology (Section III Society for a Science of Clinical Psychology), a sub-discipline within clinical psychology (Section IX Assessment Psychology), or segments of the membership (Section VIII the Association of Psychologists in Academic Health Center and Section X Graduate Students and Early Career Psychologists). The Sections are places of vibrant exchanges of ideas among leading scholars and clinicians who share a passion for their area of specialty, and lie at the vanguard of the field with respect to innovations in assessment and treatment, development of new conceptual models, training, etc. Section VII, Clinical Emergencies and Crises, is unique in that it is organized around clinical problems that occur across all clinical populations and are relevant to all clinical psychologists, namely the assessment and management of suicide and violence risks and the issue of victimization. Under the leadership of President-Elect David Tolin, a Clinician Toolkit has been developed containing clinical tools of use to most D12 members, ranging from HIPAA forms to a social history questionnaire. To contribute to this toolkit, Section VII is developing a set of resources relevant to the assessment and management of suicide risk.

Founded by Phillip Kleespies in 2000, Section VII aims to develop and improve the clinical assessment, treatment, and management of behavioral emergencies, and promote the scientific understanding of such emergencies through research on suicide, violence, and vulnerability to victimization by violence. It advocates for state-of-the-art graduate education and professional training in the clinical abilities and scientific knowledge psychologists require to evaluate and treat behavioral emergencies. The Section also promotes furthering the understanding of the professional, forensic, and ethical issues involved in emergencies, as well as the clinical abilities needed to evaluate and manage them.

A list of recent contributions illustrates the work of Section VII: fact sheets on **Minimizing the risk of violence in the workplace,** on **Diversity and suicidal behavior,** on **Management of mental health emergencies,** and on **Understanding when your child may be suicidal and how to help,** a database on internships with training in behavioral emergencies, all available on the Section VII website (http://www.apa.org/divisions/div12/sections/section7/), and the article **Psychologist suicide: Incidence, impact, and suggestions for prevention, intervention, and postvention,** published in *Professional Psychology: Research and Practice* in 2011.

Section VII welcomed the challenge by immediate past-president Danny Wedding and current President Gayle Beck to develop a set of resources on suicide prevention that would be useful to all D12 members. A work group was assembled to develop these resources consisting of Lanny Berman from the American Association of Suicidology, David Drummond from the Oregon Health and Sciences University, Lisa Firestone from the Glendon Foundation, co-chaired by Marc Hillbrand from Connecticut Valley Hospital and Section founder Phillip Kleespies from the Boston VA. The workgroup consensus was that resources relevant to suicide prevention should include information about suicide risk factors and about protective factors, about best practices in suicide risk assessment and management, about special populations, and about training

opportunities in suicide prevention.

The workgroup is planning to finish this project before the end of the year, and welcomes your suggestions.

We expect adding the following resources to the Clinician Toolkit:

- A fact sheet on factors that increase suicide risk (risk factors)
- A fact sheet on factors that decrease suicide risk (protective factors)
- A fact sheet on diversity and suicide
- A fact sheet on jail and prison suicide
- Links to training resources such the American Association of Suicidology's training institute entitled "Recognizing and Responding to Suicide Risk (RRSR)" and the Suicide Prevention Resource Center's training institute entitled "Assessing and Managing Suicide Risk (AMSR)"
- Links to easily accessible resources such as a video of a talk by David Jobes on suicide prevention available on YouTube

Keep your eye in future issues of TCP for details!

References

Kleespies, P., Van Orden, K., Bongar, B., Bridgeman, D., Bufka, L., Galper, D., Hillbrand, M., & Yufit, R. (2011). Psychologist suicide: Incidence, impact, and suggestions for prevention, intervention, and postvention. *Professional Psychology: Research and Practice,* 42 (3), 244-251.

Section VIII: Association of Psychologists in Academic Health Centers

Rita Hauera, Ph.D., Editor

Plans for the 7th National APAHC Conference are moving forward. The meeting will be held in Nashville, Tennessee at the Hutton Hotel on February 1 and 2, 2013. An "Early Career Boot Camp" will be held the day before the meeting for new and early psychologists in academic health centers. Traditionally, this has been a very successful and well-received program.

Ed Christophersen (Mercy Children's Hospital, Kansas City) and Zee Butt (Northwestern) have finished a new resource for APAHC, a Promotion Primer for Psychologists in Academic Health Centers. Though much of the information is specific to this setting, all academic psychologists will find it a helpful read. Be on the lookout for this when it is released.

Finally, APAHC will host three invited addresses at APA:

- Richard Seime, the Ivan Mensh Award Winner, will speak on 8/02 from 9:00 AM - 9:50 AM at the Convention Center.
  Title: It's a Wonderful Life: Life As an Academic Health Center Psychologist and Educator
- Dorothy Hatsukami, the Bud Orgel Award Winner, will speak on 8/04 from 12:00 PM - 12:50 PM at the Convention Center.
  Title: Future Direction in Disease Prevention: Tobacco Control As a Case Example
- John Robinson, the Matarazzo Award Winner, will speak on 8/04 from 1:00 PM - 1:50 PM at the Convention Center.
  Title: But You Don't Act Like a Psychologist

Looking for back issues of The Clinical Psychologist?

Past issues of
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www.div12.org/clinical-psychologist

APA DIVISION 12: THE SOCIETY OF CLINICAL PSYCHOLOGY

CALL FOR AWARD NOMINATIONS

The Society of Clinical Psychology invites nominations for its 5 psychologist awards, 3 early career awards, and 3 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 a psychologist 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. Nominees must be current members of Division 12.

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

SENIOR AWARDS

Award for Distinguished Scientific Contributions to Clinical Psychology
Honors psychologists who have made distinguished theoretical and/or empirical contributions to clinical psychology throughout their careers.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology
Honors psychologists who have made distinguished advances in psychology leading to the understanding or amelioration of important practical problems and honors psychologists who have made outstanding contributions to the general profession of clinical psychology.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology
Honors psychologists who have made remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind.

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology
Honors psychologists who display excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty. It will recognize those individuals who have been outstanding in supporting, encouraging and promoting education and training, professional and personal development, and career guidance to junior colleagues.

MID CAREER AWARD

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

EARLY CAREER AWARDS

David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology
Given for contributions to the science clinical psychology by a person who has received the doctorate

Continued on next page

Continued from previous page

within the past seven years and who has made noteworthy contributions both to science and to practice. Up to $500 for travel to the APA Convention is awarded.

Theodore Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology (given jointly with APF)
Honors a clinical psychologist for professional accomplishments in clinical psychology. Accomplishments may include promoting the practice of clinical psychology through professional service; innovation in service delivery; novel application of applied research methodologies to professional practice; positive impact on health delivery systems; development of creative educational programs for practice; or other novel or creative activities advancing the service of the profession. Nominees should be no more than seven years post doctoral degree. Amount of the award is $4000.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology
This award will be conferred annually to an early career psychologist who has made exemplary contributions to diversity within the field. Such contributions can include research, service, practice, training, or any combination thereof. Nominees should be no more than seven years post doctoral degree.

GRADUATE STUDENT AWARDS

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

Please submit nomination materials electronically to Education & Training Committee Chair, Dr. John Pachankis at john.pachankis@einstein.yu.edu. The deadline is November 1st.

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

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

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

JOIN A DIVISION 12 SECTION

Division 12 has eight sections covering specific areas of interest.

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

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

To learn more about the Society of Clinical Psychology, visit our web page:

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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**.

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