

THE CLINICAL PSYCHOLOGIST



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

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Diane J. Willis, Ph.D.
Professor Emeritus
Department of Pediatrics
University of Oklahoma
Health Sciences Center

PRESIDENT'S COLUMN

The Drugging of Young Children: Why is Psychology Mute?

Diane J. Willis

The recent headlines in newspapers—"Many Preschoolers Get Psychiatric Drugs"—should alarm all of us working with young children. The headlines referred to an article published in the *Journal of the American Medical Association (JAMA)*, reporting that the number of two- to four-year-old children on stimulant and antidepressant drugs (such as Ritalin, Prozac, etc.) increased dramatically between 1991 and 1995 (Zito et al., (2000). This report suggests to me at least four possible notions: 1) exceedingly poor judgment on the part of those writing the prescriptions; 2) desire for a "quick

fix" by parents and daycare or preschool workers; 3) lack of knowledge about alternative ways to treat a young child's behavioral or emotional problems; and 4) a reflection of the current health care mentality whereby rule-makers support the most inexpensive and expedient treatments (i.e., use of drugs) over brief psychological interventions that may be more expensive but offer more long term benefits. In my practice with children 12 years of age and younger, I have witnessed the recent increase in medicating children and have observed some of the adverse effects of this practice.

When we consider the reasons behind the current trend in medicating young children, parents, physicians, and even psychologists must bear some of the responsibility. Parents often do not choose psychological interventions over medications because of the extra demands on their time to participate in therapy or bring their child for therapy. The expense of psychological interventions is measured in terms of time demands as well as professional and clinic fees, and busy parents may be unwilling to devote the effort to weekly sessions and/or practice new management techniques with their child. Parents may also consider a medically treatable diagnosis to be less of a personal reflection on their parenting skills or their own characteristics, and therefore less stigmatizing. When parents ask their child's physician for treatment suggestions, there is pressure on the physician to address the parent's concerns immediately, and prescribing medication is often the result. However, the least expensive approach to managing a young child's behavior (i.e., medication) may end up, in the long run, being the most costly. If we look at who is doing the medicating, it is often general practitioners and pediatricians rather than mental health professionals such as child psychiatrists. The *JAMA* report notes that there is insufficient follow-up of young children while on medication. Little is known about the effects of early or long-term use of stimulant and antidepressant medications. As astounding as it sounds, the United States uses 80 percent of the world's methylphenidate (Ritalin), and the FDA does not

(continued on page 2)

approve giving the drug to children under six years of age!

Not only do parents and physicians contribute to the trend in medicating young children, but psychologists also must bear responsibility for failing to adequately inform the public and convince managed care companies about the efficacy and benefits of psychological interventions for young children and their families. For example, brief interventions for young children with oppositional defiant disorders have an impressive research base to illustrate their efficacy. Often drastic improvements in the child's behavior can occur in only a few weeks time, with interest and willingness of the parents to participate in treatment. Relational problems between children and significant others can be treated more effectively during the preschool years, and the impact of the treatment upon children's further emotional development is more pronounced. Although psychological interventions may be more expensive than medication, I believe they are more effective and do not have potential adverse long-term consequences for the child that medications may have. Teaching a parent to recognize the rea-

sons for their child's disruptive behavior and change their approach to managing these behaviors can positively influence parenting skills for years to come. As a profession, we need to be more effective in getting this message across to others and marketing the skills we have.

In 1991 I co-authored an article entitled, "The case for prescription privileges: A logical evolution of professional practice" (DeLeon, Folen, Jennings, Willis & Wright). I reported on the task force results of the Division 12 Section of Clinical Child Psychology (now Division 53) where Russell Barkley et al. (1990) surveyed clinical child psychologists about their opinion on prescription privileges. "Over 80% of those surveyed felt that services to underserved children, or children in rural areas, would improve if psychologists had such prescription privileges" (p. 262). I strongly believe that clinical child and pediatric psychologists would not be guilty of over-medicating young children. Psychologists have the training in developmental psychology, behavioral assessment/intervention, and research that enables us to offer more appropriate treatment to young children who are difficult to

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manage, anxious, or depressed. We recognize that children are not generally born to be difficult and that the environment and parent behavior affect young children. When I see a new client in my practice I often ask, "Who is the patient?" Is it the stressed out single mother who continually gives in to her normally active child so that the child has never learned limits? Is it the parents, whose troubled relationship leads to psychological maltreatment between the parents? Is it the overindulgent parent who yearned for a son and gives in to him to the point that he is now the "boss" and is unmanageable? Too often the referral questions posed to my colleagues and me begins with the questions, "Is my child hyperactive? The teacher or daycare worker thinks he is and I have trouble making him mind at home." In more cases than not, the child is not hyperactive and after 12-16 weeks in treatment for oppositional or difficult behavior, the parents can learn the skills to regain control of the child's modified behavior.

When I initiated a therapeutic nursery for three- to five-year old children who had been abused, I had five or six children attending who had all the symptoms of depression. Rather than medicate these children we began permitting and teaching them the joy of therapeutic play in a safe environment, to learn social skills, to empower them, and to heap praise and warmth on them during the three-hour period twice a week that they spent in the nursery. Some of these children had been severely and sadistically physically abused and they had not known much joy in their young lives. Within a two-week period we could observe obvious changes in the demeanor and behavior of these children and by the end of an eight-week period we no longer detected depression. None of these children needed to be medicated.

As psychologists advocate for gaining prescription privileges, it will be critically important to repeatedly speak out against abuses of this privilege and to point out that psychologists have many other skills that would offset the need for writing a prescription. We need to be taken to task as a field to demonstrate which of our treatments are effective, under what conditions, with which populations, at what ages, etc. We must also do a better job of marketing this information effectively to the general public and within the health care system. All of our clinical and counseling psychology graduates should be taught to use effective treatments with young children. In addition, we should advocate for a public

hearing on the overmedicating of young children. I am currently reading an excellent book on substance use among children and adolescents (Pagliaro & Pagliaro 1996). This excellent resource helps me to understand the nature, extent, and effects of substance use from conception to adulthood, and it is helpful in providing the background information we need to be vocal advocates for limiting the overmedication of young children. As psychologists, our research training also places us in a unique position to study and assess the appropriate use of medication with children.

In conclusion, if we as psychologists market our skills effectively and talk about the perilous overmedicating of young children we can do a service to the public and for ourselves. Let us not be mute about our extensive training and knowledge, and what we can do to treat young children and their families effectively. □

References

- DeLeon, P.H., Folen, R.A., Jennings, F.L., Willis, D.J., & Wright, R.H. (1991). The case for prescription privileges: A logical evolution of professional practice. *Journal of Clinical Child Psychology, 20*, 254-267.
- Barkley, R.A., Barclay, A., Conners, C.K., Gadow, K., Gittelman, R., Sprague, R., & Swanson, J. (1990). Task force report: The appropriate role of clinical child psychologists in the prescribing of psychoactive medication for children. *Journal of Clinical Child Psychology, 19* (Suppl.). 1-38.
- Pagliaro, A.M., & Pagliaro, L.A. (1996). *Substance use among children and adolescents*. New York: Wiley and Sons.
- Zito, J.M., Safer, D.J., dosReis, S., Gardner, J.F., Boles, M., & Lynch, F. (2000). Trends in the prescribing of psychotropic medications to preschoolers. *Journal of the American Medical Association, 283*, 1025-1030.

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Interested readers can find additional articles on children's mental health, with a focus on pediatric psychopharmacology, in a special section in Volume 33, Issue 2 (pages 115-147) of *Professional Psychology: Research and Practice*, published in April 2002.



American Psychological Association Convention

Division 12 Program Summary, 2003

Thursday, August 7, 2003

Symposium: Developments with the Emotional Assessment System: An Adaptive DSM-IV Inventory

8/07 Thursday: 11:00AM – 11:50AM

Metro Toronto Convention Centre

Meeting Room 715B

James P. Choca, Stephen Strack, Michael Helford, Yossef S. Ben-Porath

Symposium: Contemporary Issues in ADHD

8/07 Thursday: 11:00AM – 12:50PM

Metro Toronto Convention Centre

Meeting Room 701A

Stephen V. Faraone, C. Keith Connors, Timothy E. Wilens, Joseph Biederman

Section VII (Emergencies and Crises) Symposium: The National Center on Disaster Psychology and Terrorism: Establishment of a National Research Agenda

8/07 Thursday: 12:00PM – 12:50PM

Metro Toronto Convention Centre

Meeting Room 718B

Bruce Bongar, Philip G. Zimbardo, Larry Beutler, Eric Crawford, Glenn Sullivan, Lisa M. Brown, Tracy Rinquist, James Breckenridge

Section VII (Emergencies and Crises) Paper Session: The Suicidal Patient: Forensic-Based Practice Parameters

8/07 Thursday: 1:00PM – 1:50PM

Metro Toronto Convention Centre

Meeting Room 701A

Robert I. Yufit, Alan L. Berman

Symposium: 2002 Competencies Conference – Update on Future Directions

(co-sponsored with Division 43)

8/07 Thursday: 1:00 PM – 2:50 PM

Metro Toronto Convention Centre

Meeting Room 810

Nadine J. Kaslow, Kathleen Bieschke, Nadya Fouad, Frank L. Collins, Jr., Cynthia De Las Fuentes, Mary E.

Willmuth, Catherine Yarrow, Karen R. Cohen, Leon VandeCreek, Radhika Krishnamurthy, Patricia Arredondo, Joseph Rallo, Louise Douce, Carl D. Stoltenberg, Jenny Cornish, Amy Bjorkman, Carol Falender, Rodney Goodyear, Catherine Grus, Robert Hatcher, Gerald Leventhal, Lisa Porche –Burke, David Ramirez, Edward Shafranske, Sandra Sigmon, Richard Steffy, Martha Dennis Christiansen, Michael C. Roberts, Kathi A. Borden

Symposium: Research Developments in Geriatric Suicide

8/07 Thursday: 2:00PM – 2:50PM

Metro Toronto Convention Centre

Meeting Room 715 B

Marnin J. Heisel, Paul R. Duberstein, Kenneth R. Connor, James R. Rogers

Paper Session: Terror and Trauma: Contemporary Research

8/07 Thursday: 2:00PM – 2:50PM

Metro Toronto Convention Centre

Meeting Room 801B

Chebon A. Porter, Ibrahim A. Kira, David Clifford, Abumuslim Alhyadar, Paul H. Van Valin, Stacey Y. Scott, Lisa D. Butler, Cheryl Koopman, Jay Azarow, Sue DiMiceli, David Spiegel, Joseph A. Boscarino, Charles R. Figley

Section IV (Clinical Psychology of Women) Symposium: Feminist Ethics: Practice and Perspective

8/07 Thursday: 2:00PM – 3:50PM

Metro Toronto Convention Centre

Reception Hall 104B

Linda K. Knauss, Melba J.T. Vasquez, Cynthia Strum, Laura S. Brown, Patricia M. Bricklin

Poster Session: Anxiety, Stress, and Trauma

8/07 Thursday: 3:00PM – 3:50PM

Metro Toronto Convention Centre, Exhibit Hall

Section IX (Assessment Psychology) Presidential Address: Empirically Based Bender-Gestalt Test Personality Assessment: Adults and Children

8/07 Thursday: 3:00PM – 3:50PM

Metro Toronto Convention Centre

Meeting Room 205D

Alan J. Raphael

Section VIII (Assoc. of Medical School Psychologists) Symposium: Impact of Federal



American Psychological Association Convention

Division 12 Program Summary

Funds for Training: Report from Grant Recipients

8/07 Thursday: 3:00PM – 3:50PM

Metro Toronto Convention Centre

Meeting Room 717B

Gerald Leventhal, Robert P. Archer, Jeff Baker, Bradley O. Hudson

Symposium: Best Practices in the Community Treatment of Mentally Ill Offenders

8/07 Thursday: 3:00PM – 3:50PM

Metro Toronto Convention Centre

Meeting Room 801B

Wesley A. Bullock, Lois A. Ventura, Robert N. Baker, Jo Ann Harris

Symposium: Latino/as in Health Care Settings: Challenges and Solutions in Psychological Consultations

8/07 Thursday: 3:00PM – 3:50PM

Metro Toronto Convention Centre

Meeting Room 715A

Eduvigis Cruz-Arrieta, Lorna Myers-Escudero, Fran Melendez

Symposium: Efficacy of CBT With and Without Parent-Training for Depressed Girls

8/07 Thursday: 3:00PM – 4:50PM

Metro Toronto Convention Centre

Meeting Room 715B

Janay B. Sander, Kevin D. Stark, Rand Glenn, Mary G. Yancy, Jane Simpson, Sarah Schnoebelen, Johanna M. Molnar, Michelle L. Neimeier, Laura M. Stapleton, Deborah M. Giroux, Nadine J. Kaslow

Section VIII (Association of Medical School Psychologists)

Board of Directors Meeting

8/07 Thursday: 4:30PM – 6:30PM

Division 12 Hospitality Suite

Royal York Hotel

(Check hotel upon arrival for room #)

Section IX (Assessment Psychology) Business Meeting

8/07 Thursday: 5:00PM – 5:50PM

Crowne Plaza Toronto Centre Hotel

Caledon Room

Alan J. Raphael

Section IV (Clinical Psychology of Women) Board of Directors Meeting

8/07 Thursday: 6:00PM – 7:50PM

Division 12 Hospitality Suite, Royal York Hotel
(Check hotel upon arrival for room #)

Friday, August 8, 2003

Section II (Clinical Geropsychology) Symposium: Prevention and Treatment of Dementia and Depression in Older Adults

8/08 Friday: 8:00AM – 8:50AM

Metro Toronto Convention Centre

Meeting Room 717B

Paula Hartman-Stein, Forrest R Scogin, Robert Wilson, Michael Marsiske

Symposium: Coping and Emotional Processes in Native Americans

8/08 Friday: 8:00AM – 8:50AM

Metro Toronto Convention Centre

Meeting Room 714B

Chebon A. Porter, Shari A. Robinson, Daniel W. McNeil, Cynthia R. Kalodner, Michael J. Zvolensky, Joseph E. Trimble

Symposium: Mindfulness Meditation: Conceptual Basis and Empirical Evidence

8/08 Friday: 8:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 717A

Jean L. Kristeller, Scott Bishop, James Carmody, Shauna L. Shapiro, Seth Segal, Ruth Baer

Section IX (Assessment Psychology) Symposium: Enhancing the Future of Psychological Testing

8/08 Friday: 8:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 716B

Alan J. Raphael, Charles Golden, Thomas Achenbach, James Butcher, Irving Weiner, Charles D. Spielberger

Symposium: Bipolar Children and Adolescents: Effective Treatments

8/08 Friday: 9:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 206F

Nancy B. Austin, Gianni P. Faedda, Ira P. Glovinsky



American Psychological Association Convention

Division 12 Program Summary

Section II (Clinical Geropsychology) Symposium: Revenue Enhancement Under Medicare: Coding, Documentation, and Passing Audits

8/08 Friday: 9:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 717B

Paula Hartman-Stein, James Georgoulakis, Donna Rasin-Waters, Antonio E. Puente

Section VI (Clinical Psychology of Ethnic Minorities) Executive Meeting

8/08 Friday: 9:00AM – 9:50AM

Division 12 Hospitality Suite

Royal York Hotel

(Check hotel upon arrival for room #)

Helen Pratt

Section VI (Clinical Psychology of Ethnic Minorities) Business Meeting

8/08 Friday: 10:00AM – 10:50AM

Crowne Plaza Toronto Centre Hotel, Ontario Room

Helen Pratt, President

Award Recipient Presentation: Scientific Contributions Award – Cognitive Vulnerability to Depression

8/08 Friday: 12:00PM – 12:50PM

Crowne Plaza Toronto Centre Hotel, Ontario Room

Lyn Y. Abramson, Lauren B. Alloy

Award Recipient Presentation: Florence Halpern Award for Distinguished Professional Contributions – Questionable Fads and Practices in 20th Century Clinical Psychology

8/08 Friday: 1:00PM – 1:50PM

Crowne Plaza Toronto Centre Hotel, Ontario Room

Gerald P. Koocher

Section III (Society for a Science of Clinical Psychology) Presidential Address: Dynamic Markers of Psychopathology

8/08 Friday: 2:00PM – 2:50PM

Metro Toronto Convention Centre

Meeting Room 201D

Kenneth Sher

Poster Session: Personality, Psychopathology, Psychotherapy, and Professional Issues

8/08 Friday: 2:00PM – 2:50PM

Metro Toronto Convention Centre, Exhibit Hall

Nicole J. Siegfried

Award Ceremony (Section II, Clinical Geropsychology): M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology: Lillian Remembers, An Episode on Ward 211

8/08 Friday: 2:00PM - 2:50PM

Metro Toronto Convention Centre

Reception Hall 104D

Robert Kastenbaum

Section VI (Clinical Psychology of Ethnic Minorities) Presidential Address: Working with Diverse Families

8/08 Friday: 2:00PM – 2:50PM

Crowne Plaza Toronto Centre Hotel, Ontario Room

Helen Pratt (President), Stephanie I. Coard, Mia Smith Bynum, Kim Usher

Section III (Society for a Science of Clinical Psychology) Symposium: Empirically Supported Principles of Therapeutic Change: Beyond Manuals

8/08 Friday: 2:00PM – 3:50PM

Metro Toronto Convention Centre

Meeting Room 714B

Larry E. Beutler, Louis Castonguay, Shelia Woody, Barbra McCrady, Jacques Barber, Bruce E. Wampold

Section IV (Clinical Psychology of Women) Presidential Address: The Role of Emotions and Values in Ethical Decision Making

8/08 Friday: 3:00PM – 3:50PM

Metro Toronto Convention Centre

Meeting Room 717B

Linda K. Knauss

Symposium: At-Risk Youth: Focus on the Overlap Between Aggression and Substance Abuse

8/08 Friday: 3:00PM – 3:50PM

Metro Toronto Convention Centre

Meeting Room 801A

Christine Wekerle, Anne-Marie Wall, Goldstein L. Abby, Jane E. Dumas

Section VIII (Assoc. of Medical School Psy- chologists) Symposium: Psychology in Academic Health Centers: Thriving in the New Millennium



American Psychological Association Convention

Division 12 Program Summary

8/08 Friday: 3:00PM – 4:50PM

Metro Toronto Convention Centre

Reception Hall 104A

Richard J. Seime, Cynthia D. Belar, Cheryl A. King, Ronald H. Rozensky, Barry A. Hong, Kristofer J. Hagglund

Section II (Clinical Geropsychology) Presidential Address: Mental Health Interventions in Long-Term Care Settings

8/08 Friday: 4:00PM – 4:50PM

Metro Toronto Convention Centre

Meeting Room 711

Victor Molinari

Paper Session: Emotional Disorders: Anxiety, Depression, and Their Comorbidity

8/08 Friday: 4:00PM – 4:50PM

Metro Toronto Convention Centre

Meeting Room 801B

Michael J. Zvolensky, Nancy L. Kocovski, Norman S. Endler, Brian J. Cox, Richard P. Swinson, Sandra Lecce, Kirk R. Blankstein, Denise Hui, Allison Crawford, Carmen L. Rivera-Medina, Jeannette M. Rossello, Guillermo Bernal, Michelle M. Cornette, Rochelle F. Hanson, Heidi S. Resnick

Roundtable Discussion: Questions and Answers for Students on Research and Clinical Work with Special Populations

8/08 Friday: 4:00PM – 4:50PM

Metro Toronto Convention Centre

Reception Hall 104C

Daniel W. McNeil, Stephen Hampe, Diane J. Willis, Ascuncion M. Austria, A. Marie M. Austria, Martha R. Crowther

Symposium: Effects of September 11 Relief Operations on Red Cross Workers

8/08 Friday: 5:00PM – 5:50PM

Metro Toronto Convention Centre

Meeting Room 707

Gerard A. Jacobs, Erika Johnson-Jimenez, David L. Meyer, Shannon E. McCaslin, Jane Morgan

Section VI (Clinical Psychology of Ethnic Minorities) Discussion: NIMH Priorities for Children's Mental Health: Research for Diverse Populations

8/08 Friday: 5:00PM – 5:50PM

Metro Toronto Convention Centre

Meeting Room 713B

Delores L. Parron, Cheryl A. Boyce, Belinda E. Sims, LeShawndra Price, Joel Sherrill, Heather Ringeisen

Paper Session: Accumulating Evidence for Psychotherapeutic Approaches with Special Populations

8/08 Friday: 5:00PM – 5:50PM

Metro Toronto Convention Centre

Meeting Room 716A

Jeanette M. Rossello, Guillermo Bernal, Carmen L. Rivera-Medina, Cheryl Koopman, Tasneem Ismailji, Danielle M. Holmes, Catherine Classen, Talor Bendel, David Spiegel, Kenneth E. Hart, David A. Shapiro, Niki Gervais, Heather Wilkie, Tobi Wilson, Tania LeComte, Claude Leclerc, Til Wykes, Charles J. Wallace, Jocelin LeComte

Symposium: Cultural Competency Training in Clinical Psychology: Content, Process, and Resistance

8/08 Friday: 5:00PM – 5:50PM

Metro Toronto Convention Centre

Meeting Room 713A

Beverly Greene, Gladys L. Croom, Janet B. Baker, Francis K. Trotman

Section VIII (Association of Medical School Psychologists) Invited Award Winner Addresses

8/08 Friday: 5:00PM – 5:50PM

Metro Toronto Convention Centre

Meeting Room 801B

Suzanne Bennett-Johnson, James H. Bray

Section II (Clinical Geropsychology) Business Meeting

8/08 Friday: 5:00PM – 5:50PM

Division 12 Hospitality Suite, Royal York Hotel
(Check hotel upon arrival for room #)

Victor Molinari

Section VIII (Association of Medical School Psychologists) Business Meeting

8/08 Friday: 6:00PM – 6:50PM

Division 12 Hospitality Suite

Royal York Hotel

(Check hotel upon arrival for room #)

Gerald Leventhal



American Psychological Association Convention

Division 12 Program Summary

Saturday, August 9, 2003

Paper Session: Interpersonal Violence, Trauma, and Posttraumatic Stress Disorder

8/09 Saturday: 8:00AM – 8:50AM

Metro Toronto Convention Centre

Meeting Room 717B

Chebon A. Porter, Shelia Chiffrieller, James J. Hennessy, David M.S. Kimweli, Naomi L. Baum, Ruth Pat-Horenczyk, Regan Shercliffe, Marilyn M. Bowman, Stephen Hart, William J. Koch

Symposium: Psychology's Efforts to Obtain GME Inclusion: An Update

8/09 Saturday: 8:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 801A

Robert G. Frank, Marilyn Richmond, Nadine Kaslow, Susan Zlotlow

Symposium: End-of-Life Care: An Emergent Field for Psychology

8/09 Saturday: 8:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 713B

Julia E. Kasl-Godley, Dale G. Larson, William E. Haley, Antonette M. Zeiss, James Breckenridge, Paula Hartman-Stein

Section VI (Clinical Psychology of Ethnic Minorities) Symposium: Mainstreaming Multiculturalism in Graduate Clinical Psychology: Seeking Unity in Diversity

8/09 Saturday: 9:00AM – 9:50AM

Metro Toronto Convention Centre

Reception Hall 104A

Maria Garrido, Vonda Jones-Hudson, Lisa L. Harlow, Patricia Morokoff, Lisa Bowleg, David Faust, Charles E. Collyer, Maram Hallak, Paul B. DeMesquita, Melvin Wade, Anna Varna Garis

Section VII (Emergencies and Crises) Paper Presentation: Assessment of Acute Risk of Violence: Research Update

8/09 Saturday: 9:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 703

Dale E. McNiel

Paper Session: New Conceptual Approaches to Psychopathology

8/09 Saturday: 9:00AM – 9:50AM

Metro Toronto Convention Centre

Meeting Room 701A

Dennis R. Combs, David L. Penn, Thomas A. Wills, Jody Resko, Carmella Walker, Don Mendoza, Michael G. AINETTE, Robert F. Sawicki, Amy A. Paschane, Maryam Sayyedi, G. Leonard Burns

Symposium: Psychology Across the Lifespan in Urban Healthcare Centers: Challenges/Opportunities

8/09 Saturday: 10:00AM – 10:50AM

Metro Toronto Convention Centre

Meeting Room 701B

Robert A. DiTomasso, Rosemary B. Mennuti, Barbra A. Golden, Bruce S. Zahn, Jeffery McCleary

Poster Session: Best Clinical Practices and Research for Children, Adolescents, Parents, and Families

8/09 Saturday: 10:00AM - 10:50AM

Metro Toronto Convention Centre, Exhibit Hall

Maureen Sullivan

Invited Address: Bridging the Gap Between Standard and Multicultural Assessment Practice: An Agenda for Research and Training

8/09 Saturday: 10:00AM – 10:50AM

Metro Toronto Convention Centre

Meeting Room 801A

Richard H. Dana

Symposium: 2003 EMPathy Symposium on Emotion, Motivation, and Personality (co-listed with the American Psychological Foundation, and Divisions 3 and 8)

8/09 Saturday: 11:00 AM – 12:50 PM

Metro Toronto Convention Centre

Meeting Rooms 205A & B

Charles D. Spielberger, Nadine J. Kaslow, Arie W. Kruglanski, Elizabeth A. Phelps

Section IV (Clinical Psychology of Women) Business Meeting

8/09 Saturday: 1:00PM – 2:50PM

Crowne Plaza Toronto Centre Hotel, Niagara Room

Linda Knauss



American Psychological Association Convention

Division 12 Program Summary

Section III (Society for a Science of Clinical Psychology) Business Meeting

8/09 Saturday: 2:00PM – 2:50PM

Division 12 Hospitality Suite, Royal York Hotel
(Check hotel upon arrival for room #)

Kenneth Sher

Division 12 Presidential Address: Best Practices with Special Populations – Meeting the Needs of Today's Families

8/09 Saturday: 3:00PM – 3:50PM

Fairmont Royal York Hotel, Upper Canada Room
Diane J. Willis, President

Section II (Clinical Geropsychology) Executive Committee Meeting

8/09 Saturday: 3:00PM – 6:50PM

Division 12 Hospitality Suite, Royal York Hotel
(Check hotel upon arrival for room #)

Award Ceremony: Society of Clinical Psychology Awards

8/09 Saturday: 4:00PM – 4:50PM

Fairmont Royal York Hotel, Upper Canada Room
Lyn Y. Abramson, Michael E. Addis, Lauren B. Alloy, Julia Kasl-Godley, Gerald P. Koocher, Stanley Sue

Division 12 Social Hour

- Poster Session for Section III (Society for a Science of Clinical Psychology)
- Poster Session for Section IX (Assessment Psychology)

Social hour co-sponsored by the International Society of Clinical Psychology

8/09 Saturday: 5:00PM – 6:50PM

Fairmont Royal York Hotel, Concert Hall
Diane J. Willis

Sunday, August 10, 2003

Section VII (Emergencies and Crises)

Business Meeting

8/10 Sunday: 9:00AM – 9:50AM

Division 12 Hospitality Suite
Royal York Hotel (Check hotel upon arrival for room #)
Bruce Bongar

Symposium: Across the Great Divide: Including Spirituality in Mainstream Clinical Psychology

8/10 Sunday: 9:00AM – 10:50AM

Metro Toronto Convention Centre, Meeting Room 707

William R. Miller, Carl E. Thoresen, Kenneth I. Pargament, Carlo C. DiClemente, Peter E.D. Nathan

Symposium: Alexithymia: New Developments in Theory and Research

8/10 Sunday: 10:00AM – 11:50AM

Metro Toronto Convention Centre

Meeting Room 717B

Louise Sundararajan, James D. Parker, R. Michael Bagby, Graeme J. Taylor, Michael A. Lumley, Jane Kelley, Christina Kraft, Pam D'Souza, Sally Norman, Richard D. Lane, Lenhart Schubert, Mary M. Fox

Paper Session: Suicidality and End-of-Life Issues

8/10 Sunday: 11:00AM – 11:50AM

Metro Toronto Convention Centre

Meeting Room 716A

Marnin J. Heisel, Paul R. Buberstein, Rheedra L. Walker, LaRicka Wingate, Thomas E. Joiner, Deidre L. Donaldson, Anthony Spirito, Christianne Esposito, Rudy V. Nydegger

Roundtable Discussion: Children's Mental Health Preparedness in Response to Terror and Disaster

8/10 Sunday: 11:00AM – 11:50AM

Metro Toronto Convention Centre

Meeting Room 715A

Robin H. Gurwitsch, Claude Chemtob, Betty Pfefferbaum, Robert Pynoos, Merritt D. Schreiber, Jon A. Shaw, Eric M. Vernberg

Poster Session: Clinical Assessment

8/10 Sunday: 12:00PM – 12:50PM

Metro Toronto Convention Centre, Exhibit Hall

Symposium: Nonverbal Accuracy and Adjustment Among Various Cultural Groups

8/10 Sunday: 12:00PM – 12:50PM

Metro Toronto Convention Centre

Meeting Room 801B

Patricia W. McClanahan, Wendy C. Bailey, Virginia B. Wickline, Abigail A. Marsh

Section VII (Emergencies and Crises) Presidential Address: The Suicidal Patient: Clinical and Legal Standards of Care

8/10 Sunday: 12:00PM – 12:50PM

Metro Toronto Convention Centre

Meeting Room 801A

Bruce Bongar



American Psychological Association Convention

Division 12 Program Summary

Thank you Division 12 APA Convention Program Reviewers!



Dan McNeil, Ph.D.

Proposals to the Division 12 program of the 2003 APA convention were for symposia, discussion hours, papers, and posters. Each of the regular submissions was subjected to peer review by at least two reviewers; the identity of the proposals' author(s) were masked to the reviewers. Given the structure of APA convention programming, reviewers have a very short time line to review the typical number of 8 to 15 proposals; nevertheless, the reviewers were outstanding in their timeliness and responsiveness. I am grateful to the 50 of our colleagues listed here, who were kind enough to serve as reviewers this year. In addition to a number of reviewers who have served our Society of Clinical Psychology in this capacity year in and year out, several new professionals were invited and were willing to join the ranks of reviewers. I am very grateful to all of you for your expertise and important contributions to our Division.

Dan McNeil,
2003 Program Chair
Division 12, Society of Clinical Psychology

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The Relevance of the American Psychological Association's Multicultural Guidelines for Research, Practice, and Education

In view of the adoption of Multicultural Guidelines by APA, an important task is to translate the Guidelines into useable principles for researchers, clinicians, and educators. The Division 12 Science and Practice Committee has asked some distinguished authorities on multiculturalism to share with us their views of what the Guidelines mean for research, practice, and education/training. The next several issues of *The Clinical Psychologist* will include brief articles that analyze the implications of the Guidelines. The first article by Gordon Hall examines the implications for psychological research. We welcome reactions or responses to these articles.

Martin M. Antony, Editor of *The Clinical Psychologist*
Stanley Sue, Chair, Science and Practice Committee




Cultural Competence in Clinical Psychology Research

Gordon C. Nagayama Hall
University of Oregon

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 In August of 2002, the American Psychological Association (APA) Council of Representatives approved as APA policy the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. The term “multicultural” in the Guidelines refers to interactions between individuals from minority ethnic and racial groups in the United States and the dominant European-American culture. These guidelines encourage scientists, educators, and practitioners to become culturally competent. The guideline that is most relevant to clinical psychology research is: “Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds” (APA, 2002, p. 36). Culture-centered research considers that behavior may be shaped by culture, the groups to which one belongs, and cultural stereotypes, including those about stigmatized group members (APA, 2002).

Recommendations concerning cultural competence for psychologists have existed for at least 30 years without much impact on clinical psychology research (Hall, Iwamasa, & Smith, in press). Unlike standards that are mandatory and carry an enforcement mechanism, guidelines are aspirational, in that they suggest or recommend behavior for psychologists. Thus, many clinical psychologists may feel no particular obligation to heed these guidelines. So, why should this latest set of guidelines make a difference for clinical psychology researchers?

In this article, I discuss reasons for the dearth of attention in clinical psychology research to culture and ethnicity, existing methods that have failed to inform us about the meaning and influence of culture and ethnicity on behavior, and how clinical psychology can implement the Guidelines for rigorous research that can conceptualize and measure ethnic and cultural influences. Elsewhere, I have discussed options for psychology with respect to cultural and ethnic minority issues (Hall et al., in press). One



Cultural Competence in Clinical Psychology Research

option would be to refer these issues to another discipline that may be better equipped to address them, such as cultural anthropology, sociology, or social welfare. Another option would be to insure some minimum level of cultural competence in psychology via professional sanctions. Accreditation could be withheld from training programs that do not provide adequate cultural training, and institutional review boards, funding agencies, and journal editors could prevent culturally insensitive research from being conducted, funded, or published (Hall et al., in press). A more positive incentive would be an opportunity for researchers to create new directions

“Analysis of combined samples potentially obscures variability across subsamples.”

for theory and research in clinical psychology by applying scientific rigor to the study of culture and ethnicity. The inclusion of culture and ethnicity can expand the scope of clinical psychology research to make it more relevant to a rapidly diversifying society.

Common Approaches in Clinical Psychology to Culture and Ethnicity

Clinical psychology has avoided, combined, and categorized culture and ethnicity in research. Perhaps the most common approach in clinical psychology to cultural issues has been to avoid them. Culture and ethnicity are often viewed as nuisance variables rather than as central constructs that can inform science (APA, 2002; Hall, 2001; Sue, 1999). Ethnic minority issues have largely been absent from clinical psychology journals (Case & Smith, 2000; Hall & Maramba, 2001; Iwamasa & Smith, 1996). Perhaps this is because clinical psychologists view culture and ethnicity as having limited impact on psychopathology, assessment, treatment, and prevention. Or perhaps those who view the context of culture and ethnicity as important are in the minority. Most research on ethnic minority populations is conducted by ethnic minority authors (Hall & Maramba, 2001). Ethnic minority persons constitute less than 6% of the membership of APA and only 15% of the doctoral degrees awarded in 2001 were to persons of color (APA, 2002). A lack of skills may further hamper both minority and non-minority clinical psychologists who wish to study culture and ethnicity. Most

graduate training programs in clinical psychology have little or nothing in their curricula concerning cultural and ethnic diversity (Bernal & Castro, 1994). The net effect of a “color-blind” psychology is to ignore potentially important differences that may shape and effect behavior (Iwamasa, 1997).

One method to improve the generalizability of research samples is to include ethnic minority participants in combination with ethnic majority participants. The assumption is that overall findings for a diverse sample equally apply to all subsamples. However, when culturally diverse participants have been included in research samples, subsamples of these participants typically have not been separately analyzed (Hall, 2001). Analysis of combined samples potentially obscures variability across subsamples. If the majority of a combined sample is from one group, the influence of this group is likely to overwhelm any effects of subgroups.

An example of the advantages of subsample analyses is found in recent work on European American and Asian American men’s sexual aggression (Hall, Teten, & Sue, 2002). European Americans were 53% and Asian Americans were 47% of the total sample. Structural equation modeling of the total sample resulted in a model including culturally-relevant constructs that explained only 8% of the variance in these men’s sexually aggressive behavior. When mainland Asian American and Hawaiian Asian American subsamples were analyzed separately, the structural equation models accounted for 29% and 9% of the variance in sexual aggression, respectively. A structural equation model of the European American sample actually accounted for less variance in sexual aggression (4%) than the combined model did. Had the analyses been limited to the total sample, it could inaccurately have been concluded that the constructs in the model offered an inadequate explanation of sexual aggression for any of the groups, precluding the identification of informative culture-specific models.

When culture and ethnicity are directly considered in clinical psychology research, a group differences approach is typically used in which culture/ethnicity is treated as a categorical demographic variable (Quintana, Troyano, & Taylor, 2001). Broad, heterogeneous groups are created (e.g., Asian Americans, European Americans) and similarities

Cultural Competence in Clinical Psychology Research

and differences between these groups are investigated on some set of dependent measures. Although the dependent measures are usually carefully conceptualized and designed (e.g., major depression, paranoid schizophrenia, psychopathy), the independent variable is assessed by means of a one-item test: Which group do you belong to?

Not surprisingly, research with such a poorly defined independent variable has yielded few ethnic differences. Hall, Bansal, and Lopez (1999) conducted a meta-analysis of ethnic-comparative research on the Minnesota Multiphasic Personality Inventory (MMPI) and MMPI-2, the most widely studied instruments in clinical psychology, that had been published over a 31-year period. Differences between European Americans, African Americans, and Latino Americans were limited. In all but a very few studies, a category of ethnicity (e.g., African American) was used as the independent variable.

“...culture resides neither within an individual nor within society.”

Group differences research often is atheoretical and does not offer or measure a rationale for why differences may exist. Thus, even when a difference is identified, it

is unknown if culture or ethnicity is the basis of the difference. When differences are not detected, it also cannot be assumed that the same mechanisms of the behavior exist for all groups or that the impact of the same behavior is the same for all group members unless the mechanisms and impact are identified and measured (Hall, 2001). Culture and ethnicity are psychological variables that are not fully captured when they are reduced to demographic proxies (Quintana et al., 2001).

New Directions in Culture and Ethnicity

Clinical psychology is capable of approaching culture and ethnicity in a more sophisticated and comprehensive manner than simply ignoring, combining, or categorizing them. One such approach has been the study of the effects of ethnic identity on psychopathology. Ethnic identity is one's level of identification with a particular ethnic group (Phinney, 1996, 2003). Ethnic identity has consistently been demonstrated to be a protective factor against psychopathology, particularly among ethnic minority persons (Caldwell, Zimmerman, Bernat, Sellers, &

Notaro, 2002; McMahon & Watts, 2002; Roberts, Roberts, & Chen, 1997; Yasui, Dorham, & Dishion, in press). Persons who are strongly identified with their ethnic group are at lower risk for psychopathology than those who are less strongly identified with their ethnic group. However, the association between ethnic identity and psychopathology generally has been moderate, which may suggest that there are mediators of this association. In other words, a strong sense of ethnic identification is not sufficient to prevent psychopathology. It is likely that ethnic group norms mediate the association between ethnic identity and psychopathology. Thus, it is not ethnic group identification per se that prevents psychopathology, but identification with an ethnic group's norms.

Lopez and Guarnaccia (2000) in their review of cultural psychopathology have defined culture as the product of interactions between an individual and society. Thus, culture resides neither within an individual nor within society. Ethnicity involves these cultural interactions within a particular group of people who share a common heritage (e.g., Vietnamese Americans, Mexican Americans).

Although culture and ethnicity have been conceptualized as an interactive process, these constructs have primarily been measured via individual self-reports (Hall, 2002). Existing self-report measures of cultural variables, such as individualism-collectivism, or ethnic variables, such as ethnic identity, offer individual perspectives. Such individual perspectives do not adequately assess the social contexts in which these perspectives develop and function. Thus, a measurement process that can directly investigate cultural/ethnic interactions between individuals and groups is necessary.

Clinical psychology has been at the forefront of conceptualizing and assessing interpersonal interactions. Psychotherapy process research has identified mechanisms of interpersonal influence and change (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Behavioral observational methods have explored family and peer influences on psychopathology (Dishion, Spracklen, Andrews, & Patterson, 1996). It is likely that some of the same interpersonal processes involved in psychotherapy and in family and peer interactions also are involved in the transmission of ethnic influences between individuals and groups (Hall, 2002). The expertise of clin-



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ical psychologists potentially can inform the conceptualization and measurement of culture and ethnicity.

Tom Dishion, Andra Teten, and I are in the process of identifying the process by which ethnic group norms are transmitted in the contexts of dyads and family groups. In the multiethnic sample that we are examining, self-reported ethnic identity was found to be a strong protective factor against externalizing behaviors (Yasui et al., in press). In addition to being administered self-report measures, participants in the sample were videotaped in dyadic and family interactions. Our goal is to identify observable behavioral indicants of culture and ethnicity in these interactions that may be the basis by which ethnic identity develops and is transmitted. Similar efforts to conceptualize culture and ethnicity, and to determine the impact of these constructs on psychopathology, are needed in clinical psychology.

“It is no secret that tension and suspicion has existed between clinical psychology researchers and ethnic minority communities...”

minority participants. Standard methods of recruitment have typically not resulted in adequate ethnic

The Importance of Research Collaboration with Ethnic Minority Communities

Collaboration with ethnic minority communities and researchers has been advocated as means of creating culturally-relevant research (APA, 2002; Hall, 2001). One practical reason for collaboration is gaining access to ethnic

minority samples, as ethnic minority groups are often underrepresented in settings in which clinical psychology research occurs (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Thus, partnerships with ethnic minority community leaders and researchers can facilitate access to these communities.

Another critical reason to collaborate is to insure the development of culturally-informed research approaches. Exporting methods developed in majority populations to ethnic minority populations without modification is unlikely to adequately address influences on psychopathology that are unique to ethnic minority contexts, including interdependence, spirituality, and discrimination (Hall, 2001). The paucity of literature in clinical psychology on ethnic minority groups suggests that clinical psychology has largely been developed by and for European Americans. The default mode in examining ethnic minority populations is ethnocentric. The first multicultural guideline is: “Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves” (APA, 2002, p. 17). Collaboration with ethnic minority communities in the conceptualization, implementation, and interpretation of clinical psychology research is likely to yield results that capture the complexity and richness of ethnic minority cultural contexts (APA, 2002; Hall, 2001).

It is no secret that tension and suspicion has existed between clinical psychology researchers and ethnic minority communities (Hall, 2001). Clinical

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Division 12 has six sections that reflect the wide range of interests in the Division. These are separate memberships, and dues vary. If interested, contact the Division 12 Central Office.

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



Cultural Competence in Clinical Psychology Research

psychology researchers have been concerned about their approaches being compromised in extending them to minority communities. Ethnic minority communities have been concerned about exploitation by researchers. Thus, effective collaborations between clinical psychology researchers and ethnic minority communities are challenging to establish.

Despite these challenges, productive collaborations between ethnic minority communities and clinical psychology researchers have been developed. One example is the Oregon Social Learning Center (OSLC) in Eugene, Oregon. OSLC has been conducting research on Latino American and on American Indian populations. Strong ties with these communities and their leaders have been established. Moreover, OSLC's research team includes Latino American and American Indian psychologists who are involved in the conceptualization, implementation, interpretation, and dissemination of research.

A second example of community research collaboration is the National Research Center on Asian American Mental Health (NRCAAMH) at the University of California, Davis. Almost all the psychologists and other researchers at NRCAAMH are Asian Americans, as is its community advisory board. A unique aspect of NRCAAMH is that it trains Asian American undergraduate and graduate students to become researchers, thus creating a pipeline from Asian American communities to psychology. NRCAAMH and OSLC are prototypes of implementation of the Multicultural Guidelines into psychology research.

Conclusion

Although culture and ethnicity have been on the periphery of clinical psychology research, clinical psychology researchers can offer scientific rigor to the study of culture and ethnicity. It is critical for clinical psychology researchers to collaborate with ethnic community members, leaders, and experts if research efforts are to be successful. Clinical psychology research risks becoming culturally obsolete if it does not attempt to consider cultures and ethnic groups other than European American ones (Hall, 1997). Therefore, clinical psychology researchers would do well to heed the APA Multicultural Guidelines. The guidelines are scheduled to expire as APA policy by 2009, at which time they are likely to be revised. My hope is that

clinical psychology researchers take a leadership role in developing culturally competent research during the next six years instead of their historic stance of uninvolvedness. □

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Applying for Fellow Status in Division 12

Fellows Applicants:

For those individuals who would like to apply to Division 12 as "new" Fellows, (those who are not yet a Fellow in any other Division) should submit their application to the Division Central Office by December 1st of any given year. Notification will be in February of the following year. Ratification of the Fellows Committee's choices, however, must be done by APA's Membership Committee when they meet in August at the Convention. The Fellow status will begin the following January 1st.

For those who are already Fellows in another Division, but who would like to apply for this status in Division 12, applications should be sent to the Division Central Office by February 15th of any given year. Notification of outcome will be in April, with ratification by APA's Membership Committee in August.

Send all application to:

Fellowship Committee Chair
Div 12 Central Office
P.O. Box 1082
Niwot, CO 80544-1082

To request applications:

Tel: 303-652-3126
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email:div12apa@attbi.com



APA – Division 12 Society of Clinical Psychology

PROFESSIONAL DEVELOPMENT INSTITUTES CE CREDIT
Pre-Convention August 5-6, 2003 Toronto, Ontario
Sheraton Centre Toronto Hotel

Half-day Tuesday, August 5 4 CE Credits

A - Advanced Competence: Ethics, Professional and Legal Issues

Norman Abeles, Ph.D.

(8:30am-12:30pm)

B - Working with Families: Ethical and Legal Considerations

Robert H. Woody, Ph.D., J.D.

(8:30am-12:30pm)

C - Psychopharmacology for Non-Physician Therapist

Sheldon Whitten-Vile, M.D.

(1:00pm-5:00pm)

D - Avoiding Ethical, Licensing, and Malpractice Complaints: Guidelines for Psychologists

Robert H. Woody, Ph.D., J.D.

(1:00pm-5:00pm)

Full-day Tuesday, August 5 9:00am-5:00pm 7 CE Credits

E - Neuropsychological Assessment of Learning Disabilities Across the Lifespan

Jan L. Culbertson, Ph.D.

F - Frontal Lobe Function and Dysfunction

Paul F. Malloy, Ph.D.

Full-day Wednesday, August 6 9:00am-5:00pm 7 CE Credits

G - Neurodevelopmental Assessment of ADHD Across the Lifespan

Jan L. Culbertson, Ph.D.

H - Effective Strategies for Treating Anxiety Disorders

Martin M. Antony, Ph.D. and Randi E. McCabe, Ph.D.

I - Neuroimaging for Psychologists

Paul F. Malloy, Ph.D.

J - Behavioral Emergencies: Suicide Risk, Violence Risk, Vulnerable Victims

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Full Day Tuesday 9:00am-5:00pm (E or F) _____	\$ _____
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Before June 6 Discount (subtract \$10 x number of workshops) \$ _____

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Visa/MasterCard registrations may be made by telephone (303) 652-3126 (8a.m. to 5p.m. MST) or fax (303) 652-2723 anytime.

Discount for early registration: Fees are discounted \$10 per workshop per day if check or credit card payment is received by June 6, 2003.

Cancellation/Refund Policy: Full refund is given if a workshop is cancelled by Division 12 and for registrant cancellations received before June 20. A 25% handling charge is imposed on cancellations received between June 21 and July 11. No refunds can be given for cancellations received on or after July 11, 2003.

Time/Location: 8:00a.m to 5:00p.m. Sheraton Centre Toronto Hotel, Toronto, Ontario.

On-Site Registration: On-site registration (for workshops with remaining seats) will be conducted at the Sheraton Centre Toronto Hotel 8a.m. to 9a.m. August 5 and 6.

Wait List for Full Workshops: Enrollment is limited. If a workshop is filled, we will notify you by phone or email. You can choose an alternate or be placed on the waiting list.


CE Credits: CE credits for each workshop will be given as indicated in the description. The number of CE credits is equal to the number of contact hours. Full attendance at the workshop is prerequisite for receiving CE credit. Partial credit may NOT be earned.



Clinical Psychology Records: Reconciling HIPAA, the 2003 APA Ethics Code, State Statutes and Administrative Rules, and Practice Standards

Robert Henley Woody
University of Nebraska at Omaha

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 Much has been written about the increasing regulation of psychological practices by governmental sources (Woody, 2001). For many (most?) clinical psychologists, 2003 may seem to be the unprecedented year for loss of personal decision making in clinical practice, namely because of the advent of the Health Insurance Portability and Accountability Act (HIPAA; Title 45, Volume 1 [45 CFR] 160), the new ethics code promulgated by the American Psychological Association (APA; APA, 2002), and a continued avalanche of regulatory (licensing) statutes and administrative rules. The prescriptions and proscriptions from all of these authoritative sources must, of course, be integrated into existing (and presumably preferred) practice standards prevailing among practitioners.

With HIPAA in effect, the clinical psychologist (referred to in HIPAA as a Covered Entity) must be aware that there are two kinds of clinically-related notes: Routine Notes (start and stop times or duration, treatment modalities or types, frequencies of treatment furnished, and summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, and results of psychological tests) and Psychotherapy Notes (defined in detail later herein) (Zuckerman, 2003).

HIPAA and the APA ethics code contain numerous principles and standards that range across an array of topics. Space precludes comprehensive coverage. Thus, this article focuses on the single

issue of clinical psychology records. Of particular concern will be the HIPAA provisions for so-called Psychotherapy Notes.

Keeping Clinical Records

There was a time when the clinical psychologist had considerable discretion about keeping records of clinical services (e.g., whether records were kept at all and, if so, what should be in the records). Without tracing the evolution, suffice it to say that both HIPAA and the APA code of ethics make clear the requirement for records, and, indeed, certain required contents.

Under HIPAA, clinical records contain Protected Health Information (PHI). Health information means: "any information, whether oral or recorded in any form or medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual" (p. 669), including provision of and payments for health care, as well as demographic information.

The APA ethics code does not prescribe or delineate the contents for psychological records but states in Standard 6.01 Documentation of Professional and Scientific Work and Maintenance of Records:

(a) Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (p. 1067)

It appears that specifying the contents for clinical records, beyond what HIPAA defines as PHI, is done by state statute or administrative rule or by professional standard; and this authority prevails over HIPAA as far as it provides greater protection of the right of privacy and benefit for the client. For example, the Florida Administrative Code (64B19-19.0025) seems to go beyond HIPAA, stating: "To serve and protect users of psychological services, psychologists' records must meet minimum requirements for chronicling and documenting the services performed by the psychologist, documenting informed consent and recording financial transac-



tions.” Further, Section (1) details the information to be included:

Records for chronicling and documenting psychologists’ services must include the following: basic identification data such as name, address, telephone number, age and sex; presenting symptoms or requests for services; dates of service and types of services provided. Additionally, as applicable, these records must include: test data (previous and current); history including relevant medical data and medication, especially current; what transpired during the service sessions; significant actions by the psychologist, service user, and service payer; psychologist’s indications suggesting possible sensitive matters like threats; progressive notes;

“...I often encounter a prosecuting attorney who scrutinizes the Respondent’s clinical records for a treatment plan, searching for short-term goals and long-term objectives.”

copies of correspondence related to assessment or services provided; and notes concerning relevant psychologist’s conversation with persons significant to the service user.

Section (3) indicates that the information about the involvement of a supervisor

must be in the psychological records, and Section (4) requires that “data relating to financial transaction” be included in the psychological records. Keep in mind that these administrative rules are for Florida, but exemplify the sort of provisions contained in state statutes and administrative rules that relate to both HIPAA and the APA code of ethics.

Treatment Planning

Although a requirement for treatment planning may not be stated specifically, it appears that HIPAA, the APA code of ethics, the prevailing practice standards, and many requirements imposed by third-party payment sources support (and sometimes mandate) the inclusion of a treatment plan in the clinical records. A treatment plan should, of course, be monitored, and amendments would need to be entered in the clinical records. [As a defense attorney in licensing complaint cases, I often encounter a prosecuting attorney who scrutinizes the Respondent’s clinical records for a treatment plan, searching for short-term goals and long-term objectives.]

Psychotherapy Notes

When learning about HIPAA, clinical psychologists are quick to recognize the emphasis given to Psychotherapy Notes:

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. (p. 689)

Recall the earlier point that treatment planning is now necessary. Note that the foregoing HIPAA definition includes the term treatment plan, and the fact that treatment plan, being a Routine Note, is not considered to be a Psychotherapy Note (and is not subject to certain exclusions, to be discussed later).

When the psychotherapy notes involve, say, family members, the APA code of ethics, Standard 10.01, Informed Consent to Therapy, states that “psychologists inform clients/patients as early as is feasible in the therapeutic relationships about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask Questions and receive answers” (p. 1072); and Standard 10.02, Therapy Involving Couples or Families indicates:

(a) When psychologists agree to provide services to several person who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients, and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist’s role and the probable uses of the services provided or the information obtained.” (pp. 1072-1073)

At the level of practice standards, it seems that there is a modern-day rationale for asserting that PHI may apply to others besides the person who was referred or pays for services, “such as a collateral

Clinical Psychology Records: Reconciling HIPAA, the 2003 APA Ethics Code, State Statutes and Administrative Rules, and Practice Standards

source involved in a transmission of information to and from a mental health professional” (Woody, 2001, p. 37); and “It would seem...it is the collateral source who has the right to determine or assume confidentiality...[and] that the collateral source potentially controls the decision about whether there will be confidentiality, and it is doubtful that the mental health professional can assuredly make a unilateral declaration that there will be no confidentiality” (p. 49).

Given that clinically-related communications from multiple sources may be included in a single file folder, the release of PHI may necessitate redacting communications for certain persons. However,

“Under HIPAA, disclosure of psychotherapy notes requires more than just generalized consent...”

since Routine Notes and Psychotherapy Notes must be separated (and the information must be kept nowhere else and the form of the information is irrelevant), distinguishing

and separating the records of different sources should be, with preplanning, reasonably attainable (Zuckerman, 2003).

Disclosure of Psychotherapy Notes

The HIPAA emphasis on Psychotherapy Notes conveys new protections for a client’s PHI. Holloway (2003b) reports:

HIPAA affords psychotherapy notes more protection—most notably from third-party payers—than they’d been given in the past. Under HIPAA, disclosure of psychotherapy notes requires more than just generalized consent; it requires patient authori-

zation—or specific permission—to release this sensitive information. And, whereas in the past insurance companies have requested entire patient records—including psychotherapy notes—in making coverage decisions, now health plans cannot refuse to provide reimbursement if a patient does not agree to release information covered under the psychotherapy notes provision. (p. 22)

Holloway (2003a) underscores further the HIPAA support for providing insurance companies with the minimum amount of information.

In keeping with this expanded protection, authorization for disclosure of Psychotherapy Notes must be obtained, except: “(i) to carry out the following treatment, payment, or health care operations...: (a) use by originator of the psychotherapy notes for treatment; (b) use of disclosure by the covered entity in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (c) use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual” (p. 702).

Of particular importance, although various notices may be combined into one document, there is an exception for Psychotherapy Notes: “An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes” (p. 706).

Consent and Authorization for Disclosure

There is a myriad of details about a client’s consent and authorization for disclosure of PHI (the matter of consent for uses and disclosures is dealt with in

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Section 164.506). As stated earlier, notice about the release of PHI and written consent and authorization from the client is commonly necessary.

Certain uses or disclosures do not require written consent or authorization, provided that the individual receives advance notice, which can be done orally, and is informed that he or she can agree or object to (or restrict) the use or disclosure, which can also be done orally (see Section 164.510). For example, this would include using the individual's personal information (e.g., name, address, medical condition, religious affiliation) for a directory that might be released to clergy or persons asking for the individual by name (see p. 707). Information about care can be disclosed "to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information relevant to such per-

"A source of consternation for some clinical psychologists is the client's HIPAA-based right to inspect and have a copy of PHI."

son's involvement with the individual's care or payment related to the individual's health care" (p. 708). There are provisions for limited uses and disclosures when the individual is not present or is incapacitated, such as for an emergency circumstance or a disaster relief (see p. 708), or as required by law for public health (at p. 709), abuse, neglect, or domestic violence (at p. 710), governmental oversight, e.g., audits, licensing, etc. (at p. 710), and law enforcement (at p. 712), military (at pp. 715-716), national security (at p. 716), and correctional (at p. 717) purposes. Of course, legal process, such as by subpoena/summons or court-order warrant, must be honored (at p. 712). In accord with state law, coroners and medical examiners may dutifully access information without authorization (at p. 713). Institutional Research Boards (IRBs) and privacy boards may establish waivers of authorization (at p. 714).

Payment sources receive considerable mention in HIPAA. For insurance or managed care: "A health plan may condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan" (p. 703). Relevant to making payments: "A health plan may condition payment of a claim for specified ben-

efits on provision of an authorization..., if: (A) the disclosure is necessary to determine payment of such claim; and (B) the authorization is not for a use or disclosure of psychotherapy notes..." (p. 703) (see Section 164.508 (b)).

Note that the foregoing exceptions are predicated on numerous criteria, including (but not limited to), in some circumstances, obtaining written assurances that the information will be safeguarded. Given the special sanctity of Psychotherapy Notes, the foregoing uses and disclosures may not, depending on the idiosyncratic factors of the situation, reach beyond Routine Notes.

The authorization for accessing PHI must contain specifics. If the PHI is to be released to another covered entity (e.g., a subsequent treating clinical psychologist), the covered entity requesting the authorization must also contain: "(i) a description of each purpose of the requested disclosure; (ii) except for an authorization on which payment may be conditioned..., a statement that the covered entity will not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on the individual's providing authorization for the requested use of disclosure; and (iii) a statement that the individual may refuse to sign the authorization" (p. 704). The individual must receive a copy of any signed authorization (at p. 704 and p. 705). The authorization can incorporate other consents, e.g., to participate in research, and notices, e.g., privacy practices (at p. 705); however, there is again an exception for Psychotherapy Notes: "An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use or disclosure of psychotherapy notes" (p. 706).

Space limitations preclude comprehensive details of the contents for consents and authorizations, releasing information based on requests and authorizations from personal representatives (including for children), and numerous other important considerations. Reference to an authoritative treatise (e.g., Zuckerman, 2003) and appropriate legal counsel is recommended.

Right to Inspect or Copy

A source of consternation for some clinical psychologists is the client's HIPAA-based right to inspect and have a copy of PHI. Also, Section 164.508 provides notice requirements. The clinical psychologist must

Clinical Psychology Records: Reconciling HIPAA, the 2003 APA Ethics Code, State Statutes and Administrative Rules, and Practice Standards

provide the client with a notice that: the protected health information may be inspected or copy the protected health information obtained by the client (or properly authorized designee); and the client can refuse to sign the authorization for inspection or release (see Section 164.508). If there is a fee for a copy of the records, the notice to the client (and third parties) must make this specific. A fee can be charged for copying, as well as when there is agreement for a summary or explanation of the protected health information: "the covered entity may impose a reasonable, cost-based fee," including only costs for supplies and labor, postage, and preparing an explanation or summary" (p. 730).

Right to Object and Amend

One reason for psychologists' consternation about a client's HIPAA-based right to inspect and copy is the concomitant right to object to the contents of the PHI. The client has the right enter amendments into the clinical records, but this is not a right to correct or change the record as entered and preferred by the clinical psychologist (see Section 164.526[c][1]).

Conclusion

The clinical psychologist: (1) has restricted decision-making authority about psychological records; (2) must keep psychological records; and (3) and must

tailor the structure and substance or contents of clinical records to HIPAA, the APA code of ethics, state statutes and administrative rules, and practice standards. Since this matrix of authorities creates a complex and sometimes ill-defined situation, the clinical psychologist must studiously pursue understanding of the legal-ethical substance, which will likely require consultation and legal counsel. □

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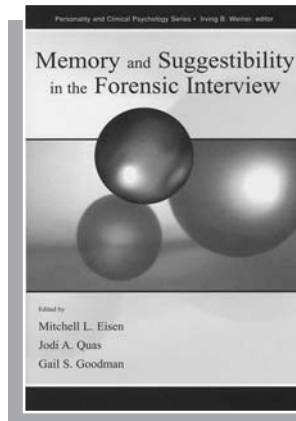


Book Review

Eisen, M.L., Quas, J.A. & Goodman, G.S. (Eds.) (2002). *Memory and suggestibility in the forensic interview*. Mahwah, NJ: Lawrence Erlbaum Associates.

ISBN: 0-8058-3080-4/\$55.00 Special Prepaid Price

Reviewed by Lynn Hulse, M.A. and Amina Memon, Ph.D.
University of Aberdeen, Scotland.



The proliferation of research on memory and suggestibility in the last few decades has led to enlightenment and confusion in equal measures. While some studies have answered many of the theoretical questions, others have sparked debates and raised more practical issues. The publication then of Eisen, Quas and Goodman's new book is wel-

come. The editors promise to provide a "comprehensive and balanced overview" of what research has uncovered about the strengths and weaknesses of eyewitness memory. Packing in 18 chapters authored by a mixture of venerable psychologists, one can see that Eisen et al. intend to deliver on this promise.

Part I of the book is an introduction to basic memory processes. Roediger and Gallo open with an overview that resembles a who's who of memory and suggestibility research. The authors then turn to forensically-relevant factors that play a role in true and false memories. This coverage is structured around the four-stage memory concept (pre-event, encoding, storage, and retrieval), something that readers will be fully familiar with by the end of the book.

Hyman and Loftus (Chapter 3) outline a convincing case for what they describe here (and in earlier publications) as the three necessary, but somewhat independent, processes for the creation of false memory: *plausibility judgement*, *memory construction* and *source monitoring error*. Continuing the theme of memory distortions, Saywitz and Lyon review the child suggestibility literature. Readers interested in interviews with child witnesses should view Chapter 4 as a summary of some "dos and don'ts" and turn to Part IV of the book, which looks more specifically at children in the forensic interview context.

The last chapter in Part I, written by

Brigham, covers the vast topic of face recognition. It is cleverly organized into issues particularly relevant to, firstly, infants, then older children, and finally through to adults. Although the terminology may sometimes be more understandable to those with a psychology background, Brigham does cater to the uninitiated too, including regular definitions of concepts and concluding each section with a consideration of the forensic relevance. What might also appeal to the reader is Brigham's frank and open attitude towards the topic; he is candid about the limitations of current findings and offers many interesting areas for further research.

Part II turns to the effects of stress and trauma on people's memory. It also marks a change from reviews of mostly theoretical research findings to clinical ones. Engelberg and Christianson (Chapter 6) look at the more extreme emotional events and the different reactions to them, and they suggest some techniques that may help to "unlock" memories. Chapter 8 (Dalenberg, Hyland & Cuevas) begins with a stark anecdote illustrating how children can make fantastic allegations about abuse. However, reading on, one discovers such statements are not necessarily flights of fancy but rather grounded in rational beliefs often borne out of true experiences. For example, incidents involving "monster attacks" would not be so far removed from everyday reality for a child who has grown up being regularly exposed to violent and fearsome episodes (e.g., domestic violence). This is an insightful chapter and one that forensic interviewers, medical examiners, and the courts may find of particular interest.

So far, eyewitnesses have been treated as a homogenous group, but Chapter 9 (Eisen, Winograd & Qin) examines individual differences. The authors ask—and go some way to answering—why some individuals are more suggestible to misinformation than others. Following Schooler and Loftus' (1993) distinction, Eisen et al. split their review into *immediate* acceptance of misinformation and *delayed* acceptance—an important distinction, overlooked in the misinformation literature, which throws light on why there have been apparent discrepancies in some of the studies.

Part III (rather tenuously titled, "Adults in the Forensic Interview Context") actually focuses on the methods used by forensic interviewers and therapists and covers both adult and child literature. Fisher, Brennan and McCauley begin by examining the accu-



racy of Cognitive Interview-elicited testimony. Although much has already been published on the Cognitive Interview (CI), this chapter is worth reading. However, readers should not overlook the critiques made in earlier papers (e.g., Memon, Holley, Milne, Koehnken & Bull, 1994, highlighting that unless sufficient time and resources are put into training interviewers, the CI is unlikely to be any more effective than a standard interview). The next two chapters (Lynn, Neuschatz & Fite, Shobe & Kihlstrom) examine retrieval techniques used in therapeutic-forensic settings and impress upon the reader the disturbing ease with which false abuse memories may be suggested to and taken on by clients. Surely a stark warning to those practitioners employing these practices.

Part IV evaluates children's suggestibility in the forensic interview context specifically. Thus Fivush, Peterson and Schwarzmuller, and Poole and

"...an invaluable shortcut to learning the theories on applied human memory..."

Lindsay (Chapters 14 and 15 respectively) consider the accuracy of children's responses to certain types of questions about experienced events within and across interviews and delays. Fivush et al. end their chapter with an important point (p. 350): "The question is not how credible are child witnesses; the question is how careful are forensic interviewers." Interviewer behavior is also considered in Davis and Bottoms' chapter, which emphasises that it is not only what the interviewer says but also the manner adopted that can influence children's reports. Before interviewers start feeling pressured, they should turn to Chapter 17. Here, Sternberg, Lamb, Esplin, Orbach and Hershkowitz offer a structured interview protocol that provides a "script," thereby removing some of the burden placed on interviewers to remember and employ only those recommended invitations and prompts learned during a brief, intensive training period. A preliminary evaluation of the protocol finds very promising results. This must surely prompt more efforts to develop initiatives that not only improve children's reports, but also support the interviewer in their difficult job.

Overall, this book does exactly what it sets out to do. That is, it provides an up-to-date summary of the existing literature, informs the reader of

the current views and recommended practices, and suggests new directions for "anyone involved in elucidating, interpreting, and reporting the memories of others." Where we feel the book fails, is its reliance on the work conducted predominantly in one continent. The majority of authors, and the work they cite, is North American. This overview of memory and suggestibility might have been even more "comprehensive and balanced" with input from Europe where similar high quality, innovative research has been conducted and is being developed further (see Westcott, Davies & Bull, 2002, for a good overview). Furthermore, many of the same studies are covered in several of the chapters. For readers unfamiliar with the literature, this may reinforce the theories, empirical results and implications described therein. Others reading from cover to cover might find it repetitious. The editors acknowledge in the preface that they made a conscious decision not to impose a rigid structure on authors for their chapters and that a degree of overlap is "inevitable". Some people may feel by the end of the book that stricter editing might have been preferable.

In conclusion, this book is a worthy addition to the bookshelves of academics and professionals interested in forensic interviews but should not sit on those shelves for long. Rather, it is the sort of book to be kept at hand, to refer back to again and again. Students studying memory accuracy and distortion will also find this volume an invaluable shortcut to learning the theories on applied human memory and can save many hours otherwise spent on literature searches. One hopes however, that rather than interpreting this book as the last word on "Memory and Suggestibility in the Forensic Interview", people will realize that there is still much work to be done and that the book will act as a motivating force for a further exploration into eyewitness memory. □

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Book Review

Kazdin, A. E. (2003). *Methodological issues and strategies in clinical research* (3rd ed.). Washington, DC: American Psychological Association.

ISBN: 1-55798-959-1/\$39.95 List

Steven Taylor, Ph.D., University of British Columbia



 Sherlock Holmes often referred to the vexing elements of his cases as his “little problems,” to which he applied his famous detective method. Like Holmes, the clinical investigator encounters a host of little problems. And, as with Holmes, many of these problems are not exactly “little.” Just as Dr. Watson’s chronicles

have aided forensic science in real-life, it would be useful to have a Holmesian handbook for clinical investigators. One that bridges theory and application, and distills the accumulated wisdom for anticipating, identifying, understanding, and overcoming the many little problems in clinical research. This is precisely what Alan Kazdin has done in what is now the third edition of his book on clinical research methods.

The book has many strengths. Unlike edited volumes, which tend to be uneven in quality, Kazdin has assembled 37 previously published papers (in addition to his introductory and concluding chapters), hand-picked because of their special contribution to clinical research. I can think no person better qualified than Alan Kazdin for selecting the articles. He has decades of experience as journal editor, researcher, and reviewer, and so has probably seen most of the little problems encountered by clinical investigators.

The book’s 37 chapters have been previously published mostly in leading journals, thereby ensuring their high quality. Most of the chapters are reprints from either the *American Psychologist* (10 chapters) or the *Journal of Consulting and Clinical Psychology* (10 chapters). Most of the remaining chapters are from other APA journals (*Psychological Assessment*, *Psychological Bulletin*, *Psychological*

Methods, and *Professional Psychology*). The chapters were previously published between 1978 and 2002, with most published in the 1990s.

The book is enormous, weighing-in at over 900 pages, and comprehensive in its coverage. The chapters tend to emphasize conceptual and research-planning issues, although there is some discussion of statistical formulae. The articles are generally written in a clear, engaging style. The primary focus is on clinical psychology, with topics covering virtually all aspects of the research process. For example, formulating research questions, methodology, assessment issues, data analysis and interpretation, ethical issues, and guidelines for preparing the manuscript for publication.

In my view, the book has four limitations, but these are generally minor. First, my copy was in softcover. After pouring through its 900-plus pages, my copy was becoming the worse for wear, with pages falling out. Such a massive book might be better set in a more sturdy, hardcover format. An added advantage of a hardcover format is that the book’s sheer weight would make it an excellent weight-training device. According to recent rumors, the hardcover edition is very popular among members of the Bulgarian Olympic weightlifting team.

The second limitation is that when the articles were converted from journal articles to chapters, their abstracts were removed. Although Kazdin does provide introductory commentaries in each of the book’s sections, it would have been useful to see the abstract accompanying each chapter. That would help readers skim the book for topics of interest.

The third limitation is that, inevitably, some important topics are omitted or not discussed in much detail. There is little or no discussion, for example, of some important, widely-used methodologies, such as structural equation modeling, behavioral-genetic (twin) methods, and taxometric procedures. These omissions are no doubt necessary, given the enormous amount of material to be covered.

The final limitation is that the final chapter—discussing general lessons to guide research—tends to be a little weaker than the other chapters, and seems to contain an error. At one point in that chapter, Kazdin (p. 885) says that he advocates the use of invalid and unreliable measures. But from the con-



text of the chapter it seems that he really means that we should consider using measures of unknown reliability and validity, especially where no better measures exist. Measures with unknown psychometric properties can be profitably used for investigating under-explored issues and phenomena. Apart from this error, I would have liked to have seen a more thoughtful discussion in the final chapter, so that we readers could better benefit from Kazdin's decades of accumulated wisdom.

But these limitations are trifles. Overall,

I highly recommend this volume. This book is a valuable resource for all involved in clinical research, from graduate students to seasoned researchers. The book highlights the importance of anticipating the many little problems in clinical research, so that the researcher can plan to avoid them rather than to try to fix them once they arise. The chapters are generally outstanding in quality, and discuss many of the little problems that we encounter in clinical research. □

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The annual race and walk at the 2003 Toronto Convention of APA will be held on Saturday morning, August 9th, at 7 AM. The registration form is available online at www.apa.org/about/division/div47.html or by emailing kcooke@apa.org, calling 202-336-6197, or faxing 202-218-3599. Final information on the venue for the race will appear in the APA Monitor on Psychology, the Division 47 web site (www.psyc.unt.edu/apadiv47), and in your convention packet. If you pre-register, you will be notified via email or post.

Pre-registration will run until August 1st - which means that the entry form and fee must be received by that date. THE ENTRY FEE FOR PRE-REGISTERED RUNNERS IS \$20.00, which includes a commemorative shirt, raffle chance, and post-race refreshments. PAST AUGUST 1ST, CONVENTION AND DAY-OF-RACE REGISTRATION FEE IS \$25.00. Pre-registration for students is \$10.00 and onvention/day-of-race student registration is \$14.00. PLEASE pre-register to help us avoid too many convention and day-of-race registrations.

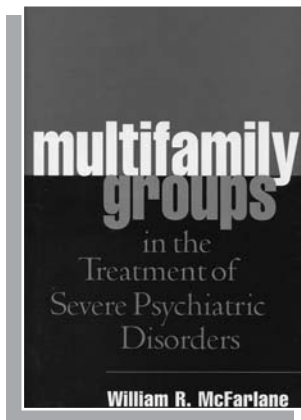
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Book Review

McFarlane, W. R. (Ed.) (2002). *Multifamily groups in the treatment of severe psychiatric disorders*. New York, NY: Guilford Press.

ISBN: 1-57230-743-9/\$45.00 List

Reviewed by Kathleen McGrath, B.A. and Steven Sayers, Ph.D.
University of Pennsylvania, Philadelphia, PA



It has been almost half a century since H. Peter Laqueur, the father of multiple family therapy, first pioneered its use in a population of schizophrenic patients and their families. At that time, its benefits became immediately apparent to Laqueur and his colleagues. Over the past twenty years, empirical evidence supporting the effectiveness of

multifamily groups has been mounting steadily. Yet, this treatment method documented to improve long-term outcome in schizophrenic patients remains remarkably under-utilized.

William McFarlane's *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*, the first book to be published on multiple family therapy, has the potential to change that. McFarlane, who is one of the most outspoken supporters of multifamily groups, edits and contributes substantially to this volume, which focuses on the application of multifamily psychoeducational treatment groups to schizophrenic patients and their families.

McFarlane describes schizophrenia as a "biologically based vulnerability to stress." He begins the book with a thorough review of the psychobiology and the clinical course of schizophrenia. This information can be applied by clinicians directly, by passing this knowledge on to patients and their family members, or indirectly, by influencing their clinical practice.

Next, Ellen P. Leukens and McFarlane describe the impact of environmental factors, such as stress, the family context and social support, and stigma, on the course and symptomatology of schizophrenia. In multifamily groups, addressing family members' needs is considered a critical component of patient care, given the impact that family members have on patients and their symptomatology.

Moreover, the processes taking place within the group actually alleviate patient symptomatology and caregiver burden, both perceived and actual.

The majority of expressed emotion research indicates that schizophrenic patients function best in environments that are "calm, benign, relatively simple and flexible, with known social structure and behavioral limits, controlled performance expectations, continuity of membership, and a high degree of predictability." Multifamily groups give patients the opportunity to practice their social skills in such an environment. Moreover, the presence of family members facilitates patients' transfer of these skills to other contexts, resulting in fewer negative symptoms.

Multifamily groups address the chronic nature of the disease by providing patients and their family members with the information needed to understand schizophrenia, and by extending to them a social support network, which potentially could be maintained long after treatment has been terminated.

Multifamily groups offer several distinct advantages over family therapy and caregiver support groups of the past, which frequently left the patients feeling belittled and their family members blamed. As Leukens describes, multifamily groups "facilitate a paradigmatic shift from an...adversarial perspective to a strengths-based collaborative approach in which families, patients, and professionals are key players in promoting rehabilitation." Multifamily treatment groups have been shown to be more efficacious than family or psychoeducational therapy, and have been shown to be particularly effective in treating families with high expressed emotion and patients responding poorly to antipsychotic medications. Furthermore, the authors point out that the approach helps with "absorbing" more anxiety in families regarding the disorder than single-family approaches.

Having justified the merits of the multifamily approach, McFarlane gives the reader the information and tools needed to implement treatment. McFarlane and his co-authors delineate how to form groups, implement educational and problem-solving interventions, integrate family psychoeducation with pharmacological treatment, and facilitate community re-entry.

In the third and final portion of the book, the multifamily group treatment model is applied to



bipolar disorder, major depressive disorder, borderline personality disorder, obsessive-compulsive disorder, and chronic medical conditions. This portion of the book may be of limited interest to those readers working predominantly with the schizophrenia population. The volume appears to lose focus in

“...this treatment method documented to improve long-term outcome in schizophrenic patients remains remarkably under-utilized.”

this section, in that the information is more limited in detail and less useful for clinicians focusing on treatment of those disorders other than schizophrenia.

Multifamily Groups in the Treatment of Severe Psychiatric Disorders should be considered essential

reading for anyone interested in implementing or learning more about the use of multifamily groups with schizophrenic patients and their families.

McFarlane provides information so detailed that the second portion of the book functions as a treatment manual. Additionally, those interested in studying the efficacy of multifamily groups with non-schizophrenic populations may find this to be a useful literature review. This volume is exceptionally accessible, and therefore, suitable for students interested in working with schizophrenic patients and those interested in better understanding the biological, psychological and social processes influencing the course and symptomatology of schizophrenia. Leukens and McFarlane's thorough treatment of the social and psychological contexts of schizophrenia is one of this book's greatest strengths and recommending features.

McFarlane and his contributing authors have done the mental health community a great service by increasing awareness of multifamily therapy, an under-utilized and empirically-supported hybrid of family therapy, group therapy, and psychoeducation. □

INSTRUCTIONS FOR ADVERTISING

Want ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of *The Clinical Psychologist*. Ads will be charged at \$2 per line (approximately 40 characters).

Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, phone number, and advertisement to the editor. E-mail is preferred.

For display advertising rates and more details regarding the advertising policy, please contact the editor.

Please note that the editor and the Publication Committee of Division 12 reserve the right to refuse to publish any advertisement, as per the advertising policy for this publication.

Submission deadlines for advertising and announcements:

February 15 (April 15 issue)
May 15 (July 1 issue)
September 15 (November 1 issue);
November 15 (January 1 issue).

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ABBREVIATED MINUTES
SOCIETY OF CLINICAL PSYCHOLOGY,
BOARD OF DIRECTORS MEETING
SANTA FE, NEW MEXICO, JANUARY 10-12, 2003

FRAMING OF THE AGENDA

Diane J. Willis presented her future for the Division noting that the Division had taken leadership of empirically supported treatments, but, now the division should think about



Left to right: Irving Weiner (Section 9 Representative), Carl Zimot (CoS Liaison), and Robert Woody (Finance Committee Chair) at the January meeting of the Division 12 Board of Directors

major problems of diverse populations of the United States. Notably, what can clinical psychology offer those in poverty, at war, substance abusers, domestic violence victims, and families of incarcerated persons. She has asked Elizabeth King, Stanley Sue, and Gary Melton to conduct projects on three areas of concern

(impact of mother's cancer on children, best practices for research on minority populations, and impact of incarceration on families of prisoners).

PROGRAM COMMITTEE

There were 231 submissions for the division's regular program this year. The theme is "Best Practices with Special Populations."

MOTION: The Society encourages the Program Chair to seek sponsorship of the social hour and the hospitality suite, with the proviso that sponsors keep the same criteria of sponsorship as previously used by Division 12. PASSED

FINANCE COMMITTEE AND TREASURER'S REPORTS

There is a \$50,000 budgetary deficit for the Division, although the Society has approximately \$200,000 in reserves. Some of the following motions are in response to the need for cost cutting measures.

MOTION: The Society plan to offer a limited number of Professional Development Institutes for the 2004 APA Convention in Hawaii, taking into account past PDIs that have attracted a large number of participants, and the prevailing criteria for cancellation of proposed PDIs. PASSED

MOTION: The Society endorses the spirit of the interdisciplinary panel's "consensus statement on improving the quality

of mental health care in America's nursing homes" and supports further efforts to endorse both non-pharmacological and pharmacological treatments as first-line approaches to the treatment of major depression in nursing homes. PASSED.

MOTION: A contract for the new Editor of Clinical Psychology: Science and Practice, Phil Kendall, shall be created. PASSED.

MOTION: The Board supports lifting the American Psychological Association's ban on military advertising, and directs its president to express the Society's strong opposition to any government policy or law that discriminates against gays and lesbians in the military. PASSED

MOTION: The Board shall adopt the resolution on Families of Incarcerated Offenders, (described more fully in the agenda, appendix p. 3.34). PASSED

MOTION: The Society shall sponsor the Hogrefe and Huber series, "Updates on practices in Clinical Psychology." The publication committee will review the proposal, and take to the Board for e-mail vote. PASSED

MOTION: The Bylaws will be amended so that every three years the council election will have an ethnic minority slate. PASSED. This change will be sent to the membership for vote, along with a pro/con statement.

MOTION: A new Society award is created and titled, The Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology. The first award is given to Stanley Sue. PASSED

MOTION: The Society shall support Continuing Education courses at the January midwinter meeting with two – three workshops for each of the participating Divisions (53 and 12). PASSED

MOTION: The Finance Committee will assist the Publication Committee in researching member interest in having the journal offered on-line as a subscription. PASSED

MOTION: Only elected (voting) board members are invited to be present at the fall meeting, with others to be available by conference call. PASSED

**Respectfully submitted,
Annette Brodsky, Ph.D., Secretary**



Instructions to Authors



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

Material to be submitted should conform to the format described in the Fifth Edition of the Publication Manual of the American Psychological Association (2001). It is preferred that a single electronic copy of a submission be sent as an attachment to e-mail. Alternatively, send four copies of manuscripts along with document file on computer disk for review. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

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

THE CLINICAL PSYCHOLOGIST

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