



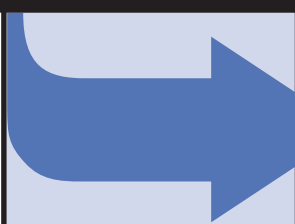
# The Clinical Psychologist

A Publication of the Society of Clinical Psychology  
Division 12 - American Psychological Association

VOL. 52 • No. 3

SUMMER 1999

## IN THIS ISSUE



- President's Column . 1
- Use of Mental Health Services by Ethnically Diverse Groups within the United States .. 4
- Evolving Visions ... 16
- Division 12 Program 1999 Meeting of the APA ..... 20
- Beutler Set to Deliver Rosalee G. Weiss Lecture ..... 23
- Society News ..... 26
- Position Openings . 30



Paul Pilkonis is awarded (p. 29)

### Editorial Staff

Paul D. Rokke, PhD, Editor  
Department of Psychology  
North Dakota State University  
rokke@plains.nodak.edu  
(701) 231-8626

Wanda A. Kapaun, MS  
Editorial Assistant  
wkapaun@plains.nodak.edu  
(701) 231-8738

## Empirically Supported Treatments: Promises and Pitfalls

The identification, development, and promulgation of empirically supported treatments (initially referred to as empirically “validated”) for the field of clinical psychology has not been without considerable controversy. Although the roots of this “movement” were present long before 1995, the publication of the Division 12 report of the Task Force on Promotion and Dissemination of Psychological Procedures (chaired by Dianne Chambless) in *The Clinical Psychologist* surely served as the focal point of this controversy, serving much as the proverbial lightning rod. An update on empirically supported therapies published in 1998 by Chambless and fellow members of the newly named Division 12 Task Force on Psychological Interventions (the Clinical Psychologist) served to add more electricity and to spark a veritable fire. Major journals including the *Journal of Consulting and Clinical Psychology*, *Psychotherapy*, *American Psychologist*, *Cognitive and Behavioral Practice*, and our own flagship journal, *Clinical Psychology: Science and Practice*, produced special sections and/or special issues on this hotly contested and controversial topic. Luminaries in our field, including the likes of Sol Garfield, Hans Strupp, Terry Wilson, Marvin Goldfried, Jerry Davison, Larry Beutler, Jackie Persons, Alan Kazdin, John Weisz, Phil Kendall, and Rosemary Nelson-Gray among others, contributed commentaries and reactions to this movement – sometimes heated ones that served, in some instances, to fan the flames of this rapidly spreading fire. Others served to quell the fire, at least momentarily.

On the surface, it hardly seems possible that anyone could argue against the identification of treatments that have been shown to be “efficacious in controlled research with a delineated population” as defined by Dianne Chambless and Steve Hollon in their recent article in the *Journal of Consulting and Clinical Psychology* (1998). Surely, “treatments that work” are desirable and their development and promulgation should be encouraged; after all, to argue the converse – that is, that “treatments that do *not* work” should be developed and disseminated hardly seems tenable and makes little sense for a profession committed to the welfare of those whom we serve. Advocating such would seem patently foolish and



Thomas H. Ollendick, PhD  
Professor of Psychology  
Virginia Polytechnic Institute  
and State University

## President's Column

*“What is it about the notion of examining the empirical status of our treatments that has led to such deep division in our field?”*

clearly indefensible. Why then all the uproar? What is it about the notion of examining the empirical status of our treatments that has led to such deep division in our field? For some, a smoldering fire if not a civil war is said to exist within our profession.

Of course, the surface view is likely to be an unsatisfactory and superficial one. We must go below the surface to find the "real" reasons as to why this notion causes such heated controversy. Part of the controversy appears to be embedded in the attempts to define "well-established," "probably efficacious," and "experimental" treatments. Clear guidelines are available for these designations in the published reports. The primary distinction between well-established and probably efficacious treatments is that a well-established treatment should have been shown to be superior to a psychological placebo, pill, or another treatment whereas a probably efficacious treatment must be shown to be superior to a waiting-list control only. In addition, effects supporting a well-established treatment must have been demonstrated by at least two different investigators or investigatory teams, whereas the effects of a probably efficacious treatment need not be (the effects can be demonstrated by two studies from the same investigator or investigatory team, for example). For both types of empirically supported treatments, characteristics of the clients must be clearly specified (e.g., age, sex, ethnicity, diagnosis) and the clinical trials must be conducted with treatment manuals. Experimental treatments, on the other hand, are those that have not been established as at least probably efficacious (they may be extant but untested treatments or truly new and innovative ones). Based on these criteria, not all treatments were found to enjoy the preferred status of being designated as "well-established." And this is where much of the controversy resides. The "Dodo Bird" verdict that maintains no treatment is superior to another treatment and that has long characterized the presumed efficacious status of our various treatments is no longer admissible nor tenable under such an approach. Some treatments have more empirical support than others.

A second major criticism of this movement is the insistence that probably efficacious and well-established treatments must have been conducted with treatment manuals. In its simplest form, a treatment manual can be defined as a set of guidelines that instruct or inform the user as to "how to do" a certain treatment. Early on, Luborsky and DuRubeiss (1984) commented upon the potential use of treatment manuals in a paper entitled "The use of psychotherapy treatment manuals: A small revolution in psychotherapy research styles." The important observation for our purposes here is that manuals existed long before the 1995 report on empirically supported treatments was published. The 1995 report simply affirmed a movement that had been present for some years and that had

become the official policy of the National Institute of Mental Health for funding research studies exploring the efficacy of various psychotherapies. In a very real sense, a manual provides an operational definition of the treatment to be implemented, providing instruction in how to conduct the treatment in a relatively standard manner. Assuming the treatment was implemented in a fairly standard way, manuals could also allow for potential replication of efforts across therapists and settings. The integrity of their implementation could be evaluated and the competence with which the treatment was implemented could be determined. Who could argue against the specification of what constitutes a certain type of therapy or how it is to be implemented for a given type of client or patient? Or, that a certain type of treatment ought to be provided in a relatively consistent way in order for the treatment to be so labeled? Of course, "manualization" of psychotherapy implied something different to some from our discipline. The potential positive outcomes associated with the use of manuals were said to be offset by those who argued that psychotherapy in the 90s had become "cookbooks ... and paint by number" exercises (Silverman, 1996) and others who pointed to the danger of treatment manuals becoming "more of a straightjacket than a set of guidelines" (Goldfried & Wolfe, 1996). These latter concerns point to the potential dangers of treatment manualization. Quite obviously, a variety of reactions about this movement abound. To the extent that such negative outcomes prevail and treatment manuals constrain us rather than liberate us, they indeed may become pitfalls – a trap or danger for the unsuspecting or unwary, as suggested by Marvin Goldfried and Barry Wolfe. Such outcomes need to be seriously considered and actively guarded against.

Still a third major concern about the empirically supported or evidence-based treatment movement is evident in differences between what have come to be called efficacy studies versus effectiveness studies. Basically, efficacy studies demonstrate that the benefits obtained from a certain treatment administered in a fairly standard way (via a treatment manual) are due to the treatment and not due to chance factors or to a variety of confounding factors that threaten the internal validity of the demonstration of efficacy. Typically, such studies are conducted in laboratory or university settings under tightly controlled conditions. Most consist of randomized clinical trials – RCTs. Appropriate concern has been raised about the exportability of these "laboratory-based" treatments to the real world – the world of clinical practice. Arguments have been mustered that the "subjects" in RCTs do not represent real-life "clients" or that the "experimenter" therapists in RCTs do not represent typical "clinical" therapists in applied practice settings. Moreover, it is argued, the settings themselves are significantly different – ranging from tightly controlled laboratory conditions to ill-defined and highly variable client-centered conditions in a practice set-

ting. To many of us, this conundrum raises the ever-present concern about the need to erect a strong bridge between science and practice, a bridge recommended by the founding fathers and mothers of clinical psychology 50 years ago and embodied in the Boulder model of clinical training. There are no easy answers, however, to resolving this gap between efficacy and effectiveness studies and no clear blueprints on how to build the bridge between “research” therapy and “clinic” therapy (to borrow from words used by John Weisz, 1996). Nonetheless, it does seem imperative that effectiveness studies that demonstrate the external validity of our treatments are vitally important; moreover, I would maintain, they need to be conducted in a way that will allow us to conclude that the treatments produce the observed changes we see in our clients, not chance or other extraneous factors. Demonstration of both internal *and* external validity are equally important. One should not be viewed as more important than the other. In fact, a similar point was suggested in the 1995 Task Force Report that served as the impetus for discussion about empirically supported treatments.

In addition to these three major concerns about empirically supported treatments, several others have been voiced. Space does not permit a full articulation of each of them in this presidential column. However, it is safe to conclude that, for many of us, this movement demonstrates considerable promise; still, for others, it is equally safe to conclude that this movement portends a major *pitfall*, full of lurking and unspecified dangers. I hope to address some of these issues in more depth in my presidential address in Boston at our annual convention this summer. I do not promise solutions to these vexing issues, rather I suggest that rational and informed dialog on these issues is of utmost importance. Only an active collaboration between clinicians and researchers can address this dilemma in an informed and productive way. The challenge is before us. See you in Boston? ■

### References

- Chambless, Dianne L & Hollon, Steven D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7-18.
- Goldfried, Marvin R. & Wolfe, Barry E. (1996). Psychotherapy practice and research: Repairing a strained relationship. *American Psychologist, 51*, 1007-1016.
- Luborsky, Lester & DeRubeis, Robert J. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review, 4*, 5-14.
- Silverman, Wade H. (1996). Cookbooks, manuals, and paint-by-numbers: Psychotherapy in the 90's. *Psychotherapy, 33*, 207-215.

*TherapyWorks Half Page Advertisement*

## Use of Mental Health Services by Ethnically Diverse Groups Within the United States

Cynthia Breaux  
Rush Presbyterian-St. Lukes  
Medical Hospital/Rush Medical Hospital  
Chicago

Donald H. Ryujin  
California Polytechnic  
State University  
San Luis Obispo

*To assess national racial/ethnic trends in the utilization of mental health services, large-scale national and regional studies are reviewed. NIMH data from 1986 are also newly analyzed. While inconsistencies occur, Asian Americans/Pacific Islanders appear to utilize outpatient and inpatient services at a rate much lower than either their population proportion or the rate at which Euro Americans/Caucasians/Whites utilize such services. African Americans/Blacks appear to utilize services at a higher rate. Native Americans/American Indians/Alaska Natives appear to utilize services at a rate either higher than, or equivalent to proportional numbers. Inconsistent findings for Latinos(as)/Hispanics/Mexican Americans make definitive patterns difficult to discern. Cautions about the data are offered, and possible reasons for utilization patterns are discussed.*

Recent trends in graduate clinical training indicate that universities are increasing courses in multicultural counseling (Hills & Strozier, 1992; Ponterotto, 1995). Given projections of the rapid ethnic diversification of the United States over the next 50 years, the increase in such courses seems warranted. Conservative estimates predict an equal proportion of non-Whites to Whites by the year 2050 (Aponte, Rivers & Wohl, 1995). Less conservative estimates predict equal proportions by 2010 (Sue, Arredondo & McDavis, 1992).

The implication of the changing demographics of the United States is that mental health professionals will be serving an increasingly diverse group of people. While this is undoubtedly true, the adequate and appropriate delivery of services requires more than knowing that there will be a general increase in multicultural clients. Information about the rates at which mental health services are being used by various ethnic groups would also be helpful. Such rates, by themselves, do not indicate whether a group is "over-" or "under-utilizing" services, much less why they are or are not seeking psychological help. But, utilization rates do provide a baseline by which to gauge the delivery and use of services. This baseline provides an index from which questions about over- or under-utilization can be asked, and hypotheses about the reasons for such use can be tested.

The intent of this paper is, therefore, to survey several, prior, large-scale national and regional studies from the past decade to establish national patterns of utilization for various

ethnic groups. Included in this survey is a new analysis, examining National Institute of Mental Health (NIMH) data from 1986. Large-scale national and regional studies were selected to establish patterns of usage reflecting either national trends or trends applicable to large numbers of individuals from certain racial/ethnic groups. The racial/ethnic groups targeted for the survey are those considered in the research literature to have been historically the focus of discrimination and unequal treatment: African Americans/Blacks, Asian Americans/Pacific Islanders, Latinos(as)/Hispanics/Mexican Americans, and Native Americans/American Indians/Alaska Natives (Aponte et al., 1995).

### Utilization Rates from Large-Scale National Studies

Possibly due to the major undertaking involved in a national survey of utilization rates, the number of such studies is limited. The most comprehensive data come from NIMH and concern the *initial* use of mental health services by various racial/ethnic groups. The results from the three NIMH surveys presented in this review are listed in Table 1. The Table is presented in an effort to lessen the confusion fostered by the numerous findings across the various studies.

### 1980-81 NIMH

An early examination of the use of mental health services focused on the analysis of *inpatient* data for various racial/ethnic groups. Examining NIMH data from 1980-1981, Snowden and Cheung (1990) noted that African Americans/Blacks (AA/Bs) and Native Americans/American Indians/Alaska Natives (NA/AI/ANs) were represented in greater proportions in the national inpatient population than Euro Americans/Caucasians/Whites (EA/C/Ws; see Table 1). The EA/C/W inpatient rate was 550.0 persons per 100,000. In

---

*Correspondence concerning this article should be addressed to Donald H. Ryujin, PhD, Psychology and Human Development Department, California Polytechnic State University, San Luis Obispo, CA 93407, dryujin@calpoly.edu.*

Table 1  
National Studies of Outpatient/Inpatient Mental Health Service Utilization Rates

	STUDIES			
	NIMH 1980-81	NIMH 1983	NIMH 1986	BCBS 1979-81
<b>RACIAL/ETHNIC GROUP</b>				
African Americans/ Blacks				
Outpatient	-	↑↑	↑↑	↓↓
Inpatient	↑↑	↑↑	↑↑	↑↑
Asian Americans/ Pacific Islander				
Outpatient	-	↓↓	↓↓	-
Inpatient	↓↓	↓↓	↓↓	-
Latinos(as)/Hispanics Mexican Americans				
Outpatient	-	↑↑	↑↑	↓↓
Inpatient	↓↓	↓↓	↓↓	↑↑
Native Americans/ American Indians/ Alaska Native				
Outpatient	-	↔	↔	-
Inpatient	↑↑	↔	↔	-

↑↑ = greater than expected use.  
 ↓↓ = less than expected use.  
 ↔ = equivalent to expected use.  
 - = the data for a given ethnic group were not collected in the study.

NIMH = National Institute of Mental Health.  
 BCBS = Blue Cross/Blue Shield.

contrast, the inpatient rate for AA/Bs was 931.8 per 100,000 and for NA/AI/ANs it was 818.7 per 100,000. On the other hand, Latinos(as)/Hispanics/Mexican Americans (L/H/MAs) comparatively demonstrated moderate under-representation (451.4 per 100,000), while Asian Americans/Pacific Islanders (AA/PIs) showed a very pronounced pattern of under-representation (268.1 per 100,000).

The authors also reported that African Americans/Blacks and Latinos(as)/Hispanics/Mexican Americans were diagnosed with schizophrenia more frequently than were Euro Americans/Caucasians/Whites. EA/C/Ws were diagnosed more frequently with “affective” disorders than were either AA/Bs or L/H/MAs. And, while Asian Americans/Pacific Islanders were under-represented in inpatient services, once admitted, their lengths of stay were notably longer than those of EA/C/Ws.

**NIMH 1983**

In a separate article (Cheung & Snowden, 1990), the same researchers who examined the NIMH data from 1980-81 also examined later NIMH data from 1983. Their presentation of the later data was more inclusive, covering statistics on both inpatient and outpatient services (see Table 1). The inclusion of outpatient services is critical, as they cover the vast majority of mental health services utilized by clients.

In terms of such outpatient services, Cheung and Snowden (1990) found that African Americans/Blacks constituted a larger proportion of the outpatient population (16.2%) than their proportion in the national population (11.7%). Latinos(as)/Hispanics/Mexican Americans appeared slightly more often in the outpatient population (7.4%) than expected from their population proportion (6.4%), and Native Ameri-

cans/American Indians/ Alaska Natives used outpatient services at a rate equivalent to their population proportion (both at 0.7%). In contrast, Asian Americans/Pacific Islanders constituted a much smaller proportion of the outpatient population (0.6%) than their proportion in the national population (1.5%).

In terms of inpatient statistics, the findings from the 1983 NIMH data are basically congruent with those from 1980-81 (see Table 1). The only exception is the Native Americans/American Indians/Alaska Natives. In the 1980-81 data they were over-represented in the inpatient population. In the 1983 data they showed inpatient utilization rates (0.6%) comparable to their proportion in the national population (0.7%). African Americans/Blacks were still over-represented in terms of inpatient care; they comprised 11.7% of the national population, but constituted 21.0% of the inpatient population. Latinos(as)/Hispanics/Mexican Americans were still under-represented, comprising 6.4% of the U.S. population, but constituting 3.8% of the inpatient population. Finally, Asian Americans/Pacific Islanders again exhibited a clear pattern of lower utilization; they comprised 1.5% of the U.S. population, but used only 0.4% of the inpatient services.

#### **NIMH 1986**

In order to present new data and to examine the reliability of the findings from the prior NIMH studies, the current authors analyzed data from a 1986 NIMH survey. As with all such NIMH data, the information is extensive. The data are based upon a complete enumeration within the United States of clients and/or patients of all organizations classified into the following categories: state and county mental hospitals, private psychiatric hospitals, Veterans Administration psychiatric organizations, residential treatment centers for emotionally disturbed children, non-federal general hospital psychiatric services, free-standing psychiatric outpatient clinics, free-standing psychiatric day/night organizations, multi-service health organizations and other residential organizations.

Results from this study are identical with those from the 1983 NIMH survey (see Table 1). African Americans/Blacks evidenced significantly greater outpatient and inpatient utilization ratios (18.6% and 20.1%, respectively) than their population proportion (12.2%). Latinos(as)/Hispanics/Mexican Americans showed an outpatient proportion slightly higher (9.0%) than their population proportion (7.7%) and an inpatient proportion slightly lower (5.2%) than their population proportion (7.7%). Native Americans/American Indians/Alaskan Natives again evidenced utilization rates nearly equal to their population proportion. Constituting 0.7% of the general population, they utilized 0.6% of the outpatient

services and 0.5% of the inpatient services.

For Asian Americans/Pacific Islanders, there remained a clear, consistent pattern of lower utilization. An earlier, separate analysis of this data for AA/Pis (Matsuoka, Breaux & Ryujin, 1997) found that they were three times less likely than their Euro American/Caucasian/White counterparts to use available mental health services. And, this pattern of differential usage generally extended to the level of the individual states as well as to the nation as a whole.

#### **Summary, NIMH Studies**

There is internal consistency within the national utilization data from NIMH (see Table 1). Across studies, African Americans/Blacks evidenced greater utilization of both outpatient and inpatient mental health services when compared to either their proportion in the general population or to the rate of use by Euro Americans/Caucasians/Whites. Latinos(as)/Hispanics/Mexican Americans evidenced slightly greater utilization of outpatient services and slightly lower utilization of inpatient services. Asian Americans/Pacific Islanders clearly evidenced lower rates of usage for both outpatient and inpatient services.

The only inconsistency in the data occurs with Native Americans/American Indians/Alaska Natives. And, this occurs only with respect to inpatient data (see Table 1). In terms of outpatient data, the 1983 and 1986 NIMH surveys indicated that this group utilized such services at a rate approximately equal to their population proportion. These two surveys also agree that NA/AI/ANs similarly used inpatient services at a rate equal to their population proportion. However, the 1980-81 data indicated that, compared to Euro Americans/Caucasians/Whites, NA/AI/ANs are more likely (rather than equally likely) to use inpatient services. Aside from this single discrepancy, the data across the three NIMH surveys are consistent with each other. However, when another source of national data is examined, the utilization patterns change.

#### **Blue Cross/Blue Shield 1979-1981**

A study by Scheffler and Miller (1989) compared the use of mental health services by African Americans/Blacks, Latinos(as)/Hispanics/Mexican Americans and Euro Americans/Caucasians/Whites enrolled in the Blue Cross/Blue Shield Federal Employee Health Benefits Plan. The researchers used a random national sample of policyholders enrolled between 1979 and 1981. All selected policyholders shared the same coverage, and statistical analyses controlled for income. Thus, differences in the demand and use of mental health services were assumed to be related to the policyholders' ethnic/racial background along with other demographic variables.

In contrast to the NIMH data, the results from the Blue Cross/Blue Shield (BCBS) study indicated that both African American/Blacks and Latinos(as)/Hispanics/Mexican Americans were proportionally *less* likely than Euro Americans/Caucasians/Whites to make use of outpatient services (see Table 1). EA/C/W outpatient users had 40% more visits than AA/Bs and 38% more visits than L/H/MAs. However, both African Americans/Blacks and Latinos(as)/Hispanics/Mexican Americans had a higher probability of inpatient use (see Table 1). AA/Bs had 23.5% and L/H/MAs had 13.5% more inpatient visits than Euro Americans/Caucasians/Whites. The authors cited preference, more serious diagnoses, more severe mental health problems, or family support systems that encouraged inpatient care as possible explanations for the high inpatient but low outpatient use.

These data show little consistency with the NIMH data. The only point of agreement is the greater utilization of inpatient services by African Americans/Blacks (see Table 1). However, a national sample of BCBS policyholders is not necessarily a representative sample of the population of the nation as a whole. The incongruity between the findings may be a function of differences between the BCBS sample and the national population. Nonetheless, the Blue Cross/Blue Shield data caution against generalizing national findings to more specific samples. This is especially important to keep in mind when looking at data from large-scale regional studies.

#### **Utilization Rates from Large-Scale Regional Studies**

For the purposes of this paper, large-scale regional studies can be helpful in several ways. If regional findings on the utilization of mental health services are consistent with national trends, the findings provide evidence for the reliability of the national data. If regional findings are inconsistent with national trends, they caution against the reliability and generalizability of patterns of utilization deduced from national data. Such inconsistencies may also reflect regional characteristics and provide information about both positive and negative factors which influence the utilization of mental health services by various racial/ethnic groups.

The trends from the regional studies covered in this review are listed in Table 2. They are divided into three regions: California, Seattle, and Hawaii. These studies focus primarily on *outpatient* use, the most widely used of all the mental health services. As such, Table 2 presents only outpatient trends; the limited regional data on inpatient use is discussed only within the text of the review. Unfortunately, the lack of inpatient data limits the inter-regional and regional-national comparisons that can be made.

### **California**

#### **Los Angeles**

Sue, Fujino, Hu, Takeuchi and Zane (1991) investigated the use of outpatient services by over 200,000 Asian American (AA), African American/Black, Latino(a)/Hispanic/Mexican American, and Euro American/Caucasian/White clients entering the Los Angeles County mental health system between 1983-1988. Sue et al. (1991) compared each racial/ethnic group's percentage of outpatient use with that group's proportion in the County population. The comparison of proportions indicated that Asian Americans and Latinos(as)/Hispanics/Mexican Americans were under-represented in the outpatient population (see Table 2). AAs constituted 3.1% of the outpatient population while comprising 8.7% of the County population; L/H/MAs constituted 25.5% of the outpatient population, while comprising 33.7% of the County population (see Table 2). In contrast, African Americans/Blacks were over-represented, using 20.5% of outpatient services while comprising 12.8% of the County population.

Although only indirectly germane to initial use, Sue et al. (1991) also found that African Americans/Blacks had a significantly higher proportion, and Asian Americans had a significantly lower proportion of dropouts after one session than either Latinos(as)/Hispanics/Mexican Americans or Euro Americans/Caucasians/Whites. Sue et al. (1991) also found that AA/Bs were the least likely, and L/H/MAs were the most likely, to improve after treatment. Interestingly, ethnic match was related to length of sessions for all racial/ethnic groups, but failed to be a significant predictor of treatment outcome, except for L/H/MAs.

Another study conducted in the Los Angeles area (Bui & Takeuchi, 1992) is important because it covers the same period (1983-88) as the Sue et al. (1991) research and has a large data set (almost 1,000 subjects per each ethnic/racial group). Unfortunately, generalizations from this study are limited because the data concentrate on adolescents, ages 13-17. Interestingly, the study obtained results identical to those of Sue et al. (1991). Overall utilization rates based primarily on outpatient data, indicated that adolescent Euro Americans/Caucasians/Whites used public mental health services at a rate of 548 individuals per 100,000 in the County. In comparison, African Americans/Blacks were over-represented in the client population (791/100,000; see Table 2), while Latinos(as)/Hispanics/Mexican Americans were under-represented (447/100,000). Asian Americans again showed a pronounced pattern of under-representation (138/100,000).

Table 2  
Large-Scale Studies of Outpatient Mental Health Service Utilization Rates

RACIAL/ETHNIC GROUP	STUDIES					
	Los Angeles County	Los Angeles County (adolescents)	San Francisco-Santa Clara County	Seattle-King County	Seattle-King County	Hawaii
	1983-88	1983-88	1987-88	1971-73	1983	1972-81
African Americans/Blacks	↑↑	↑↑	↓↓	↑↑	↑↑	-
Asian Americans/Pacific Islander	↓↓	↓↓	↑↑	↓↓	↔	↓↓
Latinos(as)/Hispanics/Mexican Americans	↓↓	↓↓	↑↑	↓↓	↔	-
Native Americans/American Indians/Alaska Native	-	-	-	↑↑	↑↑	-

- ↑↑ = greater than expected use.
- ↓↓ = less than expected use.
- ↔ = equivalent to expected use.
- = the data for a given ethnic group were not collected in the study.

**San Francisco and Santa Clara Counties**

Outside the Los Angeles area, in Northern California, Hu, Snowden, Jerrell and Nguyen (1991) used data from the fiscal year 1987-88 to examine mental health service utilization rates in both San Francisco and Santa Clara counties. With a sample of almost 27,000 persons (12,000 of whom were ethnically diverse), their study compared access and level of use by ethnic minorities for a broad range of services. These services included both outpatient and inpatient care, emergency services and case management. However, about 50% of the two counties' public mental health clinics were devoted to individual outpatient mental health services.

In terms of outpatient utilization rates, the findings from this study go contrary to that from the other regional studies (see Table 2). African Americans/Blacks had a significantly lower probability of using outpatient services than Euro Americans/Caucasians/Whites. And, Asian Americans and Latinos(as)/Hispanics/Mexican Americans were significantly more likely to use outpatient services than EA/C/Ws.

The utilization of inpatient services cannot be compared across regional studies. However, Hu et al. (1991) found pat-

terns of utilization not entirely consistent with the national data presented in Table 1. Asian Americans still had a significantly lower probability of using public inpatient services. But, there were no significant differences in inpatient use between AA/Bs, L/H/MAs and Euro Americans/Caucasians/Whites.

These overall patterns of outpatient and inpatient service utilization run contrary to the findings from some of the other regional/national studies. Moreover, within their own study, Hu et al. (1991) found different results between San Francisco and Santa Clara counties. To explain such a large variation in findings, the researchers pointed to California's decentralized policy of providing public mental health services. With more local control, counties have the option to provide more or less financial support to different modes of treatment. Santa Clara County, for example, provided more generous inpatient services than San Francisco and had created eight new community mental health outpatient service centers for Asian American and Latino(a)/Hispanic/Mexican American minorities. This generous allotment and differential channeling of funds could explain why the researchers in this study found that AAs and L/H/MAs were more willing to



use outpatient services, more willing than other regional studies seem to indicate (see Table 2).

### Summary, California Data

The data from Los Angeles, San Francisco and Santa Clara counties provide an interesting pattern of mental health service utilization. Within the two Los Angeles studies (Bui & Takeuchi, 1992; Sue et al., 1991), the utilization patterns are internally consistent (see Table 2). In both studies, Asian Americans and Latinos(as)/Hispanics/Mexican Americans were less likely to use outpatient services while African Americans/Blacks were more likely to use such services. Such consistency is reassuring in terms of the reliability of the data.

However, when these results are compared to the data from San Francisco and Santa Clara counties, the findings are completely reversed (see Table 2). In these two Northern California counties, Hu et al. (1991) found that Asian Americans and Latinos(as)/Hispanics/Mexican Americans were more likely to use outpatient services while African Americans/Blacks were *less* likely to use such services. While this may argue for regional differences in utilization patterns, it also cautions against generalizing findings from national and regional studies, even when the regions are within the same state.

Cautiously, Hu et al.'s findings may also indicate the favorable impact which a county can have on the services it provides its racially/ethnically diverse population. As previously noted, Santa Clara County created eight new community mental health outpatient service centers for Asian American and Latino(a)/Hispanic/Mexican American minorities. While this does not address the pattern of outpatient utilization for African Americans/Blacks, it does correlate with the greater utilization of mental health services by AAs and L/H/MAs not found in any other regional study. Discretion must be exercised in inferring a cause-and-effect relationship from this finding (see Sue et al., 1991), but a similar pattern of enhanced utilization rates correlates with community outreach in the studies of outpatient services in Seattle (see below).

Aside from outpatient services, Hu et al. (1991) provide one of the few large-scale regional studies examining inpatient use. Since the lack of inpatient information from other regional studies prevents commensurate comparisons, Hu et al.'s (1991) findings were compared to information from national studies. The regional trends in the use of inpatient services do not match well with national trends (see Tables 1 and 2). While Asian Americans continued to remain under-represented in the inpatient population, inconsistencies occurred for African Americans/Blacks and Latinos(as)/Hispan-

ics/Mexican Americans. NIMH data indicated that the latter two groups were under-represented in the inpatient population. In San Francisco and Santa Clara counties these two groups, when compared to Euro Americans/Caucasians/Whites, utilized services at proportionally equivalent rates; there was no under-representation. As with the data on outpatient services, it may be cautiously inferred that the regional findings correlate with the more generous financial inpatient support provided in Santa Clara county. While discretion must be used in making this interpretation, we have noted that similar correlations were found in the large-scale studies of outpatient utilization conducted in Seattle.

### Seattle

Sue's (1977) study of outpatient programs in the Seattle area was conducted at a time earlier than those covered in this review. However, it is included for two reasons. First, it is one of the most often-cited studies in the literature on service delivery to ethnic minorities. More importantly, it provides a comparison for a later Seattle study (O'Sullivan, Peterson, Cox & Kirkeby, 1989) conducted in 1983.

In the original research, Sue (1977) examined mental health service utilization data from the Seattle-King County area of Washington State. The data were collected over a three year period, 1971-1973, from almost 13,000 clients (1,300 of whom were ethnically diverse). All clients were receiving community mental health services in the region. Outpatient programs made up almost 90% of the services used, but overall utilization data included inpatient and day treatment as well.

Although no statistical analyses were run, overall findings indicated that African Americans/Blacks and Native Americans/American Indians (NA/AIs) were greatly over-represented at the community mental health centers (see Table 2). AA/Bs comprised 3.4% of the County's population but 7.3 % of the community mental health centers' clients. NA/AIs comprised 0.6% of the County's population, but 3.5% of the clients. On the other hand, Asian Americans and Latinos(as)/Hispanics/Mexican Americans were under-represented. AAs made up 2.4% of the County population but constituted only 0.7% of the centers' clients. L/H/MAs comprised 1.8% of the County population, but only 0.6% of the centers' clients. As a reference point, Euro/Caucasian/White Americans made up 91.7% of the County's population and 90.2% of the clients.

There were two additional findings in this study which bear indirectly upon initial rates of service utilization. First, Sue (1977) found a 50% dropout rate after one session for all minority groups except Latinos(as)/Hispanics/Mexican Ameri-

cans. The dropout rate after one session was 42% for L/H/MAs and 30% for Euro Americans/Caucasians/Whites. Second, African Americans/Blacks were significantly more likely to be assigned to inpatient treatment and were more likely to receive a more serious diagnosis when compared to EA/C/Ws. No other significant differences were found with regard to the severity of the initial diagnosis when comparing other racial/ethnic groups with EA/C/Ws.

Ten years later, in 1983, O'Sullivan et al. (1989) replicated Sue's study in the same Seattle-King County area. Using a sample of 6,000 clients, approximately 3,000 of whom were ethnically diverse, they obtained a somewhat different pattern of results (see Table 2). African Americans/Blacks and Native Americans/American Indians remained over-represented in the outpatient population of the County's community mental health centers. Comprising 4.4% of the County's population, AA/Bs constituted 9.8% of the outpatient population. Similarly, NA/AIs comprised 1.0% of the County's population and 4.3% of the outpatient population.

The real change in utilization rates occurred for Asian Americans and Latinos(as)/Hispanics/Mexican Americans (see Table 2). Compared to their population proportions, both groups were previously under-represented among the clients of the County's mental health centers (Sue, 1977). However, ten years later, both groups were found to be utilizing outpatient services at a rate approximately equal to their County population proportions. AAs constituted 4.6% of the County's population, and 5.4% of the outpatient population. Similarly, L/H/MAs constituted 2.1% of the County's population and 1.9% of the outpatient population.

With regard to their findings, O'Sullivan et al. (1989) cautioned that there was an influx of Asian American and Latino(a)/Hispanic/Mexican American immigrants to the Seattle area between 1980 and 1983. The fact that the researchers used 1980 census data to determine County population totals means that a greater number of AAs and L/H/MAs lived in the County than was reflected in the 1980 census. Since 1983 utilization data were used, the comparison with 1980 County population data would inflate service utilization comparisons for these two groups. In essence, it is possible that Asian Americans and Latinos(as)/Hispanics/Mexican Americans were utilizing community mental health services at a rate *lower* than their larger County population proportions.

This caveat notwithstanding, O'Sullivan et al. (1989) obtained other interesting results that differed from Sue's (1977) original study. Failure-to-return rates appeared to have dramatically improved in the intervening 10 years. "In 1971-73,

all ethnic minority groups not only had significantly higher failure-to-return rates than did Caucasians but their rates also approached or exceeded 50%" (O'Sullivan et al., 1989, p. 25). In 1983 the improved rates "ranged from 11.8% for Asian Americans (reduced from 52% in 1971-1973) to 22% for [B]lacks (1971-1973: 52%), while that of the Caucasian group was 18% (1971-1973: 30%)" (O'Sullivan et al., 1989, p. 25). Further, in 1971-1973 all ethnic minority groups averaged significantly fewer sessions than Euro Americans/Caucasians/Whites. In 1983, only Asian Americans averaged fewer sessions.

O'Sullivan and his colleagues attributed the changes in utilization patterns to the increasing cultural responsiveness of Seattle's Mental Health system. More ethnic-specific mental health centers had been created since 1977. Also, more service providers from diverse groups had been hired, and more innovative treatment programs for ethnic communities had been funded. However, in response to O'Sullivan et al. (1989), Sue et al. (1991) cautioned about inferring a causal link based on a temporal relationship between the initiation of culturally responsive intervention and the later finding of improved outcomes. A similar link had previously been suggested in this review for the enhanced patterns of utilization found by Hu et al. (1991) in San Francisco and Santa Clara counties (see Table 2). Sue's point is well-taken and its importance cannot be understated, but the findings of O'Sullivan et al. (1989) and Hu et al. (1991) do leave some room for cautious optimism.

### **Hawaii**

Up to this point this review has examined large-scale utilization studies which simultaneously looked at several racial/ethnic groups at once. However, a large-scale Hawaiian study which focused primarily on Asian Americans/Pacific Islanders is included here at the end because its findings are instructive for all groups. In this study, Leong (1994), compared both outpatient and inpatient utilization rates between 1971 and 1981 for over 22,000 Chinese Americans, Japanese Americans, Filipino Americans, and Euro Americans/Caucasians/Whites.

In terms of the use of inpatient services, the data are consistent with regional and national trends (see Table 2). All three Asian American/Pacific Islander groups—Chinese, Japanese and Filipino Americans—utilized inpatient services at a rate lower than their proportions in the Hawaiian population. Interestingly, Euro Americans/Caucasians/Whites utilized inpatient services at a rate higher than their proportion in the Hawaiian population.

In terms of outpatient services, the data show that, in general, AA/PIs utilized services at a rate lower than their population proportion. Euro Americans/Caucasians/Whites utilized services at a rate higher than their population proportion. However, closer examination of each Asian American/Pacific Islander subgroup indicated that the general trend toward lower utilization did not apply equally to all ethnicities. Only for the Chinese and Japanese Americans did the general trend apply; Filipino Americans utilized outpatient services at a rate equivalent to their population proportion.

This finding cautions against the blanket assumption that utilization trends which apply to any given racial/ethnic group apply to all members of that group. The diverse mix of subgroups covered by designations such as Latino(as)/Hispanics/Mexican Americans and Euro Americans/Caucasians/Whites may mask important subgroup differences in the utilization of mental health services. Compounded by regional differences, such subgroup differences caution against the over-generalization of utilization trends for any particular group.

### **Summary**

Keeping the above caution in mind, there may still be some overall conclusions which can be made about racial/ethnic patterns of mental health service utilization. From the studies reviewed in the preceding sections, it seems that consistent utilization trends may exist for certain racial/ethnic groups.

#### *Asian Americans/Pacific Islanders*

The clearest pattern in utilization rates seems to be for Asian Americans/Pacific Islanders. Across both national and regional studies they consistently used fewer outpatient and inpatient services than expected (see Tables 1 and 2). The exceptions are regional studies in San Francisco-Santa Clara counties by Hu et al. (1991) and in Seattle-King County by O'Sullivan et al. (1989). Hu et al. (1991) found that AA/PIs were using outpatient services at a rate higher than expected, while O'Sullivan et al. (1989) found AA/PIs were using such services at a rate equal to what was expected. As previously noted, these inconsistent findings may be explained by the newly instituted services established specifically for ethnic groups in the communities investigated by both of these studies. While such an explanation needs to be made with caution, the hopeful link between outreach and positive outcomes should not be ignored.

In terms of Asian Americans/Pacific Islanders specifically, and in terms of racial/ethnic groups generally, it is important

to reiterate Leong's (1994) findings in Hawaii. While Asian Americans/Pacific Islanders as a group showed their typical pattern of lower outpatient and inpatient utilization, a specific subgroup, Filipino Americans, utilized outpatient services at a rate equivalent to their statewide population proportion. Thus, utilization trends that apply to a racial/ethnic group as a whole may not apply to a subgroup within that cluster.

#### *African Americans/Blacks*

The pattern of mental health service utilization for African Americans/Blacks also shows some consistency. Across both national and regional studies they appear to have utilized inpatient and outpatient services at rates higher than typically expected (see Tables 1 and 2). The exceptions to this pattern are the national Blue Cross/Blue Shield study by Scheffler and Miller (1989) and the regional study by Hu et al. (1991). Consistent with the pattern of higher utilization, the Blue Cross/Blue Shield study found that African Americans/Blacks used inpatient services at a rate greater than expected. However, contrary to this pattern, the study found that AA/Bs used outpatient services at a rate lower than expected. Even more discrepant, Hu et al. (1991) found that AA/Bs in San Francisco-Santa Clara counties used outpatient services at a rate lower than expected, and inpatient services at a rate equivalent to their population proportion.

The inconsistency in the outpatient findings for the Blue Cross/Blue Shield study may be due to differences in the population sampled. As previously noted, a national sample of Blue Cross/Blue Shield policyholders may not be the same as a representative sample of the population as a whole. More inclusive data, such as those from NIMH, may be more representative of national utilization rates.

In terms of the study by Hu et al. (1991), their findings of lower outpatient and equivalent inpatient use in San Francisco-Santa Clara counties are more problematic. The region studied appears to have been sensitive to racial/ethnic issues. Eight new community mental health outpatient centers targeted for Asian Americans and Latinos(as)/Hispanics/Mexican Americans were built in Santa Clara County. While the centers were not specifically for African Americans/Blacks, some sensitivity to racial/ethnic issues seems to have been present. However, this would argue for enhanced, rather than lower or equivalent usage. Regardless, these findings are important because they argue for caution when trying to generalize national utilization trends to specific regions of the country.

### *Native Americans/American Indians/Alaska Native*

The data for Native Americans/American Indians/Alaska Natives are very limited. The national and regional data that do exist show mental health service utilization rates that are either higher or equivalent to expected rates (see Tables 1 and 2). In terms of outpatient information, two NIMH studies (Breux & Ryujin, current review; Cheung & Snowden, 1990) found equivalent usage, while two regional studies in Seattle-King County (O'Sullivan et al., 1989; Sue, 1977) found greater than expected use. There are no regional data on inpatient care, but two NIMH studies (Breux & Ryujin, current review; Cheung & Snowden, 1990) found equivalent use while one NIMH study (Snowden & Cheung, 1990) found greater than expected use.

The inconsistencies between the national and regional data again argue for caution in generalizing national utilization patterns to specific regions of the country. Still, there is a consistency within the data. No study, either national or regional, indicates lower than expected use of mental health services for Native Americans/American Indians/Alaska Natives. Without a fuller understanding of the social and economic situation of this group, the implications of this finding are difficult to discuss. But, the purpose here is to evaluate utilization patterns so that discussion and research can ensue.

### *Latino(as)/Hispanics/Mexican Americans*

The weakest patterns of mental health service utilization are for Latino(as)/Hispanics/Mexican Americans. In terms of outpatient services two NIMH studies found greater than expected rates of use (see Table 1). The national Blue Cross/Blue Shield study found lower than expected rates of use. Again, this discrepancy might be attributed to differences between the national population and the Blue Cross/Blue Shield sample.

Regionally, only one study, Hu et al. (1991), found greater than expected rates of outpatient use (see Table 2). Three of the regional studies (Bui & Takeuchi, 1992; Sue, 1977; Sue et al., 1991) show lower than expected rates of use, and one (O'Sullivan et al., 1989) shows a level of use equivalent to expected rates. As before, the findings of enhanced or equivalent use might be attributable to the outreach made towards Latinos(as)/Hispanics/Mexican Americans in the two regions involved in these studies. These regions—Seattle-King County and San Francisco-Santa Clara counties—created new services targeted to assist L/H/MAs. Considering such special local circumstances, the overall pattern of outpatient use for the remaining regions seems to favor a trend towards lower service utilization.

If this is the case, national and regional data portray opposing patterns of outpatient utilization; while national data indicate slightly greater utilization, regional data indicate slightly lower utilization. Yet, both patterns could be accurate. The regional studies were done on the West Coast (California and Washington State) where the primary racial/ethnic subgroup is Mexican Americans. The regional trend towards lower outpatient utilization may reflect racial/ethnic subgroup differences and/or regional differences subsumed under a more general national trend.

The pattern of inpatient use for Latinos(as)/Hispanics/Mexican Americans is also inconsistent, and analysis is difficult due to the dearth of regional information on inpatient use (see Tables 1 and 2). Nationally, three NIMH studies indicate that L/H/MAs use inpatient services at levels lower than expected. National Blue Cross/Blue Shield data indicate higher than expected levels of use. The lone regional study with relevant inpatient data, Hu et al. (1991), indicates a level of use equivalent to expected rates. Again, it is possible that the Blue Cross/Blue Shield sample is different from the more inclusive NIMH population. And, the regional study involved Santa Clara County which financed more *outpatient* centers to reach L/H/MAs. Such centers and the concerns underlying them may have enhanced not only outpatient but inpatient utilization. Thus, there may be a tendency, at the national level at least, for L/H/MAs to use inpatient services at a rate slightly lower than expected. However, given the findings for outpatient use, it is clear that this national trend should not be assumed to reflect regional rates of inpatient utilization.

### **Discussion**

It is necessary to preface any discussion of mental health service utilization rates with a comment on the time period in which the data were collected. In an effort to establish utilization patterns for several ethnic/racial groups, we have focused on national and large-scale regional studies from the past decade. For the most part, earlier studies were not included. More importantly, there is a dearth of recent data. Thus, findings specific to the current decade are not presented. Older data are useful to establish past trends, but they do not reflect temporal changes. Still, it is hoped that the current review will help to establish racial/ethnic "baselines" for mental health service utilization to which future research can refer.

Aside from the nature of the data, there are other complications in establishing the link between initial service use and racial/ethnic group. One complication arises in homogenizing the racial/ethnic subgroups. As noted, Leong (1994) found significant differences in service use among various Asian American/Pacific Islander subgroups in Hawaii. Such

subgroup differences may have resulted in the differences between national and regional patterns of outpatient use found for Latinos(as)/Hispanics/Mexican Americans.

There are also regional disparities in results which may have to do with local policies and programs. As pointed out several times, local policies may explain the differential results for the O'Sullivan et al. (1989) study in Seattle-King County and the Hu et al. (1991) study in San Francisco-Santa Clara counties. Local policies certainly influence accessibility of service resources, a consistent factor affecting the probability of use among racial/ethnic groups.

Other confounds in existing studies include the effects of education, income, gender, age, and level of acculturation. Many of these effects are not controlled for statistically, and several are powerful predictors of service use in and of themselves. For example, Bui and Takeuchi (1992) concluded that ethnicity is predictive, but found poverty status and referral sources to be more consistent predictors of utilization variables.

### **Commonalities**

Some common themes appear to prevail among racial/ethnic groups in initial service utilization. Financing, as implied above, may play an important role among the poor and near-poor, where minority groups may be disproportionately represented. Predictably, continuous Medicaid coverage almost doubles one's chances of using ambulatory mental health services (Taube & Rupp, 1986). Trends in future mental health coverage in light of national health care issues may have an interesting impact on service use.

If financing is a common theme, cultural incongruity may be at least as powerful a factor in help-seeking behavior. Mental health is a culturally embedded notion. There are various cultural views of mental health, psychological disorder, and illness. Supernatural models emphasize spirit intrusion, or soul loss, for example. Religious explanations focus on moral integrity and ethical conduct. Natural explanations consider underlying principles of balance, as in yin/yang (Torrey, 1986). Perhaps groups in various cultures may conceptualize "problems" and "solutions" in different ways. Differential conceptualization would certainly overlap with the type of help group members would seek.

Religion, prayer, and spirituality may be key aspects of coping styles among racial/ethnic groups (Cheung & Snowden, 1990). Citing a national study on stress and coping among African Americans/Blacks, Snowden and Cheung (1990) report that as the seriousness of problems increased, so did the number of African Americans/Blacks who felt prayers helped

them the most. Prayer is also a widely used coping mechanism for Latinos(as)/Hispanics/Mexican Americans (Acosta, 1984). Spiritualism and use of prayer are important to Native American/American Indian cultures as well. Many of the healing ceremonies for physical and emotional ills include use of spiritual, tribal rituals (Manson, 1986).

Another factor common to several of the ethnic/racial groups discussed in this paper is language. While language does not have a uniform impact across and within ethnic/racial groups, it affects both the utilization and efficacy of therapy. Altarriba and Santiago-Rivera (1994) hint at the breadth of this problem when they indicate that "Spanish remains the dominant language spoken in most Cuban, Puerto Rican, and Mexican-American homes" (p. 388). In terms of Asian Americans, Takeuchi, Mokuau and Chun (1992) indicate that more than 30 different languages are spoken by the more than 20 different ethnic groups classified within this category. Furthermore, the problem involves more than the therapist's ability to understand the surface meaning of the client's words. As pointed out by Musser-Granski and Carrillo (1997), the therapist must be able to understand "subtle meanings, idiomatic expressions, sayings, implied meanings, affect, tone of voice, facial expressions and other non-verbal clues . . . . [And, the therapist] must be able to accurately communicate to the client words of encouragement, respect, praise, concern, warmth, confrontation and direction" (p. 54).

Beyond language is the larger issue of culturally sensitive and culturally competent therapist (see Pope-Davis & Edwards, 1997 for articles on this topic). To be competent, therapists for different ethnic/racial groups must be culturally sensitive. We argue that such sensitivity is not merely a matter of the therapist's race or ethnicity, nor a matter of having academic knowledge. Cultural sensitivity is often a non-verbal understanding that comes with common experience, and occurs on an emotional as well as cognitive level. Hence, an ethnically/racially similar therapist is helpful, but not sufficient; conversely, the lack of an ethnic/racial match does not necessarily rule out therapeutic competence. We also argue that classroom knowledge is helpful but not sufficient. Experiential training, such as that recommended by Pope-Davis, Breaux, and Liu (1997), is needed for the non-cognitive aspects of understanding to occur. Regardless of one's position on this issue, culturally competent therapy affects the utilization and efficacy of mental health services to all groups, not just those designated by ethnicity/race (e.g., groups designated by sexual orientation, religion, socioeconomic status, etc.). Thus, cultural sensitivity and competence is an issue that must be addressed to ensure professional competence; ethnic/racial groups merely highlight the possible problems associated with this issue.

### **Culture-Specific Effects**

Asian Americans/Pacific Islanders have the most consistent pattern of service use indicating a disinclination to seek treatment. Many reasons have been offered to explain this behavior and most have to do with culturally embedded values. Root (1985) claims that discussing psychological problems with a mental health worker may be viewed as bringing disgrace on the family. She also suggests that Asian Americans/Pacific Islanders may try to resolve their problems on their own, believing that problems can be averted by avoiding bad thoughts and exercising will power. Atkinson and Gim (1989) offer submergence of individuality, reluctance to display strong feelings, and respect for authority as attitudes that may exist as barriers for help seeking. The authors also suggest that Asian Americans/Pacific Islanders simply may not view psychological services as a credible source of help.

While African Americans/Blacks appear to utilize services at greater than expected rates, there may be some impediments to seeking therapy. Sussman, Robins and Earls (1987) found that the barriers to care most frequently cited by African Americans/Blacks were lack of time, fear of being hospitalized, expense, and the belief that they should be strong enough to handle the problem themselves without professional help. African Americans/Blacks significantly more than Euro Americans/Caucasians/Whites cited fear of being hospitalized as the primary reason for not seeking care. This is reasonable, given that AA/Bs are typically diagnosed with more severe psychological impairments than EA/C/Ws (O'Sullivan et al., 1989). Sussman et al. (1987) also offered an explanation for why African Americans/Blacks might not seek treatment for depression as readily as EA/C/Ws. They suggest that AA/Bs may more frequently feel they have a reason to be depressed and consider their symptoms to be normal outcomes of everyday problems, stresses, and strains. Thus, they may not interpret their symptoms within a mental health framework. Also, treatment-seeking decisions may be made in a familial context. Sussman et al. (1987) contend that family and extended kin networks are important in the African American/Black community and a breakdown in this system has been related to decisions to seek help. On the other hand, Broman (1987) contends that AA/Bs are more likely than Euro Americans/Caucasians/Whites to seek help from mental health sources for economic and health problems. It seems that AA/Bs defined these problems as relevant for help seeking, perhaps pointing to a conceptual difference in defining "problem" and "solution" as was previously mentioned.

Rogler, Malgady, and Rodriguez (1989) offer an alternative resource theory to explain Latino(a)/Hispanic/Mexican American "under-utilization." Help-seeking efforts are seen in the full context of interpersonal relations and networks—the family, the circle of friends, neighbors, the co-parent (god-parent) system, and indigenous folk healing institutions—rather than just viewing bureaucratic service structures as the only source of aid. Use of family for support is a particularly predominant and consistent theme in the literature (Escovar & Kurtines, 1983; Rogler et al., 1989). Specific folk beliefs may be at work as well. For example, Rogler and Hollingshead (1985) examined Puerto Rican cultural conceptions of the *loco* or crazy person. To be perceived as *loco* carries much stigma and is viewed in a moral context, thus inviting suppression or avoidance of symptoms that might indicate such a condition.

Literature on Native American/American Indian/Alaska Native service use is sparse and possible explanations must be inferred. Data, while sparse, indicate more than expected use of services. Perhaps continuing extreme conditions for N/AI/ANs may contribute to the amount of service sought. For example, Herring (1992) found that between 25% and 35% of all Native American/American Indian children have been separated and placed in foster homes, adoption homes, boarding houses or institutions. He also reports a mean annual NA/AI income of \$1,500, unemployment rates of 60% on reservations, widespread alcoholism, and a nationwide suicide rate among young NA/AI men of more than twice the average for their age group.

### **Final Note**

The act of investigating mental health service use among ethnically diverse populations may imply the supposition of an "ultimate" use rate. We do not believe that there is one. However, the negative implication inherent in the case of "under-utilization" is that needs are not being met. In the case of "over-utilization," it is that certain groups are in greater distress or are being diagnosed more seriously. Establishing consistent trends in use rates may be the first step in uncovering and addressing the negative aspects of mental health service utilization. For example, it is now very clear that Asian Americans are the least likely group to utilize services. Therefore, research can be conducted to understand this phenomenon and to determine if changes in outreach and/or therapy would be appropriate. By themselves, utilization studies do not resolve issues and problems. They are important because they help to indicate where issues and problems exist. And, this helps to focus the direction of future research. ■

## References

- Acosta, F. X. (1984). Psychotherapy with Mexican Americans: Clinical and empirical gains. In J. L. Martinez, Jr. & R. H. Mendoza (Eds.), *Chicano Psychology (2nd ed.)*, pp. 163-185. Orlando, FL: Academic Press.
- Altarriba, J. & Santiago-Rivera, A. L. (1994). Current perspectives on using linguistic and cultural factors in counseling the Hispanic client. *Professional Psychology: Research and Practice, 25*, 388-397
- Aponte, J. F. & Crouch, R. T. (1995). The changing ethnic profile of the United States. In J. F. Aponte, R. Y. Rivers and J. Wohl (Eds.), *Psychological interventions and cultural diversity*, pp. 1-18. Needham Heights, MA. Allyn and Bacon
- Aponte, J. F., Rivers, R. Y. & Wohl, J. (1995). *Psychological interventions and cultural diversity*. Needham Heights, MA. Allyn and Bacon
- Atkinson, D. R. & Gim, R. H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 36*, 209-212.
- Broman, C. L. (1987). Race differences in professional help seeking. *American Journal of Community Psychology, 15*, 473-489.
- Bui, K. & Takeuchi, D. T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*, 403-417.
- Cheung, F. K. & Snowden, L. R. (1990). Community mental health and ethnic minority populations. *Community Mental Health Journal, 26*, 277-291.
- Escovar, L. A. & Kurtines, W. M. (1983). Psychosocial predictors of service utilization among Cuban-American elders. *Journal of Community Psychology, 11*, 355-362.
- Haviland, M. G., Horswill, R. K., O'Connell, J. J. & Dynneson, V. V. (1983). Native American college student's preference for counselor race and sex and the likelihood of their use of a counseling center. *Journal of Counseling Psychology, 30*, 267-270.
- Herring, R. D. (1992). Seeking a new paradigm: Counseling Native Americans. *Journal of Multicultural Counseling and Development, 20*, 35-43.
- Hills, H. I. & Strozier, A. L. (1992). Multicultural training in APA-approved Counseling Psychology programs: A survey. *Professional Psychology: Research and Practice, 23*, 43-51.
- Hu, T., Snowden, L. R., Jerrell, J. M. & Nguyen, T. D. (1991). Ethnic populations in public mental health: Services choice and level of use. *American Journal of Public Health, 81*, 1429-1434.
- Leong, F. T. L. (1986). Counseling and psychotherapy with Asian-Americans: Review of the literature. *Journal of Counseling Psychology, 33*, 196-206.
- Leong, F. T. L. (1994). Asian Americans' differential patterns of utilization of inpatient and outpatient public mental health services in Hawaii. *Journal of Community Psychology, 22*, 82-96.
- Manson, S. M. (1986). Recent advances in American Indian mental health research: Implications for clinical research and training. In M. R. Miranda & M. L. Kitano (Eds.), *Mental health research and practice in minority communities: Development of culturally sensitive training programs*. Rockville, MD: NIMH.
- Matsuoka, J. K., Breaux, C. & Ryuji, D. H. (1997). National Utilization of mental health services by Asian Americans/Pacific Islanders. *Journal of Community Psychology, 25*, 141-145.
- Musser-Granski, J. & Carrillo, D. F. (1997). The use of bilingual, bicultural paraprofessionals in mental health services: Issues for hiring, training, and supervision. *Community Mental Health Journal, 33*, 51-60
- O'Sullivan, M. J., Peterson, P. D., Cox, G. B. & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology, 17*, 17-30.
- Ponterotto, J. G. (1995). Multicultural counseling training: A competency model and national survey. In D. B. Pope-Davis (Chair), *Becoming multiculturally competent: Strategies for changing curricula, training, and supervision*. Symposium conducted at the annual meeting of the American Psychological Association, New York, NY.
- Pope-Davis, D. B. & Coleman, H. L. K. (1997). *Multicultural counseling competencies: Assessment, education and training, and supervision*. Thousand Oaks, CA. Sage Publications.
- Rogler, L. H., Malgady, R. G. & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research*. Malabar, FL: Robert E. Krieger Publishing Company, Inc.
- Rogler, L. H. & Hollingshead, A. B. (1985) *Trapped: Puerto Rican families and schizophrenia (3rd ed.)*. Maplewood, NJ: Waterfront Press.
- Root, M. P. P. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy, 22*, 349-356.
- Scheffler, R. M. & Miller, A. B. (1989). Demand analysis of mental health service use among ethnic subpopulations. *Inquiry, 26*, 202-215.
- Snowden, L. R. & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*, 347-355.
- Sue, D. W., Arredondo, P. & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477-486
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32*, 616-624.
- Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T. & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*, 533-540.
- Sussman, L. K., Robins, L. N. & Earls, F. (1987). Treatment-seeking for depression by black and white Americans. *Social Science and Medicine, 24*, 187-196.
- Taube, C. & Rupp, A. (1986). The effect of Medicaid on access to ambulatory mental health care for the poor and near-poor under 65. *Medical Care, 24*, 677-686.
- Takeuchi, D. T., Mokuau, N. & Chun, C. (1992). Mental health services for Asian Americans and Pacific Islanders. *Journal of Mental Health Administration, 19*, 237-245.
- Torrey, E. F. (1986). *Witchdoctors and psychiatrists*. New York: Harper and Row.

## EVOLVING VISIONS

Pat DeLeon, *President-Elect, American Psychological Association*

It has admittedly been some time since I had the pleasure of being actively involved within the governance of the Division. Subsequently, I have had the opportunity of serving on the APA Board of Directors for several terms, and this past year was elected President-Elect of the Association. This is a tremendous honor and privilege and I enthusiastically look forward to leading the Association into the 21<sup>st</sup> Century. We will have three specific presidential initiatives, which I hope the Division's membership will find intriguing. 1.) Women in Science and Technology, co-chaired by Connie Chan, Mary Beth Kenkel, Nancy Russo, Cheryl Travis, and Melba Vasquez [Paul Nelson, pnelson@apa.org]; 2.) Law and Psychology, co-chaired by Don Bersoff, Allen Brown, Bill Foote, and Mary McGuire [Donna Bevers & David Nickelson, dbeavers@apa.org]; and 3.) Prescriptive Authority, co-chaired by Anita Brown, Chuck Faltz, Ray Folen, and Sandy Rose [Sidney Rocke, srocke@apa.org]. Those interested in their deliberations should feel free to be in direct contact with any of the appropriate co-chairs or the APA staff.

Over the years, I have come to appreciate the extent to which serving on the Division or APA Board of Directors gives one a truly unique perspective on how psychology has matured and the extent to which we really are one family—practice, science, education, and public interest. We are a relatively young profession. It was only back in 1975, that psychology became licensed/certified in all 50 states. Today, we are included in almost every federal health care program; there are in excess of 81,000 licensed health care psychologists; 159,000 members of APA; and most excitingly, at the San Francisco convention our graduate student organization (APAGS) celebrated its 10<sup>th</sup> anniversary, possessing 64,300 members. Serious consideration is being given by the APA Board of Directors to ensuring that APAGS will have a real presence at every board meeting, including at our retreats. This is a very nice evolution.

For those of us particularly interested in the prescriptive authority agenda, APA Board member Ruth Paige recently made the very astute observation that our next major focus should be on ensuring that our state licensing boards and continuing education programs enthusiastically embrace this evolution. In 1995, the Association of State and Provincial Psychology Boards (ASPPB) hosted a debate entitled: "Prescription Privileges: Implications for the Practice and Regulation of Psychology". Although it is now APA policy that psychology should seek prescriptive authority, it has become

quite evident that a significant number of the appointed members of our state and provincial licensing boards are personally not as supportive of this particular policy agenda as one might wish. Former APA Board member Janet Matthews served as the Board's liaison to ASPPB for three years, attending two conferences annually plus two additional executive committee meetings. Her thoughts: "As psychologists have worked to develop prescriptive authority legislation, our focus has been on the role of our state psychological associations (SPAs) in supporting this effort. It is true that our SPAs provide the base for educating legislators in this domain. A companion area which has received less attention, however, is the role our state licensing boards play in this process and the importance of having psychologists who are not only supportive of this movement, but see it as high priority, appointed to these boards.

"The process of being named to the state licensing board varies considerably among jurisdictions. Several steps are needed to work on this piece of the whole. First, psychologists who are active in the movement to obtain prescriptive authority need to become familiar with the process of being named to their state licensing board. Second, identify several psychologists who are willing to devote the time to this activity, if named. In some states this is a five-year commitment of at least monthly meetings plus outside paperwork. Third, among the identified psychologists try to determine which one is most likely to be named (based on the selection process for that state). Finally, provide the identified psychologist with assistance in the application process.

"The type of assistance needed will vary among states. Depending on the state, there may be an election among licensed psychologists with several names then being submitted to the governor for consideration. In this case, campaign support is similar to any APA election. The process may also involve consideration of the psychologist's past political contributions and affiliation. Support letters sent from key legislators and other political leaders within the state to the governor are an important part of this process. Using a group approach to licensing board selection, rather than having the individual psychologist attempt to muster this level of support, may encourage some psychologists to agree to candidacy who might otherwise decline, as well as increase the probability of appointment. Although many states require an 'arms length' relationship between the state licensing board and the state association, it is also helpful to have a psycholo-



gist appointed who communicates easily with the leadership of the state association as well as having an understanding of national resources which can be used in this process.” The alternative, we have unfortunately found, can result in the licensing board chair testifying before the local legislature that he/she does not see the need for their state to be “the first” to provide this clinical responsibility, notwithstanding APA and local psychological association policy – not the most resounding endorsement. Interestingly, back in the fall of 1996, Ruth reported that the State of Washington psychology examining board proposed a rule which would require 45 hours of didactic and clinical instruction in psychopharmacology as part of doctoral-level programs beginning in 1998; the rule would require 105 hours of instruction in the year 2000. There is support for the prescriptive agenda across the country – Elaine Levine reports that the New Mexico psychological association board recently voted 7-2, endorsing APA policy.

*Growing Interest Within Academia:* Gary Davis, University of Minnesota, Duluth: “For the past three years, several local psychologists urged me to create a psychopharmacology course so they could take it. I am known in my community for my psychopharmacology expertise as a result of precepting at the family practice residency for many years and assisting residents with diagnostic and medication decisions. In addition, they know that I pursued additional education through the Prescribing Psychologists’ Register (PPR). I resisted their pressure for quite some time because I didn’t need the extra work! The director of graduate studies in the psychology department approached me a year ago and asked me to do a psychopharmacology course that would allow the graduate students to meet their biological bases of human development requirement. That tipped the scale.

“We offered the course for the first time this past Spring quarter as a three credit course. The University of Minnesota is going to semesters in the Fall, so next spring it will be a three credit semester course which will allow us an additional 15 hours of class time. I co-taught the course with Mustafa al’Absi, an assistant professor in my department and a biological psychologist who completed an APA approved internship. We created more than 500 power-point slides and used John Preston’s book as the text. Eight graduate students enrolled, as well as three psychologists. Two of the psychologists are faculty in the psychology department with an acute

awareness of their need for more psychopharmacology. One of the faculty is a Ph.D. who was originally educated as an MS in nursing. She is also the department director of graduate studies. The other is a recent Ed.D. who has a part time clinical practice in addition to her full time faculty position. I was impressed that these two faculty members put their egos aside and took the course along with their current graduate students. One audited it and the other took it for credit for her nursing continuing education.

“Following a four hour neurobiology overview and three hours of pharmacokinetics and pharmacodynamics, the course was topically organized and covered antidepressants, mood stabilizers, anxiolytics, antipsychotics, psychostimulants, drugs used with addiction disorders, and sleep disorders. We also spent some time talking about the FDA approval process, teratogenicity, and controlled substances.

“The course was very well received and is going to be an annual offering. I am going to try to continue to recruit licensed psychologists into the course as students. I cannot find a suitable text for our vision, so I think we are going to write one and try to connect it in some way with a related web site (that we will create) that will allow a more dynamic approach than a CD-ROM. More on that later...”

*An Objective Review:* During its deliberations on the fiscal year 1999 Department of Defense Appropriations bill [P.L. 105-261], the Senate Armed Services Committee included language addressing the issue of psychology obtaining prescriptive authority: “The Psychopharmacology Demonstration Project – The Psychopharmacology Demonstration Project (PDP) was funded by Congress in 1991 to train military psychologists in the prescription of psychotropic medications, pursuant to section 8097 of the Department of Defense Appropriations Act for Fiscal Year 1992. The committee understands that ten military psychologists successfully completed this training prior to termination of the program. The committee directs the Comptroller General to conduct a study to determine the extent to which these health providers have been integrated into the Military Health System, to include the quality of care provided to military personnel and their beneficiaries, contributions of these providers to cost effectiveness, and their impact on medical readiness.” Not surprisingly, the Congress soon heard from organized medicine – “The American Medical (AMA) would like to express our strong objection to the language in the ‘Department of De-

## EVOLVING VISIONS

(Continued)

fense Authorization Act for Fiscal Year 1999' that directs the Comptroller General of the U.S. General Accounting Office (GAO) to conduct a study on the Psychopharmacology Demonstration Program (PDP)... The AMA believes that the Senate should reconsider this language because the PDP has been terminated by the Congress (P.L. 104-106). In addition, a 1997 GAO report concluded that 'training psychologists to prescribe medications is not adequately justified because the [Military Health Service System] has no demonstrated need for them, the cost is substantial, and the benefits are uncertain.' The Comptroller General is the head of the GAO and it is improbable that a second report would yield a different conclusion. Further, it is our understanding that the Military Health Service System has the necessary number of psychiatric physicians and other physicians to meet current and projected readiness needs. The AMA has a long-standing commitment to ensuring that military personnel and their families have access to the finest health care available, including mental health services. We agree with the GAO report, however, and believe that the PDP and the report demonstrate that there would be no benefits from this program. The APA appreciates your consideration of these comments." [June 2, 1998]. So much for valuing objective evidence.

In June 1999 the GAO released its newest report: "Prescribing Psychologists – DOD Demonstration Participants Perform Well but Have Little Effect on Readiness or Costs". Some of the highlights: "The Military Health System (MHS) provides for the mental health care needs of the approximately 8 million active-duty members, retirees, and their dependents. To meet these needs, MHS employed 431 psychiatrists and 430 clinical psychologists in fiscal year 1999.... By June 1997, when the project was terminated, 10 psychologists had completed their training and were subsequently assigned to various Air Force, Army, and Navy military medical facilities across the country. At the time of our review, 9 of the 10 program graduates were still treating patients and prescribing medications at military hospitals and clinics.

"The 10 PDP graduates seem to be well integrated at their assigned military treatment facilities. For example, the graduates generally serve in positions of authority, such as clinic or department chiefs. They also treat a variety of mental health patients; prescribe from comprehensive lists of drugs, or formularies; and carry patient caseloads comparable to those of psychiatrists and psychologists at the same hospitals and clin-

ics. Also, although several graduates experienced early difficulties being accepted by physicians and others at their assigned locations, the clinical supervisors, providers, and officials we spoke with at the graduates' current and prior locations – as well as a panel of mental health clinicians who evaluated each of the graduates – were complimentary about the quality of care provided by the graduates.

"However, granting drug prescribing authority to 10 military psychologists cannot substantially affect the medical readiness of an organization staffed by more than 800 psychiatrists and psychologists.... Nonetheless, clinic and hospital officials told us that the graduates – by reducing the time patients must wait for treatment and by increasing the number of personnel and dependents who can be treated for illnesses requiring psychotropic medications – have enhanced the peacetime readiness of the locations where they are serving.

"We project that the Department of Defense (DOD) will spend somewhat more on these 10 prescribing psychologists than it would have spent to provide similar services without the prescribing psychologist. Primarily because of the DOD's higher training costs, we estimate that over the course of the PDP graduates' careers, DOD will spend an average of about 7 percent more (or about \$9,700 annually) per PDP graduate than it would spend on a mix of psychiatrists and psychologists who would treat patients in the absence of the PDP graduates.

"PDP graduates are well integrated into MHS. Although the graduates were initially supervised closely, all but two have been granted independent status, meaning that they are subject only to the same level of review as psychiatrists at their locations....

"The nine program graduates remaining in the military at the time of our visits are serving as the chief of a clinic or department, suggesting the high professional esteem in which they are held.... Although PDP guidance limits graduates to seeing patients between the ages of 18 and 65, most graduates see a mix of patients, including active-duty personnel, retirees, and dependents....

"Overwhelmingly, the officials with whom we spoke, including each of the graduates' clinical supervisors, and an outside panel of psychiatrists and psychologists who evaluated each of the graduates rated their graduates' quality of

care as good to excellent. Further we found no evidence of quality problems in the graduates' credential files.... Without exception, these supervisors – all psychiatrists—stated that the graduates' quality of care was good. One supervisor, for example, noted that each of the graduate's patients had improved as a result of the graduate's treatment; another supervisor referred to the quality of care provided by the graduate as 'phenomenal'. The supervisors noted that the graduates are aware of their limitations and know when to ask for advice or consultation or when to refer a patient to a psychiatrist. Further, the supervisors noted that no adverse patient outcomes have been associated with the treatment provided by the graduates...."

Two views of the cost-effectiveness/quality of care resulting from psychology prescribing. Recall the GAO projection that each PDP graduate will cost DOD about \$9,700 per year – or about 7 percent – more than the cost of the combination of psychologists and psychiatrists that would be used to treat patients in their absence—in our judgment, an excellent investment in patient care. However, after the first GAO report was released our colleagues in the APA informed the Congress that: "...the PDP is not and never was needed by the military, has no discernable benefit, and to-date has cost an astounding \$610,000 per PDP 'graduate'. In contrast, four full years in a public medical school costs about \$40,000. In other words, for one PDP trained psychologist – whom the military never needed and did not request – as many as 15 individuals could complete four years of medical school.... We urge you to resist any attempt to reopen or reinstate this dangerous and wasteful program..." [April 23, 1997]. John Sexton, one of the first PDP graduates, recently reported that: "Today I saw my 700<sup>th</sup> new patient in the past 21.5 months. We stay very busy. Now as department head, I must fight to keep from losing one of my three psychiatrist billets. If it happens, we'll be seeing more than two new patients per day...." Two radically different pictures of psychology's maturation.

The Final Months of the Clinton Administration. In many ways, the Administration has been successful in instituting truly revolutionary changes in our nation's health care system—from the utilization of advanced technology, the enactment of far reaching legislation, to the strategic use of the Executive Order. On May 18<sup>th</sup>, the DOD Uniformed Services University of the Health Sciences (USUHS) graduate school

of nursing held their first-ever "virtual" graduation. This was a fitting finale for the first class earning their post-masters adult nurse practitioner certificate through the DOD and Department of Veterans Affairs distance learning program. The program, started in 1997, used teleconferencing and other technological strategies to link eight VA medical center remote sites with the graduate school of nursing classroom. These pioneers, 26 nurses from across the country, proved the effectiveness of distance learning. The virtual graduation used teleconferencing to link the VA medical centers in Atlanta, Baltimore, Bronx, Charleston, Fayetteville, San Diego, and Los Angeles with USUHS. The eighth site, Leavenworth, could not link up because of weather. With all the pomp and speeches of any graduation, the ceremony was shared by all. When the time came for awarding the post-masters certificates, each site was brought up on the teleconferencing screen as their graduates' names were read and handed their certificates. Everyone enjoyed the exuberance of the graduates celebrating their accomplishments. Distance learning and virtual graduation – these 26 nurses and their faculty have demonstrated a new paradigm of advanced education for the 21<sup>st</sup> century.

The enactment of the Child Health Insurance Program (CHIP), as a provision of the Budget Reconciliation Act of 1997 [P.L. 105-33], provided an additional \$24 billion (over five years) for necessary health care required by an estimated five million children; the bill also provided for Medicare coverage of Telehealth Services—reflecting the advances in technology that will be so critical as we enter the 21<sup>st</sup> Century; the Health Insurance Portability and Accountability Act of 1996 [P.L. 104-191] and the Domenici-Wellstone Mental Health Parity Act [P.L. 105-65] represent a fundamental re-definition of the federal government's role in shaping private health care benefits. Just prior to the July 4<sup>th</sup> recess, the Senate passed the Disability-to-Work Act by a vote of 99-0, legislation which would help disabled citizens keep their government-financed health benefits when they become employed. And, of particular interest to psychology, the White House hosted a major conference on Mental Health Care – attended by Ray Fowler and APA President Dick Suinn – where the President directed that there shall be parity for mental health and substance abuse coverage in the Federal Employees Health Benefits Program. These are indeed exciting times. ■

*Division 12 Program*  
*1999 Meeting of the American Psychological Association*  
*Boston, Massachusetts*

**Friday, August 20<sup>th</sup>**

Section 3 Student Poster Session Exhibit Hall A	8:00 AM-8:50	Division 12 Symposium: Meeting Room 102 "Serious Mental Illness and Managed Care" Jeffrey H. Nathan, Ph.D., Chair	11:00 AM-12:50
Section 3 Invited Address: Meeting Room 306 "Using Clinical Case Modeling Software to Generate Idiographic Causal Models" William O'Brien, Ph.D.	9:00 AM-9:50	Section 6 Symposium: Meeting Room 203 "Developing Cultural Competence Plans Jean Lau Chin, Ed.D., Chair	12:00 PM-12:50
Section 6 Symposium: Meeting Room 106 "Music Video Constructions of Black Women: Race and Gender" Jessica Henderson Daniel, Ph.D., Chair	9:00 AM-9:50	Division 12 Poster Session Exhibit Hall A	12:00 PM-1:50
Division 12 Symposium: Meeting Room 202 "Critical Issues in Clinical Forensic Assessments: Guidelines for the Practitioner" Allen K. Hess, Ph.D., Chair	9:00 AM-9:50	Section 3 Presidential Address: Meeting Room 100 "The Nuts and Bolts of Evidence-Based Clinical Practice" Jacqueline C. Persons, Ph.D.	1:00 PM-1:50
Section 7 Symposium: Meeting Room 207 "Managing Behavioral Emergencies From an Empirically Informed Perspective" Robert Yufit, Ph.D., Chair	9:00 AM-10:50	Section 2 Symposium: Meeting Room 101 "The Proficiency in Clinical Geropsychology: Demand, Procedures, and Mechanisms" Sara Honn Qualls, Ph.D., Chair	1:00 PM-1:50
Section 3 Invited Address: Meeting Room 100 "NIMH Collaborative Trial on the Treatment of Panic Disorder" David Barlow, Ph.D.	10:00 AM-10:50	Section 3 Invited Address/Distinguished Scientist Award: Meeting Room 100 "Current Status of (Lack of) Theory in Psychotherapy Research" Alan Kazdin, Ph.D.	2:00 PM-2:50
Section 6 Symposium: Meeting Room 102 "The Adolescent Health Data Set: Focus on Black Adolescents" A. Toy Caldwell-Colbert, Ph.D., Chair	10:00 AM-10:50	Section 6 Presidential Address: Meeting Room 102 "Clinical Psychology: New Health Specialty? An International and Ethnocultural Response" Victor De La Cancela, Ph.D.	2:00 PM-2:50
Section 7 Invited Address: Meeting Room 100 "Suicide Prevention in the ER Setting" Marsha Linehan, Ph.D.	11:00 AM-11:50	Section 2 Presidential Address: Meeting Room 101 Interdisciplinary Teams and the Process of Geriatric Care" Antoinette Zeiss, Ph.D.	2:00 PM-2:50
Section 6 Symposium: Meeting Room 206 "Ethnicity and Psychopharmacology" A. Toy Caldwell-Colbert, Chair	11:00 AM-11:50	Section 2 Business Meeting Meeting Room 101	3:00 PM-3:50
		Section 6 Business Meeting Meeting Room 102	3:00 PM-3:50

\*\*All scheduled events are located in the Hynes Convention Center\*\*

**Saturday, August 21<sup>st</sup>**

Section 3 Symposium: 9:00AM-10:50  
Meeting Room 102  
"A Critical Look at the Rorschach"  
Robert Archer, Ph.D., Chair

Division 12 Invited Symposium: 9:00AM-10:50  
Meeting Room 311  
"Evaluation of Laboratory and Performance-  
Based Measures of Childhood Disorders"  
Paul J. Frick, Ph.D., Chair

Section 5 Invited Address: 11:00 AM-11:50  
Meeting Room 103  
"Integration of Pediatric Psychology  
in the Care of Children with Cancer"  
Howard J. Weinstein, M.D.

Division 12 Invited Symposium: 11:00 AM-12:50  
Meeting Room 302  
Division 12 Youth and Violence Task Force  
Mark Weist, Ph.D., Chair

Division 12 Poster Session 12:00 PM-1:50  
Exhibit Hall A

Section 6 Symposium: 1:00 PM-1:50  
Meeting Room 102  
"New Voices and Old Problems: Culturally Relevant  
Community Research and Clinical Practice"  
Victor De La Cancela, Ph.D., Chair

Division 12 Presidential Address: 2:00 PM-2:50  
Meeting Room 306  
Thomas H. Ollendick, Ph.D.

Division 12 Awards Ceremony 3:00 PM-4:50  
Meeting Room 309

Division 12 Social Hour (with Sections 1 and 5) 6 PM-7:50  
and Internships on Parade  
Meeting Room 311

**Sunday, August 22<sup>nd</sup>**

Division 12 Invited Symposium: 9:00 AM-10:50  
Meeting Room 304  
"Current Trends in Developmentally Based  
Psychotherapies With Children and Adolescents"  
Thomas H. Ollendick, Ph.D., Chair

Section 1 Symposium: 11:00 AM-12:50  
Meeting Room 304  
"Adolescent Substance Use and Abuse:  
Prediction From Childhood Psychopathology  
and Personality, and Mediating Pathways"  
William Pelham, Jr., Ph.D., Chair

Division 12 Symposium: 11:00 AM-12:50  
Meeting Room 200  
"Developmental and Affective Considerations  
in Couples Therapy: Clinical Perspectives"  
Douglas K. Snyder, Ph.D., Chair

Division 12 Poster Session 12:00 PM-1:50  
Exhibit Hall A

Section 4 Presidential Address & Awards 12:00 PM-1:50  
Ceremony  
Meeting Room 306  
"Clinical Supervision: Does Gender  
Make a Difference?"  
Natalie Porter, Ph.D.

Section 5 Symposium: 1:00 PM-2:50  
Meeting Room 203  
"Outcomes in Children With Cancer  
Treatment That Involves the CNS"  
Bartlett Moore III., Ph.D., Chair

Section 5 Business Meeting & Awards 3 PM-4:50  
Ceremony  
Meeting Room 203

**Monday, August 23<sup>rd</sup>**

Section 5 Conversation Hour: 8:00 AM-8:50  
Meeting Room 104  
"Grant Preparation and Funding  
Opportunities in Pediatric Psychology"  
Brandon Briery, M.A., Chair

Section 5 Symposium: 9:00 AM-10:50  
Meeting Room 106  
"Behavioral, Social, and Ethical Issues  
in Childhood Cancer Treatment"  
Mary Jo Kupst, Ph.D., Chair

Section 2 Symposium: 9:00 AM-10:50  
Meeting Room 103  
"The Business of Geropsychology"  
Deborah Frazier, Ph.D., Chair

Division 12 Invited Symposium: 9:00 AM-10:50  
Meeting Room 100  
"NIMH Multimodal, Multisite Treatment Study  
for ADHD: Post-treatment Results"  
Laurence Greenhill, M.D., Chair

Section 4 Invited Address: 11:00 AM-11:50  
Meeting Room 203  
"Sexual Health and Risk Taking of HIV  
Positive Women: Challenges to Clinicians"  
Gayle Wyatt, Ph.D.

Section 1 Symposium: 11:00 AM-12:50  
Meeting Room 100  
"Evidence-Based Treatments for Childhood Mental Health  
Problems: Update and Extension of the Section 1 Clinical  
Child Task Force"  
Chris Lonigan, Ph.D., Chair

Division 12 Symposium: 11:00 AM-12:50  
Meeting Room 103  
"Examination for Professional Practice in Psychology:  
Issues for Practitioners"  
Lynn P. Rehm, Ph.D., Chair

Division 12 Poster Session Exhibit Hall A	12:00 PM-1:50	Division 12 Poster Session Exhibit Hall A	10:00 AM-11:50
Division 12 Invited Symposium: Meeting Room 100 "Childhood Bipolar Disorder— Myth or Reality?" Ross W. Greene, Ph.D., Chair	1:00 PM-2:50	Division 12 Symposium: Meeting Room 202 "Predoctoral Internship Training in Mental Health Policy and Systems Intervention" Richard B. Weinberg, Ph.D., & Gerald Leventhal, Ph.D., Co-Chairs	11:00 AM-11:50
Division 12 Symposium: Meeting Room 103 "Self, Society, and Psychopathology: Essays in Honor of Daniel R. Miller" William F. Flack, Jr., Ph.D.	1:00 PM-2:50	Division 12 Symposium: Meeting Room 203 "The Importance of Violence Prevention in Early Childhood" Jacquelyn H. Gentry, Ph.D., Chair	11:00 AM-12:50
Division 12 Symposium: Meeting Room 202 "Vulnerability to Psychopathology" Marvin Zuckerman, Ph.D., Chair	2:00 PM-3:50	Division 12 Symposium: Meeting Room 104 "Health-Related Quality-of-Life Outcomes Assessment: Consumers With Schizophrenia" Emanuel J. Mason, Ed.D., & Walter Penk, Ph.D., Co-Chairs	12:00 PM-12:50
Section 7 Presidential Address: Meeting Room 110 "Behavioral Emergencies: The Need for a Training Initiative" Phillip Kleespies, Ph.D.	3:00 PM-3:50	Division 12 Symposium: Meeting Room 202 "Cultural Competency in Managed Care: Challenges or Opportunities" Jean Moise, Ph.D., Chair	12:00 PM-1:50
Section 1 Presidential Address: Meeting Room 306 "Comprehensive Treatment for ADHD: Just Say 'Yes' to Drugs?" William Pelham, Jr., Ph.D.	3:00 PM-3:50	Division 12 Symposium: Meeting Room 103 "Prospective and Longitudinal Analyses of Survivors and Perpetrators of Violence" Christine A. Gidycz, Ph.D., Chair	1:00 PM-1:50
Section 7 Business Meeting Meeting Room 110	4:00 PM-4:50	Division 12 Symposium: Meeting Room 106 "New Research Directions in Seasonal Affective Disorder" Sandra T. Sigmon, Ph.D., Chair	1:00 PM-2:50
Section 1 Invited Address/Distinguished Contribution Award Meeting Room 306 Dante Cichetti, Ph.D.	4:00 PM-4:50	Division 12 Symposium: Meeting Room 101 "Explanatory Style and Diversity" Jane E. Gillham, Ph.D., & Derek Isaacowitz, M.A., Co-Chairs	2:00 PM-3:50
Section 1 Business Meeting Meeting Room 306	5:00 PM-5:50		

**Tuesday, August 24<sup>th</sup>**

Division 12 Symposium: Meeting Room 106 "Impact of Trauma on Parenting" Linda J. Alpert-Gillis, Ph.D., Chair	9:00 AM-9:50
Division 12 Symposium: Meeting Room 100 "New Research on ADHD—From Controversy to Scientific Reality" Joseph Biederman, Ph.D., Chair	9:00 AM-10:50
Division 12 Symposium: Meeting Room 202 "Taking Psychology on the Road—The Dissemination of Effective Treatments" Randy J. Paterson, Ph.D., & Marv V. Gilbert, Ph.D., Co-Chairs	9:00 AM-10:50

*Division 12  
Postdoctoral Institutes*

Workshops for the year 2000! Those interested in presenting a Continuing Education workshop for Division 12 prior to the APA Convention in Washington, D.C. should send proposals to Dr. Mark Whisman, Department of Psychology, University of Colorado at Boulder, Boulder, CO. Questions can also be directed to the Division 12 Central Office (303) 652-3126.

## *Miniconvention on Consumers and Psychologists in Dialogue to be Held at Summer APA Convention*

Ronald F. Levant, APA Recording Secretary

Psychologists are not currently major providers in the care and treatment of patients suffering from long-term mental illness. However, psychologists could play a very significant role in the care of this population. The outcome research literature strongly indicates that while psychoactive medications can suppress the symptoms of serious mental illness, psychological rehabilitation actually holds out hope for recovery. In this endeavor, psychologists would be well advised to work to develop partnerships with recovered consumers. There is a growing cadre of people who have recovered from serious mental illness who can serve as invaluable allies in the recovery process because of their ability to relate to the consumer's experience. Such consumers, also known as "survivors of psychiatric treatment" and "ex-mental patients" are interested in collaborating with psychologists, and deeply believe from their own experiences that psychotherapy and psychosocial rehabilitation can be very beneficial. But to develop such a coalition, consumers state clearly that psychologists must understand the perspectives of consumers on such matters as participating in their own recovery, the integration of self-help with professional services, living with a diagnosis of serious mental illness, forced treatment and its alternatives, and on the abuses that many have experienced in the mental health system.

There will be a mini-convention this summer at the APA convention in Boston on this very topic. Titled "Consumers and Psychologists in Dialogue", its purpose is to open a dialogue on the topic of recovery from long term mental illness

between the larger psychological community and the community of recovering consumers of mental health services, and to begin the process of developing partnerships and coalitions to our mutual benefit.

The idea for the mini-convention was generated during a weekend in August 1998 sponsored by the Center for Mental Health Services of SAMSHA, in which ten representatives each from the psychologist and the consumer communities were invited to Washington to work on developing a dialogue. The participants found this meeting to be of such significance that we decided that it would be a good idea to present some of the content to the larger community of psychologists. For, in this era of cost containment in mental health services, the time may be ripe for the formation of a broad-based coalition between consumers of mental health services and psychologists.

The mini-convention will consist of 11 sessions including a "Town Hall Meeting", in which psychologists specializing in the psychology of long term mental illness conduct a dialogue with consumers of mental health services, and in which prominent leaders in psychology serve as discussants. The mini-convention is sponsored by the APA Board of Directors and cosponsored by CAPP, APAGS, BPA, BEA, BAPPI, division 18, division 35, division 42, division 43, and division 31. The mini-convention is partially supported by the Center for Mental Health Services, Substance Abuse and Mental Health Administration. The co-chairs are: Ronald Levant, EdD, Catherine Acuff, PhD, Robert Coursey, PhD, Ronald Bassman, PhD.

## *Beutler Set to Deliver Rosalee G. Weiss Lecture*

Larry E. Beutler, PhD, one of the best known and most well-published leaders in the field of clinical psychology, will deliver a talk titled "David and Goliath: When Psychotherapy Research Meets Health Care Delivery Systems," as the 1999 Rosalee G. Weiss lecture, at the APA convention in Boston this August. Beutler's lecture will specifically focus on research findings that can make psychological care more manageable, efficient, and predictable.

Beutler is professor and recent director of the Counseling/Clinical/School Psychology Program at the University of California, Santa Barbara. He serves as the co-editor of the *Journal of Clinical Psychology*, and he was the former editor of the *Journal of Consulting and Clinical Psychology*. A fellow of the American Psychological Association and the Ameri-

can Psychological Society, Beutler is the author of some 300 scientific journal articles and chapters, and the editor or co-author of eleven books on psychotherapy and psychopathology. He is currently writing and editing an Oxford University Press (OUP) series of comprehensive treatment guidebooks that will present treatment guidelines for affective disorders, anxiety disorders, alcohol and drug abuse, and schizophrenia. Beutler is also an associate editor for the upcoming APA-OUP *Encyclopedia of Psychology*.

The Rosalee G. Weiss Lecture series was established in 1994 by Dr. Raymond A. Weiss to honor his wife. Lecturers are selected from among the outstanding leaders in the field of psychology, or from among leaders in the arts and sciences whose work has had a significant impact on psychology.

*AAPB Workshops Full Page Ad*



*APS Full Page Ad*



# Society News



Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. Telephone (303) 652-3126. Fax (303) 652-2723.

## *Distinguished Contribution Awards for 1999*

Thomas H. Ollendick, Awards Committee Chair for 1999, is pleased to announce the Division 12 recipients of the 1999 Distinguished Contributions Awards.

### *Award for Distinguished Scientific Contributions to Clinical Psychology*

**Gordon L. Paul, Ph.D.**

### *Award for Distinguished Professional Contributions to Clinical Psychology*

**Jerome H. Resnick, Ph.D.**

### *1999 David Shakow*

### *Early Career Award*

for outstanding early career contributions to the science and practice of Clinical Psychology

**Patricia A. Arean, Ph.D.**

### *1999 Theodore H. Blau*

### *Early Career Award*

for outstanding early career contributions to the profession of Clinical Psychology

**Juan Carlos Gonzalez, Ph.D.**

The Division 12 Award ceremony will be held at the APA Convention this summer. It is scheduled for Saturday, August 21, 1999. A reception will follow.

## *Call for Nominations Division 12's 2000 Distinguished Contribution Awards*

### *Award for Distinguished Professional Contributions to Clinical Psychology*

### *Award for Distinguished Scientific Contributions to Clinical Psychology*

Send nominee's name, recent vita, and a concise (1-2 page) type-written summary of his/her achievements and contributions.

### *2000 David Shakow Award for Early Career Contributions*

The recipient will be a psychologist who has received the doctoral degree in 1991 or later and who has made noteworthy contributions both to the science and to the practice of Clinical psychology. Letters of nomination should include the nominee's vita and a summary of his/her contributions.

### *2000 Theodore H. Blau Award*

This award is being funded by PAR (Psychological Assessment Resources), and began in 1998. The award will be given to a Clinical Psychologist who has made an outstanding contribution to the profession of Clinical Psychology. Given the difficulty of making such contributions very early in one's career, the award will be given to a person who is within the first 10 years of receiving his or her doctorate. Letters of nomination should include the nominee's vita and a summary of his/her contributions.

### *Send nominations to:*

Thomas Ollendick, PhD, Chair 2000 Awards Committee  
c/o Division 12 Central Office, P.O. Box 1082  
Niwot, CO 80544-1082

Deadline: October 30, 1999  
The awards will be presented at the  
2000 APA Convention in Washington, D.C.



## Minutes of the Division 12 Board of Directors' Meeting\*

May 22-23, 1999

The meeting was called to order by Dr. Thomas Ollendick at 8:30 am, May 22<sup>nd</sup>, 1999, in the Baronet Room, Hotel Halifax, Halifax, Nova Scotia. The minutes from the January 1999 meeting were approved with minor changes. Future meeting sites were discussed, as were appointments to the Publications, Science and Practice and Program Committees.

Dr. Michael Goldberg, Treasurer, and Dr. Resnick, Finance Committee Chair, discussed the Division's finances. Membership income has declined somewhat, particularly in the dues-exempt category. The PDIs were also discussed, since they generate income for the Division, and it was noted that registrations are doing well this year.

Committee reports were given by Dr. Ollendick: he reiterated the awardees for 1999, and asked for the names of individuals for the 2000 conference; he asked the Board for nominees for positions opening on the Board itself; he reported that membership initiatives were being generated. The Board then discussed the publications fee for dues-exempt members, and decided this fee should cover increased publication costs and equal that of students. A motion to raise Dues-exempt fees to \$25 was entertained and approved unanimously. Further discussion centered around the fact that the Society has a large number of older members, and the need for retaining younger members will factor prominently on future



agendas. Dr. Resnick then reviewed the by-laws, where the nominations and election process is noted. He asked that the Committee develop the slate, present it to the Board, and that the Board then approve/finalize the ballot.

Dr. Goldberg then discussed the timing of the mailing for The Clinical Psychologist (TCP). In order to have the candidate information out in a timely fashion, he asked that Dr. Rokke publish the newsletter earlier (deadline of March 1<sup>st</sup>), and Dr. Rokke agreed to do so. Dr. Rokke further reported that he has been in contact with the Canadian Psychological Association's Clinical Section, and that the newsletter editors for each organization have exchanged copies of recent newsletters. It was suggested that newsletters be sent to all board members in the future. Further, he clarified the limitations for candidate statements in the newsletter: 500 words for the presidential candidates and 300 words for others.

Dr. Thomas Ollendick discussed the Program and PDIs, including a lengthy discussion pertaining to the cost, time, etc. for California obtaining approval. The Board felt the Division should not continue to do this unless the workshops were to be in California. Further, the Board unanimously decided that a letter should be written to CPA and copied to APA, expressing the Division's displeasure at this require-



*The spring division board meeting was held in Halifax, Nova Scotia in conjunction with the annual meeting of the Canadian Psychological Association. Division leaders took this opportunity to invite board members of the CPA Clinical Section to their meeting to exchange views and information. Division 12 Board Members and their guests in the picture include:*

*1. Sheila Woody; 2. Deborah Dewey, U. Calgary, CPA Clinical Section (CPA-CS) Treasurer; 3. Paul Rokke; 4. Charlotte Johnston, U. British Columbia, CPA-CS Chair; 5. Annette Brodsky; 6. Jerome Resnick; 7. Joseph Scropo; 8. Asuncion Austria; 9. Carl Zimet; 10. Norman Abeles; 11. John Service, Executive Director, CPA; 12. Michael Goldberg; 13. Susan Hartley, President, Association of Psychologists of Nova Scotia, Rep. of Council of Provincial Association of Psychologists; 14. Lesley Graff, U. Manitoba, CPA-CS; 15. Sam Mikail, CPA Board of Directors (Practitioner); 16. Barry Hong, Rep. Medical School Psychologists; 17. Larry Beutler; 18. Lynn Rehm; 19. Edward Craighead; 20. James Johnson; 21. Lorne Sexton, U. Manitoba, Past-Chair, CPA-CS; 22. Paul Pilkonis; 23. Thomas Ollendick; 24. Anthony Spirito; 25. William Haley*

\*A complete set of minutes of this meeting will be available from the Division 12 office once they have been approved at the October 1999 Board meeting.

ment. Final decisions regarding the reimbursement policies for the PDI Chair and Program Chair, as well as the newly appointed Hospitality Suite Chair, were pursued.

Dr. Larry Beutler then discussed a concern held by Division 12, Section 3, that advertising in the Monitor had recently been for courses without an empirical basis. There was much discussion over the fact that this is a controversial issue, and that it would be a huge task to police, should a requirement of some kind be made mandatory. Dr. Beutler felt it would help to simply encourage the CE office to distinguish between each kind of course. He further suggested that Section 3 would invariably agree to be an "endorser" of empirically designed workshops.

Committee on Science and Practice Chair, Dr. Paul Pilkonis, reported next. He briefly described the Pittsburgh meeting in June 1998 and the extensive 30-page report that came out of it. He also discussed upcoming publications from this group's research, both in the Division 12 newsletter and Journal. Further, after having met with the CPA group, he noted that our Canadian colleagues were going to formally endorse the Division 12 work. The Committee is very interested in collaboration with the Canadian contingent, and a decision was made to add a CPA member to the Committee. Dr. Ollendick then presented a plaque to Dr. Pilkonis in gratitude for his diligent and conscientious efforts on behalf of the Division. Dr. Pilkonis gave thanks and expressed his hope that the Committee would continue to grow.

Task Force reports were updated, Dr. Norman Abeles giving an extensive report on the Ad Hoc Task Force on Membership - Retainment of Aging Members, and Dr. Austria a detailed report on the Ad Hoc Task Force on Diversity Representation in the Society Governance (DRSG). Dr. Edward Craighead briefly discussed his new Task Forces, the Task Force on Dual Career Issues, the Task Force on HMOs to Practicing Members, and the Task Force on Retention of Junior Members.

Section Reports followed, with both Section 1 and Section 5 representatives requesting that the Board of Directors of Division 12 vote to dissolve the sections and transfer all assets to their respective divisions, 53 and 54, on Dec 31, 1999. These motions passed unanimously. Dr. William Haley reported on Section II, noting that they are electing new officers and presenting the 1999 Program at Convention. Dr. Sheila Woody reported for Section III, noting that they are trying to improve the environment on the net. The code of conduct suggested was not well received. The Section is proposing new by-laws that address this issue. Dr. Woody listed the awards for 1999 - The Distinguished Scientist will be presented to Alan Kazdin, and the Outstanding Dissertation will be presented to John Forsythe, Dr. David Barlow being his mentor. Dr. Annette Brodsky reported for Section 4, also noting that they have a Task Force on outcomes of therapy with women, and this group has compiled a report from a survey.

They are also developing a policy manual, in order to keep issues and transfers of leadership efficient. Finally, she discussed how and what the mentoring award is, and asked the Board for nominations for mentors who are women in psychology. Dr. Asuncion Mitera Austria reported for Section VI, stating that they participated in and co-sponsored the National Multicultural Conference and Summit in California. The Section is also sponsoring a Mentor Award given to an individual committed to teaching and training clinical psychologists to work more effectively with ethnic minority clinical populations. They have received funding from CEMRRAT for their newsletter, developed a program for the 1999 Convention, and welcomed the new APAGS liaison, Danelle Reed-Inderbitzen into their group. Dr. Joseph Scropo reported for Section VII. This group, newly formed this year, has over 70 members, and is increasing that number. In March, they had their election - with a 90% return rate. This group seeks to increase training at postdoctoral levels for those treating clinical emergencies. Dr. Barry Hong was asked to speak about the new section (name and number yet to be decided) to be formed by the Association of Medical School Psychologists (AMSP). The group hopes to bring an organized voice forward to address these national issues of concern to medical school psychologists, and thinks it will be helpful to be a part of this organization. Dr. Ollendick noted how pleased the Board was that this group decided to join Division 12.

The meeting adjourned at 3:00 for the session with the Canadian Psychological Association's (CPA) Clinical Section. This portion of the meeting informally discussed the avenues of receiving care in Canada, as well as current issues and topics that affect Canadian psychologists.

The next meeting of the Division 12 Board of Directors will be October 2-3, Boulder, CO

Respectfully submitted, Lynn Peterson, Administrative Officer, for Dr. Elsie Go Lu, Secretary



*President Tom Ollendick (l) and Council Representative Lynn Rehm (r) recognize the valuable service provided by Paul Pilkonis. The plaque reads, "Awarded to Paul A. Pilkonis, Ph.D. for outstanding contributions as Chair of the Committee on Science and Practice, May 22, 1999, Society of Clinical Psychology, American Psychological Association"*

## Position Openings

ASSISTANT PROFESSOR, ADULT CLINICAL PSYCHOLOGY. The University of Miami Department of Psychology seeks a graduate of an APA-approved training program in clinical psychology for a full-time tenure-track Assistant Professorship starting in the fall of 2000. We are especially interested in candidates with a strong background in personality-social and/or anxiety disorders, as well as clinical psychology. The successful candidate will join a young faculty group with a broad range of interests in clinical, health, personality-social psychology, and neuroscience. Long-standing collaborations between the faculty of the School of Medicine and Department of Psychology offer excellent opportunities for interdisciplinary research. The Department of Psychology has 40 full-time faculty and is located on the University's suburban Coral Gables campus. More information can be found at [www.psy.miami.edu](http://www.psy.miami.edu) <<http://www.psy.miami.edu>> . In addition to an independent research program, responsibilities include undergraduate and graduate teaching, research and clinical supervision, and service on thesis, dissertation and other departmental committees. Requirements include a Ph.D. in Psychology and a track record in research publication. Applications will be reviewed until the position is filled. Applicants should submit a curriculum vitae, reprints or preprints, a statement of current research and teaching interests, and four letters of reference to: Adult Faculty Search Committee, Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL 33124. Minorities and women are encouraged to apply. The University of Miami is an Affirmative Action/Equal Opportunity Employer.

ASSISTANT PROFESSOR, CHILD DIVISION. The University of Miami Department of Psychology invites applications for a tenure-track assistant professor position in child psychology for the Fall of 2000. We are seeking a person with an interest in community-based approaches to children's issues, especially those of minorities. The Child Division includes child clinical, pediatric health clinical and applied developmental graduate tracks. The Department of Psychology has 40 full-time faculty and is located on the University's suburban Coral Gables campus. Opportunities are available for research with varied ethnic populations, and there are excellent opportunities for interdisciplinary research.. Responsibilities of this full-time position include research, undergraduate and graduate teaching, as well as serving on thesis, dissertation and other departmental committees. Requirements include a Ph.D. in Psychology and a track record in research and publication. Applicants can obtain additional information

from [www.psy.miami.edu](http://www.psy.miami.edu) <<http://www.psy.miami.edu>> . Applications will be reviewed until the position is filled. All applicants should submit a curriculum vita, representative reprints or preprints, a statement of current research and teaching interests and four letters of reference to: Child Faculty Search Committee, Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL 33124. Minorities and women are encouraged to apply. The University of Miami is an Affirmative Action/Equal Opportunity Employer.

HEALTH PSYCHOLOGY/PSYCHO-ONCOLOGY. The University of Miami Department of Psychology, in collaboration with the Sylvester Comprehensive Cancer Center, invites applications for a mid-level tenure-track faculty position with a projected start date of January or August, 2000. We are especially interested in a person with an interest in community-based approaches to cancer control, who has a track record of securing extramural funding, and who has interests in collaborating with an interdisciplinary team of behavioral and biomedical researchers. The successful candidate will join a faculty with a broad range of interests in clinical, health, personality, social, and developmental psychology and neuroscience. Long-standing research collaborations between the faculty of the Medical School and Department of Psychology offer excellent opportunities for interdisciplinary research. The University of Miami is a private, independent research university with over 13,000 undergraduate and graduate students. The Department of Psychology has 40 full-time faculty and is located on the University's suburban Coral Gables campus, with additional facilities located on the Medical School campus. Opportunities are available for research with varied ethnic, adult, and elderly populations. This full-time position includes undergraduate and graduate teaching responsibilities, research and clinical supervision, as well as serving on thesis, dissertation and other departmental committees. The position will have a primary appointment in the Department of Psychology, Health Psychology Division, as well as an appointment at the Sylvester Comprehensive Cancer Center. Requirements include a Ph.D. in Psychology and a track record in research, publication, and external research funding. Applications will be reviewed until the position is filled. All applicants should submit a curriculum vita, representative reprints or preprints, a statement of current research and teaching interests and future directions, and four letters of reference to: Health Faculty Search Committee, Department of Psychology, University of Miami, P.O. Box 248185, Coral Gables, FL 33124. Minorities and women are encour-

aged to apply. The University of Miami is an Affirmative Action/Equal Opportunity Employer.

UNIVERSITY OF OTTAWA: Psychology. Subject to budgetary approval, the School of Psychology of the University of Ottawa anticipates filling three tenure-track positions effective July 1, 2000, at the Assistant Professor level. Priority will go to applicants in the areas of 1) clinical psychology (with a preference for adolescent, child or family psychology), 2) quantitative methods in psychology, and 3) social psychology. Applicants should meet the following minimum requirements: Doctorate in Psychology and research competence. Fluency in French and English (i.e., ability to teach in both languages) is essential. The minimum salary for the current academic year is \$45,352. Applications should be received before November 1, 1999. Submit a letter of application, curriculum vitae, names and addresses of three individuals who will be sending letters of reference, and reprints of two recent publications in refereed journals or other visible evidence of scholarly publication to: Dr. Henry Edwards, Acting Assistant Director, School of Psychology, Lamoureux Hall, University of Ottawa, Ottawa, Ontario, Canada, K1N 6N5. In accordance with Canadian immigration requirements, this advertisement is directed to Canadian citizens and permanent residents. Equity is a University policy, and as such, the University strongly encourages applications from women.

**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). Submission deadlines are February 15 (April 1 edition), May 15 (July 1 edition), September 15 (November 1 edition), and November 15 (January 1 edition). Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, and advertisement to Wanda Kapaun, Assistant to the Editor of TCP, [wkapaun@plains.nodak.edu](mailto:wkapaun@plains.nodak.edu), North Dakota State University, Department of Psychology, Minard Hall 115, Fargo, ND 58105-5075.

### *Call for Papers Clinical Psychology: Science and Practice*

The Journal is interested in receiving scholarly papers on topics within Clinical Psychology. Papers are welcome in any content area relevant to theory, research, and practice. The Journal is devoted to review and discussion papers and hence is not a primary outlet for empirical research. For consideration for publication, please submit four (4) copies of the manuscript (APA Publication format) to: David H. Barlow, PhD, Editor, Clinical Psychology: Science and Practice, Center for Anxiety and Related Disorders, Boston University, 648 Beacon Street, 6<sup>th</sup> Floor, Boston, MA 02215-2002. Authors with queries about the suitability of a given topic or focus should direct correspondence to the above address.

### *Free Book Offer for Members of D-12*

Oxford University Press will offer \$50 worth of free books to any D-12 member who gets their library to subscribe to *Clinical Psychology: Science and Practice*, the official journal of the Society of Clinical Psychology. The journal has quickly become one of the most frequently and widely cited journals in the field of clinical psychology.

It frequently takes a "personal" nudge to get libraries to subscribe as they receive many such offers. If you are successful in doing so, Oxford University Press will provide you a \$50 coupon for purchase of books from their wide selection of interesting and timely offerings. Library subscriptions to the journal, of course, help defray the cost of the journal to you and our other members.

For additional information contact Joy Cox at Oxford University Press (ph: 919-677-0977 x5279 or e-mail: [jmc@oup-usa.org](mailto:jmc@oup-usa.org)).

## *Division 12 Sponsored Continuing Education Workshops*

Boston, MA, at the Boston Park Plaza Hotel  
August 18-19, 1999, just prior to the APA Convention

**One Day Workshops, Wednesday, August 18, 1999, 7 CE Credits, \$185**

- A. Neurodevelopmental Assessment of ADHD Across the Lifespan, Jan L. Culbertson, PhD
- B. Racial Identity in the Therapy Process: Theory and Assessment, Janet E. Helms, PhD
- C. Treatment of OCD in Children and Adults, Deborah C. Beidel, Ph.D. and Samuel M. Turner, PhD
- D. Advanced Competence: Preparing for the ABPP Examination, Norman Abeles, PhD
- E. Marital Therapy As A Treatment for Depression and Alcohol Problems, Mark Whisman, PhD and Barbara S. McCrady, PhD
- F. Changing Paradigms in Child Mental Health: Expanding Practice in Schools, Mark Weist, PhD
- G. Advances in the Psychological Treatment of Anxiety Disorders, C. Alec Pollard, PhD
- H. Explosive/Noncompliant Children and Adolescents, Ross Greene, PhD

**One Day Workshops, Thursday, August 19, 1999, 7 CE Credits, \$185**

- I. Neuropsychological Assessment of Learning Disabilities Across the Lifespan, Jan L. Culbertson, PhD
- J. Dialectical Behavior Therapy for Borderline Personality Disorders, Marsha Linehan, PhD
- K. Cognitive Behavior Therapy for Binge Eating and Bulimia Nervosa, G. Terence Wilson, PhD
- L. Overview of Forensic Psychology, Robert Kinscherff, J.D., Ph.D. and Eric Drogin, J.D., PhD, ABPP
- M. A Scientific Approach to the Clinical Assessment of Children and Adolescents, Paul Frick, PhD
- N. Multisystemic Therapy: Outcomes, Clinical Procedures, and Policy Implications, Scott Henggeler, PhD
- O. Cognitive Behavior Therapy for Depression, Zindel Segal, PhD
- P. Cognitive Behavior Therapy for Sexually Abused Children, Esther Deblinger, PhD

FOR MORE INFORMATION: Contact the Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082.  
Tel. (303) 652-3126 Fax (303) 652-2723 Email: [lpete@indra.com](mailto:lpete@indra.com)

# The Clinical Psychologist

Division of Clinical Psychology (12)  
American Psychological Association  
P.O. Box 1082  
Niwot, Colorado 80544-1082

Non-Profit Organization  
U.S. Postage  
**PAID**  
Fargo, ND  
Permit #1159

Canada Goods and Services Tax  
Registration No. 127612802