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CONTENTS

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PRESIDENT'S COLUMN

Embracing the Diversity of Clinical Psychology

Nadine J. Kaslow, Ph.D., ABPP

Happy New Year! I hope that all of you have a year that is productive and full of joy and peace.

Embracing the Diversity of Clinical Psychology

I am honored to serve as the President of the Society of Clinical Psychology (APA, Division 12). My goals for this year are to enhance the sense of community among Division 12 members by increasing our communication efforts within the Division and conveying a sense of inclusiveness for all psychologists and graduate students who identify as clinical psychologists. To this end, my theme is Embracing the Diversity of Clinical Psychology. According to APA 2002 statistics, 44,598 individuals currently self-identify as clinical psychologists. This is by far and away the largest group of individuals identifying with a major field within psychology. I would like all of these people to feel welcome in our division. In addition, I would like to welcome all students in graduate programs in clinical psychology, as well as clinical psychology graduate students on internships and during their postdoctoral experience.

The following is the archival description of Clinical Psychology in the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology Document: *Clinical psychology is a general practice and health service provider specialty in professional psychology. Clinical psychologists assess, diagnose, predict, prevent, and treat psychopathology, mental disorders, and other individual or group problems to improve behavior, adjustment, adaptation, personal effectiveness, and satisfaction. What distinguishes clinical psychology as a general practice specialty is the breadth of problems addressed and of populations served. Clinical psychology, in research, education, training, and practice, focuses on individual differences, abnormal behavior, and mental disorders, and their prevention and lifestyle enhancement.* It is clear from this archival definition, that clinical psychologists are scientists, practitioners, educators and trainers, and people interested in advancing psychology through their public interest efforts. Of course, most of us wear many hats and want to be part of a division in which all aspects of our professional functioning are valued and welcomed. In addition, this definition underscores the fact that as clinical psychologists, we serve individuals from cradle to grave through multiple modalities and in multiple contexts and settings.

One strategy that I will use to increase communication within the Division is to create an

Inside:
Candidate Statements for 2004 Elections!

(continued on page 2)

ISSN 0009-9244

Announce Only listserv in which I will provide division members with a monthly update about division activities. As an Announce Only listserv, recipients will not be able to reply to the list, and thus, people will not become inundated by the responses of others. If you want to communicate with me about any Division related issues, feel free to email me directly at nkaslow@emory.edu. I welcome your input. If you want to engage with other division members, I encourage you to join the Division 12 listserv by contacting div12apa@comcast.net, and asking to be added to the division listserv.

It is my sincere hope that more of you become involved in our division and that you will encourage your students to become involved as well. I would like to hear from you about ways in which you would like to become involved and suggestions that you have for improving our division. Your input will be invaluable to me as the division leadership takes this year to focus on strategic planning.

Competencies in Clinical Psychology

I would like to take this opportunity to discuss a topic near and dear to my heart, namely competencies in Clinical Psychology. The Society of Clinical Psychology was one of many groups to sponsor the 2002 Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology. Detailed publications from this conference will appear in multiple journals including *The Journal of Clinical Psychology*, *Professional Psychology: Research and Practice*, and *The Counseling Psychologist*. I hope that all members of our division will focus their efforts as practitioners, scientists, educators, and public servants on the competencies required to be effective and to move the profession forward.

The mission of the Competencies Conference was toward gaining greater agreement about the identification, training, and assessment of competence by bringing together representatives from diverse education, training, practice, public interest, research, credentialing, and regulatory constituency groups. The competency domains of interest were: (a) scientific foundations of psychology and research; (b) ethical, legal, public policy/advocacy, and professional issues; (c) supervision; (d) psychological assessment; (e) individual and cultural diversity; (f) intervention; (g) consultation and

interdisciplinary relationships; and (h) professional development. Additional attention was paid to the assessment of competence and specialties.

The following is a brief summary of the common themes that emerged across workgroups. Workgroups reaffirmed the conceptualization of competence as including knowledge, skills, and attitudes. It was noted that there are cross-cutting competencies relevant to all aspects of competence at all levels of professional development, including but not limited to individual and cultural diversity, ethical practice, interpersonal and relationship skills, critical thinking, and knowledge of self. All groups highlighted the value of developmentally informed education and training, the use of creative and innovative teaching methods, the crucial role of establishing and maintaining a respectful and facilitative learning environment, the importance of close mentoring relationships as key to high level professional training, the central role of the integration of science and practice into all aspects of education and training, the value of evidence-based and informed practice, and the need to establish during training an internalized commitment to life-long continuous learning and improvement. There was consensus that we need to develop strategies to become equally effective at assessing knowledge, skills, and attitudes for each competency domain. The assessment of overall competence in both integrated and competency-by-competency formats, is an area ripe for growth in the context of education, training, and credentialing. Matching assessment strategies to training goals is essential. Both formative and summative assessment procedures are needed. A developmental perspective in training and assessment must be maintained, particularly in deciding which competencies should be mastered, when they should be mastered, and how to establish developmentally-appropriate assessment criteria. Assessments should be multi-method and multi-informant. Diversity considerations need attention in all approaches to assessment. Several methods of assessment seem particularly promising at this point in time, including the development of simulations or standardized vignettes, improvement in the effectiveness of supervisor ratings, and training in diverse methods of self-assessment that can be used by psychologists throughout their careers.

Finally, workgroups identified the need for educators, trainers, credentialers and regulators, practitioners, and policy-makers to collaboratively create strategies for evaluating competencies in professional psychology so that our assessment practices are comprehensive and integrative across the spectrum of education, training, and practice. New and innovative assessment methods need to be developed, pilot-tested, and incorporated into academic training before they become part of assessment for licensure.

The intent of the conference was to initiate an ongoing dialogue in the profession that will transform education, training, and credentialing practices in professional psychology. It is hoped that such transformation will yield a conceptually coherent and broadly endorsed perspective on competencies, yet one that allows for creativity and innovation. Hopefully, as a division and as clinical psychologists, we can give serious attention to articulating the core competencies associated with being capable clinical psychologists, can work together to develop more effective and innovating educational strategies, and can develop more meaningful strategies for the assessment of competence of ourselves and others. This will enable us to better train the next generation of clinical psychologists and will strengthen our discipline.□

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Division 12 Elections Candidate Statements

Elections for several Division 12 positions will occur this Spring. Ballots will be mailed to members in the middle of April 2004, and must be returned no later than June 1, 2004.

PRESIDENT-ELECT

Suzanne Bennett Johnson, Ph.D., ABPP

Suzanne Bennett Johnson, Ph.D. is Professor and Chair of the Department of Medical Humanities and Social Sciences at Florida State University College of Medicine. She received her B.A. in psychology from Cornell University and her Ph.D. in clinical psychology from SUNY at Stony Brook. She was a 2001-2002 Robert Wood Johnson Health Policy Fellow, working in the office of Hillary Rodham Clinton. Previously, she was Professor and Director of the Center of Pediatric Psychology and Family Studies at the University of Florida. A licensed psychologist in Florida, she has her ABPP in clinical health psychology. A fellow of Division 12 and 38, she has a long history of service to the Division and the APA (e.g., President of Section 5—now Division 54; Chair of the Division's Task Force on Effective Psychosocial Interventions: A Lifespan Perspective; Chair of APA's Board of Professional Affairs; Chair of APA's Board of Scientific Affairs). An author of many journal articles, chapters and books in the areas of pediatric psychology, clinical child psychology and clinical health psychology, her research has been funded by the National Institutes of Health for the last 24 years.

For me, Division 12 has always represented the consummate blend of good clinical science and good clinical practice. Its leaders have been some of the most renown American psychologists. To run for President of this august body, is an honor indeed. However, no group, however prestigious, can rest on its laurels. The Division has the responsibility to use its wisdom and resources to take a hard look at the future of clinical psychology and to plan for that future effectively. For more than 50 years, US health care has been characterized by the biomedical model. This model, defined by mind-body dualism, "carved out" mental health problems from usual health care; clinical psychologists' roles were limited to mental health concerns and patients had to pay more for mental health services, if they received any mental health services at all. In the 21st century, the serious limitations of the biomedical model are becoming increasingly apparent as the US health care system struggles with chronic illnesses and the recognition that human behavior accounts for more than 50% of death and disability in this country. Clinical psychologists are the experts in human behavior. We have the opportunity to become truly integrated into the US health care delivery system. However, this will not happen unless we assert and establish our expertise beyond our own discipline. This will take not only political will, but interdisciplinary bridge-building. It will also take rethinking of how we train clinical psychologists for future research and practice. There is much to do, but I can think of no group other than Division 12 that has the intellectual expertise, clinical experience and commitment to take on this task effectively. As Division 12 President, I would be honored to begin the dialogue. □

PRESIDENT-ELECT

Lillian Comas-Diaz, Ph.D.

After receiving my Ph.D. in clinical psychology from the University of Massachusetts, I taught at Yale University School of Medicine and directed its Hispanic Clinic. Later on, I became the Director of the APA Office of Ethnic Minority Affairs. This experience familiarized me with the intricacies of psychology at a national and international level. Currently, I am a Clinical Professor of Psychiatry and Behavioral Sciences at George Washington University, Director of the Transcultural Mental Health Institute, and a private practitioner.

Personally and professionally I am committed to education, practice, and research in clinical psychology. As a scholar and a practitioner, I have authored numerous publications. Currently I serve on five editorial boards, including Clinical Psychology: Science and Practice, and American Psychologist. Additionally, my work on multiculturalism led me to establish a journal, Cultural Diversity and Ethnic Minority Psychology, which is now the official journal of Division 45.

I have been honored to receive the Committee of Women in Psychology Leadership Award, the Distinguished Contribution to Psychology in the

Public Interest (Senior Career) Award, Division 45 Distinguished Service Award, Division 35 Heritage Award, and the American Psychological Foundation Rosalee G. Weiss Award for Contributions to Professional Psychology. My activities within Division 12 include chairing a Task Force on Diversity (1991-93), serving as a Council Representative (1998), being president of Section 6 (1998-99), and currently serving on the fellows committee.

I believe that I can offer a special type of leadership, one that capitalizes in respecting differences while affirming unity. Clinical psychology is at an exciting crossroads. My extensive APA governance experience and ability to collaborate with diverse groups can be useful in achieving our vision and goals. If you elect me as president, I will work towards receptiveness to innovation while affirming our identity as clinical psychologists.□

PRESIDENT-ELECT

Gerald C. Davison, Ph.D.

I am Professor and Chair of the Department of Psychology at the University of Southern California, where I served as Director of Clinical Training from 1979 to 1984 and Chair of the Department of Psychology from 1984 to 1990. From 1994 to 1996 I was Interim Dean of the USC Annenberg School for Communication. Previously I was at the State University of New York at Stony Brook (1966-1979). I'm a Fellow of APA and have served on the Executive Committee of the Division of Clinical Psychology, on the Board of Scientific Affairs, on the Committee on Scientific Awards, on the Council of Representatives, and most recently on the Continuing Professional Education Committee, where I took a leadership role in proposing a revision of the policies and procedures for APA-approved sponsors of continuing education. I am a licensed psychologist in California and am listed in the National Register of Health Service Providers in Psychology.

Among more than 130 publications, my book *Clinical Behavior Therapy*, co-authored in 1976 with Marvin Goldfried and reissued in expanded form in 1994, is one of two publications that have been recognized as Citation Classics by the Social Sciences Citation Index. My textbook *Abnormal Psychology*, co-authored with John Neale and Ann Kring, was recently published in its ninth edition and is widely used in North America and around the world.

Good science and accountable, effective application are interdependent. I have pursued this goal throughout my career and have contributed to refining the arguments and promoting the importance of psychological science in education, research, and application. As a clinician and clinical instructor, I appreciate the importance of application to the development of a relevant science. It is a serious mistake to discount the importance of applied experience. It is through their exposure to the complexities of applied work that innovators have the opportunity to discover phenomena and appreciate relationships that may go unnoticed by those less involved in the hurly-burly of the clinical arena. Different kinds of data and differing levels of information are obtained in the laboratory and in the applied setting. Each is necessary, useful, and desirable for the continuing development of a clinical psychology that can make empirical contributions to both science and application.

I am well aware of and sympathetic to the concerns and uncertainties that clinicians face in this era of managed care. A science-based clinical psychology is, to my mind, the best way to maintain psychology's unique role in the development and application of therapeutic interventions.

I will bring to the position of Division 12 President experience in a broad range of professional, educational, administrative, and scientific contexts; an ability and eagerness to work with others, including those with whom I may have differences of opinion; a willingness and ability to represent clinical psychology's interests within APA and in the public arena; and a strong commitment to preserve and enhance the position of clinical psychology as science-based application and application-relevant science.□

Division 12 Candidate Statements

PRESIDENT-ELECT

Irving B. Weiner, Ph.D., ABPP, ABAP

Irving B. Weiner received his Ph.D. in clinical psychology from the University of Michigan and began his professional career in the Department of Psychiatry at the University of Rochester. After becoming Professor of Psychiatry and Pediatrics and serving four years as Head of the Division of Psychology at the University of Rochester Medical Center, he went to Case Western Reserve University as Professor and Chair of the Department of Psychology. Following five years as Department Chair and three years as Dean of the School of Graduate Studies at Case Western Reserve, he served two 4-year terms as Vice President for Academic Affairs, first at the University of Denver and then at Fairleigh Dickinson University. In 1989 he returned full-time to psychology, as Professor of Psychiatry and Behavioral Medicine at the University of South Florida and Director of Psychological Services in the USF Psychiatry Center. He subsequently took early retirement from the USF faculty, remaining as a Clinical Professor, and entered the independent practice of clinical and forensic psychology. Dr. Weiner is an ABPP Diplomate in Clinical Psychology and in Forensic Psychology and an ABAP Diplomate in Assessment Psychology. He is a Fellow of Division 12, a Fellow of Divisions 5, 42, and 53, and a member of Divisions 39, 41, and 52. In Division 12 he has been on the Fellows Committee and for the past 2 years and has served on the Board of Directors as representative of Section 9 (Assessment Psychology) and as a member of the Finance Committee.

I believe that Division 12 should provide an attractive professional home for all clinical psychologists, whatever their theoretical orientation, whatever their specialized areas of interest and other division or organization memberships, and whether they identify themselves primarily as clinical scientists, scientist practitioners, or practitioner scholars. Under able leadership, we have been making progress toward this goal, and I seek the presidency of the division for an opportunity to sustain and accelerate this progress. I think that my administrative background and broad experience as an academician and practitioner in clinical psychology will help me do so effectively.

I have been a medical school psychology division head, an internship and postdoctoral training director, a psychology department chair, a university graduate dean and academic vice-president, and an independent practitioner. I have published books concerned with child and adolescent development, developmental and adult psychopathology, psychological assessment, psychotherapy, clinical methods, and forensic psychology.

Division 12 should be committed to advancing knowledge in the substantive areas of psychopathology, psychological assessment, and intervention and to pursuing constructive applications of this knowledge as a means of helping people of all ages and from diverse ethnic and sociocultural backgrounds who need and want our services. We share interests with other APA divisions that specialize in some of these purposes, but ours is the only division that attends to all of them and, by so doing, fosters integration and cross-fertilization among them. The theme of my presidency would be balanced and determined advocacy for the cornerstones of our concerns—science, practice, education and training, and public policy as they relate to all of clinical psychology.□

APA COUNCIL REPRESENTATIVE (General Slate)

Annette M. Brodsky, Ph.D.

Annette M. Brodsky, Ph.D. has been an APA member since 1971, and a fellow since 1978. She is Professor Emerita of the David Geffen School of Medicine at UCLA and former Chief Psychologist and Director of Psychology Training for the last 24 years at Harbor-UCLA Medical Center, a large public hospital serving indigent patients from Los Angeles County. Her Ph.D. in Clinical Psychology is from the University of Florida, and she interned at Walter Reed Army Hospital in 1963.

She brings experience as a professor from two APA accredited graduate programs (University of Alabama and Southern Illinois University) and as a researcher on clinical issues. Publications include

Psychotherapy of Women: Research and Practice (Edited with Rachel Hare-Mustin), and *Sex in the Therapy Hour* (co-authored with Carolyn Bates)

I would be honored to represent Division 12 on Council. I have served Division 12 and APA in many capacities over the last three decades and can address issues from the point of view of three sections and the Board of Directors, in addition to several committees and boards of APA. I am eager to apply my governance background and personal fortitude to the task of seeing that Clinical Psychology is in a leadership position in APA when discussions of future directions and the expenditures for them are decided by Council. Division 12 is the primary voice of the scientific and scholarly sectors of practitioners and training programs in APA. I relish the opportunity to represent Division 12 on Council.□

APA COUNCIL REPRESENTATIVE (General Slate)

Lawrence J. Siegel, Ph.D., ABPP

Larry Siegel is Dean and Professor at Ferkauf Graduate School of Psychology of Yeshiva University. He received his Ph.D. from Case Western Reserve University in 1975. He has been on the Clinical Psychology faculty at the University of Missouri, the University of Florida, and was Director of the Division of Pediatric Psychology at the University of Texas Medical Branch. He is a Fellow of Divisions 12, 37, 38, 53, and 54 of APA and he is a Diplomate (ABPP Clinical). He has published more than 100 articles and is the author or co-author of five books in the field. In addition, he has obtained numerous research and training grants. He serves on the Editorial Boards of a number of journals in clinical and child psychology.

For more than a decade he has provided active service to Division 12. He served as President of the Society of Pediatric Psychology (Section V) and was the Editor of the Newsletter Progress Notes. In addition, he has been the Editor of Division 12's The Clinical Psychologist. More recently, he served as chair of the Publications Committee, the Membership Committee, and the Division representative to CAPP. Finally, he has served as Chair of the Program Committee for Division 12.

As one of the largest Divisions of APA, Division 12 must work to establish a greater presence within the organization to influence its policies and agenda. Our Division has considerable potential to play a major role in helping APA respond to the challenges facing our profession as service providers, researchers, and educators. I am committed to ensuring that the governance and committee structure of APA reflects the diversity of our membership. I would be honored to serve as APA Council Representative and I am committed to promoting an agenda that furthers the mission of our Division.□

APA COUNCIL REPRESENTATIVE (General Slate)

Antonette M. Zeiss, Ph.D.

Antonette M. Zeiss is Clinical Coordinator and Director of Training, Psychology Service, VA Palo Alto Health Care System. Toni is a Fellow of Division 12 and Past-President of the Association for the Advancement of Behavior Therapy (1996-97) and of Division 12, Section II: Clinical Geropsychology (1999). She was a member of the APA Committee on Aging (2000-2003) and Chair in 2002. She serves on the Editorial Board of seven journals, including Clinical Psychology: Science and Practice. She is the current Program Chair for Division 12. Her professional interests include clinical geropsychology, interdisciplinary teams for health care delivery, and clinical supervision and training. She has received several awards related to her clinical training role, including being the first person to receive the APPIC Award for Excellence in Internship and Postdoctoral Training (2002).

As an active member of Division 12 for over 20 years, I have served as Program Chair for two Sections (II and III) and for the overall Division, and have been President of the Clinical Geropsychology Section (II). Division 12 plays a vital role within APA, as

home to members who are committed to clinical practice and to support for the development and utilization of a strong evidence base for provision of clinical services. It is important for this approach to be represented actively and thoughtfully in Council, in a way that is supportive of the challenges faced by practicing clinicians. My background in working with interdisciplinary teams would serve me well in that task. That experience has helped me to be an advocate for the role of psychology as an important provider in all health care settings, and it has helped me learn to articulate support for an evidence-based psychological approach while demonstrating respect for the concerns and ideas of health care providers working from diverse perspectives.□

APA COUNCIL REPRESENTATIVE (Ethnic Minority Slate)

Asuncion Miteria Austria, Ph.D.

Asuncion Miteria Austria is Professor, Chair, and Director of Clinical Training, Graduate Program in Clinical Psychology, Cardinal Stritch University. She received her Ph.D. in Clinical Psychology from Northwestern University; completed her internship at the Institute for Juvenile Research in Chicago; and postdoctoral fellowship at the Neuropsychiatric Institute, University of Illinois Medical Center. She has trained students in the scientist-practitioner model for over 25 years.

A Fellow of Divisions 12, 35, and 45, she has held leadership positions in Division 12 for over 20 years, including committees on Membership, Fellowship, and Nominations and Elections. She was chair and member of various division task forces; served as Section IV President, Newsletter Editor, Chair of the Awards, and Mentoring Award Committees. She was Treasurer of Section VI and recently completed her term as its Representative to the Division Board. She currently chairs the Division's APA Governance Committee. She served as Chair of the Committee on Ethnic Minority Affairs (CEMA), member of the Policy and Planning Board, and currently serves as member of the Board of Educational Affairs and Lead Consultant, including site visits, for the APA/NIGMS Project. She has received several awards including the Distinguished Humanitarian Award from the American Association of Applied and Preventive Psychology, and Outstanding and Unusual Contributions to the Clinical Psychology of Women from Section IV in 1993 and 2003.

I would be honored to bring my broad experience in governance as your Representative to Council. I am well informed of the mission and important challenges facing the Society of Clinical Psychology, including the tension between science and practice. With my extensive experience in APA and the Division for over two decades, and commitment to diversity issues for psychology as a science and profession, I can represent the values and varied interests of the Society. As my track record shows, I will work tirelessly for the interests of the Division.□

APA COUNCIL REPRESENTATIVE (Ethnic Minority Slate)

Barry A. Hong, Ph.D., ABPP

Barry A. Hong is Professor of Psychiatry and Vice-Chairman for Clinical Affairs in the Department of Psychiatry at Washington University School of Medicine in St. Louis. In addition, he holds appointments in Internal Medicine and Clinical Psychology. He received his Ph.D. in psychology from St. Louis University in 1978. He is a Fellow of Division 12 and a diplomate in clinical psychology (ABPP). He serves as the Chief Psychologist at Barnes-Jewish Hospital.

He has served as President of the Association of Medical School Psychologists, and he worked with other AMSP leaders to bring AMSP into Division 12. He served as a Section VIII representative to the Board of Division 12. He is an active medical psychologist, clinically working with patients with HIV, liver and renal disease. He has been an investigator and consultant to various federal agencies including the NIH, NIMH, NIDR, HRSA, CDC and Health and Welfare of Canada. Presently, he serves as an Associate Editor for the *Journal of Consulting and Clinical Psychology.*

I am honored to be nominated as a Council Representative from Division 12. I have been fortu-

nate to have served as a clinical psychologist during a historical period that witnessed the unparalleled growth of psychology in medical settings. I would like to make my experience available to the Council as APA enters a new era of change in health care settings. Clearly, there will be new opportunities to apply the science and practice of psychology to the health care of our nation, and I believe the Council of Representatives can play a lead role in helping the profession respond to these new opportunities.□

APA COUNCIL REPRESENTATIVE (Ethnic Minority Slate)

Helen Diann Pratt, Ph.D.

Helen Diann Pratt is Professor of Pediatrics and Human Development, Department of Pediatrics, College of Human Medicine at Michigan State University. She received her Ph.D. in Clinical Psychology from Western Michigan University, completed her internship at the Kalamazoo Regional Psychiatric Hospital, State of Michigan. She has been an active member of Division 12, Section VI since 1998 and had served in leadership positions including past-president, president, president-elect and secretary.

I am very interested in being an active participant in the governance of our Division. I began my involvement in APA at the Section level because it afforded me an opportunity to be mentored by outstanding psychologists who took a personal interest in helping the membership develop leadership skills. The time has come to broaden that experience and begin to become involved in the Division. I firmly believe that in order to ensure that issues of diversity and multiculturalism be addressed, the membership must be actively involved in the activities and governance of Division 12. Although my experience in leadership positions in the Division are limited, they are not limited in other areas of my professional and personal career. If elected, I promise to be a dedicated and effective Council Representative.□

SECRETARY

A. J Finch, Jr., Ph.D., ABPP

A. J Finch, Jr., Ph.D., ABPP is currently Dean of Humanities and Social Sciences at The Citadel. He obtained his doctorate at the University of Alabama and completed a Post-doctoral Fellowship at the Deveroux Foundation. He has been a fellow of Division 12 since 1983. He was formerly president of Section 1 (now Division 53) and the Clinical Board of the American Board of Professional Psychology (ABPP). Currently he is president of the Clinical Child and Adolescent Board of the ABPP, President Elect of the Board of Trustees of ABPP, President Elect of the Southeastern Psychological Association, and Chair of the Fellows Committee of Division 12.

I am honored to be nominated. I believe that I would bring a slightly different perspective to Division 12 which would help is serve the interests of the thousands of clinical psychologists. I am committed to quality in training, research and service and believe that Division 12 needs to focus on all three of these areas if it is going serve the many clinical interests of its members and potential members.

Enough said. I would ask for your support so that I can begin working to meet these needs.□

Division 12 Candidate Statements

SECRETARY

Michael A. Goldberg, Ph.D.

Michael A. Goldberg, Ph.D. is the Director of Child and Family Psychological Services, Inc., Scientific Associate Staff at Boston Children's Hospital and Instructor in Psychology at Harvard Medical School. He currently serves as a consultant for a NIMH funded depression prevention study and for Inflexxion's multimedia divorce adjustment intervention project. Michael's past Division 12 service includes: Treasurer, two terms as Post-doctoral Institutes Chairperson, Nominations Committee, and Founding Chairperson of the Task Force and Committee on APA Governance. Michael is the President-Elect of the Massachusetts Psychological Association. He has also chaired their Education Committee for four years and served a term on their Board of Directors. Division 12 recognized Michael with their 2002 Theodore Blau Early Career Award for outstanding contributions to the field of Clinical Psychology.

I am honored to been nominated and to have the possibility of returning to the governance of Division 12. The gap between science and practice has widened in recent years and building constructive bridges is essential. My election to board would foster this goal by diversifyng the division's leadership with regard to the science-practice continuum. I am a true scientist-practioner working everyday to integrate science into clinical and other applied areas. Likewise, as an early to mid career psychologist I would help the leadership better understand and respond to the needs of our earlier career colleagues. Along with knowledge of the division's mission and operations, I can bring more experience from the practice world to the division leadership and help fight the inertia often experienced in trying to close the gap between science and practice. I also have a strong commitment to integrating cultural, gender, and ethnic diversity concerns into the division's mission. I look forward to the opportunity of bringing my energy and experience back to Division 12's leadership and appreciate your support.□

SECRETARY

LINDA K. KNAUSS, Ph.D., ABPP

Linda K. Knauss received her doctorate in Clinical Psychology in 1981 from Temple University. She is Director of Internship Training and an Assistant Professor at Widener University. She is also a state and nationally certified school psychologist and has a private practice specializing in children, adolescents and families. She holds a diplomate in Clinical Psychology and is a Fellow of the Academy of Clinical Psychology. Currently she is the APA representative from Pennsylvania and a member of the Executive Committee of the APA Caucus of State, Provincial, and Territorial Representatives. She has held many leadership positions at the regional, state, and national levels including: President of Section IV of Division 12, Clinical Psychology of Women; Mentoring Award Chair of Section IV; Chair of the APA Child and Adolescent Caucus; President of the Pennsylvania Psychological Association, Pennsylvania Psychological Foundation, and Philadelphia Society of Clinical Psychologists.

Issues of importance to the Society of Clinical Psychology include legislative advocacy, increasing membership, and standards for clinical training. Many challenges face Clinical Psychology. Responding to the political and economic events of the time requires an aggressively proactive legislative agenda. We must continue to advocate for quality care for the public by encouraging innovative solutions to policies that adversely affect the delivery of psychological services. This includes encouraging more funding for research, providing job opportunities for new professionals, and meeting the mental health needs of children, families, and underserved populations. As a director of training and APA site visitor for many years, I am committed to high quality clinical training. I have been a conscientious recorder of events as the secretary of the Academic Affairs Committee and secretary of the faculty at Widener University. I would be honored to serve as secretary of the Society of Clinical Psychology.□

Putting on Blinders or Bifocals: Using the New Multicultural Guidelines for Education and Training

Leslie C. Jackson, Ph.D.
Georgia State University

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Clinical training programs are faced with an interesting dilemma in the twenty-first century. The issue is how to train an increasingly diverse student body, using a multicultural psychology curriculum, taught by a faculty that probably lacked multicultural preparation in their own clinical training. Consequently, some faculty may continue to have reservations about whether they can teach this material effectively. Additionally, some faculty may not have explored the own values around diversity issues, resulting in a color blind approach to material that is more complicated and that deserves a more sophisticated treatment. As a consequence, multicultural and diversity material continues to be experienced emotionally as territory to avoid, rather than a new intellectual landscape to explore. Even though there have been several advances in the field to make teaching diversity more user friendly, faculty continue to wonder if they are "doing it right," and faculty of color continue to take the lead in this area of training. The focus of this article is to provide a brief overview of strategies to show 1) how to use multicultural concepts in the classroom, 2) how diversity concepts affect clinical supervision and the mentoring of students, and 3) how learning processes may be enhanced by mentoring students from diverse cultural backgrounds.

To achieve multicultural competency goals, clinical psychologists can benefit from three important advancements in psychology. First, the newest edition of the APA's Ethics Code (American Psychological Association, 2002a) outlines specific guidelines for working with diverse populations. The new guidelines outline psychologists' awareness and training needs for working with ethnic and other diverse populations. The onus is then on faculty to prepare the next generation of psychologists to better serve diverse populations. Often training in issues related to diversity is left for clinical supervisors, because little attention to these issues is given in the classroom. Faculty have to confront their own fears and apprehension around awareness issues and help students find safe environments to discuss their fears and apprehension about working with diverse clients (Jackson, 1999). Using politically correct strategies (e.g., the "color blind" approach), focusing only on material that is personally comfortable, and avoiding discussing assigned articles or chapters that cover diversity content will only increase student anxiety when faced with diverse clients. These tactics also make it difficult for students to feel comfortable bringing up their own personal fears and concerns about cultural competency. Faculty can create an environment where students can discuss these issues since they are on the front lines working with diverse clients in various clinical settings. Faculty should also be prepared to confront those students whom fail to see diversity training as useful to their clinical careers or training experience (Thomas, 2003).

The second major advancement is the requirement by the APA Committee on Accreditation (American Psychological Association, 2002b) that clinical psychology programs produce data from their respective programs to show how they have included diversity in their curriculum and training process. This requirement has been helped by the prolific publications by psychologists of color and non-minority psychologists who have contributed to the multicultural data base and program evaluation of diversity initiatives within doctoral level training programs (Bluestone, Stokes, & Kuba, 1996; Carlson, Brack, Laygo, Cohen, & Kirkscey, 1998; Steward, Wright, Jackson, & Han, 1998; Yutrzenka, 1995.) Publishers and authors are recognizing the value of including diversity issues in both undergraduate and graduate textbooks. This greatly

helps psychologists to bridge the gap in their preparation of courses and to educate themselves regarding multicultural issues. Faculty can no longer avoid discussing multicultural issues by referring to the lack of research in this area.

The third major advancement was the approval and publication of the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists by the American Psychological Association (2002c). The guideline can serve as a primer for those faculty in clinical departments who are either unsure what the relevant issues are or where to get needed information. The publication does not indicate how to translate these guidelines into practical steps for classroom teaching and clinical supervision, but it does highlight areas of concern as well as goals to increase one's level of cultural competence. The remainder this article will attempt to offer suggestions on ways to bring diversity and multicultural concepts into graduate clinical training, as encouraged by APA's (2000c) Guideline #3: *As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.*

"A multiethnic faculty/ student teaching team can help students taking the course to express their feelings and self-disclose during class discussion."

Institutional Models of Training

Some suggest that inclusion of multicultural concepts in the classroom can detract from a psychological perspective. Bringing diversity issues into the classroom has often been viewed as coming from a historical or political perspective and lacking in scholarship. Another obstacle to teaching diversity content is faculty members who are not comfortable with their own awareness, knowledge, and skills with respect to multicultural material. Even though many clinical programs attempted to meet the mandates from APA, some programs continue to struggle with how to improve training in this area. Jones-Hudson (2003) indicates that the systemic obstacle in many programs is the lack of awareness "of the ways in which the dominant culture has shaped their notions of scholarship and pedagogy" (p. 315). This "white privilege" is often omitted as a topic of inquire in diversity courses and it is at the root of most organizational resistance. Thus, the educational system we rely on to teach diversity to graduate students has to challenge the systemic beliefs about what constitutes appropriate training. Departments and programs need mechanisms in place to reward faculty for creating the structure and programming to achieve multicultural education and training.

Although most clinical programs are striving to meet the goals set forward by APA, more needs to be done to evaluate the effectiveness of curricula in this area. The requirement that diversity material be included in all courses is rarely evaluated beyond looking for references on faculty syllabi. Holding subject area training meetings where new and experienced faculty can share and discuss how to use diversity material in the classroom is one way to assure that material is covered in an appropriate fashion. This should not be an additional responsibility just for the minority faculty member. If necessary, consultants and experts from the community should be periodically invited to lead training discussions.

Clinical programs can also share the responsibility of training students by creating training teams to teach diversity courses. Making it a requirement to teach the diversity course in teams can become a model for training additional faculty. It can also serve the purpose of shifting the responsibility of the course to the department rather than a particular faculty member (typically a member of an ethnic minority group). This creates system support for diversity training and communicates to students that diversity is an important part of the curriculum and not just an interest of one or two faculty members. This rotation system can be a very effective training method. It also creates a potential evaluation team of faculty who have taught the diversity courses and other courses that include diversity material. To be successful, the process needs to occur in the context of a collaborative atmosphere, rather than a competitive one. This approach also helps to educate faculty about the diversity course and to become aware of their own strengths and limitations within a supportive training environment.

Another important strategy is to have diversity committees within departments serve as both a resource and a way to communicate to administration departmental needs concerning curriculum

development, staffing, and training needs. Another important and successful strategy for teaching a diversity course in graduate programs is to have students who have taken the course serve as teaching assistants for the course. A multiethnic faculty/student teaching team can help students taking the course to express their feelings and self-disclose during class discussion. The students can co-lead group exercises in class and become student members of an evaluation team.

Colloquium speakers with expertise in research with various diverse populations and or diversity issues can be invited to speak and can also work with the department on curriculum development in this area. Students and faculty should be rewarded and encouraged to develop evaluation teams to collect data on the effectiveness of the diversity training within their program. This strategy creates an opportunity for departments to develop a culture of inconclusiveness and also an opportunity to discuss what changes are expected and how to measure those changes (e.g., what are the expected outcomes from this training?). Many clinical programs include diversity questions on their oral exams or qualifying exams with the expectation that students acquire, improve, or change their awareness, knowledge and skills within the program. Clinical programs can also evaluate whether students in all ethnic groups are having experiences with diverse populations. Are more students who are conducting research with diverse populations or developing their own research with diverse populations adequately supported and recognized? Has the department established linkages within the university community and the broader community to increase its expertise on multicultural issues and to create opportunities for faculty and students to interact with populations where the power differences are challenged and discussed?

"...unfortunately too many programs continue to rely on the single multicultural course to satisfy the training needs of students."

Clinical Training and the Supervision Process

It is just as easy to require students to discuss and understand how historical and cultural context influences diagnosis and psychopathology across cultures as it is to only discuss race, ethnicity and social class. The latter three variables are traditionally emphasized when discussing cultural and diversity issues and they are often not be presented in a context that is useful for students (e.g., translating these issues into effective clinical interventions). Strategies to help faculty integrate this material into coursework have been identified by many (Davis-Russell, Bascuas, Duran, & Forbes, 1991; Homma-True, Green, Lopez, & Trimble, 1993; Mio & Morris, 1990; Sue, 1991; Sue & Zane, 1987). But, unfortunately too many programs continue to rely on the single multicultural course to satisfy the training needs of students.

This traditional model of teaching cultural content (usually knowledge and awareness, or knowledge and skills) fails to help students to see multicultural issues in an integrative context. Consequently, these issues remain marginalized by those unfamiliar with diversity issues in general and they risk being seen as personal and emotional instead of academic and scientific matters. Davis-Russell (2003) discussed the attractiveness of a "separate course model" as an alternative to an "integrative model" in clinical programs "because it ensures coverage of ethnic minority content without requiring a total program evaluation or overhaul in this area" p. 340.

Over the years many models of training have been put forth to help clinical programs to reach the goals put forth by APA's accrediting body. All of these models for diversity training express the importance of administrative support, increased faculty and student diversity, integration diversity content into the total curriculum (including clinical practica), and a program evaluation component (Bluestone, Stokes, & Kuba, 1996; Davis-Russell, 2003; Jones-Hudson, 2003; La Roche & Maxie, 2003; Sue, 1991).

Multicultural training ideally will help students to understand the differences between culture, ethnicity, and a host of other diversity variables (e.g., age, gender, sexual orientation, social economic status, etc.), and how to assess individual differences within groups that differ with respect to these variables. Students from the dominant culture, as well as students of color, need guidance and support as they negotiate values, belief systems, and experiences that are different, and can be guided to appreciate the difference between accurate appraisals and stereotyping.

In clinical supervision, students' color blind-

ness and denial of difference can be understood as avoidance of uncomfortable feelings or as a way to avoid confronting a lack of knowledge about a particular group. Allowing students to present clinical cases without recognizing the importance of demographics reinforces this color blind defensive stance. It is important to understand how being a gay or lesbian, a person of color, a bi-racial individual, or a person in another diverse category influences the client's clinical presentation. Students need to be taught to assess whether the client's status (context) is salient to the client's clinical needs. Diversity and multicultural content may or may not influence the client's clinical concerns, but it should not be assumed that it does not. Students need to feel comfortable discussing issues around culture, class, race, ethnicity, gender, and sexual orientation with their clients and supervisors. Supervisors need to be open to having these discussions with their supervisees.

"...today there are more senior supervisors of color than there have been in the past..."

Experts in the area of integrating multicultural issues into the supervision process have identified the barriers to effective supervision of students. An empirical study by Steward, Wright, Jackson, and Han (1998) on the relationship between multicultural counseling training and cultural sensitivity of counselors found support for this training as beneficial for both trainees and supervisors. One barrier to effective cultural sensitivity identified in the study was the tendency of White supervisors with limited multicultural training to give their trainee's lower evaluations when these students focused on race as an issue for minority clients. This obviously discourages students from bringing these issues into supervision.

In a case study of barriers to cross-cultural supervision, Leong and Wagner (1994; as cited in Daniels, D'Andrea, & Kyung Kim, 1999) noted two common problems with supervisors and their students: they either did not discuss how multicultural issues affect the supervision dyad, or they over evaluated the importance of these issues in supervision. Daniels et al. (1999) stressed the importance of discussing possible cultural differences between the supervisor and supervisee and exploring openly how these differences may negatively affect the supervision relationship.

The issue of racial matching in supervision is an important area of research because today there are more senior supervisors of color than there have been in the past (Owens-Patterson, 2000). Thus, there is a higher potential for students to be in cross-racial and cross-cultural supervision dyads as a part of their clinical training experience. Owens-Patterson (2000) analyzed the supervision relationship when the supervisor was an African American. Her observations were that this changes the power differential and shatters the traditional notions of power when the race of the supervisor in the relationship has shifted. She states this can either, ". . . perpetuate the status quo or elicit greater intensity in these relationships" (Owens-Patterson, 2000, p. 147). Her analysis of the transference and countertransference issues in both matched and unmatched supervision dyads with an African American supervisor illustrates how these issues are both identified and effectively addressed to further the development of multicultural competence in supervision with diverse clients and supervisees.

Mentoring Students and Students of Color

What is the role of mentoring in clinical psychology programs? Very little empirical research on mentoring exists for clinical training programs. Clark, Harden, and Johnson (2000) surveyed 800 recent graduates of clinical psychology programs on their mentoring relationship with graduate students. They found that student initiated mentor relationships were most effective in creating satisfactory relationships between faculty and graduate students regardless of the gender of the mentor. They also noted that one third of the graduates had not been mentored through their programs. The Clark et. al. (2000) study raises questions about the need for students to have requisite assertiveness to secure a mentor and the necessity for departments to foster mentoring in the departmental culture. A review of the literature on effective mentoring relationships for women identified three relationship variables to be helpful in educational settings: psychosocial support, role modeling, and professional development (Blackwell, 1989; Jacobi, 1991; both as cited in Bruce, 1995). Mentoring students of color in graduate programs has received little attention in the literature. Brown, Davis, and McClendon (1999) examined the art of mentoring graduate students of color in educational programs. They concluded that academic

institutions need to address how the institutional culture affects students of color as they traverse through graduate programs.

Students can be taught the ethical responsibility they have to value diversity and multicultural issues for all groups and categories of difference. But without an organized plan by the faculty to integrate these issues into training, the responsibility will often fall on the shoulders of the few women and minorities to teach this material to students. Students need encouragement to push themselves into their uncomfortable zones around multicultural issues with support from faculty mentors. Faculty need to encourage students of color to see themselves as stakeholders in this learning and discovery process (Jackson, 1999). Too often, the message is given to students of color is that they have nothing new to learn because of their group membership, or their experience is devalued and they are not allowed to discuss this as a diversity issue within either their mentor relationship or the classroom.

Departments that encourage, support, and model inclusiveness based on shared power and resources, will find that their students will join with faculty to explore multicultural issues. This is especially true in clinical departments with both a critical number of both students of color or students interested in working with diverse populations and faculty who are able to articulate these issues effectively and openly. A strong mentoring program that encourages diversity in research teams with diverse faculty will help to avoid factionalism within the department and student population. This is not easy work to do and many people are wary of approaching these topics. What is needed is an approach that is embedded in the context of relationship building and mutual respect of learning.□

References

American Psychological Association. (2002a). *Ethical principles and code of conduct*. Washington, DC: Author.

American Psychological Association. (2002b). *Guidelines and principles for accreditation*. Washington, D.C: Author.

American Psychological Association (2002c). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, D.C.: Author.

Bluestone, H. H., Stokes, A., & Kuba, S. (1996). Toward an integrated program design: Evaluating the status of diversity training in a graduate school curriculum. *Professional Psychology: Research and Practice, 27*, 394-400.

Brown II, M. C., Davis, G. L., & McClendon, S. A. (1999). Mentoring graduate students of color: Myths, models, and modes. [Electronic version]. PJE: *Peabody Journal of Education, 74*, p. 105. Retrieved, February 18, 2003.

Bruce, M.A. (1995). Mentoring women doctoral students: What counselor educators and supervisors can do. [Electronic version]. *Counselor Education and Supervision, 35*, 139-150.

Carlson, M. H., Brack, C. J., Laygo, R., Cohen, R. & Kirkscey, M. (1998). The exploratory study of multicultural competence of counselors in training: Support for experiential skills building. *The Clinical Supervisor, 17*, 75-87.

Clark, R. A., Harden, S. L., & Johnson, W. B. (2000). Mentor relationships in clinical psychology doctoral training: Results of a national survey. [Electronic version]. *Teaching Psychology, 27*, p. 262. Retrieved, February 18, 2003.

Daniels, J., D'Andrea, M. & Kyung Him, B.S. (1999). Assessing the barriers and changes of cross-cultural supervision: A case study [Electronic version]. *Counselor Education and Supervision, 38*, 191-205. Retrieved, September 23, 2003.

Davis-Russell, E. (2003). Integrating multicultural issues into graduate clinical psychology training. In P. Bronstein & K. Quina (Eds.), *Teaching gender and multicultural awareness: Resources for the psychology classroom* (pp. 339-346). Washington, D.C: American Psychological Association.

Davis-Russell, E., Bascuas, J., & Duran, E., Forbes, W. T. (1991). Ethnic diversity and the core curriculum. In R. L. Peterson, J. D. McHolland, R. J. Bent, E. Davis-Russell, G, E. Edwall, K. Polite, D. L. Singer, & G. Stricker (Eds.), *The core curriculum in professional psychology* (pp. 147-151). Washington, D.C: American Psychological Association.

Homma-True, R., Greene, B., Lopez, S., & Trimble, J. E. (1993). Ethnocultural diversity in clinical psychology. *The Clinical Psychologist, 46*, 50-63.

Jackson, L. C. (1999). Ethnocultural resistance to multicultural training: Students and faculty. *Cultural Diversity and Ethnic Minority Psychology, 5*, 27-36.

Jones-Hudson, V. D. (2003). Building a multicultural community: One department's transformation. In P. Bronstein & K. Quina (Eds.), *Teaching Gender and Multicultural Awareness: Resources for the Psychology Classroom* (pp. 315-323). Washington, DC: American Psychological Association.

La Roche, M. J. & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice, 34*, 180-186.

Mio, J. S., & Morris, D. R. (1990). Cross-cultural issues in psychology training programs: An invitation for discussion. *Professional Psychology: Research and Practice, 21*, 434-441.

Owens-Patterson, M. (2000). The African American supervisor: Racial transference and countertransference in interracial psychotherapy supervision. In L.C. Jackson & B. Greene (Eds.), *Psychotherapy with African American women* (pp. 145-165). New York: Guilford.

Steward, R. J., Wright, D. J., Wright, D. J., Jackson, J. D., & Han I. J. (1998). The relationship between multicultural counseling training and the evaluation of culturally sensitive and culturally insensitive counselors [Electronic version]. *Journal of Multicultural Counseling and Development, 26*. Retrieved, September 23, 2003.

Sue, D. W. (1991). A model for cultural diversity training. *Journal of Counseling and Development, 70*, 99-105.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42*, 37-45.

Thomas, J. (2003, September/October). Diversity, multicultural issues top APA agenda. *The National Psychologist*.

Yutrzenka, B. A. (1995). Making a case for training in ethnic and cultural diversity in increasing treatment efficacy. *Journal of Consulting and Clinical Psychology, 63,* 197-206.

CALL FOR NOMINATIONS

The American Psychological Foundation Theodore Millon Award

The American Psychological Foundation (APF) Theodore Millon, Ph.D. Award will be conferred annually (from 2004 through 2008) to an outstanding mid-career psychologist (doctoral degree received between 8 and 15 years ago), engaged in advancing the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. A scientific review panel appointed by Division 12 of the American Psychological Association will select the recipient upon approval of the APF Trustees. The winner will receive $1,000 and a plaque, to be presented at the 2005 APA convention in Washington, DC.

Nominations should include a cover letter outlining the nominee's contributions to the science of personality psychology in one or more of the following areas: personology, personality theory, personality disorders and personality measurement. Nomination materials should include an abbreviated curriculum vitae and up to two support letters. Self-nominations are welcome. APF and Div. 12 will notify the recipient after Feb. 10, 2005.

Nominations should be sent to:
Nadine Kaslow, Ph.D.
Chair, Division 12 Awards Committee
P.O. Box 1082
Niwot, CO 80544-1082

Deadline (for the 2005 award year): Dec 1, 2004

CALL FOR NOMINATIONS

Three Awards for Distinguished Contributions in Clinical Psychology

Distinguished Scientific Contribution Award
This award honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology.

Florence Halpern Award for Distinguished Professional Contributions
This award honors psychologists who have made distinguished theoretical or empirical advances in psychology leading to the understanding or amelioration of important practical problems.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology
This award shall be given to a psychologist who has made remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind. Other contributions may be broadly conceived as advancing knowledge through research; developing innovative approaches to service delivery, teaching or consultation; or providing mentoring and active promotions of people of color.

Two Awards for Early Career Contributions in Clinical Psychology

David Shakow Award for Early Career Contributions
This award shall be given for contributions to the science and practice of Clinical Psychology. The awardee will be a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to the science and to the practice of Clinical Psychology.

Theodore H. Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology
This award will be given to a Clinical Psychologist who has made an outstanding contribution to the profession of Clinical Psychology. Outstanding contributions are broadly conceived as promoting the practice of Clinical Psychology through professional service, innovation in service delivery, novel application of applied research methodologies to professional practice, positive impact on health delivery systems, development of creative educational programs for practice, or other novel or creative activities advancing the profession. Given the difficulty of making such contributions very early in one's career, the award will be given to a person who is within the first 10 years of receiving his or her doctorate. This award is made possible through the sponsorship of Psychological Assessment Resources, Inc.

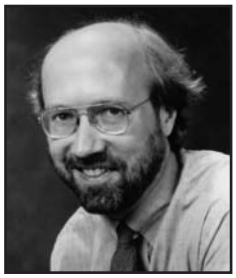
To nominate someone for any of these five awards, send nominee's name, recent vita, and a concise (1-2 page) typewritten summary of his/her achievements and contributions to:

Nadine Kaslow, Ph.D., Chair
2005 Awards Committee
c/o Division 12 Central Office
P.O. Box 1082
Niwot, CO 80544-1082

Deadline: October 1, 2004

The awards will be presented at the 2005 APA Convention in Washington, DC.

Looking Ahead to DSM-V



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The fourth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994) was published about ten years ago. The stage is now being set for the fifth edition. Nobody at this point can say for certain when it will be published or what changes will occur. The task force and work groups have not been formed; nor even has the chair been selected.

Using a linear regression analysis, Blashfield and Fuller (1996) predicted that DSM-V would be published in 2007 (1998 when they used a logarithmic analysis), would include 390 diagnoses and 11 appendices, would be chaired by Gary Tucker, and would be published with a brown cover. My own clinical prediction is that the task force will begin meeting in 2006-2007, with DSM-V being published in 2010-2011 with a gray cover.

Preparatory work has begun. In 1999, a conference jointly sponsored by the National Institute of Mental Health (NIMH) and the APA was held to identify research that would be most informative for the authors of DSM-V (McQueen, 2000). Research planning work groups were formed, the result of which was a series of papers edited by Kupfer, First, and Regier (2002). The next step will be a series of international conferences that will each focus on a particular issue, many of which follow from the recommendations of the DSM-V Research Planning Work Groups (Kupfer et al., 2002). International collaboration is important in part because the development of DSM-V is likely to be coordinated fully with the construction of the next edition of the International Classification of Diseases.

I will highlight here some of the issues that might be tackled by the authors of DSM-V. It is difficult to anticipate all of the significant issues that will be addressed or will arise in the course of the development of DSM-V. There will probably be hundreds of issues that will need to be addressed, every one of them having considerable importance. I will highlight here cross-cutting issues that surfaced in the course of the NIMH and APA Research Planning Workgroups, presented in the context of my own perceptions and opinions.

Definition of Mental Disorder

Spitzer and Endicott (1978) conceptualized a mental disorder as "a medical disorder whose manifestations are primarily signs or symptoms of a psychological (behavioral) nature, or if physical, can be understood only using psychological concepts" (p. 18). They provided a more specific, 280-word operational definition, a revised version of which was used in subsequent editions of the manual. The authors of DSM-IV were not entirely satisfied with this operational definition but were skeptical that a sufficient improvement would likely emerge (Frances, Widiger, & Sabshin, 1991). Wakefield (1992), however, subsequently provided quite thorough and compelling critiques of the Spitzer and Endicott (1998) and DSM-IV (APA, 1994) definitions of mental disorder, and offered as an alternative his elegantly succinct "harmful dysfunction" conceptualization. Wakefield's definition has drawn considerable attention (Clark, 1999), including even the endorsement by Spitzer (1999).

As expressed by the DSM-V Researching Planning Nomenclature Work Group, "the most contentious issue is whether disease, illness, and disorder are scientific biomedical terms or are sociopolitical terms that necessarily involve a value judgment" (Rounsaville et al., 2002, p. 3). Wakefield's (1992) definition is innovative in part because it accepts that a definition of mental disorder includes a value judgment. Wakefield's definition has been applauded by persons who have been critical of mental disorder diagnoses because harmful dysfunction implies to them an admission that the concept is fundamentally an arbitrary moral judgment relative to local social-cultural values. However, this is perhaps a misunderstanding of the value component. The value judgment that is inherent to the general concept of mental disorder is comparable to the value judgment that is inherent to the concept of a physical disorder (Widiger, 2002). The value judgment provides the premise for the concept; it does not necessarily imply that the concept is fundamentally flawed or biased in its specific formulation.

It would be difficult to imagine a species surviving that placed no value on physical health; the same could be said for a society or tribe that placed no value on psychological health. Inherent to any concept of psychological or physical health is the value judgment that health is desirable, but the value

one places on health might itself have a strong sociobiological foundation. However, determining what constitutes optimal or healthy psychological functioning is exceedingly difficult in part because this decision must consider the (healthy and unhealthy) social and cultural context in which the person is functioning, and this consideration will be susceptible to social and cultural biases (Kirmayer, Young, & Hayton, 1995), but the most accurate and effective determination of what specifically constitutes healthy psychological functioning need not be an arbitrary value judgment (Widiger, 2002).

However, missing from Wakefield's (1992) definition of mental disorder is any reference to dyscontrol. Harm within Wakefield's conceptualization is concerned with the presence of impairment; dysfunction with the presence of pathology. Mental disorders, however, are perhaps better understood as dys-controlled impairments in psychological functioning. "Involuntary impairment remains the key inference" (Klein, 1999, p. 424). Dyscontrol is one of the fundamental features of mental disorder emphasized in the "significant restriction" (Bergner, 1997) and "dyscontrolled maladaptivity" (Widiger & Sankis, 2000; Widiger & Trull, 1991) definitions of mental disorder.

"...the most accurate and effective determination of what specifically constitutes healthy psychological functioning need not be an arbitrary value judgment..."

Fundamental to the concept of a mental disorder is the presence of impairments to feelings, thoughts, or behaviors over which a normal (healthy) person is believed to have adequate control (Widiger & Sankis, 2000). To the extent that a person willfully, intentionally, freely, or voluntarily engages in harmful sexual acts, drug usage, gambling, or child abuse, the person would not be considered to have a mental disorder. Persons seek professional intervention in large part to obtain the insights, techniques, skills, or other tools (e.g., medications) that increase their ability to better control their mood, thoughts, or behavior. In sum, impairment and dyscontrol might provide the optimal means with which to identify a meaningful boundary between, or an important parameter for quantifying, normal and abnormal psychological functioning, if these constructs can be more precisely defined, calibrated, and assessed.

Dimensional Versus Categorical Models of Classification

"In the last 20 years, the categorical approach has been increasingly questioned as evidence has accumulated that the so-called categorical disorders like major depressive disorder and anxiety disorders, and schizophrenia and bipolar disorder seem to merge imperceptibly both into one another and into normality . . . with no demonstrable natural boundaries" (First, 2003, p. 661). The DSM-V Research Planning Nomenclature Work Group concluded that it will be "important that consideration be given to advantages and disadvantages of basing part or all of DSM-V on dimensions rather than categories" (Rounsaville et al., 2002, p. 12). Mental disorders appear to be the result of a complex interaction of an array of biological factors and environmental, psychosocial events (Rutter, 2003). Even schizophrenia might not be adequately characterized as a categorically distinct condition (Appelbaum, Robbins, & Roth, 1999; Tsuang, Stone, & Faraone, 2000). "A dimensional view of schizophrenia is especially consistent with multigene models of inheritance, and these models provide the best account of the familial transmission of schizophrenia" (Tsuang et al., 2000, p. 1043).

It might be unrealistic to expect the maladaptive cognitions, affects, and behaviors that constitute any particular mental disorder to have a single, specific etiology (Widiger & Coker, 2003). There are physiological and environmental determinants worth identifying, but in order for there to be a meaningful categorical diagnosis, a determinant would have to have provided a uniquely strong contribution to its etiology (Meehl, 1977) and, equally important, the pathology would have to have been largely resilient to the influence of other genetic and environmental influences (Widiger & Sankis, 2000). The symptoms and pathologies of mental disorders appear to be, in contrast, highly responsive to a variety of neurochemical, interpersonal, cognitive, and other mediating and moderating variables that have helped to develop, shape, and form a particular individual's psychopathology (Appelbaum et al., 1999; Rutter, 2003; Tsuang et al., 2000; Widiger & Clark, 2000).

A model for the future might be provided by one of the better established diagnoses, mental retardation (Widiger & Clark, 2000). Its point of demarcation is an arbitrary, quantitative distinction along the normally distributed levels of multifactorially defined intelligence. This point of demarcation is

arbitrary in the sense that it does not carve nature at a discrete joint, but it was not randomly or mindlessly chosen. It is a well-reasoned and defensible selection that was informed by the impairments in functioning commonly associated with different levels of intelligence. There are persons below an IQ of 70 who have a qualitatively distinct disorder, but this disorder is not mental retardation, it is a physical disorder (e.g., Down syndrome) that can be traced to specific biological event (i.e., trisomy 21). Intelligence is itself distributed as a multifactorial, continuous variable, as most persons' level of intelligence, including many of those with mental retardation, is the result of a complex interaction of multiple genetic, fetal and infant development, and environmental influences. There are no discrete breaks in the distribution of intelligence that would provide an absolute distinction between a normal and abnormal (pathological) level.

The diagnosis of anxiety, sleep, sexual, substance, mood, psychotic, personality, and other mental disorders should perhaps follow the model provided by mental retardation (Widiger & Coker, 2003). Widiger, Costa, and McCrae (2002), for example, propose a four step procedure for the diagnosis of personality disorders. The first step is to obtain a multifactorial description of an individual's general personality functioning, thereby providing a reasonably comprehensive description of adaptive as well as maladaptive personality traits (comparable to a multifactorial description of intellectual functioning). The second step is to identify social and occupational impairments and distress associated with the individual's characteristic personality traits. The third

A Message from: Sharon Rae Jenkins–President, The Clinical Psychology of Women

Presidential Initiative: Gender, Culture, and Clinical Assessment

I invite you to participate in our section's examination of intersections among gender, culture, and clinical assessment practice. This initiative will bring together issues central to three of Division 12's Sections by evaluating the current status of clinical assessment practice with women and men as it is affected by the social construction of gender in the context of specific cultures (including mainstream U.S. Anglo-dominant culture). Historically, Section IV has examined gender issues in diagnosis, but I know of no comparable attention given to assessment.

Section IV's program at APA in Hawai'i includes an invited symposium and a presidential address:

Invited Presidential Symposium: "Gender, Culture, and Clinical Assessment: Celebrating Best Practices"

Chair and Discussant: Sharon Rae Jenkins, Ph.D., University of North Texas

1. Culturally Proficient Assessment with Ethnic Minorities, Lisa A. P. Sánchez-Johnsen, Ph.D. and Israel Cuellar, Ph.D., University of Hawai'i, Manoa
2. The Relevance of Ethnicity, Language and Gender in Clinical Assessments, Julia Ramos Grenier, Ph.D., Grenier Consulting Associates
3. Overlooked and Underserved: Women with Head Injuries, Martha Banks, Ph.D. and Rosalie Ackerman, Ph.D., ABackans Diversified Computer Processing, Inc.
4. Assessing Latinos/as: Perils and Best Practices in Using the MMPI-2, Maria Garrido, Psy.D., University of Rhode Island
5. Black Women and Depression: Cultural Assessment of Signs and Symptoms, BraVada Garrett-Akinsanya, Ph.D., L.P., Brakins Consulting & Psychological Services
6. Finding Culture in African-American Adult Assessment: Lessons from the SCID, Rosa Thomas Lawrence, Ph.D., Steven J. Trierweiler, Ph.D., and James S. Jackson, Ph.D., Program for Research on Black Americans, Research Center for Group Dynamics, Institute for Social Research
7. Assessment of Mentoring Relationships, Belle Liang, Ph.D., Boston College, and Allison Tracy, Wellesley College Center for Research on Women

Presidential Address: "Gender, Culture, and Clinical Assessment: Individual Evaluation and Social Systems"

Chair: Mae Billet-Ziskin, Ph.D., independent practice, Los Angeles
Participant: Sharon Rae Jenkins, Ph.D., University of North Texas

The scope of the issues includes, but is not limited to:

A. General clinical issues that bear on assessment, such as:
- Current status in clinical practice of constructs related to gender and culture
- Culture as a context shaping gender-related social roles and socialization processes
- Normative social responses to gender role atypicality within specific cultural systems

B. Core issues specific to the role of culture and gender in assessment, such as:
- How referral questions are framed
- Choice of assessment approaches
- Design and validation of assessment tools
- Interpretation of findings and resulting recommendations
- Institutionalized assessment practices shaped by assumptions about client

If you are interested in participating, please contact me describing your preferred focus. I am particularly interested in work that helps to define the issues, at the level of the "big picture" or the specific anecdote, best practices or lessons learned, and anywhere else that important information can be found. I can be reached by email at jenkinss@unt.edu, and at 940-565-4107 most afternoons after 3:30 Texas time.

step is to determine whether the dysfunction and distress reach a clinically significant level of impairment (Regier & Narrow, 2002). The fourth step is a quantitative matching of the individual's personality profile to prototypic profiles of diagnostic constructs. This last step is provided for clinicians and researchers who wish to continue to provide single diagnostic labels to characterize a person's personality profile. However, prototypic profiles will be quite rare within clinical practice and the matching will serve largely to indicate the extent to which any particular diagnostic category fails to be adequately descriptive.

Should Clinical Utility Play a Role in Determining DSM-V Categories?

The authors of each revision to the APA diagnostic manual have been concerned primarily with reliability and validity (Spitzer, Williams, & Skodol, 1980). This emphasis has been appropriate, as editions of the manual prior to DSM-III were notoriously suspect with respect to both validity and reliability and a diagnostic manual with no validity will have no clinical utility.

"No diagnostic manual can be atheoretical or entirely neutral."

The authors of DSM-IV attempted to increase attention given to matters of utility, as it was apparent that an emphasis on the concerns and interests of researchers were not always consistent with the concerns and interests of the practicing clinician (Frances, Widiger, & Pincus, 1989). This consideration is likely to be increased further for DSM-V. First et al. (in press) suggest that systematic attention should be given to the impact of proposed revisions on clinical practice. For example, it is apparent that many of the lengthy criterion sets are too cumbersome for use in clinical practice (Frances et al., 1989). First et al. also suggest that the authors of DSM-V survey users' reactions to proposed revisions, assess the acceptability of the proposals in the context of actual pilot applications, and measure objectively the impact of the proposed changes on ease of usage.

There is no question that clinical utility warrants more consideration. A manual that cannot be used effectively by a clinician could be as useless as an invalid diagnostic manual. On the other hand, it is unclear how much weight should be given to ease of use or clinician receptivity, relative to reliability and validity. For example, it is unclear where the problem lies if clinicians lack sufficient time or resources to provide the systematic and comprehensive assessments that might be necessary to provide reliable and valid diagnoses. In addition, it is evident that some of the concerns of clinicians are driven by financial pressures that complicate their ability to provide effective clinical treatment. For example, the Assembly of the APA has passed resolutions to explore proposals to change the name of borderline personality disorder and to move personality disorders to Axis I. It is apparent that the motivation for these resolutions has been, at least in part, the frustration clinicians experience obtaining reimbursement for the treatment of personality disorders (Widiger, 2003). It is unclear to what extent treatment reimbursement decisions should impact the construction of the diagnostic manual.

Should DSM-V Aspire to be Atheoretical?

One of the intentions of the authors of DSM-III was to have the diagnostic manual be atheoretical, or at least be reasonably neutral with respect to alternative models of psychopathology (Spitzer et al., 1980). The diagnostic manual is used by clinicians and researchers from a wide variety of theoretical perspectives (Frances et al., 1989) and it does appear that it has been reasonably effective in providing a common language of communication (Wakefield, 1998). Nevertheless, each theoretical perspective finds the manual to be at least somewhat cumbersome and problematic. As expressed by the DSM-V Research Planning Neuroscience Work Group, "although there is a large body of research that indicates that a neurobiological basis for most mental disorders, the DSM definitions are virtually devoid of biology" (Charney et al., 2002, pp. 31-32). As expressed by a more psychoanalytically-oriented clinician, "as the succeeding editions of the [DSM] have become increasingly objective, descriptive, and putatively atheoretical, they have inevitably minimized the subjective and inferential aspects of diagnosis on which most clinicians actually depend" (McWilliams, 1999, p. 1).

The optimal solution to these concerns is unclear. No diagnostic manual can be atheoretical or entirely neutral. Some therefore suggest that DSM-V abandon its theory-neutral aspirations. As expressed by the DSM-V Research Planning Neuroscience Work Group, "questions have been raised by many critics (McHugh, 2001) that the DSM's descriptive approach may have outlived its usefulness and is in fact potentially misleading" (Charney et al., 2002, p. 31). The trend does appear to be toward a neurobiological perspective. An appendix was added to DSM-IV for defense mechanisms and new diagnoses were

included in the V-code section to represent relational disorders, but neither of these additions had the authoritative recognition of being within the body of the text. In contrast, new sections within the text devoted to laboratory and physical exam findings leaned strongly toward neurobiological models (Widiger & Clark, 2000).

Arguing in support of favoring particular theoretical perspectives is the importance of having the decisions be governed by empirical research (Frances et al., 1989). Perhaps a manual that is guided by research can't in fact be neutral. If the empirical research favors one particular model relative to another (and it would be inevitable for this to occur, unless all theoretical models are equally valid), then perhaps DSM-V should represent more heavily the theoretical model with the strongest empirical support.

"it is precisely this reliance upon subjective and idiosyncratic clinical interviewing that undermines the reliability and ultimately the validity of clinical diagnoses"

On the other hand, perhaps the manual should continue to attempt to remain above the fray rather than embrace the team who currently has the most points. The construction of the DSM can at times become a battleground for the expression of fundamental disputes among opposing theoretical perspectives (go to http://www.npr.org/ features/feature.php?wfId=1400925 for a nice reminiscence by Robert Spitzer). DSM-IV is the authoritative language for professional and scientific communication. Impacting this language provides not only an explicit authority, it also has a more subtle, cumulative effect on the subsequent scientific discourse and clinical practice. A language that favors one particular perspective does not provide an equal playing field (Wakefield, 1998). Perhaps the manual should not favor one particular perspective relative to another if it is to be used effectively or meaningfully in research attempting to determine the validity of alternative theoretical perspectives (Frances et al., 1989). It might be impossible to construct a truly neutral diagnostic manual, but the inability to be entirely successful in one's aspirations might not be a compelling argument for abandoning the effort (Pitino, 1998).

The Role of Psychological Tests

Each of the disorders included within DSM-IV is accompanied by a text discussion of its typical course, prevalence, associated features, and other information that might be relevant to its diagnosis. The authors of DSM-IV added new subsections concerned with laboratory and physical examination findings. The addition of this material within the text is in anticipation of their eventual inclusion within diagnostic criterion sets (Frances, First, & Pincus, 1995). Notably absent from this material, however, was any reference to psychological tests (e.g., self-report inventories or semi-structured interviews). The text of DSM-IV refers to neurotransmitters that might be involved in a disorder's pathophysiology, but no reference is made to cognitive, behavioral, or interpersonal models of pathology. This is somewhat ironic, as "not one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes" (Kupfer et al., 2002, p. xviii), yet self-report inventories and semi-structured interviews have been shown to provide quite reliable and valid means with which to diagnose mental disorders (Segal & Coolidge, 2003; Wood, Garb, Lilienfeld, & Nezworski, 2002).

"Although diagnostic criteria are the framework for any clinical or epidemiological assessment, no assessment of clinical status is independent of the reliability and validity of the methods used to determine the presence of a diagnosis" (Regier et al., 1998, p. 114). Clinicians often prefer to rely on their own experience, expertise, and subjective impressions obtained through the course of an unstructured interview (Westen, 1997), but it is precisely this reliance upon subjective and idiosyncratic clinical interviewing that undermines the reliability and ultimately the validity of clinical diagnoses, in part by allowing if not fostering false assumptions, attribution errors, and misleading expectations (Segal & Coolidge, 2003; Wood et al., 2002).

Mental retardation provides a good model for the rest of the manual not only through its multifactorial, dimensional model of classification but also through the method with which the diagnosis is made (Widiger & Clark, 2000). The diagnosis of mental retardation requires the administration of an objectively scored psychological test that is usually a combination of a structured interview (e.g., a required set of verbal questions, the answers to which have explicit guidelines for scoring) and laboratory probes (e.g., tasks and puzzles that again have explicit guidelines for scoring). Imagine attempting to diagnose mental retardation simply on the basis of an unstructured clinical interview, yet this is the

most commonly used method for most other disorders. Perhaps the rest of the diagnostic manual should follow this lead and require the administration of an objectively scored psychological test to diagnose anxiety, mood, personality, and other mental disorders. "At present, results of psychological testing are not included in DSM-IV diagnostic criteria, with the exception of IQ testing and academic skills…[and] this exception points the way for research that could lead to incorporation of psychological test results as diagnostic criteria for other disorders" (Rounsaville et al., 2002, p. 24).

Conclusions

The development of the diagnostic manual is never without substantial controversy (Frances et al., 1989). DSM-V is unlikely to be an exception. Many additional controversies could have been addressed herein (e.g., the process of construction, cross-cultural applications, international coordination, ethnic and gender biases, impairment versus pathology as a basis for determining diagnostic thresholds, organismic versus relational disorders, and cross-sectional versus lifespan diagnoses), but space limitations prohibit a comprehensive coverage. Hopefully, this brief paper will be useful in arousing helpful discussions of and interest in some of the issues that were raised.□

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Appelbaum, P.S., Robbins, P.C., & Roth, L.H. (1999). Dimensional approach to delusions: Comparison across types and diagnoses. *American Journal of Psychiatry, 156*, 1938-1943.

Bergner, R.M. (1997). What is psychopathology? And so what? *Clinical Psychology: Science and Practice, 4*, 235-248.

Blashfield, R.G., & Fuller, A.K. (1996). Predicting the DSM-V. *Journal of Nervous and Mental Disease, 184*, 4-7.

Charney, D.S., Barlow, D.H., Botteron, K., Cohen, J.D., Goldman, D., Gur, R.E., Lin, K-H., Lopez, J.F., Meador-Woodruff, J.H., Moldin, S.O., Nestler, E.J., Watson, S.J., & Zalcman, S.J. (2002). Neuroscience research agenda to guide development of a pathophysiologically based classification system. In D.J. Kupfer, M.B. First, & D.A. Regier (Eds.), *A research agenda for DSM -V* (pp. 31-83). Washington, DC: American Psychiatric Association.

Clark, L.A. (1999). Introduction to the special section on the concept of disorder. *Journal of Abnormal Psychology, 108*, 371-373.

First, M.B. (2003). Psychiatric classification. In A. Tasman, J. Kay, & J. Lieberman (Eds.), *Psychiatry* (2nd ed., Vol. 1, pp. 659-676). NY: Wiley.

First, M.B., Pincus, H.A., Levine, J.B., Williams, J.B.W., Ustun, B., & Peele, R. (in press). Using clinical utility as a criterion for revising psychiatric diagnoses. *American Journal of Psychiatry*.

Frances, A.J., First, M.B., & Pincus, H.A. (1995). *DSM-IV guidebook*. Washington, DC: American Psychiatric Press.

Frances, A.J., Widiger, T.A., & Pincus, H.A. (1989). The development of DSM-IV. *Archives of General Psychiatry, 46*, 373-375.

Frances, A., Widiger, T., & Sabshin, M. (1991). Psychiatric diagnosis and normality. In D. Offer & M. Sabshin (Eds.), *The diversity of normal behavior* (pp. 3-38). NY: Basic Books.

Kirmayer, L.J., Young, A.,& Hayton, B.C. (1995). The cultural context of anxiety disorders.

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 follwing year. Ratification of the Fellows Committee's choices,k 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
Fax: 303-652-2723
email:div12apa@attbi.com

Psychiatric Clinics of North America, 18, 503-521.

Klein, D.F. (1999). Harmful dysfunction, disorder, disease, illness, and evolution. Journal of Abnormal Psychology, 108, 421-429.

Kupfer, M.B. First, & D.A. Regier (Eds.). (2002). A research agenda for DSM-V. Washington, DC: American Psychiatric Association.

McHugh, P. (2001). Beyond DSM-IV: From appearances to essences. Psychiatric Research Report, 17 (2), 2-3 & 14-15.

McQueen, L. (2000). Committee on Psychiatric Diagnosis and Assessment update on publications and activities. *Psychiatric Research Report, 16* (2), 3.

McWilliams, N. (1999). Psychoanalytic case formulation. New York: Guilford.

Meehl, P.E. (1977). Specific etiology and other forms of strong inference: Some quantitative meanings. *Journal of Medicine and Philosophy, 2*, 33-53.

Pitino, R. (1998). *Success is a choice: ten steps to overachieving in business and life*. NY: Broadway Books.

Regier, D.A., Kaelber, C.T., Rae, D.S., Farmer, M.E., Knauper, B., Kessler, R.C., & Norquist, G.S. (1998). Limitations of diagnostic criteria and assessment instruments for mental disorders. Implications for research and policy. *Archives of General Psychiatry, 55*, 109-115.

Regier, D.A., & Narrow, W.E. (2002). Defining clinically significant psychopathology with epidemiologic data. In J.E. Helzer & J.J. Hudziak (Eds.), *Defining psychopathology in the 21st century. DSM-IV and beyond*. Washington, DC: American Psychiatric Publishing.

Rounsaville, B.J., Alarcon, R.D., Andrews, G., Jackson, J.S., Kendell, R.E., & Kendler, K.S. (2002). Basic nomenclature issues for DSM-V. In D.J. Kupfer, M.B. First, & D.A. Regier (Eds.), *A research agenda for DSM-V* (pp. 1-29). Washington, DC: American Psychiatric Association.

Rutter, M. (2003, October). *Pathways of genetic influences on psychopathology*. Zubin Award Address at the 18th Annual Meeting of the Society for Research in Psychopathology, Toronto, Ontario.

Segal, D.L., & Coolidge, F.L. (2003). Structured interviewing and DSM classification. In M. Hersen & S.M. Turner (Eds.), *Adult psychopathology and diagnosis* (2nd ed., pp. 72-103). NY: John Wiley & Sons.

Spitzer, R.L. (1999). Harmful dysfunction and the DSM definition of mental disorder. *Journal of Abnormal Psychology, 108*, 430-432.

Spitzer, R.L., & Endicott, N. (1978). Medical and mental disorder: proposed definition and criteria. In R.L. Spitzer & D.F. Klein (Eds.), *Critical issues in psychiatric diagnosis* (pp. 15-39). NY: Raven Press.

Spitzer, R.L., Williams, J.B.W., & Skodol, A.E. (1980). DSM-III: The major achievements and an overview. *American Journal of Psychiatry, 137*, 151-164.

Tsuang, M.T., Stone, W.S., & Faraone, S.V. (2000). Toward reformulating the diagnosis of schizophrenia. *American Journal of Psychiatry, 157*, 1041-1050.

Wakefield, J.C. (1992). The concept of mental disorder. On the boundary between biological facts and social values. *American Psychologist, 47*, 373-388.

Wakefield, J.C. (1998). The DSM's theory-neutral nosology is scientifically progressive: response to Follette and Houts (1996). *Journal of Consulting and Clinical Psychology, 66*, 846-852.

Westen, D. (1997). Divergences between clinical and research methods for assessing personality disorders: Implications for research and the evolution of Axis II. *American Journal of Psychiatry, 154*, 895-903.

Widiger, T.A. (2002). Values, politics, and science in the construction of the DSMs. In J. Sadler (Ed.), *Descriptions and prescriptions: Values, mental disorders, and the DSMs* (pp. 25-41). Baltimore, MD: Johns Hopkins University Press.

Widiger, T.A. (2003). Personality disorder and Axis I psychopathology: the problematic boundary of Axis I and Axis II. *Journal of Personality Disorders, 17*, 90-108.

Widiger, T.A., & Clark, L.A. (2000). Toward DSM-V and the classification of psychopathology. *Psychological Bulletin, 126*, 946-963.

Widiger, T.A., & Coker, L.A. (2003). Mental disorders as discrete clinical conditions: Dimensional versus categorical classification. In M. Hersen & S.M. Turner (Eds.), *Adult psychopathology and diagnosis* (4th ed., pp. 3-35). NY: John Wiley & Sons.

Widiger, T.A., Costa, P.T., & McCrae, R.R. (2002). A proposal for Axis II: Diagnosing personality disorders using the five factor model. In P.T. Costa & T.A. Widiger (Eds.), *Personality disorders and the five factor model of personality* (2nd ed., pp.431-456). Washington, DC: American Psychological Association.

Widiger, T.A., & Sankis, L. (2000). Adult psychopathology: issues and controversies. *Annual Review of Psychology, 51*, 377-404.

Widiger, T.A., & Trull, T.J. (1991). Diagnosis and clinical assessment. *Annual Review of Psychology, 42*, 109-133.

Wood, J.M., Garb, H.N., Lilienfeld, S.O., & Nezworski, M.T. (2002). Clinical assessment. *Annual Review of Psychology, 53*, 519-543.

Student Forum

Successfully Securing a Research Grant as a Doctoral Student

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Congratulations. You are a member of a clinical psychology doctoral program. You are busily juggling your days between classes, clinical practicum placements, research or teaching assistantships, research labs largely associated with your advisor's work, and—oh yes—developing your own compelling line of research inquiry (in your spare time). If you have been in graduate school a few years now, you are beginning to think about applying for clinical internship (a sometimes agonizing and certainly time consuming process), comprehensive and oral exams, working on your dissertation proposal, and if you're interested in a career that involves research, writing up studies for publication. Wearing so many hats can be both exhilarating and exhausting. So, why in the midst of all this would one add the task of writing a research grant? Such a decision would seem diagnosable to some. There are many good reasons, but there are also many factors to consider in making such a decision. The purpose of this article is to address both the question of whether you should consider applying for outside research funding, as well as how to best do so as a doctoral student.

I was asked to write this column because I was recently awarded the *Elizabeth Munsterberg Koppitz Fellowship* from the American Psychological Association. Having gone through this application process, having researched and considered a number of different granting agencies, and having worked on larger nationally funded grants with my research mentor, I have some familiarity with the process. However, the following column reflects only a relative neophyte's experience with this process. I strongly advise seeking advice from your graduate mentors, professors, and other graduate students who have applied for grants when weighing your personal options and deciding what makes the most sense for you and your professional development. It is important to remember that one does not need to write a grant to get a Ph.D. or Psy.D.

Deciding Whether to Apply for a Grant

Four main issues to consider when deciding whether to apply for an individual research grant during graduate school include: a) your funding options, b) the nature of your study, c) timing, and d) your long term career trajectory. Regarding the first point, some individuals may have to apply for a research grant out of necessity if their graduate programs either do not provide funding to support students, or only offer funding for the first few years of graduate work. If this is your situation, and you are not independently wealthy, your choice is either to take out large loans to pay research participants while you live a life that paupers would pity or apply for grants or other financial support. Another situation in which applying for a grant may not be necessary is if you are already working as a graduate research assistant on a project from which your dissertation data will come. If this is the case, you may not have difficulty finding funding for research participants or material costs. In this situation, a grant could possibly help your vitae but would not be necessary for dissertation completion, and your time might be better spent working on completing a paper for publication or another professional development activity.

A second issue to consider is the nature of your study. Some dissertation projects need outside funding more than others. At the broadest level, one can divide dissertation projects into two types: independent studies and secondary data analysis projects. Both types of studies can be funded by outside granting agencies, but independent studies may be more likely to require outside financial support. For instance, if a graduate student needs to pay participants, pay for animals, or buy materials or special data analysis packages, having outside funding will be very helpful. This is not to suggest that individuals should not apply for grants if they are conducting secondary data analysis studies. Remember, however, many grants require a somewhat detailed explanation of and justification for how the money will be spent. Often it is very important for secondary data analysis projects to receive outside funding (e.g., to fund statistical training or to provide the graduate

student's living stipend). Adequately addressing the budgetary needs in the proposal will be very important for these types of projects. Also, some outside funding sources provide research "fellowships" that may not require a detailed budget analysis. These fellowships serve primarily to cover the graduate student's living expenses and to pay for smaller research costs. These fellowships may be good funding sources for secondary data analysis projects, as well as independent projects.

With regard to timing, when deciding to apply for a grant or fellowship as a graduate student, you typically have to start thinking about the application process at least a year prior to when you would like the funding. For example, if you are planning on going on clinical internship in your sixth year, then you likely would be working on your dissertation and therefore seek the grant to cover your project needs during your fifth year. Thus, you likely would need to submit the actual grant proposal during the Fall of your fourth year. For example, the Elizabeth Munster-berg Koppitz Fellowship from the American Psychological Foundation of the American Psychological Association has a due date of November 15, with funding beginning in September of the following year. Similarly, the NIMH dissertation awards have due dates in December with funding beginning during the Fall semester of the following academic year.

"...your long-term career goals are important to consider when deciding whether or not to seek a grant or fellowship..."

Finally, and most importantly, your long-term career goals are important to consider when deciding whether or not to seek a grant or fellowship (see Snyder, 2002). If you are confident that you are going to seek an applied position, such as starting a private practice or working in a consulting position, it may not be as important for your professional development to seek outside research funding. Your time might be better spent seeking extra practicum experiences, or attending supplementary clinical training workshops. However, if you are seeking an academic position in a psychology or psychiatry department, a private or federally funded position in a research institute, or a combined clinical and research position at a university-affiliated hospital, having prior experience in grant writing or having successfully maintained research funding in the past is likely to help make you an attractive candidate. These sorts of positions often come with the expectation that you will obtain grants to help pay for your research activities and to partially or fully fund your own salary. Showing evidence that you have done so in the past can only be an asset in your application for those types of jobs.

How to Apply for a Research Grant or Fellowship

Now that you have considered your funding options, the nature of your study, timing, and your long term career trajectory, it is time to either a) stop reading this article (i.e., if applying for a grant is not in your future), or b) delve into the actual process of writing a grant. The following discussion presumes that you have already chosen a dissertation topic with clearly specified, answerable research questions, and that you have support for your topic from your major research advisor and hopefully, your dissertation committee. But working from the assumption that you have your departmental "ducks in a row," it is time to consider the specifics of writing your proposal and the steps to take in making your application likely to be funded.

Applying for a dissertation grant or fellowship is a both time consuming and difficult undertaking, but one that can be extraordinarily rewarding, especially if you are funded in the end. To simplify this anomalous process, from my perspective, there are three main strategies to use in writing a successful application: a) using the available resources, b) writing with clarity and precision, and c) securing supportive letters of recommendation.

Helpful Resources for Writing Grants or Fellowships

There are mounds of resources to help you navigate the process of writing a grant or fellowship application. First and foremost, ask your advisor and other professors for help. Although you may think that you are inconveniencing people by asking for extra time or advice through this type of process, you are not. Professors can provide the best advice since they likely apply for grants on a regular basis, and they often enjoy these types of conversations. Further, showing the initiative it takes to write a grant also impresses people and could help you later if you wish to ask them to write a letter of support for a job. In addition to asking for their advice on the nuts and bolts of how to write a successful grant application, ask if you can see models of grants that they or other faculty have submitted. This can be extraordinarily helpful both in terms of providing a solid example of the sections included in grant applications and also in

providing an example of the succinct type of writing required for grant or fellowship applications.

Besides the resource found in your mentors, there are a number of excellent books (e.g., Darley, Zanna, & Roediger, 2004; Ries & Leukefeld, 1998), articles and chapters (e.g., Pilkonis & Cyranowski, 2003; Steinberg, 2004, Sternberg, 2004, Streiner, 1996) and internet resources (see appendix of Grohol, 1999) on the grant application process, from the view of both the applicant and the funding agency. Further, conducting simple internet searches on broad search engines such as *Google*, specific funding agencies' websites (e.g., National Institute of Mental Health, American Psychological Association, Spencer Foundation, W.T. Grant Foundation, National Science Foundation), or on your own graduate institution's web page can elucidate much information about available funding opportunities for graduate students, requirements and procedures of different grant applications, and tips on writing successful grant or fellowship applications.

Once you have chosen the funding opportunities for which you are going to apply, another great source of information is the grant or fellowship contact person for the particular granting agency. I would strongly suggest reading all of the available materials provided by that agency before phoning or e-mailing the contact person, but sometimes these individuals know inside information that would not be clearly evident from the call for proposals. For example, the materials and information provided by the American Psychological Foundation in their call for *Elizabeth Munsterberg Koppitz Fellowship* proposals were relatively brief. After familiarizing myself with these materials and noting that they sought short proposals, I phoned them to ask about the required contents of the proposals because they were of unusually short length compared to other grants I had been involved in writing with my research advisor. The only comment back was that they wanted succinct proposals that were consistent with the mission of the Koppitz funding goals. As a result of this phone call, I reviewed the main "goal" noted in their materials and made slight changes to my proposal to indicate the ways in which my study was consistent with and would contribute to this goal. In the end, this was a small semantic adjustment, but it may have helped my proposal stand out as one that was consistent with the types of projects they wished to fund.

"...reviewing other grant applications is likely to be particularly helpful."

Writing with Clarity and Precision

Now that you have spent several years in graduate school, learning how to write theses, dissertations, and publishable articles, it is time to learn yet another type of writing. Although many of the rules for writing a good article apply when writing a successful grant application, there are some differences. The most clear difference is that you have to get to the point more quickly. A point that might take two or three pages to make in an article or 10 pages to make in a dissertation, now may need to be evinced through one or two paragraphs. Further, you may need to write new sections such as a budget and budget justification for which you may not have prior experience. This is why reviewing other grant applications is likely to be particularly helpful.

I see the process of writing a grant proposal has having three goals: a) to show your study is needed, important, and stemming from a sound theoretical basis, b) to show you understand and will use the proper methodology to answer the research question(s), and c) to show that you are invested in and excited about this particular study. The most important goal, of course, is to show clearly that your study is needed, fills a gap in the literature to date, and is likely to make a significant contribution to the field. This contribution can be a scientific one, an applied one, or a methodological one. Maybe your study will help to resolve a debate for which there currently is empirical support on both sides. Maybe you will pit two theories against one another and see which one more thoroughly explains a phenomenon. Maybe your study has applied implications for how we socialize children or take care of our elderly. Whatever your goal is, write clearly, concisely, and passionately (i.e., as passionate as one can be using APA style) about why your study's goal is important and how you will meet that goal. Often this involves pointing out three issues: a) what we know, b) what we don't know, and c) how your study will fill that gap. Be sure that you have selected a funding agency that has a history of supporting the type of work that you do.

Having a clear goal identified through specific research questions is important but not sufficient to obtain funding. You need to have a well-defined methodology section. Be exact in stating the methods you will use, the analyses you will conduct, and how these methods will address your research questions. Although it is a strength to know how to do fancy quantitative methods such as structural equation modeling, hierarchical linear modeling, or survival analysis, not all projects require these sorts of approaches. Do not propose to use hierarchical lin-

ear models or structural equation models to answer questions that would be just as easily addressed by an analysis of variance or regression analysis. Trying to enhance your application using unnecessarily complicated statistics may make it appear that you are trying to pull to wool over the reviewers' eyes, or even worse, make it seem as though you do not know how to best answer you research question. If you are answering research questions that require more sophisticated types of analyses, then be clear about how and why it is best to use those particular analyses. Most importantly, be thorough and clear in the methodology and analysis sections, evincing that you are using the best method for the research question and that you have the skills required to apply your method.

Finally, throughout your writing, show that you are invested in and excited about your study. Do this by selling your ideas and their importance. The time for humility and quiet enthusiasm comes after you have received the grant, not before. Be persuasive and convincing in the manner that you write about your study. The primary question(s) should flow from investigative enthusiasm and thoroughness.

Now that you have written a thorough and compelling application that includes all required sections as laid out by the particular granting agency, clearly defined and significant research questions, and a clear methodological path to answering them, get feedback. That is, ask others to read your proposal. A pair (or multiple pairs) of outside eyes can do wonders in identifying imprecision in your writing. Based on feedback you get from mentors and graduate student peers, edit, edit, and edit some more. Be absolutely sure not only that the content is in top shape, but also that there are no clerical mistakes in your writing. Such careless mistakes are a nuisance to your reviewers and suggest you also may make mistakes in your proposed research study. Do not let carelessness get in the way of a strong application.

Securing Letters of Recommendation

Once you have decided that you are going to submit

a proposal for a grant or fellowship, it is important to get letters of recommendation from professors that know you well. When approaching faculty about writing such letters, be sure to inquire as to whether they "feel comfortable writing a strong letter of support" for your application. If the person hesitates at all in answering this question, it likely is best to ask someone else. You want to be sure that you and your work always are presented in the best light.

Just as graduate students are very busy, so are the faculty. Once you have identified the required number of recommenders, do as much as possible to make the letter writing easy for them. That is, provide them with enough time (i.e., at least two weeks, preferably three or four weeks), a copy of your vitae, a synopsis of your proposed study (this does not have to be the full application), and a letter that lists specifics of your relationship with them. That is, remind them of the classes you have taken with them, the papers you have worked on with them, and the conferences you have attended together. These activities will be important for them to mention in a letter, and they are more likely mention these activities if you remind them. Finally, provide these two or three helpful faculty members with your gratitude. Just as serving on graduate student council or hosting clinical psychology graduate applicants during interviews are tasks you perform beyond your department's requirements, for faculty, the activity of writing letters is an extra one. Do not let it go unnoticed. Send an e-mail. Write a letter. Say, "thank you."

The Waiting Period

The "luxury" of graduate school is that once you finish your grant application, you likely will not have much time to ruminate about it. Because you had put off other work in order to write the grant, you now have piles of make-up work to which you can attend. This is a blessing in disguise because it can distract you from the painful anticipation while you wait to hear from the reviewers.

Likely all of you mentors can tell a story of their best grant not getting funded, and one of their more mediocre attempts being awarded on the first try. In the end, you have to be satisfied that you have given it your best shot, and now can say that you have the experience of writing a grant or fellowship application from start to finish. This, in itself, is an accomplishment. The rest is out of your hands and not always predictable.

If you have written your own stipend funding into your grant, it may be useful to seek a back-up plan in case your study is not funded. See if the department needs an extra teaching assistant next year or if your advisor or another faulty member need a research assistant. Not having a back up plan only adds insult to injury if you don't get funded on the first try. And remember: most grants are not funded. If you have taken all the steps described above, you are well on your way to being a productive and active researcher, regardless of the outcome of this particular endeavor. Good luck! □

References

Darley, J. M., Zanna, M. P., & Roediger, H. L. (2004). *The Compleat Academic: A Career Guide, Second Edition*. Washington, DC: American Psychological Association.

Grohol, J. M. (1999). *The Insiders Guide to Mental Health Resources Online*. New York, NY: Guilford Press.

Pilkonis, P. A., & Cyranowski, J. M. (2003). Applying for NIH grants. In M. J. Pronstein & M. D. Patterson (Eds.), *The portable mentor: Expert guide to a successful career in psychology* (pp. 285-296). New York, NY: Kluwer Academic/Plenum Publishers.

Ries, J. B., & Luekefeld, C. G. (1998). *The Research Funding Guidebook: Getting it, Managing it, and Renewing it*. Thousand Oaks, CA: Sage Publications.

Snyder, C. R. (2002). Preparing for a position in clinical psychology, part 1: The graduate school stages. *The Clinical Psychologist, 55*, 19-25.

Steinberg, J. (2004). Obtaining a research grant: The granting agency's view. In J. M. Darley, M. P. Zanna, & H. L. Roediger (Eds.), *The compleat academic: A career guide, 2nd Edition*, (pp.153-168). Washington, DC: American Psychological Association.

Sternberg, R. J. (2004). Obtaining a research grant: The applicant's view. In J. M. Darley, M. P. Zanna, & H. L. Roediger (Eds.), *The compleat academic: A career guide, 2nd Edition*, (pp.169-184). Washington, DC: American Psychological Association.

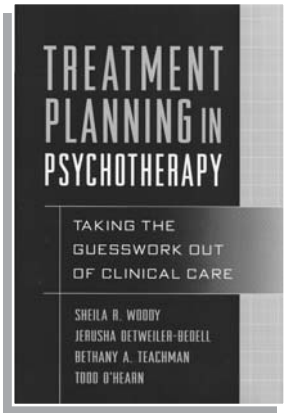
Streiner, D. L. (1996). "While you're up, get me a grant": A guide to grant writing. *Canadian Journal of Psychiatry, 41*, 137-143.

Book Review

Woody, S.R., Detweiler-Bedell, J., Teachman, B.A., & O'Hearn, T. (2003). *Treatment planning in psychotherapy: Taking the guesswork out of clinical care*. New York: Guilford.

ISBN: 1-57230-805-2/ $30.00 US List

Reviewed by John Hunsley, Ph.D., Department of Psychology, University of Ottawa.



Psychological assessment is back in vogue! Although for many clinical psychologists assessment was never really "out of fashion," based on the number of recently published assessment books there is a major resurgence of interest in assessment issues. There is, however, something distinctly different about many of these publications. New and updated books on specific measures and on the assessment of specific disorders and conditions continue to provide important information to practising clinicians, but a new class of assessment books (and practice software) focused on planning, ongoing measurement, and outcome evaluation of treatments are now available. Whether couched in the language of evidence-based practice, managed care, or practice accountability, these materials share a common theme: the critical importance of using assessment data to guide psychological interventions.

The means to incorporate solid assessment options into everyday practice—the measures, the value of ongoing assessments from multiple perspectives, the strategies for evaluating change at the level of individual clients/patients and at the program/service level—have been readily available for at least a decade. What has been lacking is an integrated, scientifically informed approach that is easily learned and used, and that has some obvious utility to practitioners. This book by Woody, Detweiler-Bedell, Teachman, and O'Hearn is aimed directly at this practice gap.

Developed while the authors were involved in a graduate training program (as faculty, postdoctoral fellows, and students), the Planning and Assessment in Clinical Care (PACC) system was designed to help trainees base their clinical work on data, even in settings that did not routinely gather service data or value the role of such data in the clinical enterprise. As their efforts continued, they expanded their focus in order to create an assessment system that was relevant across orientations and clinical settings—in other words, a system that would be valuable to all clinicians. As the authors state in the preface to their book, the purpose of the book is to provide an organized and integrated approach to using science-based tools for evaluating the extent to which treatment is meeting client needs. Starting with a presentation of the rationale for the PACC system in Chapter 1, the authors lay out the elements of the system in the subsequent chapters, with a final chapter devoted to an extended single case illustration of the use of the PACC system throughout all phases of treatment.

So what exactly is the PACC system? The main emphasis is on using repeated, (usually) brief assessments to guide the treatment, with a heavy reliance on having the client actively involved in the explicit setting of goals and the evaluation of their attainment. With the starting point that evidence-based psychological practice cannot be based entirely on the results of randomized clinical trials, the authors build their case for having locally acquired clinical data be a major contributor to the iterative decision-making process that underlies treatment planning and delivery. To this end, simple and feasible strategies are used to obtain continuous, individualized data relevant to making key treatment decisions. The authors go to great pains to emphasize that, rather than being a cold, sterile, and objectifying obstacle between clinician and client, assessment can, and should, be a collaborative, meaningful, and alliance-enhancing activity. They also emphasize that their assessment system is not a manualized treatment approach; nor is it a form of practice guideline—if nothing else, this is an important statement for potential users given the rather heated debates that have arisen recently around these topics.

The PACC system is comprised of three primary components: a problem list, a treatment plan, and a progress review. The problem list, initially generated during the first sessions of treatment but updated as needed throughout treatment, is a comprehensive summary of the problems the client(s) would like to address in treatment. The treatment plan is keyed to this list and is divided into aims,

measures, and strategies. The aims are the treatment plans specific to a given set of client problems and goals, the measures are the materials and instruments to be used to gauge the changes in problems and attainment of goals, and the strategies are the intervention options to be used to achieve treatment goals. At the end of a phase of treatment addressing a set of problems/goals, a planned progress review is conducted to determine the extent of change and to aid in the decision whether to move on to other treatment goals.

In developing and refining the PACC system the authors have been sensitive to many clinical service factors. Thus, they attempted to minimize the time and costs associated with use of the system and consciously developed their forms and assessment strategies to be as "orientation-neutral" as possible. They provide numerous clinical examples throughout the book to illustrate their points and have included many tables and forms that can be directly reproduced for clinical use. A multitude of resources are presented in the book, including website addresses and an appendix describing useful measures for tracking client progress, some of which are reproduced in the book. They also give clear, simple, step-by-step directions for using the Excel spreadsheet to track and graph client changes. Finally, they discuss many of the objections that might be raised to the type of system they are proposing, including concerns about making the treatment process so explicit, when to use standardized measures, and when to design tailor-made measures, and how to address disagreements between clients and clinicians regarding problems, goals, and evaluations.

"...assessment can, and should, be a collaborative, meaningful, and alliance-enhancing activity."

So have the authors achieved their goals with this book? As a volume intended for clinicians, the book must also be evaluated in light of clinical utility—will clinicians actually use the materials and strategies offered by the PACC system to document and improve their services? Certainly the system could be comfortably used by anyone offering cognitive-behavioral treatments, but even the "orientation-neutrality" of the system may not be enough to overcome the reluctance of some clinicians trained in other orientations to engage in overt, explicit documentation of treatment progress. However, for those clinicians now facing accountability demands by both consumers and the healthcare system, the PACC system can provide a means to achieve accountability while remaining consistent with the key tenets of their treatment approaches. The level of detail about graphing with Excel is a good example of how the authors have tried to make their system work for any clinician, but simple aspects of the packaging of the book may negatively affect the adoption of their system. Thus, for example, should the book go into a second edition, it would be worthwhile to consider adding a CD-ROM that includes copies of all the forms presented in the book. Although this may seem like a minor detail, experience with the uptake of practice initiatives in other healthcare areas has shown that ensuring the ease of implementation is a crucial aspect in altering healthcare professionals' behavior.

Overall, the PACC system is a fine example of how many aspects of evidence-based practice can be achieved by a clinician without the need to develop a new skill set or the need to spend hundreds or thousands of dollars on costly measures or software. Attention to the realities and demands of clinical practice is evident throughout the book and, indeed, throughout the components of the PACC system. Although one can quibble about the merits of some of their assessment strategies and tools relative to other individualized client tracking options, overall Woody and co-authors have produced an excellent book that offers a scientifically rigorous and clinically sensitive assessment system. Adoption of their system by any clinician would go a long way toward ensuring that clients receive optimal psychological services.□

Book Review

Hofmann, S.G. & Tompson, M.C. (2002). *Treating chronic and severe mental disorders: A handbook of empirically supported interventions.* New York: Guilford Press.

ISBN: 1-57230-765-X/ $55.00 US List

Reviewed by Peter E. Nathan, Ph.D.,
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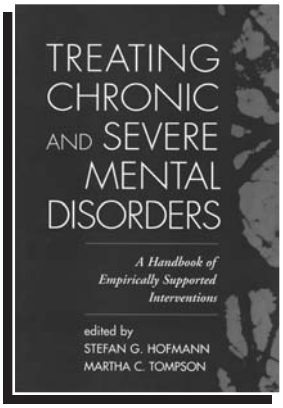

Standards of Practice?

Recognition that effective psychosocial treatments for many DSM-IV disorders now exist has grown, especially over the past decade, in part because many of these treatments have met one or another standards to permit them to be advertised as "empirically supported" or "evidence based." For this reason, *Treating chronic and severe mental disorders: A handbook of empirically supported interventions*, reflects an important development in contemporary clinical psychology: the continuing effort to establish a scientifically defensible basis for judging the effectiveness of treatments for a diverse range of psychopathologies.

At the same time, this volume differs a bit from prevailing efforts to identify effective psychological treatments. In presuming to identify empirically supported psychosocial treatments for schizophrenia, the mood disorders, especially bipolar disorder, substance abuse, and the severe personality disorders, the editors have chosen to focus on treatments that have generally been underrepresented among those most widely recognized as empirically supported. Treatments for schizophrenia and the mood disorders have largely been psychopharmacologic; substance abuse treatment continues to be primarily in the hands of members of Alcoholics Anonymous and other self-help groups; and the personality disorders have been subjected to a diverse group of treatments, none of which seems particularly effective. By contrast, psychologists have been quite successful in establishing empirical support for psychosocial treatments for the anxiety disorders and many of the mild to moderate mood disorders (e.g., Barlow, Raffa, & Cohen, 2002; Craighead, Hart, Craighead, & Ilardi, 2002); most of these treatments are broadly behavioral or cognitive-behavioral. Despite the apparent lacuna, then, in effective psychological treatments for the chronic and severe mental disorders, only recently have substantial numbers of them been developed and evaluated. This book, then, meets a clear need by providing details on the treatments themselves, as well as on the empirical research designed to establish the efficacy of psychosocial treatments for common, severe disorders. As such, it seems to accord with psychology's current thrust to identify psychosocial treatments that meet standards of proof for efficacy.

All four of the treatments for schizophrenia detailed here have cognitive-behavioral forebears: Cognitive-behavioral therapy (CBT) for schizophrenia, cognitive-behavioral family and educational interventions, social skills training, and personal therapy, the latter designed "to achieve and maintain clinical stability using both appropriate pharmacotherapy and incremental acquisition of adaptive, self-regulating strategies" (Hogarty, p. 54). Treatments for the mood disorders included in the volume are more diverse in character and ancestry. They include CBT for depression, CBT for the management of bipolar disorder, interpersonal psychotherapy for unipolar and bipolar disorders, family-focused treatment for bipolar disorder, combined behavioral couples therapy for marital discord and comorbid depression, and a family intervention for adolescent suicide attempters.

Treatments for substance abuse include the three that comprised the Project MATCH treatment comparison: Motivational enhancement therapy, cognitive-behavioral coping skills therapy, and twelve-step facilitation therapy (Project MATCH Research Group, 1997), as well as behavioral couples treatment for alcohol abuse and community reinforcement plus vouchers for cocaine dependence. The five recommended treatments for severe personality disorder include dialectical behavior therapy for borderline personality disorder (BPD), multiple family group treatment for BPD, multisystemic treatment of adolescent antisocial behavior, CBT for severe personality disorders, and short-term dynamic psychotherapy.

The chapters detailing these treatments range from those that focus almost completely on the details of the treatments themselves to those that emphasize the empirical research underpinning the

treatment—and include as well a few that attempt to portray both. Many of the chapter authors are the clinical scientists most responsible for development of one or more of the treatments described, so they are at once very knowledgeable about the treatment methods and, human nature being what it is, somewhat inclined to emphasize those empirical findings that most support their efficacy. For those readers who want an informed contemporary accounting of some of the most promising psychosocial treatments for disorders for which psychosocial treatments have not before been widely available, this would be an excellent choice.

If I had a single bone to pick with the editors of the volume, it would be that the volume does not propose a consistent metric for judging the quality of the evidence base underlying the treatments described. Here I refer, for example, to the detailed criteria for evaluating the results and methodological adequacy of efficacy research established by the Division 12 Task Force to identify "empirically validated treatments" and "treatments that are probably efficacious" (Chambless et al., 1996, 1998; Division 12 Task Force, 1995) or the six-fold hierarchy of methodological adequacy for the empirical studies of therapy outcomes used as a consistent template by the chapter authors in A guide to treatments that work (Nathan & Gorman, 1998, 2002). In this regard, the editors of the volume under review have the following to say:

> What is an empirically supported treatment? The issue of how precisely to define empirically supported treatments—and whether it even makes sense to classify treatments into those that do and those that do not meet the criteria—is hardly without controversy. One might even say that this issue raises some of the most complicated and controversial questions of contemporary psychology. The publication of this book is unlikely to resolve this controversy. (Hofmann and Tompson, 2002, p. xii)

In the absence of details on the criteria the editors used to choose the chapters that comprise the book, as well as the criteria the chapter authors used to choose the chapter contents, the reader is left to determine for him- or herself whether the findings in support of the efficacy of a given treatment meet his or her own personal standards of proof. From my perspective, this is unfortunate. Because each reader, like the book's editors and chapter authors, will evolve his or her own standards for judging efficacy, these standards will vary substantially, with the result that consensus on the empirically supported status of the treatments discussed will have to remain in question. At the same time, I have little doubt that many or most of these treatments will ultimately meet a consistent proof standard. Most have been carefully chosen and most are supported by a formidable array of empirical data.□

References

Barlow, D.H., Raffa, S.D., & Cohen, E.M. (2002). Psychosocial treatments for panic disorders, phobias, and generalized anxiety disorder. In P.E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 301-336). New York: Oxford University Press.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D.A.F., Sanderson, W.C., Shoham, V., Stickle, T., Williams, D.A., & Woody, S.R. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist, 51*(1), 3-14.

Chambless, D.L., Sanderson, W.C., Shoham, V., Bennett Johnson, S., Pope, K.S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S.R., Sue, S., Beutler, L., Williams, D.A., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 5-18.

Craighead, W.E., Hart, A.B., Craighead, L.W., & Ilardi, S.S. (2002). Psychosocial treatments for major depressive disorder. In P.E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 245-262). New York: Oxford University Press.

Division 12 Task Force. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. *The Clinical Psychologist, 48*, 3-23.

Nathan, P.E. & Gorman, J.M. (1998). *A guide to treatments that work*. New York: Oxford University Press.

Nathan, P.E. & Gorman, J.M. (2002). *A guide to treatments that work, 2nd ed*. New York: Oxford University Press.

Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. Journal of Studies on Alcohol, 58, 7-29.

ABBREVIATED MINUTES
SOCIETY OF CLINICAL PSYCHOLOGY,
BOARD OF DIRECTORS MEETING
NASHVILLE, TENNESSEE, OCTOBER 24-26, 2003

President Diane J. Willis reported that the dues increase was voted in by the board and will be announced to the membership. She also announced that the new Millon award offered by the American Psychological Foundation was now managed by Division 12.

An Education and Training Committee was proposed as a new standing committee that needs to be voted into the bylaws. The committee is already very active under the leadership of Beverly Thorn, Chair.

It is the intent of the Board that there will always be an ethnic minority person among the Division 12 Council members. Given that Division 12 will have an election for two APA Council Representatives in 2004 and that future elections might be very different each time, the following two motions were passed to clarify the current and continuing slates:

MOTION: One of the slates for the 2004 Council of Representatives will be a dedicated ethnic minority slate as defined by the APA Council, for self identification as a member of one of the following four ethnic minority groups: Hispanic, Asian and South Pacific Islanders, Black/ African-American, and Native American. **PASSED**

MOTION: The Division 12 representation to the APA Council will include at least one ethnic minority member. A dedicated slate of ethnic minority candidates, as defined by the APA Council, will be nominated whenever a vacancy exists when there is no ethnic minority member. In this case, the Article VIII, paragraph C bylaw requirement that any nominee will be placed on the slate if s/he receives endorsement of one half of one percent of the membership shall be suspended.

The 2004 Board meetings are San Antonio, January 9-11, and Las Vegas for June 26-28.

Embracing the diversity of clinical psychology is Nadine Kaslow's theme for 2004.

The Executive committee, composed of the Past President, President, President Elect, Secretary, and Treasurer) will have monthly conference calls and the full Board (17 members) could have conference calls quarterly, in March and October.

Nadine Kaslow will prepare informational announcements on a listserv to go out each month to the membership, including section members who are not Division 12 members.

All APA Fellows, not yet Fellows of 12 were invited to apply. Nadine Kaslow encouraged all others who appear to meet criteria to apply, as well. The fellow committee of Division 12 screens each applicant for our specific criteria.

Ed Craighead was appointed Chair of the Publication Committee.

The Treasurer's Report by Bob Klepac reported that the cost of running the Division is still rising. It is projected that we will come in under budget for the year after other costs not yet finalized, are factored in. The journal remains the biggest expense other than meetings.

The Finance Committee made several recommendations including: tightening up the costs of the Professional Development Institutes for one day before the Hawaii APA convention and the Division 12 Hospitality Suite, reducing Board meetings to two per year with fewer attendees, cost savings in the newsletter *The Clinical Psychologist*, and scrutiny of the cost of the journal, *Clinical Psychology: Science and Practice*.

MOTION: The board allocated $1000 in the 2004 budget for the newly formed Education and Training Committee. **PASSED**

MOTION: A Bylaws change will propose that The Finance Committee shall consist of the Treasurer and three members of the BD with staggering terms. **PASSED** (Bob Klepac recused himself and Jerry Resnick abstained.)

MOTION: The Publication committee will go forward with the Oxford proposal for a book series. **PASSED**.

MOTION: The Publication Committee will move forward with Danny Wedding's Book Series published by Huber & Hogrefe proposal **PASSED**

There are 64 Program hours for the Division for Hawaii Convention. Antonette Zeiss is doing interdivisional programs on the President's new Freedom Commission.

In closing, the Board expressed its appreciation to President Diane J. Willis for her service to the Division 12 during her presidency year.

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

Call for New Editor

The Clinical Psychologist

The Publications Committee of the Society of Clinical Psychology, Division 12 of the American Psychological Association, is currently seeking applications for the position of Editor of *The Clinical Psychologist*.

The Clinical Psychologist is published quarterly, and is the primary communication vehicle of the Society. Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Society. It serves to inform the membership about elections, Board decisions and initiatives, convention affairs, and events within APA that concern all of us. As such, it serves as an archival document for the Society. It also publishes original, scholarly articles of current interest to the field.

The editorial appointment will be made for a four year term, starting in January 2006. The Editor is responsible for all content, for overseeing the publication's annual budget, and for managing the production of the newsletter. The Editor reports to the Publications Committee of the Soci-ety, and is a non-voting board member of the Society. The Editor also receives an annual stipend.

Individuals interested in applying for the position should arrange to have a letter of application, curriculum vitae, and three letters of recommendation sent to the address below by October 1, 2004.

Chair, Publications Committee
c/o Lynn Peterson
Administrative Officer, Society of Clinical Psychology
P.O. Box 1082
Niwot, CO 80544-1082

Questions about the position can be addressed to the current Editor, Martin M. Antony, Ph.D., Tel: (905) 522-1155, ext. 3048; E-mail: mantony@stjosham.on.ca.

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

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Instructions to Authors

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

Material to be submitted should conform to the format described in the 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 generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries may be made to the editor:
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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.

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