

THE CLINICAL PSYCHOLOGIST



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

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PRESIDENT'S COLUMN

New Kid On The Block

Linda Carter Sobell

Two years ago, I ran for President of this division. When I was notified I had been elected, I was also given a timetable of things I would have to do and when. One thing I was told is that I would have to write a President's column for each issue of *the Clinical Psychologist*. I remember initially wondering what I would write about, particularly because I was the "New Kid on the Block." Interestingly, it did not take long for me to recognize what would go into this, my first column. After attending several divisional board meetings and participating in several conference calls, it was clear to me what I needed to say.

As a lead into this column let me explain what I mean by the "The New Kid on the Block." Those who know me also know that I was very active in the Association for Advancement of Behavior Therapy (AABT) for over two decades, serving on their board in several capacities, including as President in 1994. In many organizations, you see people who run for the office of President as "paying their dues" by serving on committees and running for other offices before running for President. As a result, such individuals have a considerable history with that organization, often have some vision of where they see the organization going, and can assume the reins with considerable ease and knowledge. Certainly, that was my experience with AABT. Similarly, in AABT when we saw people run for office who had little or no past organizational experience, they came in needing a catch up course. This is what I faced when I became an elected officer—I had a lot to learn. In this regard, several individuals made it easier for me to "learn the divisional ropes." While there have been many people who have provided invaluable direction and advice, some people have been exceptional. However, let me make clear that omission of anyone's name should not be taken as a reflection that I was not helped by that person. First, Dr. Nadine Kaslow, our past president, took me under her wing, and like no other person helped me, and is still providing needed advice. Others who greatly helped me over the past 18 months include Drs. Charles Spielberger, Tom Ollendick, Ed Craighead, Danny Wedding, and Marty Antony. I should also add that the able advice and direction of our current Treasurer, Dr. Bob Klepac, has not only aided me, but he and your recent officers have brought the finances of this division into a very stable state. Lastly, I would like to thank the division's Administrative Officer, Lynn Peterson, who is the glue that holds us together. I use the word glue because while officers come and go, Lynn remains in place helping us to recall what we did yesterday and what we

Inside:
Candidate
Statements for
2005 Elections!

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need to do tomorrow.

In a few words, my sense as the "New Kid on the Block" is that our division has recently been in very good hands. What I want to do for the remainder of this column is bring members up-to-date on some exciting things happening in the division and where I see my Presidential year going.

One of the most exciting new and profitable things the Society of Clinical Psychology has gotten involved in is working with Hogrefe and Huber publishers to develop and promote a book series titled *Advances in Psychotherapy: Evidence-Based*

Practice. This series will consist of approximately 20 books that will be published between 2005 - 2008. These volumes will be brief (80 - 100 pages), evidence-based, and aimed at practitioners. Members who subscribe to the series or purchase individual volumes will receive a 20% discount. In addition, members will be able to take a test on the division's website and earn APA approved CE credits. Dr. Danny Wedding is editing the series and has four associate editors working with him, all of whom are members of the division (Drs. Larry Beutler, David Wolfe, Ken Freedland, and Linda Sobell).

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Most of the contributing authors to date are members of Division 12. One of the best things for our division is that we will earn royalties from each volume sold and will receive 100% of revenues derived from the CE site.

The second thing I wanted to briefly highlight is that one of my presidential objectives is to raise the awareness among psychologists and other health care practitioners of the importance of addressing substance use in the treatment of health and mental health patients. In this regard, through the hard work of Dr. John Hunsley, this year's Division 12 Program Chair, we submitted in concert with four other divisions (28, Psychopharmacology and Substance Abuse, 38, Health Psychology, 50, Addictions; 55, American Society for the Advancement of Pharmacotherapy) a cross-cutting symposium to APA's interdivision cross-cutting convention programs. The symposium, titled *Comorbidity and Beyond: Substance Use, Health,*

"Division 12 is the second largest among 53 divisions."

and Mental Health, was accepted and has as a major goal to highlight the range of issues involved in

comorbidity involving substance abuse. The extensive problem of comorbid substance abuse and mental disorders has received increasing attention from researchers, practitioners, and health policy makers. To date, however, less attention has been paid to the treatment of substance abuse in the context of other psychiatric/medical conditions and the treatment of other psychiatric/medical conditions in the context of substance abuse. The use of abused substances, besides having direct negative effects on health, can also adversely affect health by interfering with the actions of drugs used for medical problems. Therefore, it is important for psychologists to recog-

nize the importance of considering the ways that substance use interferes with many treatments for health and mental health problems. This symposium will focus on some of the many ways that substance use impacts on, and is impacted by a range of conditions and treatments.

This past year Dr. Kaslow made graduate student recruitment one of her major objectives. In many ways, OUR FUTURE IS OUR STUDENTS. While this will be the focus of my next column, let me give you a brief glimpse into why others and I feel this way. Division 12 is the second largest among 53 divisions. While we are working to keep the division strong by appealing to new clinical psychologists and graduate students, there are many divisions and that creates competition for new members. During this past year, Dr. Kaslow has done many things to promote student involvement. In fact, her goal is consistent with one of APA's goals. APA recently approved a voting seat on Council for a representative of the American Psychological Association of Graduate Students (APAGS). In order for our division to have an even stronger voice, I have decided to extend Dr. Kaslow's goal and I am exploring additional ways of bringing clinical psychology graduate students into the fold. To this end, almost all of our division's standing committees have an appointed student representative. Division 12 has seven specialty sections, each of which has a voting board member and permanent and regular access to the board and its officers. To this end, I am exploring the utility of developing a student section. WHY STUDENTS ARE OUR FUTURE will be the topic of my next column. I would like to ask any member, including students, who have ideas for promoting graduate student involvement and recruitment to email me (sobell@nova.edu) □.

Clinical Psychology Brochure

The popular brochure "What Is Clinical Psychology?" is available from the Division 12 Central Office. It contains general information about Clinical Psychology, and is suitable for both the general public and high school/college students.

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Dear Editor:

I am writing in response to the letter to the editor by Weisz, et al., published in the Fall 2004 issue of *The Clinical Psychologist*. I agree with many of the points made in this letter, especially the importance of avoiding the "warfare" that journalists seek to frame in order to make more interesting newspaper articles. I have appointed an American Psychological Association (APA) Presidential Task Force on Evidence Based Practice that includes a range of perspectives, with members of the clinical science community

"I believe empirical validation is important and lays the foundation for good therapy."

well represented, in order to advance exactly the type of collaboration that is described in the letter. I hope that my legacy as APA President will include the adoption of an APA policy on Evidence Based Practice that reflects the views of scientists and practitioners of all stripes. I also agree that the quote in the New York Times article was unfortunate. The major topic that I discussed with the reporter was the APA Presidential Task Force. As a side bar we got into a discussion of the

well represented, in order to advance exactly the type of collaboration that is described in the letter. I hope that my legacy as APA

issue of whether practitioners should be *required* to limit their interventions to manualized treatments that have been empirically validated, a position with which I strongly disagree. However, the way the reporter quoted me did not accurately reflect my position. I believe empirical validation is important and lays the foundation for good therapy. Also important is the clinician's judgment about how to build on the evidence when it is necessary to do so to help an individual patient. I have appended the charge to the Task Force for your information.

Sincerely,
Ron Levant
APA President, 2005

**American Psychological Association
Presidential Task Force on Evidence
Based Practice, Task Force Charge**

Currently, the most widely accepted definition of Evidence-Based Practice (EBP) is one adapted from Sackett et al. (2000), that appears in an influential report from the Institute of Medicine (IOM; 2001)

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entitled *Crossing the quality chasm: A new health system for the 21st century*:

“Evidence-based practice is the integration of best research evidence with clinical expertise and patient values” (p. 147). This definition provides a broad perspective and does not imply that one component is privileged over another.

The mission of the APA Presidential Task Force on Evidence Based Practice in Psychology is three-fold, corresponding to the three components of the IOM definition:

1. To consider how a broader range of research evidence, particularly based on effectiveness research, public health research, health services research, and healthcare economics should be integrated in a consideration of evidence in the practice of psychology.
2. To articulate and explicate the application and appropriate role of clinical expertise in treatment decision-making, including a consideration of the multiple streams of evidence that must be integrated by clinicians and a consideration of relevant research regarding expertise and clinical decision-making.
3. To articulate and explicate the role of patient values in treatment decision making, including a consideration of the role of ethnicity, race, culture, language, gender, sexual orientation, religion, age, and disability status, and the issue of treatment acceptability and consumer choice.

The Task Force incorporates scientists and practitioners from a wide range of perspectives and traditions, reflecting the diverse perspectives within

the field: Clinical expertise and decision-making; health services research; public health and consumer perspectives; randomized clinical trial (RCT) science; full time practice; clinical research and diversity; non-RCT clinical research; health care economics; EBP research/training and applications. In spite of the diversity of perspectives, our experience is that the IOM definition is generally acceptable as it applies to health services. Clearly there are issues of interpretation, and it has also been criticized for failing to include reference to patient characteristics (e.g., culture, ethnicity, language, age) that may be important determinants of treatment and outcome but are not appropriately characterized as “values.” The Task Force’s work will explicitly incorporate a multicultural perspective.

The Task Force begins with the IOM definition and focuses on issues related to implementation of this understanding of evidence-based practice in the health care system, including both its use and potential misuse in the field. In this context, a major concern is the manner in which evidence based practice can be misused in the service of overzealous cost containment efforts by using it as a barrier to delivering otherwise appropriate psychological services. It is hoped that implementing a consensually agreed-upon definition of evidence-based practice with regard to psychological services can help to maximize the benefits of this important concept while mitigating its potential for misuse.

The charge of the Task Force will be to develop two documents: 1) A set of recommendations for APA governance action; and 2) A position paper with targeted messages for health care decision makers, payers, and the media supporting a broader and more sophisticated conceptualization of evidence-based practice in psychology. □

JOIN A DIVISION 12 SECTION

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

Clinical Geropsychology (Section 2)

Society for a Science of Clinical Psychology (Section 3)

Clinical Psychology of Women (Section 4)

Clinical Psychology of Ethnic Minorities (Section 6)

Section on Clinical Emergencies and Crises (Section 7)

Section of the Association of Medical School Psychologists (Section 8)

Section on Assessment (Section 9)



Dear Editor:

I am writing in response to the letter to the editor published in the last issue of *The Clinical Psychologist* (Vol 57, No. 5, Fall, 2004, pp.5-6) written by the Board of Directors of Division 53 of the American Psychological Association (Society of Clinical Child and Adolescent Psychology) and signed by its recent past presidents. I have to admit some perplexity that a letter of this sort would take aim at arguments attributed to a scientist by a reporter and issue a point by point rebuttal of these second-hand arguments when the scientist's position has been stated first-hand in peer reviewed journals that are widely available online. I would like to suggest that the authors of this letter, and members of both Divisions 12 and 53, examine the article colleagues and I published in the August issue of *Psychological Bulletin* (Westen, Novotny, & Thompson-Brenner, 2004) and draw their own conclusions. Perhaps

“Evidence based practice is not practice based on a limited subset of the available evidence.”

the signatories of the letter did not all realize that the reporter's depiction of my viewpoint in two or three sentences was his attempt to

summarize the arguments and data presented in that article. I would welcome a public discussion of the article rather than popular news accounts of it.

The letter endorsed by the Board characterizes my position as follows:

Psychologist Drew Westen is cited in the article as stating that these therapies are “by necessity short,” that “many participants are excluded because their problems are too complicated for a single diagnosis,” and that “the chaos of real life is blocked out.” These are caricatures of the actual evidence-based therapies, which are in fact quite diverse.

The remarks in quotation marks may indeed be caricatures, but they are not mine. The *Times* article was filled with the journalist's turns of phrase (including the mixed metaphor about “blocking out chaos”), which the letter, I presume inadvertently, implied by its use of quotation marks were my words. A more careful reading of the *Times* article would reveal no quotation marks around any of the

comments the letter attributed to me. I suspect we would all do well to remember (most of us having had experience with journalistic translations of our work) that there is many a slip ‘twixt the journalist's rendition and the scientist's lip. I have learned over time to be quite careful in what I say to journalists and tend to prefer direct quotes that I can either verify or not verify.

If there is a caricature here, however, it is the *Times* reporter's placing of my work in the context of a debate between scientists and anti-scientific romantics, and of the implicit message of the Division 53 letter that my argument is anti-scientific. That psychotherapy should be grounded primarily in clinical opinion has never been my position, any more than it has been the position of Tom Borkovec, Marv Goldfried, or Alan Kazdin, who have also written some very critical commentaries on the EST literature *from a scientific standpoint*. The question is not whether psychotherapy should be grounded in science, which of course it should. The question is whether a single source of data—randomized clinical trials (RCTs) applied to a very small and unsystematically selected sample of possible interventions—provides sufficient grounding for the practice of psychotherapy. As someone who has worked extensively with adolescents in both research and practice, I believe, as does the first signatory of the letter, Dr. Weisz, that researchers have too infrequently made adequate use of developmental knowledge in designing treatments for children and adolescents. Aside from immersion in practice, where psychologists in training can develop the procedural knowledge of a skilled clinician, and in supervision, where they can learn from clinicians who have seen enough patients to know their way around another person's mind and experience, I want my students immersed in the *basic* science literature on development, not just in the applied literature on treatment, when they are deciding how to intervene with a patient. It seems to me that a strong grounding in developmental theory and research (e.g., knowledge of research on social-cognitive development) should be part of the evidence base used in evidence-based practice for children and adolescents. Evidence based practice is not practice based on a limited subset of the available evidence.

I could not agree more with the sentiment expressed in the Division 53 letter about how science and practice should be integrated, namely that best practice is likely to integrate what we learn from the laboratory with what experienced clinicians

learn every day in working with their patients. If that were the agenda of the empirically supported therapies (EST) movement, I doubt there would be much tension in our field between researchers and clinicians. But that is not, in fact, the agenda, unless by “integrating” one means that researchers will tell clinicians what to do and clinicians will let them know if a few minor changes are needed as they apply manuals “transported” to “front line” clinicians. Terms like “transporting” and “disseminating” treatments imply unidirectional information flow, not integration.

The letter urges clinicians to consider science as a “close ally” rather than as an enemy, because it can be used to demonstrate that psychotherapy works and can help us identify those therapies that do work. But “science” already demonstrated that psychotherapy works, when Smith and Glass (1977) published their landmark meta-analysis, and the data remain just as clear today (Wampold, 2001). What the EST movement has done, advertently or inadvertently,

“...evidence based practice includes many forms of evidence other than data from RCTs...”

is to privilege forms of therapy predicated on assumptions about the malleability of symptoms and the independence of

those symptoms from personality (which render these treatments testable in 2 to 3 months in brief trials) over what are often called “traditional” psychotherapies, which have always assumed—it now turns out correctly—that most psychopathology is resistant to change and inextricably bound up with personality characteristics that are unlikely to change dramatically in 12 weeks and often require extensive exploration to identify and revisit over time.

We have no idea whether the longer term, often more integrative treatments that were once the norm in clinical practice and are now the norm only for more affluent patients are more or less effective than the average treatment studied in RCTs. Unfortunately, no one has bothered to test what private practitioners do with patients who can afford private treatment. But it is disingenuous to claim that science is the ally of psychotherapies that have been systematically excluded from testing because of methodological strictures designed for brief, focal treatments while declaring that only data from RCTs count as evidence. If clinicians are wary of this ally, they should be. And this includes CBT

clinicians in the community, who rarely practice 12-session psychotherapy for any disorder we have studied in the community, except when their feet are held to the managed care fire. Nor should patients consider this kind of science an ally, given that it has contributed substantially to the curtailment of their psychotherapy benefits, even though the data from the vast majority of RCTs show that the average patient assigned to an EST in the laboratory does not recover, and that only a small minority tend to recover and stay recovered over 2 years following brief treatment for anything other than relatively specific anxiety disorders (Westen, Novotny, & Thompson-Brenner, 2004).

To put it another way, EBP > EST—that is, evidence based practice includes many forms of evidence other than data from RCTs (see Wampold, 2001). I suspect the signatories of the Division 53 letter would agree, but I think they need to be more careful than they are in their letter about using *empirically supported therapy* and *evidence based practice* as synonyms.

In sum, I would be delighted to see a critical discussion of the issues raised in our recent *Psychological Bulletin* article, about which reasonable scientists can come to differing conclusions. But I suspect it would be more fruitful at this point to discuss what we actually wrote and the data we used to draw the conclusions we reached, rather than to produce position papers criticizing a journalist’s 50-word rendering of his understanding of those conclusions. □

Drew Westen, Ph.D.

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References

- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.
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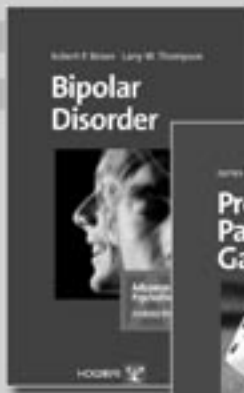
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Division 12 Elections Candidate Statements

Elections for several Division 12 positions will occur this Spring. Ballots will be mailed to members in the middle of April 2005, and must be returned no later than May 27, 2005.

PRESIDENT-ELECT

Marsha M. Linehan, Ph.D., ABPP



Marsha Linehan is a Professor of Psychology and Adjunct Professor of Psychiatry and Behavioral Sciences at the University of Washington, and Director of the Behavioral Research and Therapy Clinics, a consortium of clinical research projects developing psy-

chological treatments and evaluating their efficacy for severely disordered populations. She is founder of Marie Institute of Behavioral Technology, a non-profit organization that disseminates efficacious psychological treatments. She been extensively involved developing effective models for transferring new treatments to individual clinicians, clinical teams and health care systems.

She is a fellow and long time member of Division 12, is a member of Division 35, holds a Diplomate in Behavioral Psychology (ABPP), and is a licensed psychologist in Washington. She has received numerous awards recognizing her clinical and research contributions, including awards for Distinguished Scientific Contributions to Clinical Psychology (APA, Division 12), Distinguished Contributions to the Practice of Psychology (American Association of Applied and Preventive Psychology), Distinguished Contributions for Clinical Activities, (Association for the Advancement of Behavior Therapy), and the Distinguished Scientist Award (APA Division 12, Sec. 3). She has extensive organizational experience, having served on the Board of the Association for Advancement of Behavior Therapy, as membership chair, and as President.

I have spent my career immersed in the science and practice of psychology. As the health care field moves to a focus on providing evidence-based treatments, psychologists have an enormous

amount to offer. We have not only developed most of the effective psychological treatments for mental and stress-related disorders but we also have the knowledge and skills to train, supervise and provide these treatments. I believe one of our biggest tasks in the coming decades is getting our voice heard—by the public, by insurers, by legislatures and by our fellow mental health care colleagues. I believe that my experience and my credibility within the mental health arena will make me a strong spokesperson for psychology in the public and professional areas.

I believe that a number of factors are important to maintain and strengthen the ability of psychologists to influence the quality of mental health care provided in this country. First, we must fight for parity in health care for mental disorders, for parity in payments for psychological treatments, and for parity in payment of psychologists as treatment providers. Our data on the effectiveness and cost-benefit of psychological treatments is our strength in these battles. Thus, we must also fight for funding of psychological treatment research and training of new investigators. The coming cuts in NIH research funding make this of vital importance. I will work to make us more effective in these efforts.

Like all professions, we have the task of finding efficient and cost-effective ways to transfer new ideas, effective treatments, and research findings to those of us who have completed our professional training. The proliferation of new knowledge and skills to be learned is accelerating at a tremendous pace. I believe that we have the knowledge and skills to improve on what we already do well and will work to encourage this work.

I would be honored to begin the dialogue. □



Division 12 Candidate Statements

PRESIDENT-ELECT

Kenneth J. Sher, Ph.D.



I am Professor of Psychological Sciences at the University of Missouri-Columbia. A licensed psychologist and health service provider in Missouri, I have been actively engaged in professional and public service throughout my career. At the Federal level, I serve on the National Advisory Council on Alcohol and Alcoholism and NIAAA's Extramural Advisory Board. I have provided extensive service to several professional societies; with respect to APA, I have served on APA's Committee on Scientific Awards and as associate editor of two of its journals (*Journal of Abnormal Psychology* and *Psychological Bulletin*). Within the Division, I recently served as President of Section III—the Society for a Science of Clinical Psychology. I have published extensively in the area of the psychology of addiction and I currently hold a MERIT award to continue my research on the predictors and course of alcohol involvement, direct a combined predoctoral and postdoctoral NIH training grant, and direct the MU component of the Midwest Alcoholism Research Center.

I am interested in running for president-elect of Division 12 because I believe there are serious problems with APA and that “if you're not part of the solution, you're part of the problem.” A clear indicator of APA's “problems” is the fact that many clinical psychologists of diverse orientations (and including clinicians, educators, and researchers) are not members of APA and find APA irrelevant and, in some cases, antagonistic to their professional needs. Whatever, the reasons (and they are undoubtedly many), the lack of interest by many clinical psycholo-

gists in the APA overall and in the Division is a serious issue because it limits our ability to speak with a strong voice (even with the additional harmonics of dissenting minority opinions) to the larger profession, policy makers, and the public at large. We can be more effective in advancing issues of common interest with respect to service provision, education, and research if the Division were viewed as representing the diverse discipline of clinical psychology with broad support from the profession. For example, a particularly important issue concerns the future of prescribing authority for psychologists. As prescribing authority proliferates across multiple states, we need to be vigilant in insuring that the quality of training and certification is something that all clinical psychologists can take pride in, regardless of their feelings of whether the prescribing authority is good for the profession. Another timely issue concerns the nature of what constitutes “evidence” for evidence-based practice. I believe the issue of “evidence” is important for all of our activities (practice, education, research, policy) because it gets at the heart of accountability to the diverse constituencies we serve. In deciding what constitutes “evidence” for our various activities, we need to be respectful of each other's perspectives and understand differences in the “state-of-the-art” for establishing evidence across different activities. At the same time, we need to be rigorous and intellectually honest in evaluating the effectiveness of our activities. Doing so can only make us better at what we do and help build the trust of those we serve, and support our profession. □

PRESIDENT-ELECT

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



I am seeking the presidency of the Society of Clinical Psychology because I would like to see Division 12 become an increasingly attractive and rewarding professional home for all clinical psychologists, scientists and practitioners alike, whatever their theoretical orienta-

tion and special areas of interest. I believe that I have the administrative experience and breadth of engagement in clinical psychology to work effectively toward this goal.

I have been Professor of Psychology at Case Western Reserve University, where I served as Department Chair and later as Dean of Graduate

Division 12 Candidate Statements

Studies and Research. I was also Professor of Psychology at the University of Denver and at Fairleigh Dickinson University, while serving as Vice President for Academic Affairs for these universities. In medical school settings, I have also been Professor of Psychiatry and Head of the Psychology Division at the University of Rochester Medical Center, where I took my first position after completing my doctorate in clinical psychology at the University of Michigan, and Professor of Psychiatry and Director of Psychological Services at the University of South Florida Psychiatry Center, where I continue currently as Affiliate Professor. I am an ABPP Diplomate in clinical and in forensic psychology and a Diplomate of the American Board of Assessment Psychology, and I have maintained a part-time private practice in psychotherapy, psychological assessment, and forensic consultation throughout most of my career.

The breadth of my scholarly and applied pursuits is reflected in books I have written on psychotherapy, psychopathology, psychological assessment, clinical methods, forensic psychology, and child and adolescent development, and in my serving as editor-in-chief of the recently published 12-volume *Handbook of Psychology*. I am a Division 12 Fellow, a Fellow of Divisions 5, 39,

42, and 53, and a member of Divisions 41 and 52. In Division 12 I have served on the Fellows Committee and have just completed a 3-year term on the Board of Directors as representative of Section IX (Assessment Psychology), including 2 years as a member of the Finance Committee.

I am familiar with Division 12 operations, with the issues facing clinical psychology, and with procedural aspects of administration, having been a medical school division head, an internship and postdoctoral training director, a department chair, a university graduate dean and academic vice-president, and an independent practitioner. I believe that the Society of Clinical Psychology should remain devoted in the years ahead to advancing substantive knowledge in our field and to pursuing constructive applications of this knowledge for the benefit of those who need and seek our services. We should continue to advocate for quality education and training in our profession and for public policy that recognizes and fosters our contributions to knowledge and practice. We need as well to continue investing energy in the recruitment of new members and in efforts to retain the interest, enthusiasm, and participation of our current members. These are the purposes to which I will dedicate my term of office if I am elected Division President. □

APA COUNCIL REPRESENTATIVE (General Slate)

Larry E. Beutler, Ph.D.



My career has been a blend of science and practice. My academic work has been guided by the traditions of psychotherapy research. I have been a Director of Clinical Training in two major university programs and of two medical school internship programs. I

have written and researched widely the nature of the psychotherapy relationship, and the fit of treatment to patients. Recently, I have been co-Chair of a Task Force (Division 12) to identify the basic principles that can be extracted from our best research and readily applied to practice.

As a past President of two Division (12 and 29) and as a previous member of Council, I believe that I am prepared to help the Society of Clinical

Psychology advance its goals before APA. Division 12 is the voice that speaks on behalf of those whose activities, practices, and commitments are to the application of clinical knowledge to human welfare. As a member of Council, I will work to ensure that the Division remains strong; that we increase the appeal of the Division to the clinical members of APA, and that we better represent the broad range of views and practices that constitute clinical psychology. I will work to foster the growth and development of our sections, because I believe that it is through the sections that these goals can be largely accomplished. We should actively work to expand the diversity of sections and to increase both their visibility and their voice within the Division leadership. □



Division 12 Candidate Statements

APA COUNCIL REPRESENTATIVE (General Slate)

Nadine J. Kaslow, Ph.D., ABPP



As Past-President of the Society for Clinical Psychology (Division 12), I would be honored to continue to serve the Division as its representative to the APA Council of Representatives. I would continue to advocate for the integration of science and practice, a competencies-based approach to education and training, advocacy efforts on behalf of psychology, and the diversification of our profession.

I am a Professor at Emory University School of Medicine Department of Psychiatry and Behavioral Sciences, and Chief Psychologist, Grady Health System. I have received a number of awards including the Division 29 Krasner Award for Distinguished Early Career Contribution to Psychotherapy, Board of Scientific Affairs Award for Collaboration between Academic Psychologists and the State Psychological Association, Division 43 Award for Distinguished Contributions to Family Psychology, Spielberg Empathy Award, and APA's Distinguished Contributions to Education and Training Award. I was a Primary Care Public Policy Fellow through the

United States Public Health Service and received the Hesier Award for my efforts in legislative advocacy. I chaired the Association of Psychology Postdoctoral and Internship Centers (APPIC) and was a member of the Board of Educational Affairs. I am currently President of the American Board of Clinical Psychology. I chaired the Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology. A Fellow of the Executive Leadership in Academic Medicine (ELAM) Program for Women and the Woodruff Leadership Academy, I am the associate editor for two journals and have been a member of two NIMH Institutional Review Groups. I have published over 140 articles on culturally competent, gender sensitive, and developmentally informed assessment and treatment of family violence, depression, and suicide in youth and adults; couples and family therapy; pediatric psychology; and supervision and training of interns and postdoctoral fellows. A member of Rosalyn Carter's Mental Health Advisory Board, I serve on a number of community boards. □

APA COUNCIL REPRESENTATIVE (General Slate)

Jerome H. Resnick, Ph.D., ABPP



I am Professor Emeritus of Psychology at Temple University, having served for a decade as Director of the Department's Psychological Services Center, and beyond that post, as long-term Director of Graduate Studies of the Department's five doctoral programs. I am the 1999 recipient of our society's Award for Distinguished Professional Contributions to Clinical Psychology. In 1991, I served as President of Division 12. Currently I represent Division 12 to the APA Council and am seeking re-election. I am a Fellow of eight APA divisions; past-Chair of the Board of Professional Affairs; past-Chair of the Committee on Structure and Function of

Council; past-President of the Assembly of Scientist-Practitioner Psychologists; and a two-term member of the Policy and Planning Board. I am a former President of the Pennsylvania Psychological Association, and am the current (June, 2004) recipient of PPA's Award for Distinguished Contributions to the Science and Profession of Psychology. I was an invited participant at the 1990 National Conference on Scientist-Practitioner Education, and the 1994 Conference on Post-Doctoral Education. For seven years, I served as Eastern Regional Vice-President of Psi Chi.

Division 12, representing the field of Clinical Psychology, is pivotal in two ways: First as represent-

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ing science and practice as a mutually reinforcing entity. Second, as representing the range of arenas in which our field functions. This range includes both the life-span and the myriad of activities and sites in which we operate. We need to work to broaden and solidify our base while keeping our membership

standards high. With a record of involvement in these various aspects of our field and in the corridors of policy-making now extending for over three decades, if elected to a renewed term, I believe I can continue to be an effective leader for our interests. □

TREASURER

Robert Klepac, Ph.D.



I would like to serve a second term as Division 12 Treasurer. During my first term, I assisted in moving our budgets from serious deficits to the point where we enjoyed a balanced budget in 2003, including contributions to our reserve account for the first time in many years.

Other contributions to Division 12 include service on the Publications Committee and Section III Representative to the Board of Directors.

I received my doctorate in clinical psychology from Kent State University. I have served on the faculties of Western Washington University; North Dakota State University, where I chaired the Department of Psychology; and Florida State University, where I served as Director of Clinical Training. My current position is Director of Psychology Training at Wilford Hall Medical Center, directing a large scientist-practitioner internship program and overseeing a postdoctoral program in behavioral health psychology. I also serve as National Coordinator of Air Force Psychology Training. My

research interests lie in clinical health, and include studies of pain and the reduction of fear of intrusive medical and dental procedures for which I have enjoyed NIH support.

I've worked as an educator at levels including undergraduate, graduate, internship and postdoctoral. I've been an academic administrator, researcher, private practitioner, agency service provider, and consultant. My service to other professional associations includes: member and chair of the APPIC board of directors for six years; member of the Committee on Accreditation; president of the Society for a Science of Clinical Psychology; president of the Behavioral Psychology Specialty Council; and Representative to the Council of Specialties; among others positions. That checkered past has provided me with a broad perspective on the many facets of clinical psychology, which I bring to my roles on the board of directors. I would be honored to continue as Treasurer and member of the board of your association. □

TREASURER

Guerda Nicolas, Ph.D.



Dr. Guerda Nicolas is a licensed clinical psychologist and full time professor at Boston College in the Lynch School of Education, Department of Counseling, Developmental, and Educational Psychology. She obtained her doctoral degree in clinical psychology from Boston University. She completed her predoctoral

training at Columbia University Medical Center and her postdoctoral training at the New York State Psychiatric Institute (NYSPI) in the Department of Child Psychiatry. Her current research projects are on cultural adaptation of clinical intervention for ethnic minority adolescents, with a specific focus on Haitian adolescents, spirituality in the lives of adolescents, improving academic performance of ethnic



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minority High School students, and social support networks of Blacks.

I have been an active member of Division 12 for over 10 years and served on the Executive Committee of Section VI-Clinical Psychology of Ethnic Minorities for close to 10 years, as Membership Chair and the Newsletter Editor. In addition to my active membership in Division 12, 17, 35, 45, 53, and the Massachusetts Psychological Association, I am also a member of the APA Committee on Early Career Psychologists, Co-Chair of the Early Career Task Force, and the Federal Advocacy Coordinator of Division 35. As an early career psychologist, I believe that I have the energy, drive, wit, and compassion to serve the

Division. As a multicultural (Haitian American) and multilingual psychologist (Spanish, French, and Haitian Creole), I will work to strengthen the visibility and sustainability of the division's connection to the various mental health professionals and organizations at a national and international level. I am fully aware of the importance of overseeing the division's finances as the treasurer and I will make sure that we achieve a balanced budget that supports the highest priorities of the division. I am honored to have been nominated to serve the division and I look forward to bringing my energy and experiences in achieving the mission and vision of the division. □

TREASURER

Steven M. Tovian, Ph.D., ABPP



Steven M. Tovian, Ph.D., ABPP has been an APA and Division 12 member since 1979. He is Assistant Professor of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University. For 27 years, he was at the Evanston Northwestern

Healthcare Medical Group where he was Chief Psychologist and Director of Health Psychology in the Department of Psychiatry. He is currently in Independent Practice in Highland Park, Illinois.

Dr. Tovian is a Fellow of APA Divisions 12, 29, 38, and 42, and he is Board Certified (ABPP) in Clinical and Clinical Health Psychology. He has authored and co-edited two books, including the *Handbook of Clinical Psychology in Medical Settings*, and published numerous book chapters, and peer-reviewed articles. He serves on the editorial board for the *Journal of Clinical Psychology in Medical Settings*.

Dr. Tovian has been Treasurer of APA

Division 38 (Health Psychology) and Treasurer of the Association of Medical School Psychologists (AMSP), Section 8, APA Division 12. He has been President of the American Board of Clinical Health Psychology (ABPP). In 2004, he was awarded the Timothy Jeffrey Memorial Award for outstanding contributions to Clinical Health Psychology by APA Division 38 and the American Psychological Foundation.

I am honored to be nominated for Treasurer and have the possibility of serving in the governance of this Division. I would like to make my experience as a scientist-practitioner in Clinical Psychology in both independent practice and in medical settings, as well as in organizational and fiduciary management, available to our Division. I am well aware of the practice, educational, and research issues facing our specialty. If elected, I believe I would provide dedication, enthusiasm, and experience to Division 12. I would appreciate your support. □

Challenges in the Predoctoral Internship Application Process

The predoctoral internship is the capstone of the graduate training experience for clinical psychology students. Searching for sites with whom the “fit” is good, collecting supporting material, calculating clinical hours, writing essays... it is a daunting task for many students. For students facing personal challenges beyond those presented by this demanding process, applying for internship can be particularly complex. How might a student with a disability best navigate the application and interview process? Can the Couples Match be effectively used to keep two internship applicants geographically close without hurting their chances of a good match? How do students grapple with an often-feared outcome: not matching?

In the following, three graduate students share their experiences managing these additional challenges of the internship process. They offer the knowledge and perspective that they have gained as a resource for future students facing these and other complicating issues. □


Torrey Creed, M.S.Ed.
Temple University
Editor, Student Forum

Internship Application Process with a Difference

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 Having dealt with a hearing loss as a child and arthritic disorders as a young adult, I am now one of the thankfully growing numbers of differentially abled psychology doctoral students. But as interesting as being a doctoral student can be, having a form of physical, mental, or learning diversity is a challenge above and beyond that experience by the graduate population at large. In successfully managing graduate studies, we have become masters of cutting through academic red tape, navigating social and governmental aid systems, and wrangling with insurance companies to obtain at least what we needed to survive in that system. All this is in addition to the actual demands of our disabling condition, regular coursework, outside employment, social and family demands. If those early graduate years could be called preparatory quizzes, then the internship application process is studying for the final exam. Hopefully, this article will act as a kind of study guide in formulating your own ideas or generating additional questions.

The American Psychological Association (APA) recently published an excellent on-line guide-

book dealing with disabilities in psychology graduate students that can be downloaded at www.apa.org/pi/cdip/resource/forward.html. This short article will hopefully be an additive personal experiential component to the detailed information presented in the APA on-line guidebook.

When beginning your internship search, of primary concern is the area in which to look for a site. Besides the typical desires of specialization track, research directions, or specific amenities, you may have a focus on specific areas with appropriate medical services available. Your “goodness of fit” to the geographical locale can be another issue, such as higher altitudes being dangerous for persons with asthma or anemias. Conversely, although the American Southwest with its sunny climes might be beneficial for persons with seasonal affective disorder, it would generally not be advisable for those with Lupus or skin cancers. These are personal decisions for the applicant to make with eyes wide-open. Other thoughts on internship site applicability might center on:

- the distance of the site from your residence and the potential toll on your body and psyche via miles and hours on the road. Extra time on the road can be fatiguing to many disorders and the physical mechanics of driving alone may deplete the strength of a person with Muscular Dystrophy, for example.
- the site’s emotional and production demands combined with ongoing physical stressors. Sites

that ask for 50+ hours of weekly production time may actually add a few extra hours for special projects, and many times the hours promised for dissertation time do not materialize. Be prepared to check with your school's training office for input from past interns and the director's own experience as to real time expectations if you have doubts.

- distance from your emotional support base. Although you may not have much time to spend with your loved ones, having those few good people nearby is essential for the rough spots. Having a disability can create opportunities for all sorts of interesting situations and your friends and family can help you stay grounded no matter what adversity you may encounter.

“For most students, a juicy stipend is highly valued and greatly sought after.”

Applicants receiving Medicare or Medicaid benefits need to carefully weight their options, because if they exceed the government's financial earning limits they may lose their monthly award and medical insurance. This is where the concurrent existence of internship insurance becomes exceedingly interesting. Not only does the applicant need to know of the existence of such insurance, but also the extent and limits. Additional insurance questions include:

- Is this a group or individual policy?
- Are there any exclusions?
- Is there a prescription plan and what is covered?

As these decisions are being firmed-up, other issues may also be considered. Disclosure concerning your diversifying event is an issue for both those internship applicants whose physical diversity is not readily observable and those for whom it is. Although most people do not readily notice my hearing loss or aides, certain peculiarities could be ascertained after an encounter of more than mere moments. Missed cues, mistaken words, and my need for clarification could potentially have many meanings. Rather than leave the interviewer wondering if I was tired, overly stressed, or worse, I usually choose to inform. Hopefully, this is after providing an opportunity to

others can be dealt with such as availability of insurance and a stipend. For most students, a juicy stipend is highly valued and greatly sought after.

demonstrate my ability to appropriately deal with one on one situations, where I tend to excel!

Each person must ultimately make his or her own decisions as to who and how much information is shared. It is obviously best not to give the “blood and guts” version, yet conversely ignoring an obvious difference creates the proverbial “elephant in the living room” syndrome that we end up counseling our clients through. The Americans with Disabilities Act (ADA) and the APA regulations assure us that we have a right not to disclose any information at all. However, if we are to make the best fit with a site, judicious amounts of disclosure may be necessary to have our needs appropriately met. The intern site does have the right to ask questions regarding our ability to fulfill the baseline intern functions, given whatever portion of our disabling condition is visible or that we disclose.

Before on-site interviews, a bit of extra investigation work could prove essential for securing a safe, comfortable and hopefully problem-free visit. Having a map of the area with locators specifying handicapped parking, entrances, estimated distances to the various offices, elevators, and restrooms could result in fewer minutes spent wandering and decreased stress levels. Be prepared for travel problems with back-up plans, which might also include the number of a nearby pharmacy or a wheelchair tire shop. Staying overnight at a nearby motel could be judicious, even for a relatively close site, in order to save energies and time.

Phone interviews can be both a blessing for some and a curse for others. Personally, I do not relish the thought of attempting to perform adequately over a telephone, even with assistive listening devices. In my case, it's not just loudness and clarity, but an appropriate visual link with verbal and facial cues. Other applicants may express relief over the anonymity of a faceless conversation. Although you have the option of not applying to sites that offer only phone interviews, you can likewise take the risk of contacting the director of training and explaining your situation in hopes that he or she can change or augment the procedure.

Likewise, with group interviews you have the option of applying to these sites or not. If you participate in a group process, be prepared for potential sticky situations that can occur in larger groups of eager graduate students all vying for a few coveted spots. In my situation, do I really care to shake hands

with eight or more persons with my arthritic hands on a “bad hand day”? Or should I do a Bob Dole and hold a pen in my hands instead? Although it is doubtful the later concept would work effectively with both hands, I also may not care to share this information with a group of relative strangers. The question of disclosure arises yet again for consideration.

Finally, be prepared for rejection. Even the most brilliant, capable, non-disabled applicant will be rejected from at least some sites. Due to the increasing demand for internships and APA approved sites combined with budget cuts, available sites have become much more competitive. Having a disability is not a certainty for losing a site, but a poorly constructed Curriculum Vitae or aggressive attitude during an interview can certainly be a reason. There may be some sites that will not care to deal with the vitality and altered mindsets our population

brings. So be it – we are better without those sites. “Goodness of Fit” works both ways; the site needs to meld with our wants, needs, and desires as we do to theirs. Just keep all your stress management tools lined-up, including your emotional supporters and ever-patient faculty that have nurtured us.

Now more than ever you’ll need to rely upon the tremendous flexibility you have developed, yet at the same time we have never had such an opening of society and opportunities within our chosen profession. We have survived illness, diseases, insurance companies and the occasional poorly informed medical provider. Having lived psychology from the inside out, we might have a bit of an edge over some of our fellow doctoral students; we’ve been there and done that. Now comes the final crunch before we can all take our victory lap. Best wishes to us all, disabled and not. □


The Couples Match

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 Graduate school in psychology can be an intense and rewarding experience on many levels. The pressures encountered and partnerships formed in graduate school often lead to deeply meaningful relationships. As a result, many people leave graduate school with more than they bargained

“If you are serious about matching as a couple you will need to compromise...”

for—new friendships, a new romantic relationship, or even a new spouse or life-partner. When the final year of graduate training rolls around,

all of us face the daunting and puzzling process of applying to internship. Romantic partners who apply to internship simultaneously are faced with an additional set of challenges.

Thankfully, the Association of Psychology Post-Doctoral and Internship Centers and National Matching Services, Inc. (APPIC and NMS, respectively) have anticipated these challenges. These organizations offer a wealth of information and a very good system for applying, ranking, and matching to internship sites as a couple. Last year, my girlfriend,

Talia, and I went through this process and were successfully matched as a couple in the New York metropolitan area. In this article I shall share my experiences and advice regarding the “couples match.”

Deciding whether and how to use the couples match is a multi-step process. The first thing you and your partner should do is initiate an open dialog about the general regions each of you is considering. If you are serious about matching as a couple you will need to compromise even at this initial step (but do remain honest about your personal interest in each area). Talia and I each found ourselves considering regions (and therefore, sites) that we would not have given a second glance if the other had not expressed interest in them. Although you may find yourself applying to sites or regions where you have little intrinsic interest, you may also find, as I did, that some of these sites end up among your top choices.

To increase our chances of matching together, Talia and I decided to apply in larger metropolitan areas due to their higher concentration of internship sites. As such, we were each able to distill our selections down to 12 sites in 4 regions. If you apply in each other’s regions as we did, you will probably end up applying to many of the same sites as your significant other. This is not necessarily a bad thing. However, if you are applying to the same track of a given site you will have to figure out how you feel about competing with one another—a topic well

beyond the scope of this article.

Once you have mailed your applications and have (hopefully) started receiving interview invitations, you should consider your partner's interview schedule. If you are able to visit various regions and sites together you will be able to "preview" what your life would be like there together. You will also be able to share your initial impressions about each site with your partner. This will help you process your reactions to each site and may prevent you from harboring "secret" preferences for individual sites.

When at the internship interviews (especially when interviewing at the same site on the same day), you must agree on whether to disclose or disguise your relationship. This will depend on each of your own feelings, as well as how "friendly" you feel that site is to hearing about your personal life (I found that my comfort level varied greatly depend-

"...the most complicated part of matching as a couple is the ranking process."

ing on the site). Whether you decide to reveal or hide your relationship to your partner, you should avoid discussing whether you are considering matching as a couple, since this is a taboo piece of "match-related information."

So, you made it this far—phew. Unfortunately, though, the most complicated part of matching as a couple is the ranking process. As you have probably heard, most individual applicants find it difficult to rank 12, 8, or even 4 sites. However, since in the couples matching process you are essentially ranking pairs of sites, the total number of items on your rank list will be at least the product of your and your partner's sites. This means that if one member of a couple is ranking 10 sites and the other is ranking 9, the couple will have 90 possible combinations where each person is matched.

But what if one of you, for any of a variety of unfortunate reasons, is not matched with an intern-

ship site? This is an important issue that is often misunderstood and is tied in with the myth that the couples match process hurts your odds. If you want your chances to be exactly the same as they would be if you were matching independently, you must allow for combinations in which one member of the couple goes unmatched. This issue is effectively explained on the APPIC and NMS websites and as such I will only summarize it here. Briefly, if you do not rank match-pairs where one of you does not match, and one of you does go unmatched, then the other person in the couple will be unmatched as well, regardless of how well he or she would have done as an individual candidate. This is because the computer will not be able to use any of your combinations, since they all require that the unmatched partner being ranked somewhere. To avert this disaster, our hypothetical couple must rank the 90 combinations where both of them are matched and an additional 19 combinations where one partner is unmatched and the other proceeds through their individual rankings from most to least desirable. Total number of combinations: 109.

Each of you will develop your own strategy for deciding how to rank this dizzying number of combinations. Talia and I alternated between combinations that "favored" one or the other of us. We proceeded through the first 17 combinations that had us in the same metropolitan area, moving on to those where we were in the same region, then those that had us in far-flung regions, before finally ranking combinations where one of us went unmatched. I am happy to say that it worked very well.

That brings me to my last bit of advice regarding the couples match process: take heart. Talia and I took only a few days to complete our rankings and I can honestly say the process was not entirely unpleasant. If you prepare well, discuss matters openly, and compromise frequently, the couples match process can increase your chances of spending your internship year near the person who is most important to you. □

The Amazing Race: On Surviving a No-Match Result

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As just about anyone who has been through it can tell you, applying for predoctoral Internship is the ultimate multi-tasking challenge—and in my opinion, worthy of a prime-time reality television show all its own! If reality cameras could closely follow the applicant, what a fascinating sample of human behavior the world would see. Millions of viewers could observe him

“Misgivings remain toward the process, which in my opinion is in need of major overhauls ...”

or her diligently studying, researching, and working to help people live better lives. Then, the competition intensifies as the person begins applying for

internship, a process equivalent to a part-time job. Such a TV show might aptly be called *“Internship, the Amazing Race!”*

I have not had much time for popular culture since becoming a graduate student, but my personal match day reality could aptly be summed up as *“Survivor: Lost in Cognitive Distortions.”* When I didn’t match, I actually thought for a brief moment that something was wrong with the NMS computer! As reality sank in, my brain spun out of balance with irrational thoughts as I considered possible reasons for this outcome. I proceeded to mentally grind them at all hours, considering, attributing, and discarding reasons for failure one by one. My brain scanned images of the people I’d met, e-mails, and phone calls. I recalled interview questions, second guessing my responses. My mood spiraled into the zone of hopelessness as I pondered questions like “What if I don’t match next year?” and “I’ll never graduate.”

I wish I could report that I matched to an Internship site through the Clearinghouse but that was not the case. Paradoxically, working through Clearinghouse openings helped improve my mood. I noticed that positions listed in the Clearinghouse were disappearing almost as quickly as they’d appeared, and postings didn’t stay open for long. Just

a couple of hours after applying for one position I received an e-mail saying “Thank you for applying to a position at our agency. We received applications from one hundred people and unfortunately, we can only hire one...” *Wait a MINUTE! One hundred applications two hours after opening?* I was beginning to see evidence that external factors beyond my control might also be at play in the system.

I’ve since learned that there were hundreds of other qualified applicants that were not matched. The “supply and demand” problem was discussed on the Match list serve. Several other applicants from my APA accredited program, whom I considered to be outstanding students with great credentials and experience, did not match. Eventually I decided to wait another year, and the need to make sense out of not matching faded into the background. I explored my options and found a great opportunity for more clinical experience. I received helpful feedback from interviewers. I leaned on friends in my program, making time to talk about our experiences. I spoke with my DCT about what to do differently the next time around.

At the time of this writing I am getting ready for the match again. I am concerned about the amount of time and effort that is involved, but I am prepared. Misgivings remain toward the process, which in my opinion is in need of major overhauls to keep student needs and time demands a priority. I volunteered to write about not matching because I know there are more than a few others, who like me, have had a cognitive distortion or two along the way (and it would be great to hear from you). While it’s still tempting for me to try to pin down one or several reasons why I didn’t match, I’ve found it easier to cope by focusing on more rational thoughts.

First, hold on to the vision, ideals and goals that brought you to this exciting place in your life. Protect your sense of self, remembering that your goodness and worth as a human being is not related to the match. You are qualified and ready to continue the process. Recognize and celebrate your strengths and your achievements. And lastly, as my ten year-old daughter reminds me frequently, remember that “The key to life is relaxation.” Slow down because it’s not a race, just one amazing journey. □



CANDIDATES FOR FELLOWS WELCOME!

Any member who has made outstanding contributions to clinical psychology is eligible. **Members who are Fellows of other APA divisions are also encouraged to apply and the application process is much less demanding.**

As a guide to determine if you or somebody you are thinking of nominating fit the criteria for "Fellow" status, here is a list that APA, as well as our Division, considers when going through applications. Note that these are minimum standards under the APA Bylaws so one must meet all of these criteria:

- The receipt of a doctoral degree based in part on a psychological dissertation, or from a program primarily psychological in nature
- Prior membership as an APA member for at least one year and a member of division 12
- Active engagement at the time of nomination in the advancement of psychology in any of its aspects (for our division, the aspect would be clinical psychology)
- 5 years of acceptable professional experience subsequent to the granting of the doctoral degree
- Evidence of unusual and outstanding contribution or performance in the field of clinical psychology; this requires evidence or documentation that the person nominated has enriched or advanced the field of clinical psychology on a scale well beyond that of being a good practitioner, teacher, researcher, administrator or supervisor. The nominee's contributions have to be unusual, innovative or of seminal nature. Fellowship status is simply not conferred based on seniority or competence.
- More specifically, criteria for Fellowship can have a broad range, including direct therapeutic services, consultation, administration, research and involvement in national, regional, state and local professional governance activities. Outstanding service to APA Boards or Committees, or to Division 12 Committees meet the criteria for fellowship, provided that such services can be shown to have had a positive impact on the field of clinical psychology as a profession or science.
- For nominees in predominately clinical practice, there is a need to specify how their therapy or practice represents an innovative application with, for example, a difficult disorder or an atypical patient population. Endorses for a candidate will need to specify clearly how the nominee has made a visible impact on the field of clinical psychology. Based on experience, the person should already be on a clear career path, typically with a substantial number of publications

Applicants need to complete the Uniform Fellows Blank and provide a self-generated written statement setting forth the justification that they believe exists for election to the status of Fellow. Self-nominations are welcomed. Lastly, part of the application requires letters from three fellows. Materials are due December 1st.

If you are already a Fellow of another division, approval by the Division 12 Committee is sufficient to make you a Fellow of Division 12. To apply, please send a letter of achievements and 2-3 letters of recommendation from those who are members and fellows of Division 12. Applicants who are already APA Fellows should send their materials to the Fellows Committee no later than March 11, 2005. In addition, a statement of accomplishments outlining your contributions to the field would be helpful.

Any applicant needing additional information or if you have questions concerning criteria or the steps involved in the nomination process, please contact Charles Golden, Ph.D. Chair Fellows Committee, Society of Clinical Psychology Central Office, P.O. Box 1082, Niwot, CO 80544-1082, div12apa@comcast.net.

Some Next Steps to Improve the Usefulness of Continuing Education

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Continuing professional education is an obligation that has been in place for many years both as a statutory requirement and a professional responsibility. Maryland was the first state to enact mandated continuing education for psychologists in 1957 (Association of State and Provincial Psychology Boards, ASPPB, 2003), and as of 2002 all but 11 states mandate some form of continuing education for psychologists (Daniels & Walter, 2002). A number of survey studies have reported on the various updating practices of psychologists (e.g. Allen, Nelson, & Shreckley, 1987; McNamara, 1977) and it appears that practitioners update in order to maintain existing skills, to improve upon those skills, or develop new skills or competencies (McNamara & Flanders, 1985).

Although the importance of continuing education is highly endorsed, its usefulness to

“... the responsibility for learning and implementing new information into practice rests on the attendee...”

the practitioner is less clear. For instance, Sharkin and Plageman (2003), in a survey of Pennsylvania practitioners, found that a little over half (54%) found continuing education frequently or always useful in their practice; whereas fewer (45%) endorsed the same categories dealing with them becoming more effective clinicians. This finding suggests that continuing education offerings can be improved in order to make them more useful to a greater number of professional psychologists. The rest of this article will present some ideas that seem relevant for improving the usefulness of continuing education programs for professional psychologists.

Personal and Professional Relevance and Constructivist Theory

Currently, a majority of continuing education is conducted by either national associations or private

groups with predominantly one-time, didactic and non-interactive formats, and which offer no assurance that those attending have actually learned. Very little research has been conducted on the effectiveness of these formats within behavioral health, but within the medical field some have argued that didactic, non-interactive, one-time continuing education programs are ineffective in changing physician behavior and thus, little or no credit should be given for attendance (Davis, Thompson-O'Brien, Freemantle, Wolf, Mazmanian, & Taylor-Vaisey, 1999). Though knowledge may be obtained through lecture as well as more active formats of continuing education, the responsibility for learning and implementing new information into practice rests on the attendee, who often neither learns nor implements anything. Information from the medical realm can only cautiously be extrapolated into the behavioral health realm; however, it is reasonable to assume that if a program is unable to encourage learning among those attending, alternate methods of continuing education should be considered.

Constructivist theories of adult learning offer some guidance and suggestions for alternate ways of conducting continuing education. According to the constructivist model, the adult learner builds on what he or she knows, internally integrating new knowledge and reflecting on the material in the context of the current situation to create a more complex understanding. In general, constructivist learning requires greater integration between the theoretical and practical, which is often the goal of continuing education for practitioners. Daley (2001), using constructivist theory, investigated how knowledge becomes meaningful in professional practice and determined that each of four professionals—social workers, lawyers, adult educators, and nurses—took away information that was most directly related to how they saw themselves and their profession. For example, social workers often described themselves as “stewards” and thus



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approached continuing education looking for ways to better meet their clients' needs in this way; they needed to acquire the newest information in order to "support, defend, and advocate" for their clients (Daley, 2001, pg. 44).

According to constructivist theory, information framed in this fashion would be more fully integrated into social work practice. The implications of constructivist theory for continuing education in psychology are twofold. First, given the diverse settings in which psychologists find themselves, continuing education should be more closely related to the goals of particular professional practice settings and the role requirements attendant to those settings. This could be accomplished by increasing the use of individual facility in-services, a format which currently is not usually accredited by the American Psychological Association (APA). Second, continuing education should allow psychologists to access

"...adults learn from integrating information in order to find a solution to a clinically relevant situation."

their prior knowledge and experiences in order to fully integrate new material. Practically, this could involve course organization that allows for reflection on how

specific knowledge could be applied to a particular work situation or providing more time for sharing case studies applicable to the continuing education topic.

Active/Interactive Learning and Problem-Based Learning

In general, in order for continuing education to be active or interactive it must have participants collaborating with each other or with a tutor or presenter either directly or through some technological means. It implies that attendees are directly involved in the organization and implementation of continuing education. This method of delivery would be advocated by both constructivist and problem-based theories of adult learning, which classify adult learners as self-directed, active, integrative, and on the whole, more receptive to this type of learning. For teachers undergoing professional development programs, active learning (being involved in discussion, practice, or receiving direct or indirect feedback) was significantly correlated with enhanced knowledge or skill, though not necessarily with changes

in practice (Garet, Porter, Desimone, Birman, & Yoon, 2001). In some cases, it has been shown that continuing education interventions that include simple interactive elements, though remaining predominantly didactic, have better outcomes than those that are strictly didactic (Davis et al., 1999). Rubel, Sobell, and Miller (2000), in one of the very few studies involving a continuing education program for psychologists, evaluated a two-day workshop for motivational interviewing that used a mix of didactic and experiential techniques. Their results suggest that this type of continuing education intervention does improve subsequent participant knowledge.

A special form of active learning is problem-based learning. In this type of program adults learn from integrating information in order to find a solution to a clinically relevant situation. In a review of small groups who used a problem-based format for a continuing education program, Smits, Verbeek and de Buissonje (2002) found that in general, problem-based learning does not increase participant knowledge, however it does increase performance to a limited extent and there is encouraging evidence that it improves patient outcomes. One distinct benefit is that continuing education attendees find this type of format more enjoyable and believe, to a greater extent, that the program contributed to their knowledge and skills (Doucet, Purdy, Kaufman, & Langille, 1998). The cost in time and resources used to develop and implement problem-based continuing education must be carefully considered and may not always be commensurate with the educational benefits obtained, however.

Use of Clinical Examples

An additional component of interactive learning in continuing education curricula includes involving real, simulated, or hypothetical problems in patients. When patient-related information is included, either through role-plays, video recordings, or case studies, continuing education participants are better able to translate knowledge into practice (Davis, Thompson, Oxman, & Haynes, 1995; Davis et al., 1999). Further, allowing ample time for clinicians to reflect on and share their own personal clinical examples related to the continuing education topic would not only make the session more interactive, but it would also better facilitate the integration of prior knowledge and experience with current material as well as make material more personally relevant. In her

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descriptions of the meaning-making of knowledge across professionals, Daley (2001) found that participants' experience with their clients led to frequent changes in behavior and skill. A memorable experience obtained through a personal encounter that elicited reflection and challenged current understandings facilitated such change. It may be difficult to create memorable personal encounters within a continuing education format, but humanizing the information presented through case studies, client recordings, personal examples of participants, or otherwise relating content to the types of people that participants are likely to encounter seems like a worthwhile endeavor.

Evaluation, Technology, and Follow-Up

Currently there are very few continuing education programs that systematically evaluate what their attendees have learned, and research on the

“...there are very few continuing education programs that systematically evaluate what their attendees have learned...”

most effective ways to evaluate learning is limited. Within many continuing education programs, not only is little done to engage attendees in the learning process, but frequently a person may obtain

credit simply by being present at the session and without having learned anything. Post-tests, such as those found in many journals that offer continuing education credit, are a dominant form of evaluation and accountability. Unfortunately, there are no assurances that a person has actually read the material, or whether he or she simply looked up the answers to the questions. One potential way to address the lack of accountability for those earning continuing education credit would be to involve interactive technology. For example, during either teleconferences or live presentations, attendees could respond to presenter questions throughout the session using individual computer terminals or keypads. Internet formats of continuing education, such as those that have been used to re-educate minor traffic law violators, present another potential way to ensure active participation and to evaluate learning. The participant must visit several information pages (a minimum time required for each page must be reached before the person can move on), after which a post-test must

be completed. Multiple modules may be required before credit is given. Evaluation of social worker opinions about the use of internet for continuing education suggests that many people have the equipment, knowledge, and desire to participate in an online format (Barnett-Queen, 2001).

Accountability in continuing education is necessary not only to ensure that attendees have participated in such a way that new knowledge has been obtained, but also to ensure that their understanding is thorough enough such that they may practice any new skills and apply new information responsibly. Continuing education, as a one-time affair, may be inadequate to foster more than a rudimentary understanding of a topic.

Perhaps unsurprisingly, the more time spent learning a skill, the more likely that skill will be used and used well (Davis et al., 1999). Continuing education interventions that extend beyond a single session may not materially increase knowledge, but they do tend to improve implementation of new skills. More important than the mere length of the course, however, is the continuation of training in that area (VandeCreek, Knapp, & Brace, 1990). For example, Rubel et al.'s (2000) continuing education program aimed at improving motivational skills could have been enhanced by having a follow-up program aimed at troubleshooting problems actually encountered in professional practice. Such an approach would be particularly useful when a participant is attending continuing education in order to branch into new areas of practice.

Depth of Material and Needs Assessment

Data have shown that if a continuing education attendee has recognized a gap in his or her knowledge, which the continuing education program then fills, professional development more readily occurs (Davis et al., 1995). One of the complaints professionals have with continuing education programs is a miss-match between the information they need and the information presented. For the most part, there is no way for participants to know at what depth the material will be taught before they actually attend the session, although course labels such as Beginning, Intermediate or Advanced are sometimes used. Furthermore, clinicians looking to find information relevant to their clinical practices are often disappointed when a session is more



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suitable to the research aspect of a topic. When clinically relevant research is available, often it is presented in a way that is not readily accessible or translatable into mainstream practice. A way of classifying the depth of information and goals for a continuing education program could improve a participant's ability to select activities most useful to his or her practice, which would, hopefully, facilitate learning.

Needs assessment is another element that could be used to better match program continuing education programs to material and attendee's knowledge (Mazmanian & Davis, 2002). Indeed, continuing education programs designed from the start to match the needs of those attending generally have a greater impact on behavior (Davis et al., 1999). Such matching can exert a positive

“...greater use of new, interactive, technologies such as the internet and teleconferences should be encouraged...”

influence on continuing education programming and long term continuing education goals, though very little has been done to develop a system-

atic way of determining the continuing education needs of most psychologists. Some initial work in this area shows promise, however. Fowler and Harrison (2001) developed a psychometrically sound professional development needs inventory that could be used to develop a continuing education program for school psychologists. In medicine, Johnston and Lockyer, (1994) described two methods for determining the continuing education needs of physicians in better understanding panic disorder and depression. They found that several methods were useful for determining the needs of these providers, but that the use of focus groups was the most cost-effective procedure. Thus, regional and national psychological conferences could more frequently utilize focus groups along with surveys for the purpose of developing continuing education programming that is relevant to a particular specialty area in psychology.

Recommendations

Continuing education requirements are becoming the norm within psychology. Despite this, applied research and practical evaluation has lagged behind

other professional interest areas. Research and experience generated both within psychology and from other fields, especially continuing medical education, can provide useful ideas for improving offerings in the field. A few recommendations to improve continuing education offerings follow.

- Regional and national psychology associations should conduct more regular needs assessments utilizing both survey and specialty focus group methodology in order to develop post-graduate education suitable for members' interests and needs.
- Continuing education events should be framed according to how professionals view themselves and their role as psychologists. Furthermore, the format of events should allow for discussion and reflection on how the information presented interacts with these views and attendee experience.
- Local in-service training should be utilized more often. In order to facilitate this, much greater instruction and guidance from national and regional psychological associations is needed both at the development and accrediting stage.
- An active learning approach should be used to enhance presentations. By encouraging discussion, practicing skills, providing feedback, and involving relevant real-world and client examples, both the outcome and experience of continuing education could be improved.
- Given the lack of solid evidence that would support the effectiveness of continuing education as currently conducted, further inquiry into optional continuing education delivery systems need to be encouraged as well as what costs and benefits are attendant to such systems. Universities in cooperation with providers of continuing education should encourage and support students to conduct more research in this area.
- Finally, greater use of new, interactive, technologies such as the internet and teleconferences should be encouraged, not only to ensure that participants are actively involved in the learning processes, but also so that up-to-date information can be readily incorporated into professional practice. □

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Long-Term Care: New Challenges and Opportunities for Psychologists

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 The older segment of the U.S. population is growing at a rapid rate. According to the Administration on Aging (2002), there were approximately 35 million older adults in the United States in the year 2000, and this number is expected to grow to almost 54 million by the year 2020. This trend, combined with the elevated rates of chronic illness observed among older adults (Centers for Disease Control and Prevention, 1999), will lead to significant growth in long-term care (LTC) facilities in order to meet the needs of a subset of older adults. Individuals often need LTC when chronic conditions and illnesses necessitate 24-hour assistance in carrying out basic self-care tasks (e.g., bathing, toileting), when daily nursing care is needed, or when a caregiver is not available to assist the person in his or her home. Although multiple forms of LTC exist, including rehabilitation centers and assisted living facilities, the nursing home is the prototypical LTC facility. Care in these settings is usually provided in either a multidisciplinary or interdisciplinary context, due to the complexity of residents' problems. A report from the United States Senate Special Committee on Aging (2000) emphasized this aspect of LTC: ". . . [it] encompasses a wide array of medical, social,

personal, and supportive and specialized housing services needed by individuals who have lost some capacity for self-care."

In 1997, there were 1,465,000 people in U.S. nursing homes, representing approximately 4% of the older population (Gabrel, 2000). Currently, two out of five Americans will need nursing home care at some point in their lives, and the number of nursing home residents is expected to double by 2030 (Sahyoun, Pratt, Lentzner, Dey, & Robinson, 2001). The expansion of this proportion of the population will require a concomitant growth in the number of staff working in nursing home facilities, including psychologists.

The declines in functioning that necessitate placement in LTC facilities are frequently related to cognitive impairment, the prevalence of which varies across types of LTC settings. It is estimated that 50% or more of nursing home residents have a dementia diagnosis (US Congress, 1992) and 34% of individuals residing in assisted living facilities have cognitive impairment (US Department of Health and Human Services & Research Triangle Institute, 1999). Depression is another common diagnosis in LTC settings; prevalence estimates range from approximately 20% (Payne et al., 2002) to 34% of residents (Ames, 1991). Thus, LTC facilities have a critical need for the specialized services that psychologists offer. Indeed, mental health service opportunities in LTC were greatly expanded with the passage of the Omnibus Reconciliation Act (OBRA) of 1989, which permitted licensed psychologists and clinical social workers to serve as independent mental health providers under Medicare. In addition, OBRA 1987, 1989, and 1990 regulations included the Nursing Home Reform Act, which stressed the value of psychological services and the need to attempt psychosocial interventions in preference to chemical or physical restraints.

The Role of Psychologists in Long-term Care

Psychologists work in various capacities in LTC settings, including full-time staff members, independent practitioners and consultants, and team members from larger health care systems such as VA hospitals, and researchers. They often perform many of the same functions provided in other settings, such as conducting individual or group therapy and performing psychological evaluations. However, the professional opportunities in LTC settings are much broader than traditional direct clinical services. In addition to direct services, psychologists perform

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diverse functions such as consultation to staff and administrators, staff training and education, graduate student training, and research. Information about the consultant/staff educator role of psychologists in LTC settings has been reviewed by Louis Burgio, Ph.D. (e.g., Burgio & Burgio, 1990; Burgio, Stevens, Burgio, Roth, Paul, & Gerstle, 2002) and Linda Teri, Ph.D. (e.g., Teri, Baer, Orr, & Reifler, 1991).

The need for direct services in LTC settings is more important than many psychologists realize. A tragic and erroneous stereotype is that all LTC residents are too demented to benefit from psychotherapy. On the contrary, many residents are in need of psychotherapy to help them adjust to the numerous transitions that often precipitate and follow placement in a LTC facility. For example, catastrophic and acute illnesses such as strokes can rapidly and dramatically change a person's life. Residents placed in LTC after such an event might be faced with changes in their ability to walk,

“The need for direct services in LTC settings is more important than many psychologists realize.”

remember, or communicate. Or, in another situation, a widower may not only mourn the loss of his wife but then also may face the reality of enter-

ing assisted living or a nursing home. In addition, there are many aspects of institutional living that residents might find distressing. Issues commonly faced by residents in therapy include loss of control and independence, having to live by others' rules and schedules, sharing a small room with a person they neither knew nor chose, and trying to get along with nurses and aides with an array of interpersonal styles and approaches to residents.

Cognitive impairment and chronic medical conditions are common among LTC residents. Such conditions challenge clinicians to make adaptations to traditional psychological assessments and interventions. For example, psychologists working with older adults in LTC might be called upon to determine whether cognitive impairment is a symptom of dementia, delirium, depression, or medication side effects. In addition, interventions appropriate for community-dwelling independent patients often must be tailored for cognitively impaired, physically disabled older adults residing in LTC. For example, nursing home residents with moder-

ate cognitive impairment and depression might not be able to benefit from insight-oriented therapy if their abstract reasoning skills are compromised. Likewise, typical components of behavioral activation interventions (e.g., exercise, pleasant events) must be creatively modified in LTC facilities where there is the opportunity for increased control of environmental consequences but a decrease in the number of available reinforcers.

Another component of psychologists' work in LTC is consultation with staff regarding residents who are too cognitively impaired to benefit from psychotherapy. Most often, this entails management of behavioral symptoms of dementia such as agitation (Cohen-Mansfield & Billig, 1986). The neuropathology underlying various dementias can lead to the erosion of residents' adaptive behavioral repertoires, and to the subsequent development of maladaptive behaviors, including disruptive vocalization, wandering, and physical aggression. The psychologist working in LTC settings is particularly well suited to manage these behaviors through non-pharmacological means, such as the manipulation of the antecedents to, and consequences of problematic behaviors. Indeed, a broad literature has developed in this domain (for reviews see Allen-Burge, Stevens, & Burgio, 1999; Fisher & Carstensen, 1990; Kasl-Godley & Gatz, 2000). Often, the psychologist's role is to assess the problem behaviors and develop a behavioral treatment plan that will be implemented by the nursing home staff.

In most nursing homes, a multidisciplinary team meets regularly to discuss each resident's treatment plan. The responsibilities of psychologists on such multidisciplinary teams are numerous. Most importantly, psychologists offer key information regarding residents' cognitive, psychological, or behavioral states to be incorporated into treatment decisions. There is a tremendous need for such staff consultation and team meetings; unfortunately, Medicare, Medicaid and private insurance plans do not reimburse for this service. Indeed, many psychologists oppose this policy, and are actively involved in lobbying for its change.

Psychologists working in LTC also serve as educators. They provide staff with information about dementia and mental illness, and conduct psychoeducational inservices with topics ranging from behavioral management to the prevention of staff burnout. Research has demonstrated the benefits



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of staff training on nursing home residents' quality of life. For example, staff training may successfully lead to increased independence in residents' self-care activities (Engelman, Matthews, & Altus, 2002), reduced levels of resident agitation (Burgio et al., 2002), and lower levels of resident depression (Linn, Linn, Stein, & Stein, 1989).

Psychologists also consult with administrators in LTC facilities, assisting with the formulation of policy, program development, and nursing home compliance with federal regulations. As mentioned above, psychologists working in LTC facilities may use their expertise to affect change in Medicare and Medicaid policies. Examples of recent reforms include the development of health and behavior assessment and intervention procedure codes and

“...psychologists working in LTC facilities may use their expertise to affect change in Medicare and Medicaid policies.”

the Medicare ruling that prohibits payment denial on the sole basis of a dementia diagnosis. Finally, psychologists working in LTC commonly have the opportunity to supervise trainees, including undergraduate and graduate students, interns, and postdoctoral fellows. This often involves collaboration on research projects examining diverse topics in the areas of geropsychology, neuropsychology, and behavioral medicine.

Many psychologists were drawn into the field of clinical and counseling psychology because of the diverse opportunities available to doctoral level mental health providers. LTC is an excellent setting to practice these multiple roles as clinician, consultant, trainer, educator, and researcher. U.S. demographics further assure psychologists that opportunities in LTC work will continue to flourish. In addition to the nursing home settings highlighted in this paper, there is also considerable growth and opportunity in other LTC settings such as assisted living facilities, hospice centers, rehabilitation centers, and home health care. Given that few psychologists with general training backgrounds have had extensive training in clinical geropsychology, clinicians interested in working in LTC must make sure that they obtain the level of competency necessary for practice in these settings. Clinicians interested in doing so

are advised to become familiar with the American Psychological Association's (2003) *Guidelines for Psychological Practice with Older Adults*, and to contact the professional organization Psychologists in Long-Term Care (PLTC). PLTC was founded 20 years ago to promote the ethical practice of psychology in LTC facilities, provide educational opportunities for psychologists in these settings, and advocate for psychologists practicing within LTC. Further information is available online at <http://www.wvu.edu/~pltc/>. □

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Long-Term Care: New Challenges and Opportunities for Psychologists

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CALL FOR PAPERS

Clinical Psychology: Science and Practice

The Journal is interested in receiving scholarly papers on topics within Clinical Psychology. Papers are welcome in any content area relevant to theory, research, and practice. The Journal is devoted to review and discussion papers and hence is not a primary outlet for empirical research.

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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 curriculum vitae, and a concise (1-2 page) typewritten summary of his or her achievements and contributions to:

Linda C. Sobell, Ph.D.
Chair, Division 12 Awards Committee
P.O. Box 1082
Niwot, CO 80544-1082

Deadline: October 1, 2005

The awards will be presented at the 2006 APA Convention in New Orleans, LA.

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 2006 APA convention in New Orleans, LA.

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, 2006.

Linda C. Sobell, Ph.D.
Chair, Division 12 Awards Committee
P.O. Box 1082
Niwot, CO 80544-1082

Deadline (for the 2006 award year): Dec 1, 2005





Division 12 Joins with Hogrefe and Huber to Publish a Book Series

Danny Wedding, Ph.D.

The Society of Clinical Psychology recently signed a contract with Hogrefe and Huber, an international publisher with offices in the United States, Germany, Canada and Switzerland, to promote a series of short books addressing the evidence based practice of clinical psychology. The series is titled *Advances in Psychotherapy—Evidence Based Practice*. Contracts are in place for volumes addressing bipolar disorder, problem and pathological gambling, heart disease, child abuse, chronic pain, schizophrenia, alcoholism and problem drinking, social phobia, eating disorders and obsessive-compulsive disorder. Additional volumes will focus on mass trauma and terror, chronic pain, diabetes, depression, and borderline personality disorder.

The Society receives a \$500 advance as well as on-going royalties from each volume, and the title page of each volume will indicate that the book was developed with the support of the Society of Clinical Psychology. We anticipate that almost all contributing authors will be members of the Society.

To date, the series has generated \$3,500 in advance royalties for the Society of Clinical Psychology. The Division 12 Board entered into this relationship in response to a budget shortfall and to avoid increasing member dues.

The series is modeled after a series of short, targeted, and evidence-based German language publications that has been very successful. Each volume

will be priced at about \$25 (\$20 for members of Division 12), and those individuals who subscribe to the series by ordering at least four consecutive volumes can purchase books for \$20 each (\$18 for members).

Each volume will adhere to a tightly structured format making it easy for readers to identify quickly the information they need (e.g., epidemiology, differential diagnosis, prognosis etc.). Tables, boxed clinical “pearls,” and marginal notes enhance the clinical utility of each book, while checklists for copying and summary boxes provide tools for use in daily practice.

The launch of the series will occur this summer, and the series will be promoted at the August 2005 APA meeting in Washington, DC. In addition, the Society of Clinical Psychology is an APA approved sponsor for Continuing Education, including home study courses, and it will offer web based continuing education opportunities linked to each new volume.

Danny Wedding is the Series Editor; the Associate Editors are Society members Larry Beutler (psychotherapy), Kenneth Freedland (behavioral medicine), Linda Sobell (addictions), and David Wolfe (disorders of children). Questions about the new series can be addressed to Danny Wedding at danny.wedding@mimh.edu. □

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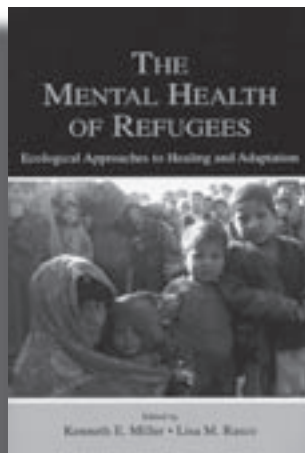


**Miller, K. E. & Rasco, L. M. (2004).
The mental health of refugees:
ecological approaches to healing
and adaptation.**

Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

**ISBN: 0-8058-4172-2 / \$99.95 (hardcover) US List
0-8058-4173-3 / \$49.95 (softcover) US List**

Reviewed by Fred Bemak, Ed.D., George Mason University



The concern for refugee mental health is a growing international and national problem which hasn't been adequately addressed by the psychology profession as a whole despite some recent cutting edge books in the area. With over one of ten individuals in the United States being foreign born, it is essential that psychologists pay closer attention to the unique mental health needs of refugees.

The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation is an attempt to address this important issue in the field from an ecological perspective. Dr. Miller has worked with Guatemalan, Bosnian, and Afghan refugees and is an Assistant Professor at San Francisco State University while Ms. Rasco is a Ph.D. candidate at the University of California at Berkeley who has worked with refugees from Bosnia and Afghanistan.

The book includes an overview of an ecological framework for working with refugees and then divides into sections that focus on the geographical regions of Africa and Asia (combined) and South and North America (combined). The book concludes with a chapter on evaluating ecological mental health interventions and a chapter on innovations and challenges.

The positive side to this book was the overall focus on an ecological approach to healing and post-migration adjustment, and the humanization of the trauma research affecting refugees. Oftentimes the research on refugee trauma and post-migration adjustment has been too "clinical" based on a medical model orientation for treatment, without consid-

ering the personal stories and pain behind the findings. Even so, the first person narratives in the book were limited in scope to the populations with whom the authors have worked, e.g. Bosnian, Afghan, and Guatemalan refugees which would be reasonable if the book was focused only on these three groups rather than a total of four continents. The book also purports to be unique in moving away from the medical model to a more culturally sensitive approach to working with refugees is an important step in the field. Many of the recent excellent books that have been written about refugee mental health have clearly documented the need to move beyond traditional Western psychological paradigms, which is based on work done for the past few decades (e.g. see *Migration: Immigration and emigration in international perspective* by Adler, & Gielen; *Counseling refugees: A psychosocial approach to innovative multi-cultural counseling interventions* by Bemak, Chung & Pedersen; *Immigrants and immigration* by Esses, Dovidio, & Dion). Thus the book's premise doesn't take into account a history of solid research and writing that has already been done in the field.

The authors present three main aims of the opening chapter that they assert have been overlooked with regards to refugees. These include poor access to mental health services, cultural inappropriateness of mental health, and a disparity between clinic-based services and displacement-related stressors. I was surprised at these issues being the core foundation for the book, given significant work in this area including the refugee mental health program developed by the National Institute of Mental Health two decades ago and numerous studies and books and subsequent programs that have already addressed these concerns. The author's claim that this is a "paradigm shift" is inaccurate—mental health professionals have been working on these issues for decades.

Although I opened the book with great anticipation to read about an ecological approach, the section and premise for the book was disappointing. They present simplistic statements such as "Most fundamentally, mental health interventions are needed that alleviate psychological distress and promote effective coping and adaptation with refugee communities." Even when they extend to include community focused interventions as integral in refugee mental health, the authors neglect to mention or include families, which are a cornerstone in post-migration adjustment.

The bulk of the book is by invited authors from various parts of the world writing about their work in different geographical regions. It is disconcerting to find disparate regions lumped together Asia and Africa (Angola, Sierra Leon, Cambodia, Sri Lanka, and East Timorese) and then South and North America (Columbia, Bosnia, Kosovo, and

“It is disconcerting to find disparate regions lumped together...”

Hmong). The result is a discrete series of 8 chapters where refugee populations such as Angolan, Cambodian, and Sri Lankan or Columbian, Bosnian and Hmong are grouped together in sections of the book, which doesn't make much sense. Each chapter describes the contributor's experiences in respective countries with a varied group of refugees. The chapters do

not hold together very well, and read like short and separate articles.

In summary, the book makes assumptions about its uniqueness and asserts to develop a “new paradigm” in refugee mental health, despite the past few decades of work in refugee mental health to develop appropriate services based on lessons learned from World War II. The authors present a limited scope of experience working with three groups of refugees, which is evident in examples used in the book. Furthermore, the organization of the book is confusing, combining sections with North and South America and Asia with Africa. It is also noteworthy that some of the major writings of the last 10 years are absent in the review of the research. Although I had “high hopes” for this book, it adds little of substance to the current literature. □

2006 APA SCIENTIFIC AWARDS PROGRAM: CALL FOR NOMINATIONS

The APA Board of Scientific Affairs (BSA) invites nominations for its 2006 scientific awards program. The Distinguished Scientific Contribution Award honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology. The Distinguished Scientific Award for the Applications of Psychology honors psychologists who have made distinguished theoretical or empirical advances in psychology leading to the understanding or amelioration of important practical problems.

To submit a nomination for the Distinguished Scientific Contribution Award and the Distinguished Scientific Contribution Award for the Applications of Psychology, you should provide a letter of nomination; the nominee's current vita with list of publications; the names and addresses of several scientists who are familiar with the nominee's work; and a list of ten most significant and representative publications, and at least five reprints representative of the nominee's contribution (reprints, preferably in electronic form).

The Distinguished Scientific Award for Early Career Contribution to Psychology recognizes excellent young psychologists. For the 2006 program, nominations of persons who received doctoral degrees during and since 1996 are being sought in the areas of:

- animal learning and behavior, comparative
- psychopathology
- health
- developmental
- cognition/human learning

To submit a nomination for the Distinguished Scientific Award for Early Career Contribution to Psychology, you should provide a letter of nomination, the nominee's current vita with list of publications, and up to five representative reprints.

To obtain nomination forms and more information, you can go to the Science Directorate web page (www.apa.org/science/sciaward.html) or you can contact Suzanne Wandersman, Science Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242; by phone, (202) 336-6000; by fax, (202) 336-5953; or by E-mail, swandersman@apa.org.

The deadline for all award nominations is June 1, 2005.

Spitzer, R.L., First, M.B., Gibbon, M., & Williams, J.B.W. (2004)
Treatment companion to the DSM-IV-TR Casebook
Washington, DC: American Psychiatric Press

ISBN: 1-58562-194-3 / \$54.00 (hardcover) US List
1-58562-139-0 / \$39.00 (softcover) US List

Reviewed by Deborah Roth Ledley, Ph.D.,
University of Pennsylvania



While the actual DSM makes for a dull, uninteresting read (albeit an important and useful one), it was a pleasant surprise to find the *Treatment Companion to the DSM-IV-TR Casebook* (2004) both interesting and engaging. Each of the 34 chapters begins with a case description, a diagnosis and explanation as to how that diagnosis was made (highlight-

ing the importance of differential diagnosis), and a commentary by one (and sometimes two) experts in the field. These commentaries typically include a description of the illness, the method by which the diagnosis is arrived at, a presentation of treatment options, ways in which clinicians would arrive at a treatment plan from among the various options, and a discussion about the patient's prognosis. The book spans the range of Axis I and Axis II disorders, and includes cases of adults and children. Many of the chapters also end with a suggested reading list.

This book is most appropriate for students who are just beginning to do clinical work. While reading the DSM is essential, it is easy to see how reading these cases alongside it would breathe life into diagnoses. Particularly when students have never seen patients, or have seen only a few, it can be difficult to imagine actual people who suffer from various disorders. This book paints vivid pictures, while also providing useful information for assessing patients and planning treatment.

The book has three major strengths. First, the cases in the *Treatment Companion* consistently illuminate the importance of differential diagnosis and describe the kinds of questions a clinician must ask to distinguish one disorder from another. This was particularly helpful with cases of more obscure disorders that clinicians don't frequently encounter (e.g., schizoaffective disorder), cases that include symptoms of two disorders (e.g., hypersomnia related to major depressive disorder), and cases of personality disorders where the clinician must ascertain whether a patient has a pervasive pattern of behaving in a certain way (suggestive of a personality disorder), or has recently experienced acute changes in personality (suggestive of an Axis I disorder). Also helpful was the series of cases of schizophrenia and related psychotic disorders, demonstrating how this complex category of mental illness can take on many guises. The *Treatment Companion* explains the level of detail with which clinicians must probe in order to arrive at a proper diagnosis, and clearly demonstrates how spending the time to do so properly results in superior care for patients.

The second strength of the book is that it does not stop at making a diagnosis (which one might assume would be the case in a DSM-related book). Rather, the commentaries move past simple diagnoses to show how to conceptualize a case and devise an appropriate treatment plan. The book communicates the level of detail necessary to make a good plan for treatment—certainly knowing a simple diagnosis is not sufficient. In the case of attention-deficit hyperactivity disorder, Jensen outlines the seemingly endless stream of questions that must be answered in order to plan an effective course of treatment for nine-year old Eddy who is "into everything." The book also emphasizes the importance of considering psychosocial factors when making treatment decisions. For example in Bauer's commentary on a case of bipolar II disorder, he selects the treatment that he thinks the patient would be most likely to comply with, based on extensive discussion with her about her own perception of her problems, her personal habits (re: alcohol use, diet, etc.), and her insight into her symptoms. This approach is very different from just selecting a drug or a therapy with no attention to the *patient* for whom we are selecting it. Many chapters demonstrate how *not* spending sufficient time gathering necessary information can result in incorrect diagnoses, incorrect approaches to

treatment, and as a result, wasted years for patients.

The third strength of the *Treatment Companion* is its focus on empirically-supported treatments. Cognitive behavioral therapy is described very well in many places in the book, and is clearly put forth as the psychosocial treatment of choice for psychiatric disorders. Various medication choices, with accompanying advantages and disadvantages of each, are also clearly outlined.

In general, the chapters on Axis II disorders are weaker than those on Axis I disorders, perhaps

"...the Treatment Casebook moves beyond seeing patients as clusters of symptoms that add up to a DSM diagnosis.

because we know less about these disorders and have less knowledge about how to treat them. In the chapter on borderline personality disorder, Gunderson's commentary seemed to

focus more on how the patient's case was mismanaged, rather than on how it could have been managed better. In the chapter on narcissistic personal-

ity disorder, Kernberg used terminology not used in the current DSM (e.g., see page 155) and offered a psychodynamic view of the patient's personality disorders symptoms as well as his homosexuality. This seemed out of step with our current approaches to understanding and treating clients. Also with reference to the case of borderline personality disorder, having two commentators did not equate to a better chapter than those with one commentator. This was the case as well with the panic disorder chapter, where Antony painted a very clear picture of conceptualizing and treating a very straight-forward case of panic disorder, while Klein seemed to be "looking for zebras instead of horses."

In summary, the *Treatment Casebook* moves beyond seeing patients as clusters of symptoms that add up to a DSM diagnosis. As Hogarty writes, "DSM-IV-TR is a necessary classification system. But diagnosis, which is needed for a thoughtful psychosocial treatment plan, represents understanding..." (p. 214). The *Treatment Casebook* very clearly communicates how this level of understanding can be reached, allowing for accurate diagnosis, case conceptualization, and treatment planning. □

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).

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November 1st (January 1st 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.

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