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Quo Vadis Clinical Psychology?

By Mark Sobell, Ph.D., APBB
Nova Southeastern University, FL

A few weeks ago I began my one-year term as President of the Society of Clinical Psychology. The now Past-President, J. Gayle Beck, set the bar very high and deserves very high accolades for the example she set. What an act to follow! I enter my term with some concerns, not just for the Division but also for clinical psychology as a field. My concerns are not new concerns, others have articulated them, but I am worried that as a field we are not taking them seriously enough.

So, what is all the concern about, why should we be worried, and what does Quo Vadis have to do with our concerns? The movie *Quo Vadis,* a star-studded film (about Rome AD 64-68) from the 1950s, itself is not relevant, but its title is. In Latin the title means "Where are you going?" and in the present era of rapid and massive change it does seem appropriate to ask clinical psychology and the Society of Clinical Psychology to address this question.

Times are Changing

It is very clear that we are in the early phase of an upheaval that may make the Industrial Revolution look small. What to call this change I will leave to others, be it the Digital Revolution, the Computer Revolution, or the Technological Revolution. Consider for example how email has changed your life (and, if you are like me and most people I know, sapped your time). And it is not just mail. Even audio-visual communication with the other side of the world is incredibly easy and accessible to just about anyone with a computer, tablet, or a cell phone. With major changes underway in many domains (e.g., 3D printers seem destined to have a huge effect on manufacturing of many products; the types of jobs that will become available and that will become obsolete), the world of mental health and of clinical psychology specifically is clearly being impacted. The major ways in which clinical psychology is likely to be impacted were eloquently pointed out recently by Alan Kazdin. Although work on evidence-based treatments is highly valuable, it is but a very small slice of the pie when the defining issue is reducing the burden of mental health problems for society (Kazdin & Blase, 2011; Kazdin, 2011). Even within the psychotherapy slice of the pie, changes are rapidly occurring. Telehealth or telemental health is not only on our doorstep, but is growing exponentially. Integrated healthcare is already present in some domains and clearly in our future. Interventions at the

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level of public health and oriented toward facilitating self-change are profoundly needed. Importantly, rather than competing with psychotherapy, self-change interventions are more likely to bring in more clients because not all self-changers succeed. Lastly, the need for new models for dissemination of what we do know is evident and proceeding is adding yet another wrinkle to how we function as clinical psychologists (Rotheram-Borus, Swendeman, & Chorpita, 2012).

Quo Vadis the Society of Clinical Psychology?

While the future undoubtedly holds incredible opportunities, they will only matter if we accept the challenge and, to the extent possible, take a leadership role. From my perspective, the question for clinical psychologists is what role are we going to play in determining how business is conducted, from teaching to clinical practice? Are we going to give the change process just a sideways glance and continue down our old but comfortable path? I hope not.

During my Presidential term I am going to ask the Division's board members and those reading this column to start thinking about the challenges and opportunities facing clinical psychology, and about the role that our Division should play in this process. This is no

small undertaking. The times are changing, and if we fail to address these changes, we will be left behind.

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See you in Hawaii

Finally, a very big thank you to Katie Witkiewitz, our Program Chair, for arranging a convention program packed with exciting and invaluable presentations. Among the treats, keynote addresses by David Barlow, APA President Nadine Kaslow, and Josef Ruzek. And not to worry about getting to the beach, APA has arranged for there to be an afternoon hiatus so attendees do not have to choose between sessions and the surf.

A new team for *The Clinical Psychologist*

Dear Colleagues,
We are your new leadership team of *The Clinical Psychologist* for 2013.

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We are looking forward to working with each of you in the upcoming year. We want to take this opportunity to express our sincere thanks to Milton for his previous work as the Editor of *TCP*. We could never fill his shoes! We are extremely grateful to the mentoring and support that he provided us in our transition. Below is a listing of our 2013 publication dates and submission deadlines:

February 15th **May 15th** **Aug 15th** **Nov 15th**

We are looking forward to working with you in 2013.

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!

Bridging Research and Practice in Community-Based Minor Consent Treatment Programs

Bryan Forrester
Palo Alto University

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Asian Americans for Community Involvement

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Note: The authors wish to thank Dr. Larry E. Beutler for encouraging us to write this article and for providing feedback and assistance.

A recent special edition of *Psychotherapy* has reintroduced the commonly addressed issue of integrating clinical research findings with everyday clinical practice. To avoid dissuading those potential readers familiar with the now, half-century-old debate, the series brought a "fresh perspective" to the topic by identifying and disseminating what was working rather than highlighting failed or inadequate attempts (Teachman et al., 2012). This article, the second in the series published in *The Clinical Psychologist,* aims to satisfy this initiative by opting to illustrate how practitioners in a California bay area community-based clinic (Asian Americans for Community Involvement: AACI) are utilizing a clinical research treatment system (Beutler & Clarkin, 1990 Beutler, Clarkin, and Bongar, 2000, Beutler and Harwood, 2002) to bridge the gap between research and practice in an adolescent substance abuse minor consent treatment program.

Asian Americans for Community Involvement (AACI), is an agency that from its inception in 1973 has maintained a focus on serving the community in a creative, yet empirically validated manner; thus its willingness to be on the forefront of current research in not surprising. AACI started as a specialized mental health advocacy and treatment center aimed at underserved cultural groups. The major focus is to improve the physical and mental health of individuals, families, and the Asian community with over 40 languages/dialects and culturally adaptive services. The founding individuals recognized that community mental health must be representative of the population and also address those who did not fit standard criteria. Since its foundation, AACI has been striving to provide culturally competent, community-based, and evidence-based services to empower those that they serve to continue to build and advance their communities. The agency focuses on advocacy, health care services, recovery programs, domestic violence programming, and community building and outreach. The organization's website (www.aaci.org) lists the variety of the programs and their various, notable contributions.

An Adolescent Substance Abuse Program (ASAP) has been implemented at AACI in response to a growing body of literature suggesting that approximately 90% of teenagers with alcohol and substance abuse are not being effectively treated (Sussman, Skara & Ames, 2008). The management and clinical staff at AACI have recognized this need and utilized the latest research to create a unique program aimed specifically at teens, taking into account culturally and developmentally appropriate elements. By taking advantage of federal and state minor consent laws, clinicians at AACI can provide services to probation-referred youth at the primary facility as well as the general population by integrating the ASAP program into local Santa Clara County high schools. The nature of the minor consent program, in addition to the school-site services, allows for confidentiality for the minors, ease of accessibility, and reduction of stigma.

The minor consent program has flourished at AACI resulting in services provided for hundreds of youths across the county, many of which successfully graduating from the program. However, along with the increased popularity of this program came concerns with quality control – namely, the program director needed assurances that the practicum therapists (a combination of PhD, PsyD, & Master – level student therapists) were integrating evidence-based practices (EBPs) into the intake and therapy interventions. To ensure this research-to-practice "gap" was filled, four areas of the program were identified as needing

improvement. The specific changes under consideration were:

1. The current intake procedures lacked identification and evaluation of non-diagnostic patient information. This information is necessary because certain non-diagnostic patient attributes are highly predictive of patient response to treatment (Cole & Magnussen, 1964) and can by synthesized with diagnostic information to tailor specific treatment interventions (Beutler and Clarkin, 1990).
2. The current guidelines used to select treatment groups needed to incorporate principles of change in order to match patients with the best-fit therapy groups (Castonguay & Beutler, 2005). Matching patients and therapist on pre-disposing agents of change can reduce the amount of sessions needed to achieve significant symptom reduction (Beutler, Clarkin, & Bongar, 2000).
3. Communication needed to be enhanced between the intake therapist, the group facilitators, the teachers and probation officers. Increasing interagency communication improves the program development and implementation in various settings and populations, including the school setting regarding student adjustment and academic performances (Rappaport, Osher, Garrison, & Anderson-Ketchmark, 2003).
4. The effectiveness of the program needed to be evaluated, both at a midpoint interval (progress) and at termination (outcome). Outcome measures are essential in determining the degree of change during and after treatment as well as accurately attributing its cause (Chambless & Hollon, 1998).

To meet these needs, the management at AACI decided to test pilot the STS/Forensio (www.Forensio.com), a *clinician-rating* version of the Systematic Treatment Selection Assessment and Report Generating System (www.Innerlife.com).

STS/Forensio is a principle-driven assessment and report-generating system, which relies on empirically-based algorithms to generate individualized treatment reports for use by clinicians. In line with recent recommendations to "integrate multiple lines of evidence (Hershenberg, Drabick, & Vivian, 2012, p.124)," STS/Forensio was chosen because of its ability to integrate non-diagnostic patient attributes with diagnostic information into the Programmatic Considerations section of the treatment plan. The decision model is based on 18 empirically derived principles, each of which implicates a decision that is likely to optimize the outcomes of psychotherapy. These decisions each implicate the role of one or more dimensions of patient, therapist, and treatment. For example, six of the dimensions which are used in deriving six corresponding principles of change include: resistance/reactance potential, subjective distress, social support, problem complexity, coping style, and functional impairment. These particular dimensions provide the clinician with information concerning: (a) what level of therapeutic directiveness should be used, (b) how motivated the patient is to progress through treatment, (c) how much the patient can rely on family/friends throughout treatment, (d) whether psychopharmacotherapy and/or multi-therapy is needed, (e) whether the patient will benefit more from behavioral or insight oriented treatment, and (f) whether or not formal treatment is necessary, if the patient will most likely improve on their own with the assistance of self-help resources or if the patient will benefit from inpatient/intensive care. Additionally, functional impairment can be used as an outcome measure, as well as a vehicle to translate the clinical utility of evidence-based practices in values associated with "impact/reach" and "cost-effectiveness" (Vivian et al., 2012).

STS/Forensio fits AACI's needs for the following reasons: first, it is a multidimensional assessment which screens for a wide range of diagnostic and non-diagnostic treatment-relevant information not assessed in the existing intake procedure. STS/Forensio screens for diagnostic symptoms (e.g., depressed mood, anxiety, sleep disturbances) and non-diagnostic characteristics (e.g., coping strategies, degree of available social support, reactance potential, subjective distress, problem complexity, and functional impairment). The integration of these data can guide student therapists in making treatment decisions regarding the most appropriate mode (individual vs. group; outpatient vs inpatient), style (degree of therapist directiveness), and intervention orientation (insight vs. behavioral) which can produce the most optimal patient response to treatment.

Second, although treatment groups in each high school follow the same protocol, an analysis of variations among and between treatment settings can vary according to specific therapist attributes such as their unique style, degree of expertise, and past personal and professional experience. In an effort to increase

the overall efficacy of the treatment program by integrating both common and specific treatment considerations, a system was needed to match patient and therapists by predisposing personality characteristics. The STS/Forensio system offers a solution for this challenge by identifying predisposing client qualities at intake and incorporating these variables when generating the programmatic considerations section of the treatment report. The programmatic considerations both identify patient pre-disposing, treatment-relevant qualities for the clinician and offers therapist matching suggestions based on the corresponding therapists' qualities. As a result, the intake therapist can use this information as a guide when deciding which group to assign the patient.

Third, the programmatic considerations serve two purposes: (1) to assist the intake interviewer in placing the client into the appropriate treatment group (described above), and (2) to inform the group therapist about the optimal style and type of intervention for the client. Here, the therapist can make adjustments to how information is presented to the client, whether to utilize behavioral or insight orientated techniques in therapy, and how much to direct the client to seek support from friends and family members. Research has shown that incorporating these specific, non-diagnostic factors into the treatment process can cause an activation effect on certain common factors of treatment (Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012) which, in turn, may result in less program attrition. In other words, clients are more likely to achieve better outcomes in fewer sessions due to the effects of specific treatment matching. The programmatic considerations are provided within the treatment report which is part of the automatic report generating function of the computerized system.

Finally, and perhaps most importantly in regards to sustaining the life of the program, a source of feedback was needed to translate data pertaining to effectiveness both in terms of patient improvement and the impact/costs. Through the ability to capture repeated measures of patient's primary and secondary symptoms as well as the patient's level of functional impairment throughout the treatment process, the STS/Forensio system provides a variety of outcome measurement possibilities. Additionally, therapists and supervisors can tap into the treatment data at any point for the purpose training and/or monitoring patient progress. By evaluating the progress of the patient, the therapists can maintain their current therapy plan with the patient or make adjustments to their method for the second half of the program. For instance, the patient may have experienced changes in the degree of social support available and the therapist can either increase or decrease the amount of reliance on social support during the remainder of the program.

STS/Forensio is an empirically-driven treatment matching system, based on years of clinical process and outcome research, and an example of how research can inform practice. AACI serves as an example of the successful integration of science and practice in a community mental health setting. The practitioners at AACI specialize in treating underserved populations and providing training opportunities in culturally-informed interventions to student therapists; most recently expanding their services to include treatment of teenagers with substance use problems. AACI management and clinical staff continue to pilot test the STS/Forensio into its substance abuse program (ASAP) to assist with initial assessment of diagnostic and non-diagnostic characteristics, matching clients with therapy groups for optimal change, enhancing communication between service providers, and evaluating outcome. The successful implementation of STS/Forensio at AACI illustrates that bridging the gap between science and practice can be achieved and can be effective in an actual clinical setting.

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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!

Guerda Nicolas, Ph.D., and Roxanne Donavan, Ph.D.—Editors

Divison elections are coming

Each member of the division will soon have the opportunity to help select the next president-elect of Division 12, the next secretary of Division 12, and two Division 12 representatives (one for a 1-year term, and one for a 3-year term) to the APA Council of Representatives. Candidates who have indicated their willingness-to-serve if elected are listed below.

PRESIDENT-ELECT
Terence M. Keane, Ph.D. *Michael Otto, Ph.D.*

SECRETARY
Kathryn Humphreys, M.A. *John C. Linton, Ph.D.*

DIVISION REPRESENTATIVE TO APA COUNCIL (1-Year)
Bunmi Olatunji, Ph.D. *David A. Smith, Ph.D.*

DIVISION REPRESENTATIVE TO APA COUNCIL (3-Years)
Guillermo Bernal, Ph.D. *Brian D. Carpenter, Ph.D.*

Statements submitted by the candidates are as follows:

Candidate statement for President-elect:

Terence M. Keane, Ph.D.

Education:

- University of Mississippi Medical Center-Jackson VA Consortium: Resident, 1977-78
- Binghamton University-SUNY: Ph.D. in Clinical Psychology, 1978
- University of Rochester: BA in Psychology, 1973

I'm pleased to be running for President-Elect of the Society of Clinical Psychology. For nearly thirty-five years I've been a part of the APA and this Division admiring its leadership's accomplishments and contributions to Clinical Psychology. During my term of office I would like to continue this strong leadership and dedication to the field. Presently, I am Associate Chief for Research & Development at VA Boston Healthcare System, Professor of Psychiatry and Psychology at Boston University, and Assistant Dean for Research at Boston University's School of Medicine. I also direct the National Center for PTSD's Behavioral Science Division.

In national and international organizations I've held many leadership roles over the course of my career. I've served on APA's Council of Representatives, helped to create the Division of Trauma Psychology (56) as a home for those of us who work in the trauma arena and eventually served as President of that Division. I have also served as President of the Anxiety and Depression Association of America (ADAA), the Association of VA Psychology Leaders (AVAPL), and the International Society for Traumatic Stress Studies (ISTSS). In all cases, the organizations experienced growth and financial stability during my term of office. More recently, I am serving as a member of the American Psychological Foundation's Campaign Cabinet.

Central to the mission of the Society is the development of clear and relevant paths to a wide variety of careers in Clinical Psychology. Graduate schools in our profession are training people to work in a variety of settings and our Society's goals should be to support and facilitate the careers of those who aim to teach, to conduct research, to practice in healthcare institutions, and to be a part of private practice organizations. Yet, our newest graduate students struggle with even the most pressing next steps in their training: access to quality internships. We, along with the APA and other like-minded Divisions, need to take a leadership role in addressing this matter with resources and creative thinking. Similarly, planning for early career transitions for teachers, researchers, and practitioners needs to be high on our agenda for the near term. Sinking debt from college and graduate education makes it increasingly important for the senior members of our profession to dedicate time and energy to supporting junior colleagues in successfully clearing these early career hurdles. These are problems for all of us. My overarching view is that it is time for all of us to give back in whatever ways we can.

In terms of my own background as a psychologist, I started one of the very first clinical programs for combat veterans (in 1979) with PTSD, infusing this program with emphases on informed clinical care, the education of interns and fellows, and conducting empirical research. With colleagues, we developed the foundation necessary for conceptualizing PTSD in cognitive-behavioral terms and then developing the application of exposure therapy to mitigate its effects. We developed five of the key clinical measures to assess PTSD coupled with a conceptual model for a sound assessment approach. For the past 34 years, I've had significant federal support for our pro-

gram of research and for the past 24 years I have been a director of the National Center for PTSD, a group that's made distinctive contributions to the study of PTSD and of psychopathology more broadly.

Many organizations have recognized these accomplishments with lifetime and career awards including the Society of Clinical Psychology Award for Distinguished Scientific Contributions (2013), APA's Distinguished Contributions to Public Service (Hildreth Award – 2012), Association for Behavioral & Cognitive Therapy's Outstanding Researcher Award (2004), the ISTSS's Laufer Award for Outstanding Scientific Achievement (1996), and the ISTSS's Lifetime Achievement Award (2004) among many others. In 2011, my alma mater, Binghamton University and the State University of New York, recognized these contributions to mental health with an honorary Doctor of Science.

I would look forward to serving the Society of Clinical Psychology.

Candidate statement for President-elect:

Michael W. Otto, Ph.D.

In my career to date, I have had the benefit of working across several practice settings. I spent the first 17 years of my career working in a large medical center (Massachusetts General Hospital/Harvard Medical School), and the last 9 years working in a university setting (Boston University). Across most of these years I also kept an active, albeit small, private practice. Hence, my clinical and psychopathology research has never had the opportunity to stray far from the realities of ongoing clinical work, and likewise, my clinical work has not strayed far from the new insights provided by the lab. I have also had the chance for unusual breadth in my clinical research: developing, testing, or disseminating interventions for panic disorder, social anxiety disorder, bipolar disorder, depression, PTSD, substance abuse, ADHD, medication adherence, and sleep and exercise. This work has helped me acquire a broad perspective on the issues facing psychologists across multiple disorders and settings.

I have also had the honor of a number of service positions, serving on the board of ABCT for six years after being elected as a Representative At Large, and, subsequently, President of the organization in 2005. I have also served the field as Co-Organizer of the World Congress of Cognitive and Behavior Therapy meeting, and, since 1998, I have served on the Scientific Advisory Committee for the ADAA. I am proud to say that I have been a fellow of APA for 15 years, and I am now especially pleased and excited to have been nominated for President of Division 12.

My overarching goal for my service to the APA membership is to increase the vibrancy of Division 12 – to increase the value of Division 12 as a resource for new and established professionals. This work will continue attention to bridging the scientist-practitioner divide. One challenge to the dissemination of empirically-supported psychosocial treatments is that full, manualized programs of treatment are often challenging to integrate within an established clinical practice. Most recently, I have been working not to promote a wholesale adoption of fixed protocols, but a foot-in-the door approach of introducing component interventions. The goal is step-by-step adoption of empirically-supported treatment elements, motivated by the success of individual components. The Division 12 Clinician Toolkit provides a forum for some of these activities. I would like to expand this toolkit to include a focus on choice points and corresponding outcomes in therapy, providing a "what can I do...and what can I expect from doing this" dialogue for clinicians in practice. I will also work to ensure that practical issues in clinical work do not take a back seat to dissemination issues. For example, as clinicians face Medicare opt-out challenges (see http://www.apait.org/apait/resources/riskmanagement/medicareaudits.aspx), Division 12 can be an educational beacon for practice issues. As a candidate for President of Division 12, I am eager to devote my experience to enhancing the vibrancy of this valuable organization.

Candidate statement for APA Council Representative for Division 12 (1-year term):

Bunmi O. Olatunji, Ph.D.

I am honored to be nominated for Council Representative for Division 12. I am currently Associate Professor and Director of Clinical training in the Department of Psychology at Vanderbilt University. Prior to arriving at Vanderbilt, I completed an APA internship at Harvard Medical School/Massachusetts General Hospital that emphasized evidence-based treatment. This philosophy is the foundation of the training that I provide as Director

of the Vanderbilt Adult Anxiety Clinic (VAAC) where we are invested in training the next generation of clinic psychologists that value empirically-based treatments. Division 12 has been an invaluable professional home for me and I have been fortunate to have my efforts to bridge science and practice recognized as a past recipient of the David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology. I have welcomed opportunities to give back to Division 12 as an At-Large member on the executive board of the Society for a Science of Clinical Psychology (SSCP), section III of Division 12. In this role, I observed firsthand how collaborative efforts can advance important empirically informed initiatives that will grow our field in meaningful ways. I also served as chair of the External Nominations Committee for SSCP where I sought recognition for clinical psychologists that exemplify the mission of Division 12. I look forward to my role as Program Chair for Division 12 at the APA convention in 2014. In this role, I plan to facilitate programing that reflects an integration of science and practice that speaks to clinical psychologist with diverse interests. As Council Representative, I would welcome the opportunity to continue to advance the mission of Division 12. Given its values, Division 12 is uniquely positioned to have a meaningful impact at multiple levels. I hope to have the honor to represent you in such efforts.

Candidate statement for APA Council Representative for Division 12 (3-year term):

Brian D. Carpenter, Ph.D.

I am honored to be nominated to stand in the Division 12 election for Council Representative. I recently served on the Division 12 Board and as the Section Representative for Clinical Geropsychology, and I observed the importance of clear, collaborative representation to Council. APA faces many challenges in the years ahead, and I am committed to bringing an open ear and strong voice from Division 12.

I received my doctorate from Case Western Reserve University, completing internship at the New Orleans VAMC and postdoctoral fellowship at the Philadelphia Geriatric Center and the University of Pennsylvania. I am currently Associate Professor in the Department of Psychology at Washington University in St. Louis. In addition to my leadership roles in Division 12, I co-chaired the Continuing Education Committee for Division 20. Locally, I serve on several university committees (Curriculum Committee, University Judicial Board, Title IX) and community Boards (Gateway Alliance for Compassionate Care at the End of Life). I am a teacher of both undergraduate and graduate students; a researcher with an active and funded program of investigation; and a clinician and clinical supervisor.

Through my leadership roles, I have come to appreciate the importance of a vital, unified APA. As a Council Representative I would be committed to 1) engaging collaboratively with all constituencies; 2) listening to the Division 12 membership and leadership for guidance on how to represent them; and 3) advocating on Council for policies and actions that are consistent with the mission of Division 12.

Candidate statement for APA Council Representative for Division 12 (3-year term):

Guillermo Bernal, Ph.D.

It is my honor to be nominated for the position of Council Representative. I believe that my experience within APA and with Division 12 places me in a unique position to maintain a strong and influential voice for our Division at Council. The APA is a complex organization and Council has policy and fiduciary responsibilities. My experiences in APA governance are the following:

- Finance Committee for two terms (2007-2009), (2010-2012), and Vice-chair (2010-20112).
- Council of Representatives (2001-2007), Ethnic Minority Caucus (Chair, 2005-2007) representing Division 45.
- APA Minority Fellowship Program, Advisory Committee (1993-2003), Chair (1996-2003).
- APA Committee on International Relations in Psychology (1992-1995).

I have served in a several divisional committees and in the Board of Directors. Since 2010 I have been the representative for Section 6, the Society for the **Clinical Psychology of Ethnic Minorities** representative to the Board of Division 12. Prior to that, I served as a member of the Committee on Diversity (2006-2008) that with other colleagues in the committee drafted the report on **Recommendations for increasing diversity within the**

American Psychological Association (APA) Division 12: Society for Clinical Psychology. I presided Section 6 (1995-1996) and I became a Fellow of Division 12 in 2001. On the one hand, these experiences with Division 12 offer me specific knowledge of the pressing issues at hand such as loss of membership; identify diffusion, and retaining its position of prominence. On the other hand, the systemic view I've acquired of APA governance together with the knowledge of the complexity of APA finances enables me to promote effectively the interests of Division 12.

I view myself as a research oriented clinical psychologist. I am a professor at the University of Puerto Rico where I direct the **Institute for Psychological Research.**

I received my BA from the University of Miami, and master's and doctorate degrees from the University of Massachusetts/Amherst. In 1978 I joined the faculty at the University of California, San Francisco. I moved to Puerto Rico to help develop a psychology doctoral program in 1986. My research is on the efficacy and effectiveness of treatments most recently for adolescent depression. Recently I have been interested in the cultural adaptation of evidence-based treatments. I have been fortunate to enjoy continuous NIH funding for my program of research and research training for the last 24 years. I teach some of the core courses in our doctoral clinical psychology program, and I supervise students primarily in family systems therapy.

There are many challenges ahead for Division 12. The diminished membership, the reduced federal funds for research an research training, depleted settings for clinical internships, a practice market challenged by managed care, and an image of the division as not welcoming to diverse communities, to name a few. I expect to advocate for increased federal resources to support research and research training programs in the service of developing future scientist-practitioners that can be responsive to needs of diverse communities. In short, I will advocate for any and all initiatives that strengthen the science and profession of clinical psychology. I ask for your support.

Candidate statement for Secretary:
John Linton, Ph.D.

John Linton is Professor and Vice Chair of the Dept of Behavioral Medicine at West Virginia University, where has received Dean's Awards for Excellence in service and teaching. He carries a considerable clinical caseload, directs the predoctoral psychology internship and the medical student clerkship and writes in the area of professional psychology in medical settings. He is a Fellow in the Society of Clinical Psychology and served for many years as Chair of the Division 12 Post-Doctoral Institutes and the Fellows Committee. He is past president of the Association of Psychologists in Academic Health Centers, which is a section of the Society of Clinical Psychology, recipient of the National Register's Lifetime Achievement Award and Board Certified in Clinical Psychology through ABPP.

"It has been my pleasure to serve as Secretary of Division 12 through some turbulent times over the past couple of years. I continue my long-term commitment to the Society and would be willing and honored to serve a second term as Secretary."

Candidate statement for Secretary:
Kathryn K. Humphreys, M.A., Ed.M.

My name is Kathryn K. Humphreys, M.A., Ed.M. I am currently a 5th year Ph.D. student in clinical psychology at the University of California, Los Angeles (UCLA). I plan to complete clinical internship in the 2013-2014 cycle.

I have been a dedicated member of Section 10 (Graduate Student and Early Career Psychologist), serving as president-elect, president, and past-president (ending in December 2012). I also am a member of Section 3 (Society for the Science of Clinical Psychology). For the broader division, I have served on the review committee for the annual convention the past 2 years, as well as served as the Editor for the Student Column for *The Clinical Psychologist* from 2011-2012.

I am committed to disseminating both research and professional development information. Accordingly, I have authored or co-authored 19 peer-reviewed publications, 4 book chapters, and 6 professional development articles. As a student who has both witnessed, and is presently experiencing, the internship shortage, as well as other pressing issues in clinical psychology, I am moved to try to take a larger role in an essential organization for our field's health and prosperity. I believe that we are in a time of significant change in our field's structure for professional development, in our roles as health care providers, and as researchers of clinical science. I hope you consider adding someone to the board with a student/early career psychologist perspective for the next term of Division 12 secretary.

Guerda Nicolas, Ph.D., and Roxanne Donavan, Ph.D.—Editors

Division 12 Award Winners, 2013

Award for Distinguished Scientific Contributions to Clinical Psychology presented to *Terence M. Keane, Ph.D.* for distinguished theoretical or empirical contributions to Clinical Psychology throughout their careers.

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

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

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology presented to *Martin M. Antony, Ph.D., C. Psych, ABPP* for excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty.

Theodore H. Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology presented to *Adrienne Juarascio, Ph.D.* for professional accomplishments in clinical psychology.

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

The American Psychological Foundation Theodore Millon Award presented to *Steven K. Huprich, Ph.D.* for outstanding mid-career advances in the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. This award is given jointly by The American Psychological Foundation and the Society of Clinical Psychology.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology presented to *John E. Pachankis, Ph.D.* for 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.

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

Distinguished Student Service in Clinical Psychology Award presented to *Kathryn L. Humphreys* for outstanding service contributions to the profession and community.

Distinguished Student Practice in Clinical Psychology Award presented to N/A for outstanding clinical practice contributions to the profession.

Join us at this year's Division 12 award ceremony at the APA 2013 Annual Convention!

Please join us for the 2013 APA Annual Convention in **Honolulu, HI** this summer. The Convention will be held from **July 31 to August 4.** See the web site **www.div12.org** for further information as we get closer to the date!

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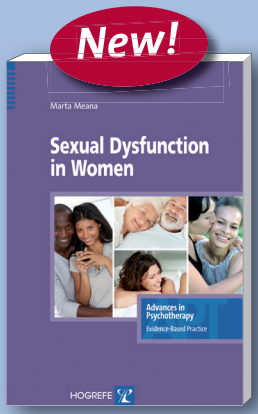

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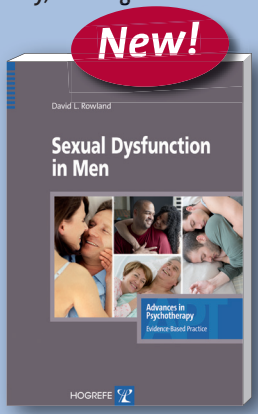

David Rowland
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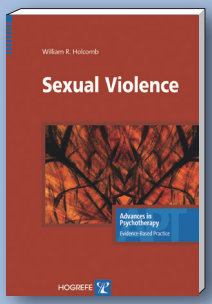

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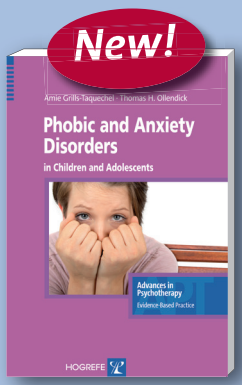

Amie E. Grills-Taquechel & Thomas H. Ollendick
Phobic and Anxiety Disorders in Children and Adolescents
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ISBN 978-0-88937-339-6

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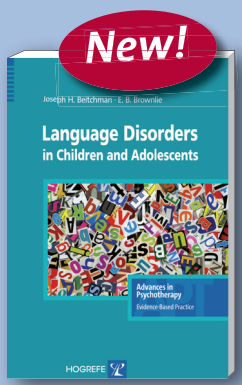

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(Coming June 2013)
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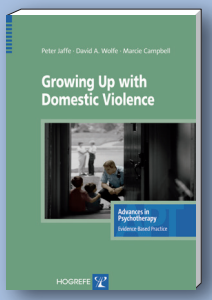

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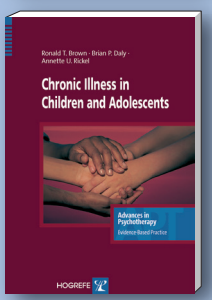

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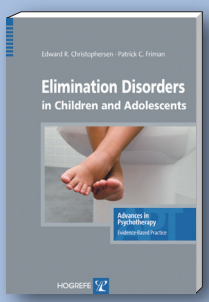

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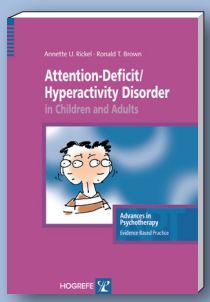

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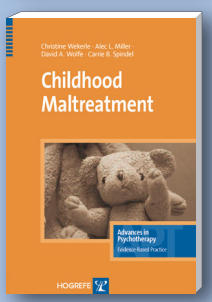

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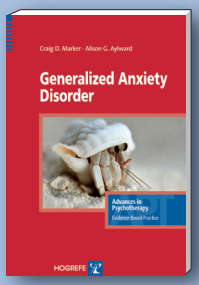

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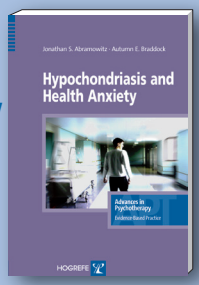

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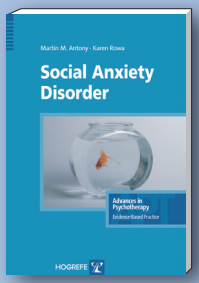

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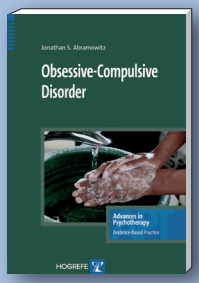

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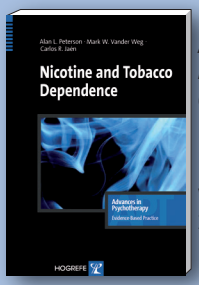

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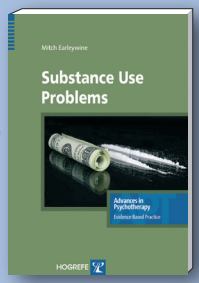

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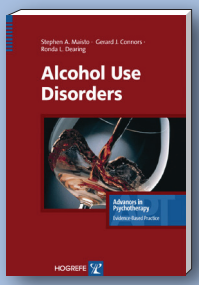

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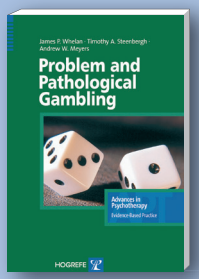

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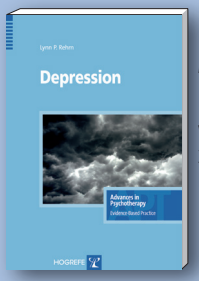

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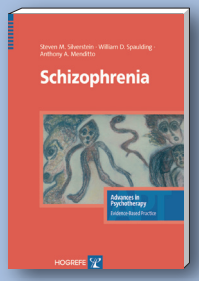

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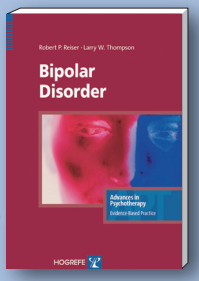

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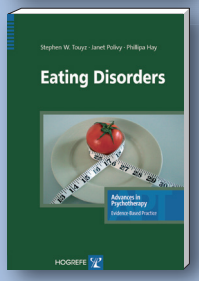

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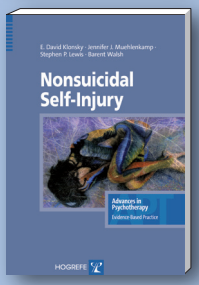

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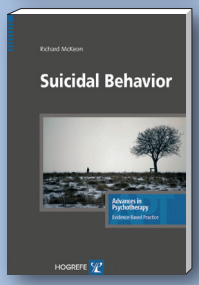

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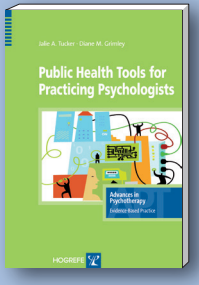

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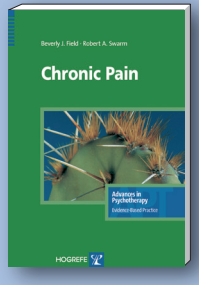

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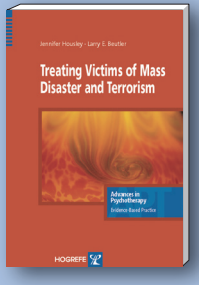

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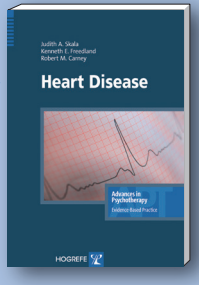

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Ethics Ain't Easy

George J. Allen, Ph.D.
University of Connecticut

I feel both privileged and somewhat intimidated to serve as ethics editor for *The Clinical Psychologist*. Privileged because the column provides a large forum for the expression of ideas that are important to our professional development and well-being; intimidated because such a position makes it is all too easy to lay claim to the moral (all-too-preachy) high ground on ethical issues. In brief, my background includes teaching at the University of Connecticut for 40 years, supervising the dissertations of almost 100 graduate students, serving as Director of Clinical Training for 19 years, and maintaining a small private practice for three decades. During the mid-1970s, I morphed a course on testing protocol into what was arguably one of the first courses devoted to law and ethics for psychologists. Throughout my career, I have been interested in how we learn about, make, maintain, and justify our ethical stances and decisions.

The one overriding lesson I took from my teaching, research, administrative, and clinical activities was that "ethics ain't easy." This theme of existential messiness was central to the writing of Jeffrey Younggren, Ph,D., my predecessor as editor of this column [see, for example, "Do the right thing: If only it were so easy" by Gottlieb and Younggren, (2011)] and has been echoed by many ethicists.

Ethical codes established by professional organizations usually are broken into two categories; aspirational principles set forth the highest levels of professional activity whereas ethical standards prescribe minimally acceptable professional conduct. These two broad categories set wide boundaries for ethical professional practice. Innumerable specialty guidelines and decision-trees have been developed to aid our decision making. Some offer revised courses of action about long-standing areas of ambiguity such as determination of authorship in faculty-student collaborations (Foster & Ray, 2012) whereas others (e.g., Devereaux & Gottlieb, 2012) offer guidance about newly emerging issues such as using "the cloud" to store sensitive clinical and personal information. Within the broad boundaries of aspirational principles and standards, and even with the assistance provided by specialty guidelines, however, our management of ethical dilemmas resides most often in messy real-world contexts where black-white decision making fades into (dare I say it?) at least 50 shades of grey.

In developing the content for this initial column, I attempted to articulate some of my central assumptions about correct human action. My initial goal was to lay out pithy articulate lessons, similar to the parting thoughts of Dr. Younggren's (2012) final column "Practical Ethics." Days of agonizing thought yielded nothing. My agony was compounded by the fact that I always insisted that my students be able to articulate reasons for the moral/ethical decisions that they make and the ensuing consequences they would likely have to deal with. I was flooded with memories of ethical dilemmas and choices; some mine, some from colleagues. How do I balance an inherent bias toward siding with those who have less institutional power and influence with fair and impartial treatment of others? Does that bias itself (which may be rooted in beneficence but also may be self-serving) undermine self-reliance and self-determination? Do I spin an innocuous lie to a second-ranked job candidate that "the position is still held up in the Dean's office" when it is, in fact, out to a top-ranked candidate? How innocuous is such a fabrication? How much intellectual ownership should an undergraduate be expected to demonstrate to merit inclusion as a co-author on a research output? How hard should I push a client to confront an on-going abuser? What kinds of safeguards, timelines, back-ups, and alternatives should we negotiate prior to such confrontation? What shorter- and longer-term consequences might ensue from such an encounter? These questionings provided the most recent experience that (even writing about) "ethics ain't easy."

My compositional struggles eventually did yield two central beliefs. First, I believe that proper ethical action most often involves painstaking exploration on multiple levels of analysis; combining careful consideration of specific situations, with guidance from general rules, while simultaneously being aware of one's multiple roles in and vantage points toward (these are not the same) those particular circumstances. Second, I believe that proper ethical action is most likely to occur when we (to paraphrase the Beatles) "get by with a little help from our friends." Relying on the collective wisdom of colleagues, peers, and even nemeses has helped guide me toward

ethical actions that afforded the best accommodations that could be achieved in messy human circumstances.

My goal in future columns is to explore nuances of ethical issues. I invite you to raise with me topics that perplex, concern, or simply interest you. Feel free to contact me at george.allen@uconn.edu with suggestions for discussion in future columns. I welcome your feedback and will do my best to engage in conversations that hopefully will be of interest to our readership.

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Are Psychologists' Attitudes about Borderline Personality Disorder Keeping Pace with Science?

Christopher Conway

Methods of psychotherapy delivery are usually at the center of conversations about the divide between science and practice in clinical psychology. It is widely acknowledged that evidence-based standards for psychotherapy are often overlooked in real-world settings. While this is clearly an important challenge for the field, I wonder if as a Division we could pay more attention to another, less publicized, science-practice gap: psychologists' attitudes about "difficult to treat" conditions *versus* current evidence about the nature and course of these psychopathologies.

I focus here on clinicians' conceptualizations of Borderline Personality Disorder (BPD). In my experience, the gap between scientific knowledge about BPD and psychologists' portrayal of the disorder—with regard to its origins, phenomenology, and prognosis—can be exceptionally large. Empirical research on BPD has advanced considerably over the past few decades, yet old stereotypes persist to a striking degree in mental health settings. I raise this issue in our Student Section with the hope of building awareness of how our misperceptions of BPD could shape the clinical training and practices of the next generation of clinical psychologists.

Conventional wisdom holds that treatment of BPD is difficult for clinicians. Generally speaking, this idea is supported by empirical evidence. However, it is common to encounter other pieces of clinical lore that are at odds with current scientific knowledge and may do more harm than good. These include axioms like "our treatments won't work for them," "BPD is a lifelong condition," and "people with BPD don't want to get better." A handful of studies conducted in mental health settings indeed indicate that professionals are more pessimistic about the prognosis of BPD, relative to other disorders, and are more likely to perceive people with BPD as intentionally undermining treatment (e.g., Markham & Trower, 2003).

On one hand, it is not hard to imagine how these attitudes developed given some of the challenges that typically come along with treating BPD. BPD is a condition marked by impulsivity, identity disturbance, cognitive dysregulation, and tumultuous interpersonal relationships. People with BPD are, compared to most other therapy consumers, prone to hostility, suspiciousness, and other antagonistic personality traits that can make collaborative work more difficult. Additionally, self-injurious behavior and suicide attempts are relatively common in this population, and these behaviors are obviously frightening for clinicians.

On the other hand, many attitudes about BPD expressed in case conferences are not evidence-based, and it would seem crucial for clinicians to know which popular opinions line up with scientific data and which do not. Regarding treatment, a growing number of clinical trials show that several (at least 4) psychotherapies are effective in reducing BPD signs and symptoms, particularly serious functional outcomes such as suicide attempts and psychiatric hospitalizations. Further, longitudinal studies of treatment-seeking populations show robust declines in BPD symptoms over time, challenging the notion that chronicity is an essential feature of BPD. For instance, in one of the largest clinical studies to date, approximately 50% of patients diagnosed with BPD at treatment outset no longer qualified for a BPD diagnosis six years later (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010). In fact, it appears that the acute symptoms likely to be most troubling to clinicians (e.g., self-injury, abandonment fears) are the quickest to remit (McGlashan et al., 2005). Finally, the idea that people with BPD intentionally cause or perpetuate their difficulties is inconsistent with evidence that BPD is associated with high rates of exposure to extreme environmental stressors (e.g., sexual abuse) that delay interpersonal and emotional development. BPD is also characterized by a strong genetic component, with heritability estimates comparable to other severe forms of psychopathology. In light of this evidence, many BPD features may be understood as the product of adverse learning histories and biological vulnerability to intense emotions. In many cases, behaviors that therapists perceive as therapy-interfering may represent patients' best attempts—given available intrapsychic and external resources—to manage distress.

There are several immediate and long-term advantages to correcting inaccurate attitudes about BPD in

clinical training facilities. First, these beliefs almost certainly shape clinicians' behavior toward patients, and pessimism regarding the course of BPD or attributions for patients' behavior could diminish our persistence with tough cases. Second, there is some evidence to suggest that (a) patients with BPD are aware of stigma surrounding the disorder and (b) the degree of perceived stigma is positively associated with treatment dropout (Rüsch et al., 2008). Third, inaccurate (or "accurate only in some contexts") stereotypes about BPD phenomenology and prognosis have a major effect on students' training. The education of the next generation of psychotherapists could be based on tradition and *a priori* assumptions about the nature of BPD, rather than the most up-to-date scientific evidence.

What measures could be useful in bridging this science-practice gap? Just as we encourage fidelity to evidence-based psychotherapies, we should emphasize evidence-based communication about BPD in case conferences and supervision. Training programs should educate students about the causes and course of BPD, as well as the adverse environmental contexts in which BPD symptoms are typically triggered. Referring trainees to organizations such as the National Education Alliance for Borderline Personality Disorder and the International Society for the Improvement and Teaching of Dialectical Behavior Therapy (to name only a couple) could also improve access to current evidence on BPD and its treatment. Overall, with a greater focus on the science of BPD, next generations of psychologists will be able to align their conceptualization and treatment of BPD with the best available evidence.

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Section II: Society of Clinical Geropsychology

Submitted by Michele J. Karel, Ph.D.

Section II news includes updates on (1) new Section officers; (2) the "GeroCentral" website, (3) application for a Geropsychology ABPP; (4) APA conference time for a symposium co-sponsored by Division 12, Division 20, and the Committee on Aging; (5) update of the APA Guidelines for Psychological Practice with Older Adults, and (6) the Institute of Medicine Report on the Geriatric Mental Health Workforce.

New 2013 officers. Amy Fiske, PhD, of West Virginia University, has started her term as President of the Society of Clinical Geropsychology. Erin Emery, PhD, of Rush University Medical Center, is now serving as Past-President, and Brian Yochim, of VA Palo Alto Health Care System and Stanford University School of Medicine, is President-Elect. I am pleased to take on the role of Section Representative to Division 12, and thank Brian Carpenter, PhD, for his excellent service in this role for the past three years. Other Section officers continue to serve their terms. The Section has many active committees including: Public Policy, Continuing Education, Mentoring, Diversity, Interdivisional Healthcare, Geropsychology Education Task Force, Awards and Recognition, Program, and Nominations/Elections.

GeroCentral: As has been reported in this column previously, the Society of Clinical Geropsychology is one of several organizations supporting the development of GeroCentral, the brainchild of the Section's Past-President, Erin Emery, PhD. GeroCentral will be a website clearinghouse of practice and training resources related to psychology practice with older adults; the plan is for the website to go live in March, 2013. The site will include tools to help evaluate one's competencies for professional geropsychology practice, a clinician's toolbox with evidence-based assessment and intervention resources, links to training and mentoring opportunities, and webinars. APA's Committee on Division/APA Relations (CODAPAR) awarded an Interdivisional Grant to The Society of Clinical Geropsychology and APA Division 20, Adult Development and Aging. Other partners in the GeroCentral effort include APA's Committee on Aging (CONA), the Council of Professional Geropsychology Training Programs (CoPGTP), and Psychologists in Long Term Care (PLTC).

Geropsychology ABPP: Section II, along with other geropsychology organizations, has supported an application to the American Board of Professional Psychology (ABPP) for geropsychology to become an ABPP specialty. Section 2 member Victor Molinari, PhD, has lead the team effort of preparing the ABPP application and defending that application during a meeting with the ABPP Board of Trustees this past December. At this point, the ABPP-geropsychology committee has been approved to enter the implementation phase. The group will be finalizing the oral examination and begin to accept applications and to examine candidates this year.

APA symposium planned on training for integrated care with older adults. APA Division 12 (Section 2), Division 20, and CONA are co-sponsoring a symposium entitled Training for Integrated Care with Older Adults: Real World Implementation and the Path Forward. The symposium will address challenges and opportunities for training psychologists to work in primary care settings, particularly to meet the needs of older adults. Geropsychology training focuses on interdisciplinary, integrated approaches to care, often in specialized care settings such as nursing homes, mental health clinics, and geriatric evaluation units and, more recently, primary care settings. The symposium will address integrated care training models at graduate, internship, fellowship, and post-licensure levels. Presenters include Patricia Areán, PhD, Erin Emery, PhD, Brian Carpenter, PhD, and Richard Zweig, PhD. The Chair is Jennifer Moye, PhD, and the Discussant is Antonette Zeiss, PhD.

Update of APA Guidelines. The APA Guidelines for Psychological Practice with Older Adults were published in 2004 (American Psychologist, 59 (4), 236-260). CONA, Division 12-Section II, and Division 20 are collaborating now to update the Guidelines, given a growing research base and advances in the field. Working group members include Gregory Hinrichsen, PhD (chair), Adam Brickman, PhD, Barry Edelstein, PhD, Kimberly Hiroto, PhD, Tammi Vacha-Haase, PhD, and Richard Zweig, PhD. A 60-day public comment period will occur early this year.

IOM Geriatric Mental Health Workforce Report.

While not directly related to 12-2 activities, readers may be interested to know about the 2012 Institute of Medicine (IOM) report, The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands? (see http://www.iom.edu/Reports/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults.aspx). The main finding is that the mental health workforce, including psychology, is insufficient to meet the mental health needs of our aging population, just as is the broader geriatric health care workforce. APA worked with several geriatric mental health professional organizations to host a briefing on Capitol Hill this past September to summarize the report's findings and policy recommendations. APA recommendations included increasing funding for training in geriatrics for psychologists and trainees; ensuring integration of psychologist into integrated health care teams; and increasing access to mental health services for older adults by supporting Medicare and Medicaid policies that appropriately reimburse psychologists.

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, Ph.D.

The Association of Psychologists in Academic Health Centers (APAHC) has enjoyed a remarkable year with 222 members. During the 6th National Conference held in Nashville, TN, in February 2013, we also celebrated the 30th Anniversary of APAHC (previously known as AMSP or Association of Medical School Psychologists)! The conference theme, Applying the Science of Psychology in Academic Health Centers: Implications for Practice, Teaching, Research, and Policy, reflects various roles of psychologists in these settings. Featured speakers and topics included Norman Anderson, PhD, APA CEO: Advancing Psychology's Role in Health: The Next Phase for APA; Cynthia Belar, PhD, ABPP, Executive Director, APA Education Directorate: Transforming Healthcare: Implications for Education and Training; and Suzanne Bennett Johnson, PhD, APA Past-President: Psychology as a Science and a Profession: Successfully Transitioning from Mental Health to Health. Other presentations highlighted diversity (Kermit Crawford, PhD), electronic psychological record keeping and ethical/legal standards of care (Jeffrey Younggren, PhD, ABPP), and patient care issues such as working with difficult patients (Bill Robiner, PhD, ABPP) and motivational interviewing (John Wryobeck, PhD, ABPP).

The APA Commission on Accreditation provided pre-conference workshops for site visitor training and self-study preparation. A conference highlight for the second year, the Early Career Boot Camp, was well received by early career professionals who learned about ways to position themselves for a strong career in academic medicine. Further highlighting the importance of this topic, a paper was published about the Boot Camp in APAHC's Journal of Clinical Psychology in Medical Settings: Early Career Boot Camp: A Novel Mechanism for Enhancing Early Career Development for Psychologists in Academic Healthcare, March 2012, Volume 19(1), 117-125, by APAHC members Kelly Foran-Tuller, William Robiner, Alfiee Breland-Noble, Stacie Otey-Scott, John Wryobeck, Cheryl King, and Kitty Sanders.

The Conference also provided an opportunity to highlight the 20th Anniversary of our longstanding and well regarded Journal of Clinical Psychology in Medical Settings. Founded by Ron Rozensky, PhD, ABPP, who served as the Editor for 13 years, the journal is also online, with Barbara Cubic, PhD, serving in the editorial role until recently transitioned to Jerry Leventhal, PhD.

Awards: During the 2012 APA Convention in Orlando, FL, APAHC recognized APAHC members with the following awards:

IVAN MENSH AWARD FOR DISTINGUISHED ACHIEVEMENT IN TEACHING: John C. Linton, PhD, ABPP - West Virginia University School of Medicine
BUD ORGEL AWARD FOR DISTINGUISHED ACHIEVEMENT IN RESEARCH: Thomas A. Wadden, PhD - University of Pennsylvania School of Medicine
JOSEPH D. MATARAZZO AWARD FOR DISTINGUISHED CONTRIBUTIONS TO PSYCHOLOGY IN ACADEMIC HEALTH CENTERS: Robert P. Archer, PhD, ABPP - Eastern Virginia Medical School

The 2011 Award Winners were featured presenters and included: Richard Seime, PhD, ABPP, Mayo College of Medicine, Dorothy Hatsukami, PhD, University of Minnesota, and John D. Robinson, PhD, ABPP, Howard University College of Medicine.

APAHC members place high value on the resources provided as a membership benefit. Most recently, Drs.

Ed Christophersen and Zeeshan Butt developed the Promotions Primer with a focus on career advancement and academic promotion. This resource was also highlighted through a recent publication in the Journal of Clinical Psychology in Medical Settings, December 2012, Vol 19 (4), 349-352: Introducing a Primer for Career Development and Promotion: Succeeding as a Psychologist in an Academic Health Center.

APAHC welcomes new members, including student members. Membership dues are low and this is a great way to add on to the benefits offered as a Division 12 member. Please join us in Honolulu for APAHC presentations at the 2013 APA Convention. For further information about APAHC/Division 12 Section 8, please check our website at http://www.div12.org/section8/index.html or contact me directly at Sharon.Berry@childrensMN.org.

DIVISION 12: 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 1. Inquiries should be directed to the Division 12 Central Office at 303-652-3126 or div12apa@comcast.net

SENIOR AWARDS

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

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

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

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

MID CAREER AWARD

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

EARLY CAREER AWARDS

David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology
Given for contributions to the science clinical psychology by a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to science and to practice. Up to $500 for travel to the APA Convention is awarded.

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

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

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

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

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

www.div12.org

Instructions to Authors

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

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

Inquiries and submissions may be made to editor Guerda Nicolas at: **nguerda@miami.edu**.

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