

# THE CLINICAL PSYCHOLOGIST



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

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August 2007

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## PRESIDENT'S COLUMN



**Marsha M. Linehan,  
Ph.D., ABPP**  
University of Washington  
President, Society of  
Clinical Psychology

### On Being Mad versus Bad: Cautionary Comments on Biology as a Causal Explanation of Mental Disorder.

Marsha M. Linehan, Ph.D., ABPP



Dear Readers:

In March of 2006, I was asked to serve as an expert on a video being made about Borderline Personality Disorder for use in a campaign to reduce stigma surrounding the disorder. The producer had been at a dinner party where a number of psychologists and psychiatrists were among the diners. She overheard these diners discussing various categories of clients seeking mental-health treatment and was shocked at the judgmental and derisive tone of the comments. She asked who were these clients the diners seemed to hate. The reply: The clients met criteria for Borderline Personality Disorder (BPD).

In October of 2007, I attended a small working meeting organized by the National Alliance on Mental Illness (NAMI). In March 2006, NAMI had decided that BPD should be included in NAMI's list of serious mental illnesses. The basis for this decision was in large part the emerging data that the disorder is associated with disorders in brain functioning. A small group of scientists, friends and families of BPD individuals and consumers were invited to advise NAMI on how to best direct advocacy efforts. The meeting had a profound effect on me. It started with introductions. Families went first. Family member after family member talked of the agony they went through trying to help their relatives. Every single family member noted the stigma of the disorder and the difficulty they had finding any therapist willing and sufficiently competent to treat their loved ones. Consumers echoed the comments, each one having a story that was almost too painful to listen to. The general sense was one of tremendous relief at finding out that the disorder is a brain disease and those with it are not, therefore, bad or of defective character.

Among clients seeing me for therapy, as well as those seeing other therapists in my research clinic, we hear over and over how relieved people are to be diagnosed with a mental illness. Over and over again, I hear the sentiment, "I thought I was a bad person; now I know that I am not. I have an illness." For many, any non-biological explanation of their problems is immediately interpreted as saying that they have a defective moral character. The belief is so entrenched that any psychological explanation for their difficulties and disorder is rejected out of hand.

The belief of clients (those with BPD as well as other disorders), mental health care providers, and indeed throughout our culture appears to be that there are only two options when behavior is disordered: "You are either mad, or you are bad."<sup>1</sup> "Mad" here refers to having a bona fide biological disease. Consider the following quotes. From the NIMH web-

*(continued on page 2)*

## President's Column (cont.)

site: "Depression is a serious medical illness; it's not something that you have made up in your head," (<http://www.nimh.nih.gov/HealthInformation/Depressionmenu.cfm>). From the NAMI website: "Mental illnesses are biologically based brain disorders. They cannot be overcome through 'will power' and are not related to a person's 'character' or intelligence," ([http://www.nami.org/Content/NavigationMenu/Inform\\_Yourself/About\\_Mental\\_Illness/About\\_Mental\\_Illness.htm](http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm)).

<sup>1</sup> I must admit, however, that at times a third alternative is also put forth: if not diseased, one can be considered a victim, or alternatively a survivor. Much of the attraction to renaming BPD as complex PTSD, I think, is due to its promise of relieving the excruciating shame attached to the BPD diagnosis.

What is important about these quotes is not that they state that mental disorders are associated with biological disorder, but that they imply that mental disorder could be otherwise, i.e., not biological. Further, the quotes imply that if they are not biological, then the disorders could be "made up in your head" or due to inadequate will power, character or intelligence. In essence, the statements are based on dualistic thinking that implies that behavior can be other than biological. However, as a colleague of mine once stated, all behavior is biological. One can, of course, also state the alternative: "All biology is behavioral." That is "anything that an organism does involving action and

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response to stimulation" (the definition of behavior) necessarily involves biological activity. We are not yet angels.

The overemphasis on disordered biology as the causal factor in mental disorders ignores the major effects of learning and environmental influences on behavior. The role of disordered learning environments is discounted. In an effort to rid ourselves of the notion of the "schizophrenogenic mom," we have thrown out the baby with the bathwater. The implication is that if disorder is the result of a faulty learning environment rather than a brain abnormality, then someone is bad, either the individual responsible for the faulty environment or the person with a mental disorder. Someone is morally responsible. The way out of this dilemma is to attribute causality to disordered biology. Another way out, rarely considered, is to drop the moralistic evaluation of disorders and persons and instead focus on identifying the causal sequences leading to disorder.

Many mental health professionals, unfortunately, are all-too happy when research data correlating biological characteristics with mental disorders are reported. Over and over, correlations of differences in brain structure and functioning with behavioral and emotional disorder is interpreted as providing a causal link. Our scientific knowledge that correlation does not equal causation somehow falls away in this domain of research. What is not noticed is that an overemphasis on identifying mental disorders with brain disease colludes with those who stigmatize mental disorder. It maintains the dichotomy of good and bad. No biological cause, the person is bad. However, all behaviors, including the patterned behaviors making up mental disorders, are caused, and causal paths are multiple and transactional.

Because of the core emphasis in psychology on the scientific study of human behavior, psychologists are uniquely qualified to identify the causal influences, including but not limited to biological influences, on behavior. By thinking that we have explained disorder once we find a biological correlate or causal sequence, we neglect the very-important question of what causes the disordered biology we have discovered. From one perspective, we could say that it indeed goes without saying that all mental disorder is biological disorder. If it is human, it is biological. However, the statement does not really address the important question of what causes the biology to become disordered. Nor does it tell us how to treat the disorder we find. We know that new learning experiences and the consequent changes

in behavioral, emotional and cognitive responses, the essence of psychological interventions, just as surely change the brain as the other way around. How could it be otherwise? Where would new learning be encoded if not in the brain? Knowing that, however, does not tell us how it happens.

The emphasis on mental disorder as a medical illness also implies that treatment itself should be medical rather than psychological. Where is the evidence, however, that disorder is best treated by directly targeting biology with medical interventions rather than via psychological interventions? With some exceptions, e.g., schizophrenia and bipolar disorder, there is scant evidence that this is the case. Indeed, the astute reader of the literature could conclude that psychological interventions are not only as efficacious as medical interventions, but much of the time are even more efficacious. How do we explain this? In particular, how do we explain this to the individual we are treating who believes medical diseases should be treated with medical interventions?

I must confess that more than once I have found myself explaining to clients how it is that classical and operant conditioning actually do change neural pathways in the brain. Indeed, I have found myself telling clients who reject psychological explanations out of hand that, in fact, new learning is one of the better ways to directly impact the brain dysfunction that they so want to be the cause of their problems. Although my ability to tell my clients that my psychological interventions have specific and identifiable effects on their brains is indeed helpful, it is in reality a tautology. I believe what I say, but I regret that saying it is so necessary.

I believe that our field would be better served if we put a much greater effort into trying to reduce the overall tendency to judge individuals in our culture, including those with mental disorders. The rhetoric of good and evil when applied to individuals does little to identify the causes of disordered and at times destructive behaviors. Without knowing causes, our ability to create effective interventions will be impossible. Over-identifying with brain mechanisms as causal factors in mental disorders can, I fear, lead us astray in identifying all the important factors influencing the development and maintenance of the mental disorders that we must treat.

Once again, I would love to hear from you about what I have written. If you send your comments, please let us know if we can publish them. ■■



## Responses to Dr. Linehan's previous column

I agree with Marsha Linehan that we need to get the word out that effective psychosocial treatments are available for many common mental disorders. This is an important message both for people suffering from disorders and for clinicians who were trained in treatment methods that have not been validated. It is also a message that needs to be delivered to policy makers at government agencies and managed care companies. Moreover, given the longstanding tensions in psychology between researchers and clinicians, it makes sense that Linehan finds it necessary to point out the merits of research to members of Division 12.

It is not clear to me, however, that clinical trials are the kind of research that is needed most criti-

***If more than one treatment has been found to work for a particular mental disorder... it would arguably be more constructive to study factors common to both treatments than to pile up more studies showing that a particular, manualized treatment usually helps.***

cally. Since we already have empirically supported psychosocial treatments for many disorders, research efforts in those areas might be better directed to studies of psychotherapy process, or dismantling designs, to identify what elements of treatment produce improvement. If more than one treatment has been found to work for a particular mental disorder, as is the case for many of the most common disorders, it would arguably be more constructive to study factors common to both treatments than to pile up more studies showing that a particular, manualized treatment usually helps.

The Division 12 Task Force on Principles of Therapeutic Change, led by Castonguay and Beutler (2006), set an innovative course that seems more promising than a continued proliferation of clinical trials. In combination with more basic research on the

causes and dynamics of psychopathology (including some clear-eyed consideration of what aspects of a disorder are part of human nature and what aspects represent true deviations from normalcy), research on common factors and integrative therapeutic principles has the potential to provide us with a genuine understanding of what makes therapy work. In contrast to clinical trials, such understanding can make future treatments *more* effective than anything available now. While the need for clinical trials will never disappear completely—and Linehan is doubtless right when she says that clinical trials are our strongest calling card in the current marketplace—ultimately, nothing will confer more clout than genuine understanding and the powerful treatments that will derive from it.

***Doxey Hatch, Ph.D.***

***Montana State University-Billings***

### Reference

Castonguay, L.G., & Beutler, L.E. (2006). Principles of therapeutic change: A task force on participants, relationships and technique factors. *Journal of Clinical Psychology*, 62, 631-638.

**I loved your column in the Spring '07 issue of The Clinical Psychologist.** One of my pet peeves is that all too often, choices among treatments are driven by prejudice rather than by data. Your column clearly illustrates and explains why this is problematic. However, it seems to me that you may be more satisfied with the quality of the evidence supporting the efficacy of various psychological interventions than many of them deserve.

Many randomized controlled trials (RCTs) of psychological interventions are rather small compared to typical drug trials in psychiatry, and most psychiatric trials pale in comparison to the enormous trials that have been conducted in cardiology and at least some other areas of medicine. Unfortunately, the results of small trials, even when they are well designed and even when they are replicated by other small trials, are poor predictors of what will emerge from larger, more definitive trials. See, for example, Mattocks, K.M. and Horwitz, R.I. *Biological Psychiatry* 2000; 47(8):693-698.

This reality is even worse than the Mattocks and Horwitz article would suggest. Robert M. Califf and David L. DeMets published a great series of 4 review articles on "Lessons Learned From Recent



Cardiovascular Clinical Trials” in *Circulation* (2002). One of the most troubling lessons is that treatments that look very promising in small clinical trials often turn out to be useless or even positively dangerous in larger trials.

Consider the recent findings of the COURAGE trial (Boden et al., *New England Journal of Medicine* 2007; 356:1503-16.) There is plenty of evidence sup-

***In many areas of psychological intervention research, we need more, larger, and better quality clinical trials. Until they have been conducted, we should not be too satisfied with the quality of our evidence base; we have to be aware of its limitations.***

porting the use of percutaneous coronary interventions (PCIs) for stable coronary disease. Most of the recent discussion about PCIs has not been about whether to perform them in patients with stable coronary disease. Instead, the literature has been dominated by controversies over whether drug eluting stents are better or worse than bare metal stents. Millions of patients already have had PCIs, and a large proportion of them have had stents implanted in their coronary arteries. Now, suddenly, the COURAGE trial shows that many of these patients would have

fared as well over 5 years with medical therapy alone as with equivalent medical therapy plus PCI. (Note: Emergency PCIs are often used to treat acute coronary syndromes. The COURAGE findings are not applicable to emergency interventions.)

In many areas of psychological intervention research, we need more, larger, and better quality clinical trials. Until they have been conducted, we should not be too satisfied with the quality of our evidence base; we have to be aware of its limitations. Of course, large clinical trials are expensive. Pharmaceutical companies may have deep pockets, but they seldom shower the kind of money on psychological intervention trials that they do on drug trials. NIH funding is also insufficient for some of the large psychological intervention

trials that are needed. It would be much better for us to acknowledge that more funding is needed for such trials than to leave the impression that high quality evidence can be accrued without sufficient resources.

***Kenneth E. Freedland, Ph.D.***

***Washington University School of Medicine***

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## Top 10 Psychology Websites


Simon A. Rego, PsyD

 Everyone loves a “Top 10” list, don’t they? It was with this notion that I decided to make this issue’s column feature a list of the top 10 websites that people use in their role as clinical psychologists. The task seemed simple: I would post a note on several electronic mailing lists to which I subscribe asking members to send me their favorite “go to” websites for information and resources in psychology, and then present the top 10 vote-getters to all of you. The column would write itself!

Yet some funny things happened on the way to this column: First, many people replied to my request—but did not offer any suggestions! Instead I was told that this was a great idea as they really did not know where to find good information on the web, and that they would love a copy of the final list once it was completed! Second, it seems that an increasing number of people are taking my approach and turning to electronic mailing list servers (similar to newsgroups or forums, except that the messages are transmitted as e-mail and are therefore available only to individuals on the list) for information rather than wasting time searching the web. Third, rather than having specific “go to” websites, people instead use search engines such as Google ([www.google.com](http://www.google.com)) or Dogpile ([www.dogpile.com](http://www.dogpile.com)) to gather the information they need on a topic. Finally, while a few people suggested books that had been written on mental health websites, all noted that these books were now outdated—lending support to the open access movement (see last issue’s column) as web content and trends often move at a pace much faster than the printed press.


In the end, I tallied 160 different website suggestions! It should be noted, however, that only the top 28 websites received more than one vote (with the first place finisher receiving 10 votes and many in the top 28 receiving only two votes). The rest (n=132) received only a single vote each! Therefore, I urge you all to email me your favorite sites ([dr.rego@gmail.com](mailto:dr.rego@gmail.com)) and I will keep an updated document that is yours for the asking. I also challenge someone out there to create a website where users can post their favorite psychology websites and/or vote on those already posted (i.e., how about using a format like Digg—[www.digg.com](http://www.digg.com)). In the meantime, without further ado, here are your top 10 websites.

Coming in first place was a site managed by Kenneth S. Pope, Ph.D. The site provides free full-text articles and other resources on assessment, therapy, forensics, etc. ([www.kspope.com](http://www.kspope.com)). Placing second was the National Institute of Mental Health (NIMH) Home Page. This site provides information from the Federal agency that conducts and supports research on mental illnesses ([www.nimh.nih.gov](http://www.nimh.nih.gov)). Finishing third was the official website of the American Psychological Association ([www.apa.org](http://www.apa.org)). In fourth was a site managed by John M. Grohol, Psy.D. The site claims to be the Internet’s largest and oldest mental health social network created and run by mental health professionals to guarantee reliable, trusted information and support communities to consumers, for over 12 years. ([www.psychcentral.com](http://www.psychcentral.com)). In fifth place was WebMD, “the leading source for trustworthy and timely health and medical news and information.” The site provides credible health information, supportive community, and educational services by blending award-winning expertise in content, community services, expert commentary, and medical review ([www.webmd.com](http://www.webmd.com)).

Coming in sixth place was the Anxiety Disorders Association of America website. This site offers complete information on anxiety, as well as a special section on teen anxiety ([www.adaa.org](http://www.adaa.org)). Seventh place went to the Academy of Cognitive Therapy, a site that offers information about cognitive therapy, how to become certified as a cognitive therapist, training in cognitive therapy ([www.academyofct.org](http://www.academyofct.org)). In eighth place was the Association for Behavioral and Cognitive Therapies (ABCT) website, which provides CEU, CME, and other educational opportunities; journals for research and clinical practice in behavioral therapy and cognitive-behavioral therapy; and referrals for those seeking psychological therapy ([www.abct.org](http://www.abct.org)). In ninth place was the Obsessive Compulsive Foundation (OCF) website. The OCF is an international not-for-profit organization composed of people with obsessive compulsive disorder (OCD) and related disorders, their families, friends, professionals and other concerned individuals ([www.ocfoundation.org](http://www.ocfoundation.org)). Finally, sneaking in at number ten was Wikipedia, “the biggest multilingual free-content encyclopedia on the Internet. Over two million articles and still growing.” ([www.wikipedia.com](http://www.wikipedia.com)). I should point out that the two people who suggested this site seemed somewhat embarrassed to do so. I am not sure why. After all, I used it myself to look up the history of the top ten list! ([en.wikipedia.org/wiki/Top\\_10\\_list](http://en.wikipedia.org/wiki/Top_10_list)). 

## Practice: Not Perfect?

Katherine L. Muller, Psy.D.

 I'll admit it- I am terrified. I am at the phase in my career where I am considering starting a private practice of my own and I cannot seem to make this decision despite months of contemplation. Now, I know many others out there are at the same point, but I have the benefit of being able to vent all my fears and concerns in a quarterly periodical! Pursuant to this overwhelming fear, this column is not about the “how-to” of starting a practice (check back in a few months for that column). Instead, I'd like to step back a bit and examine the reasons why one would even consider starting a practice. I'd also like to talk about the many questions and concerns that come up when faced with this decision, one that I know many early career psychologists will make at some point in their careers.

### Not-So-Private Practice

Merriam-Webster's Medical Dictionary defines the term “private practice” as the “practice of a profession independently and not as an employee” (Dictionary.com, 2007). In talking to colleagues and surveying the options out there, it seems that the field of psychology is stretching this definition, as private practices vary widely these days. In fact, many of them are not “private” at all. It's important to understand these different approaches to private practice to determine whether any of them may work for you.

- Exhibit A is the traditional individual private practice with a single office and a full-time clientele. Based on my surveys, this model of practice is far less common these days. As the sole proprietor, you are responsible for all costs associated with the practice.
- My colleagues seem to prefer the “group practice” model. In this model, two or more colleagues set up a practice together. Here, the partners in the group share the responsibility and costs involved in running the practice.
- For early career folks, another popular option is the “consultant” or “independent contractor” model. In this model, you contract with an established practice to provide services and they keep a percentage of the fees you receive. A major advantage of this model is that you are not responsible for rent, overhead, and, in most cases, referrals. A major disadvantage is this percentage

arrangement- while most practice owners are very fair in their take, I have also heard some horror stories.

- I've been testing the waters of private practice with a “faculty practice” model at my current job. Many employers, especially those in academic or medical centers, allow you to see clients in your “day job” office. Again, there is usually a cut involved—the employer takes a certain percentage to offset overhead costs.

### Reasons NOT to Start a Practice

Many articles and books have been written by greater minds than mine about the advantages of starting a private practice. I'll leave that side of the argument to those tomes. At the risk of sounding like a pessimist, I'd like to focus for a moment on the *disadvantages* of starting a private practice.

- **Time:** I work full-time and, most weeks, that's a lot more than 40 hours. When would I do this practice thing? I am not planning to leave my current job—which some psychologists do, of course—and I can't just sneak away for a few afternoons of practice per week. Some folks have a practice on weekends. I've tried this in the past as an independent contractor, but I am not sure if I am willing to give up a part of my treasured weekends. Bottom line: Private practice requires time. Do you have it or are you willing to make it?
- **Money:** Yes, private practice may result in an increase in your income. However, start-up can be an expensive thing. Like many other early career folks out there, the first years of professional work for me have involved paying off debts and taking on new ones (moving, rent, mortgage, malpractice insurance, licensing...need I go on?). Starting a practice will entail an up-front investment, possibly a significant one. You'll need a financial cushion to rely on while you build up referrals. You'll also need to lay out the costs involved in obtaining office space. Bottom line here: Making money means spending money. Do you have it or can you get it?

Practice is not for everyone. Certainly there are psychologists who know right off the bat that they do not want to do private practice. But for those of us on the fence, “peer pressure” (via elegant mailings




## Experiences of Women of Color with Domestic Violence in the United States

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 Domestic violence is a widespread phenomenon occurring throughout the world at all socio-economic levels (Menjivar & Salcido, 2002). Domestic violence refers to a pattern of physical, emotional, verbal, and sexual abuse, which includes, but is not limited to, threats, intimidation, isolation, and financial control (Tjaden & Thoennes, 2000). In the United States, cultural and ethnic minority continues to have an elevated risk for domestic violence (Tjaden & Thoennes, 1998). This article reviews the domestic violence literature among women of color and discusses non-traditional approaches of research and clinical interventions.


### Women of Color and Domestic Violence

According to U.S. Department of Justice (2000), data on African American, Asian American and Pacific Islander (AAPI), American Indian/Alaska Native (AI/AN), and mixed-race respondents are combined, non-white women report significantly more intimate partner violence than do their White counterparts (24.8% Whites; 28.6% Non-Whites). Similarly, studies have shown that immigrant and refugee women are vic-

tims of domestic violence more often than the U.S. women, and domestic violence situations are exacerbated by problems arising due to the stress of migration (Menjivar & Salcido, 2002).

Cultural values and social beliefs might be women of color's risk of being exposed to domestic violence. For example, battered immigrant women may be hesitant in seeking help due to cultural values, such as the belief that marriage should not be discussed with non-family members (Friedman, 1992; Jang, Lee, & Morello-Frosch, 1991) and fear of being ostracized from their community (Friedman, 1992). Furthermore, some Asian communities indicate that if women do not stay within their prescribed roles, it is culturally acceptable for men to "discipline" them by using physical abuse (Tran, 1997; Raj & Silverman, 2002). Such cultural themes and family values may explain the women of color's failure to disclose abuse to authorities and to seek help when abuse occurs (Abraham, 1995). In addition, language barriers and institutional racism faced by women of color are additional risk factors that compound the effects of domestic violence. For example, language barriers stop immigrant women from understanding the law and protecting themselves which might make them feel intimidated and helpless (Bui & Morash, 2003). In addition, women of color often encounter racism, classicism, and cultural insensitivity in the mainstream society which might hinder their willingness to seek for help. Thus, for some immigrant women, immigration and public policies, child custody, and financial demands of legal procedures might discourage from leaving their abusive relationships.

### Early Career Column (cont.)

announcing the opening of a new local practice) and the (perhaps not so realistic) allure of making not only your own schedule but also gobs of money is hard to resist. I hope you'll consider both the upside, and the downside, of private practice. I will update you on my private practice decision-making in a future column and would welcome any personal experiences or persuasive arguments you can offer. Please e-mail me at: kmuller@montefiore.org. 

### References:

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### Domestic Violence Interventions Focusing on Women of Color

Currently, culturally competent interventions concerning domestic violence adequately accounting for contextual and cultural factors are much more emphasized (Caetano, Field, & Scott, 2003). A culturally competent perspective implies a manner that is sensitive to the cultural beliefs held by a particular ethnic group. By exploring the system of shared beliefs that ethnic minority from a particular cultural group use to cope with their world, adequate support and interventions may be provided to help them face the challenges of domestic violence within their particular cultural framework (Preisser, 1999). Some qualitative studies have been done in the past few years and indicate the effectiveness of culturally competent interventions for women of color with



domestic violence, such as the Empowerment Program and Cultural Context Model (Sharma, 2001; Miller & Rasco, 2004). Both of these approaches were targeted to immigrant women and developed as collaboration as multiple partners to empower women with domestic violence based on the cultural sensitive concept, including the influence of linguistic and cultural isolation, socialization, socioeconomic status, religious values, and experiences of racism and discrimination (Sharma, 2001). However, there is lack of quantitative research to support the evidence of the effectiveness of culturally competent interventions.

### Conclusions


This article highlighted some of the cultural issues that pertain to domestic violence among women of color, including ethnic minority and immigrant women. From this brief summary, it is clear that a balanced methodology that incorporates strengths from different theoretical perspectives offers a comprehensive understanding of domestic violence. The use of measurement tools to quantify/qualify the domestic violence among women of color should be culturally adapted. Furthermore, collaboration with multicultural communities and clinics should be enhanced through the development of culturally competent intervention programs. The needs of bilingual/ bicultural staff and the cultivation of cultural competence clinical services should be reflected of the cultural backgrounds of the clients. Indeed, the experiences of women of color with domestic violence in the United States need further warrants and more attention in order to ensure that culturally competent interventions are available and implement to women who are in need of such assistance. ■■

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## The Division of Clinical Psychology, 1975-85

Donald K. Routh, PhD

 This decade focused on several topics of concern for clinical psychology, including science, professional practice, and advocacy. Division 12 presidents such as Norman Garmezy, Peter Nathan, and Lee B. Sechrest were known for their scientific activities. Garmezy had published an influential review of the childhood antecedents of schizophrenia and went on to study protective as well as risk factors for this disorder. He pointed out that certain children, though subjected to extremely stressful environments, were nevertheless *resilient* and flourished in spite of tremendous adversity. Nathan carried out systematic behavioral studies of the effects of alcohol, using suitable placebo controls. Sechrest was a notably tough-minded expert on the application of scientific methods to clinical issues. During 1975-1985 Division 12 began to make a distinction in the awards it gave each year, with one for scientific contributions and another for professional ones. During this decade the Division's Society of Pediatric Psychology began its own peer reviewed scientific publication, the *Journal of Pediatric Psychology* and also in 1980 attained more regular status within the Division as Section 5. One of the founders of the Society of Pediatric Psychology, Logan Wright, served as Division president in 1981-81 as well as APA president a few years later.

Practitioners were more prominent than ever in the Division. Its president in 1975-76 was Gordon Derner, who had founded the first practitioner-oriented doctoral program in psychology, at Adelphi, in 1951, which was APA-approved by 1957. Derner was also a founder of the National Council of Schools of Professional Psychology. Other practitioner-oriented presidents of the Division included Nicholas A. Cummings (founder of the California School of Professional Psychology, a sponsor of PsyD programs), and Allan C. Barclay, later associated with the School of Professional Psychology at Wright State University in Ohio. Another Division president, Max Siegel, was a private practitioner who championed the important issue of confidentiality on the part of psychotherapists. It was also during this decade, in 1977, that Missouri was the final state to pass a law licensing

psychologists. During this decade, practicing clinical psychologists became more involved in sponsoring freedom of choice legislation, founding a National Register of Health Service Providers in Psychology, and otherwise trying to deal with the challenges of the inclusion of psychological services in Health Maintenance Organizations and other managed care programs.

An emphasis on advocacy characterized the activities of Division presidents Seymour B. Sarason and Bonnie R. Strickland as well as a number of Section 1 leaders. Sarason, one of the founders of community psychology, had long been a critic of what he considered clinical psychology's over-identification with medicine and psychiatry. He favored, for example, closer ties to the school system and other public-sector entities. Strickland, whose research focused on depression in women, provided the impetus for the founding of the Division's Section 4, devoted to the clinical psychology of women. She also was ahead of her time in advocating closer attention by clinical psychologists to issues facing gay, lesbian, and bisexual individuals. Members of the Section on Clinical Child Psychology (Section 1), including Milton Shore and Gertrude J. "Trudy" Williams, successfully pushed for the formation of a new APA division devoted to child advocacy. Thus it was that the Division of Child, Youth, and Family Services (Division 37) came into being. Some feared that this new organization would divert interest away from clinical child psychology itself, but this did not happen. In fact, other Section 1 leaders were responsible for holding a conference at Hilton Head, South Carolina, in 1985, on the training of clinical child psychologists.


Section 2, on Continuing Professional Development (which grew out of the former Corresponding Committee of 50) continued to search for its identity within the Division. The name of the section suggests that it was concerned with running continuing education activities such as Division 12's Post Doctoral Institutes (PDIs) at APA Conventions. Actually, the PDIs began back in 1948, well before this Section existed and continue to be offered now, long after the demise of Section 2.

In 1975, Section 2 had published a pamphlet with the title, "Careers in Clinical Psychology: Is There a Place for Me?" The Division had promised to sup-



## Evidence-Based Practice in the Context of Clinical Training: An Interview with Edmund Neuhaus

George M. Slavich, PhD

 The belief that psychosocial interventions may be improved through research is not new. What is new, however, are multiple recent advancements in the movement to define and more widely employ evidence-based treatment. To examine this movement from a clinical training perspective, I sat down with Edmund Neuhaus, Ph.D., ABPP, Co-Director of Psychology Training and Director of the Behavioral Health Partial Hospital Program at McLean Hospital. The clinical internship program that Dr. Neuhaus operates with Dr. Philip Levendusky recently received the “Excellence in Internship Training” award from the Association of Psychology Postdoctoral and Internship Centers (APPIC). In the interview that follows, I asked Dr. Neuhaus to discuss evidence-based practice in the context of clinical training.

**GMS:** *First, congratulations on receiving the “Excellence in Internship Training” award from APPIC, along with Dr. Philip Levendusky, on behalf of the Psychology Training Program at McLean Hospital.*

ECN: Thank you. It is a tribute to the talented and hard working faculty, staff, and trainees, and especially to Phil Levendusky, who first brought CBT to McLean over 30 years ago and had the vision to ensconce internship training into the mainstream of psychosocial treatment here.

**GMS:** *Last year, there were 640 APPIC-listed internship training sites nationwide. What do you emphasize in the training program at McLean that makes it stand out?*

ECN: It’s several things: this hospital environment, severe psychopathology, the quality of supervision, and of course, training in the application of evidence-based treatments. The structure of the internship program epitomizes McLean’s teaching hospital mission, as training and clinical service are fully integrated and informed by research. The primary site for the internship is the Behavioral Health Partial Hospital Program, whose treatment philosophy is oriented to translate evidence-based treatments to the real world practice of hospital psychiatry with complex and

severe psychopathology. Our students typically have strong academic backgrounds in evidence-based CBT, mostly in outpatient settings. We offer unique opportunities for applying evidence-based CBT in partial hospital, which in the 21st century has patients who are virtually at the inpatient level of care. One more thing: research. There have been career opportunities for interns to work with PI’s leading to major training grants, and more recently for interns to be involved in the “live action” treatment outcome research we are doing in the Behavioral Health Program, which in turn informs the clinical treatment that interns are providing.

**GMS:** *Evidence-based practice seems to be a hot topic these days. Why is this the case in general and why now in particular?*

ECN: Evidence-based practice in mental health and medicine has been gaining momentum in the past decade. I can’t say for sure why, but accountability is one big reason in my mind. The field is healthier as more professionals are pausing to consider if what they are doing is effective; as such, they are seeking out evidence-based resources to inform their practice. Another reason, I believe, is the small, core research community of behavioral and cognitive therapies in the 1970’s and 80’s was graced with the technological advances of society to proliferate the field.

**GMS:** *You have written that evidence-based treatments are “not inherently designed to adapt to the vicissitudes of our current health care environment” (Neuhaus, 2006, p. 1). Say more about this.*

ECN: In that paper, I propose that the clinical and organizational aspects of a program must be *inherently* adaptable to maintain consistent effectiveness. Even though something works today, we must avoid complacency and embrace the changing world. I also argue that there remains a wide gap between evidence-based treatments tested under controlled conditions and the real world practice in a psychiatric hospital. The fact is, the patients we treat would never be allowed to participate in a typical efficacy study: too many “rule out” criteria, such as having several diagnoses. From the opposite angle, our typical patient could use any number of protocols: for depression, for anxiety, for borderline personality disorder, and for substance abuse. Which one to choose? I propose a flexible approach to adapt research to practice. I believe just being flexible is not the goal. We need fixed values—principles based on the most rigorous



## Student Column (cont.)

theory and research—to inform our decision-making. Fixed values are guideposts in the storm to keep us oriented.

**GMS:** *So, you believe that some amount of adaptation has to occur in order to effectively employ evidence-based treatment strategies in certain hospital settings. Along these lines, what do you see as the biggest difference between conducting clinical work in graduate school and during internship?*

ECN: One of my “July speeches” I give to interns when they arrive is that in graduate school the ethic is to achieve greater levels of complexity and sophistication. Now during internship, it’s time to get simple, not simplistic, and really think about the basic assumptions of what needs to happen to treat *that* patient sitting across from you who can’t process information so well because of depression and anxiety, or *that* group of patients waiting to learn about behavioral activation who barely can get out of bed. The point is, many students know very sophisticated things about evidence-based treatment for narrow contexts, but there is no natural bridge to treating a heterogeneous patient population with severe psychopathology. We are trying to teach, and

use in our treatments, the common elements across protocols that are effective, which I must say creates anxiety for interns, as it is often uncharted territory for them.

**GMS:** *So, what do graduate students need to know in order to make them better prepared to use evidence-based treatments during internship?*

ECN: It’s not so much what they need to know. It about being open to learn and acknowledging the limits of what they know.

**GMS:** *Looking forward, what does the future of evidence-based practice look like?*

ECN: I worry about technique overriding good clinical formulation and clinical decision-making. I don’t look forward to the next treatment manual for a very specific problem. Having said that, my hope, and there is certainly evidence for this now, is for more consolidation of evidence-based practice that highlights common factors. David Barlow’s recent work on unified treatments for emotion disorders is the best example of this from a basic research standpoint. And I hope to make a contribution, as I am developing a training manual for my flexible CBT approach, emphasizing basic principles and a clinician’s self-evaluation of treatment effectiveness.

**GMS:** *What can graduate students do to be better prepared for this future?*

ECN: Take time to *really* understand basic principles, be mindful that one’s theory and research are based on a set of assumptions and thus are not the whole truth, and be open to learn with humility.

**GMS:** *On behalf of the student members of Division 12, thanks for your time!*

ECN: It’s been my pleasure.

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*Note:* To learn more about evidence-based practice in the context of clinical internship, come to Dr. Neuhaus’ invited address on Friday, August 17th, 2007, from 8:00am to 8:50am, during the upcoming APA Convention. ☞


## History Column (cont. from page 11)

port this project financially, but when Board members saw the finished project, several objected to it, and the Board never came through with the promised funds. The problem seemed to be that the pamphlet mentioned, in a single paragraph, the fact that some psychologists with master’s degrees deliver clinical services. This raised a red flag in terms of the Division’s historic emphasis on the doctoral degree as a prerequisite for clinical practice. In any case, the pamphlet was a divisive issue for about 10 years, right up to the time when the Section, after a poll of its members, voted to disband. The “master’s issue” has continued to be a contentious one for clinical psychologists and for Division 12 long since that time. In the world of managed care, the individuals who receive third-party payments for psychotherapy and related services, include not only psychiatrists and doctoral level psychologists but also, in much greater numbers, master’s level social workers and master’s level mental health counselors, whose training is no more advanced than that of many psychologists with master’s degrees. This is not the final time this issue will be discussed in this history of the Division of Clinical Psychology. ☞



## Federal Advocacy Updates

Donna Rasin-Waters, PhD

 As your Federal Advocacy Coordinator I thought I would begin our new TCP column on advocacy by introducing Division 12 members to an excellent tool available through the APA Practice Organization. Our Legislative Action Center allows each and every one of us to quickly send letters to Congress as well as access a wealth of information about legislative activity relevant to psychology. Since Division 12 members

***I encourage our members to become active in advocacy. It only takes a moment to send a letter to your legislators and the feedback I receive about the site generally reflects how surprised psychologists are to find how quick and easy it was to write to Congress.***


pay the practice assessment, we can all use the Legislative Action Center link inside [www.APApractice.org](http://www.APApractice.org) to track important legislation involving psychology. In addition to sending letters to Congress, the site also provides biographical, contact and legislative information on your legislators, their voting records, information on the daily activities of the House and Senate, political action committee contributions to federal candidates and more. I encourage our members to become active in advocacy. It only takes a moment to send a letter to your

legislators and the feedback I receive about the site generally reflects how surprised psychologists are to find how quick and easy it was to write to Congress.

As a regular and ongoing part of the advocacy update in *The Clinical Psychologist*, I would like to hear about any advocacy events in practice, science and education that members of Division 12 have taken part in this year. To open the report on our division-wide participation in legislative and advocacy work, I will briefly talk about my attendance at the APA Practice Organization State Leadership Conference in March. I participated in the black tie event hosted by the Association for the

Advancement of Psychology honoring Senator Gordon Smith who has been a staunch supporter of mental health issues and legislation on the Hill. The goal of these AAP events is for important key legislators to be immersed in a small group of psychologists so that an extended discussion of psychology's concerns can be addressed and meaningful interaction with the group can occur in an intimate setting. Approximately 40 of us gathered for a multiple course, two hour meal during which the Senator moved from table to table to engage in discussion. It is quite a rare opportunity to have this much access to a U.S. Senator. Having already been briefed by the APA Practice Directorate Staff on the legislative agenda for 2007, we were sure to focus our discussion on Mental Health Parity and the 9% Medicare cuts to reimbursement for psychologists. Over the past 20 years, these events have produced some of psychology's strongest champions on Capitol Hill. I wish to thank the following Division 12 members for their support of this event: Drs. George Bouklas, Paula Hartman-Stein, Peter Kanaris, Linda Knauss, Deborah King, Robert Knight, Nanette Kramer, Stanley Friedland and student member Sean Sullivan. My only hope is that Division 12 members will become "regulars" at these AAP events, as there is enormous value in meeting with and supporting our legislators.


The APA State Leadership Conference always closes with a day of Hill visits. I had the privilege of visiting several NY state legislators' offices to discuss Mental Health Parity and the 9% Medicare cuts to reimbursement for psychologists. These visits are not only important, but also productive in creating a "two-way street" for shaping the direction of mental and behavioral health issues in Congress. It is often the case that our legislators need information from us as much as we need for them to hear about our concerns and requests.

It is my hope for this column that our membership will participate in advocacy for our field in all ways big and small. If you cannot visit your legislators then write to them. And if you cannot attend an AAP event then support and encourage someone who will. Psychology needs to be visible and whether clinician, researcher or educator, democrat, republican or independent our "party" is psychology. Support it by advocating! 

Direct comments to: Donna Rasin-Waters, PhD, D12, Federal Advocacy Coordinat or [DrRasinWaters@aol.com](mailto:DrRasinWaters@aol.com)

## British Researchers advance a New Methodology for Classifying Harm Associated with Substance Use

Timothy J. Bruce, PhD

 In a recent *Lancet* article,<sup>1</sup> David Nutt and colleagues describe use of a methodology for assessing harm associated with substances of potential misuse. They describe the methodology as more transparent and scientific than the current one. As described in the article, if the new methodology is implemented, it would introduce alcohol and tobacco into the United Kingdom's (UK) list of top 10 most dangerous substances.

Nutt and colleagues note that methods used in the UK to curtail substance abuse by limiting supply through police and customs control are scaled

***In rank order from highest to lowest risk for harm, the 20 substances fell out as follows: Heroin, Cocaine, Barbiturates, Street Methadone, Alcohol, Ketamine, Benzodiazepines, Amphetamine, Tobacco, Buprenorphine, Cannabis, Solvents, 4-MTA, LSD, Methylphenidate, Anabolic Steroids, GHB, Ecstasy, Alkyl Nitrates, Khat.***

by the way substances are officially classified under the Misuse of Drugs Act of 1971.<sup>2</sup> Efforts used to control demand through, for example, education, prevention, and treatment are nominally tailored to the known actions and harms of specific drugs. Drug classification systems used outside the UK, such as that of the UN and WHO, also purport to be structured according to the relative risks and dangers of illicit drugs. Nutt and colleagues call into question the process by which risk for harm is determined in these classification systems, characterizing them as “often ill-defined, opaque, and seemingly arbitrary” (p. 1047).

Their article reports results of using a more transparent, expert-consensus approach to assess risk of harm and classify drugs accordingly.

The authors began the process by defining risk for harm as a combination of three main factors, each divided into three subfactors:

- A) The physical harm to the individual user caused by the drug, subdivided into acute, chronic, or intravenous harm categories.
- B) The tendency of the drug to induce dependence subdivided into psychological, physical, or intensity of pleasure.
- C) The effect of drug use on families, communities, and society through the consequences of intoxication, other social harms, or healthcare costs.

After piloting a 4-point rating system, in which psychiatrists registered as addiction specialists rated substances on each of the nine subfactors, the authors employed what they termed “Delphic analysis”<sup>3</sup> with a second independent group to formally assess harm associated with 20 substances. Delphic analysis is essentially an expert consensus method, but uses multidisciplinary groups, ratings, and discussion to draw conclusions. In this study, the group consisted of professionals from chemistry, pharmacology, forensic science, psychiatry, other medical specialties, and legal fields—those seen as relevant to covering the multiple factors that could contribute to harm associated with substance abuse. Initial ratings were made independently by each participant for each substance on the nine previously described risk factors. The scores for each of the factors were then presented to the whole group for discussion. Individuals were invited to revise their scores, if they wished, on any of the parameters, in the light of this discussion, after which a final mean score was calculated and substances were ranked.

In rank order from highest to lowest risk for harm, the 20 substances fell out as follows: Heroin, Cocaine, Barbiturates, Street Methadone, Alcohol, Ketamine, Benzodiazepines, Amphetamine, Tobacco, Buprenorphine, Cannabis, Solvents, 4-MTA, LSD, Methylphenidate, Anabolic Steroids, GHB, Ecstasy, Alkyl Nitrates, Khat. Although the two substances with the highest harm ratings (heroin and cocaine) are also rated as Class A drugs (i.e., most harmful) in the current UK system, there was “a surprisingly poor correlation between drugs’ class according to the Misuse

of Drugs Act and [the present study] harm score,” according to the authors (p. 1050, brackets inserted). Most notable was the inclusion of alcohol and tobacco in the study’s list, two substances that do not appear on the current UK classification system.

Notably, tobacco ranked second in harm due to healthcare costs. Harm related to chronic personal health risks and harm related to intoxication elevated alcohol’s standing on the list. Supporting these rankings are estimates suggesting that 40% of all hospital illness and 60% of drug-related fatalities in the UK involve tobacco use.<sup>4</sup> Similarly, alcohol is involved in over half of all visits to emergency departments and orthopedic admissions in the UK.<sup>5</sup>

**Supporting these rankings are estimates suggesting that 40% of all hospital illness and 60% of drug-related fatalities in the UK involve tobacco use.**

The authors hope results of the study will encourage discussion within the U.K. and beyond about how drug misuse, including legal drugs such as alcohol and tobacco, should be addressed. Although they did not suggest criminalizing alcohol and tobacco use, Nutt

and colleagues argue that a more scientific approach to classification would better inform government policy and public education about the actual risks and damages involved in substance use. ■■

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4. Doll, R., Peto, R., Boreham, J., & Sutherland, I. (2004). Mortality in relation to smoking: 50 years observations on male British doctors. *British Medical Journal*, 328, 1519–28.
5. Academy of Medical Sciences. (2004). Calling time: the nation’s drinking as a major health issue. London: Academy of Medical Sciences.

### ***Congratulations to Asuncion Austria on Receiving APA Presidential Citation***

Dr. Asuncion Miteria Austria received the 2007 Distinguished Elder/Senior Psychologist Award at the National Multicultural Conference and Summit (NMCS) held in Seattle, Washington, January 24-26 for her “pioneering work and years of distinguished service that has laid the path for those who walk behind her.”

The American Psychological Association Presidential Citation reads, “For her lifelong devotion to multiculturalism reflected in all of her work in psychology. Through her commitment to issues for women and ethnic minorities, Dr. Asuncion Miteria Austria has advocated, without hesitation, on controversial issues to propel the diversity and social justice agenda within psychology as well as within the community. Dr. Austria has worked tirelessly to raise awareness and knowledge of the Filipino experience in the United States. She has dedicated her professional life to education, mentoring, and advocacy for social justice. Through her teachings, numerous publications, and presentations, she gives voice to those who have none.”

Dr. Austria is Chair and Director of Training of the Graduate Program in Clinical Psychology at Cardinal Stritch University. She was elected as Member-at-Large and Chair of the Committee on Diversity on the Board of the Society of Clinical Psychology (2007-09). She also was elected as Representative of the Society for the Psychology of Women to the APA Council of Representatives (2007-09).



## BOOK RECOMMENDATIONS

Lata K. McGinn, PhD — Section Editor


### **Lincoln's Melancholy: How depression challenged a president and fueled his greatness**

**Joshua Wolf Shenk**

**Boston: Houghton Mifflin Company, 2005**

**350 pages**

**Reviewer: Jeremy D. Safran, PhD  
Psychology Department  
New School for Social Research**

 Abraham Lincoln, the sixteenth president of the United States experienced at least two clear-cut episodes of major depression, and struggled with chronic depression throughout his life. In his remarkable biography, *Lincoln's Melancholy*, Joshua Wolf Shenk carefully documents Lincoln's struggle with ongoing depression and the role it played in helping him to develop internal resources that he was able to harness to become one of the greatest American presidents. Shenk's book is at once a fascinating biography of a great man, a critique of the medicalization of psychology, an astute analysis of the interplay between culture and psychology, and a meditation on the meaning of human suffering.

Although Lincoln does not appear to have been depressed in his late teens, his friends and neighbors first became concerned about him in his early twenties, when his dedication to studying law developed into an obsessional drive, leading to a deterioration of his physical and mental health. At the age of 26, the death of his young friend Anna Mayes Rutledge appears to have precipitated a full blown major depressive episode. During this period Lincoln spent days wandering around by himself in the woods with a gun, and often spoke about suicide. His friends were deeply concerned about his welfare. Lincoln's second episode of major depression took place at the age of 31, and appears to have been related to a number of factors including problems in his political career, a fear that moral obligation would force him to marry a woman he didn't love (Mary Todd, who later became his wife), and the prospect that his best friend was either going to marry the woman Lincoln really did love, or move to another state.

Although Lincoln ultimately recovered from this episode, he continued to struggle with chronic depression and deep periods of despair throughout

his life, his presidency, as well as the Civil War. Shenk convincingly argues that this struggle taught Lincoln to tolerate the pain and disappointment of life, to face life's hardships and adversities with perseverance and without self-deception, and to develop a deep sense of clarity and resolution about what life is worth living for. Shenk documents the way in which Lincoln consciously shifted his goal away from personal contentment (which he realized he could never gain) to a concern with universal justice. Although it is customary for contemporary biographers to deemphasize the role of depression in Lincoln's life, and to emphasize his stoicism, ethical virtue, humor and political skill, Lincoln's struggle with depression was widely accepted by students of his life in the nineteenth and early twentieth centuries. According to Shenk, serious historians began to dismiss the evidence of Lincoln's depression in the 1950's and 60's, as cultural attitudes towards depression began to change. Shenk links this attitudinal shift to the development of a modern understanding of depression that conceptualizes it exclusively as an illness to be treated rather than as an organic part of the individual's way of being in the world. This shift in turn is associated with emphasis on personal happiness as an end in and of itself. Shenk argues, that although even in Lincoln's day, many thought of depression as "unmanly", there was also a cultural emphasis on depression (or what was termed melancholy), as a potentially valuable aspect of a man's life. According to Shenk, melancholia could signify "an existential unrest, a gloomy or morbid state that lurked in the background of one's life, but also a connection to insight and a drive for heroic action."

Shenk does not fall into the trap of romanticizing depression or of conceptualizing it in simplistic terms as an exclusively psychological phenomenon. He clearly documents the familial and probable genetic sources of Lincoln's depression as well as the psychological and environmental influences. What Shenk does provide us with, however, is a scholarly and compelling argument for the importance of conceptualizing human beings in holistic terms, and of continuing to remember the inseparability of psychological, moral and political discourse, at a time when various forces in our culture such as consumerism, instrumentalism and "quick fix" attitudes make this difficult. ■■



### Section II: Society of Clinical Geropsychology

**Deborah A. King, Ph.D.**

I am delighted to report on the following updates from our Section. First of all, we have a new name! Section 2 members voted to approve an amendment to the Section bylaws changing our name to the "Society of Clinical Geropsychology".

Second, we would like to congratulate Dolores Gallagher-Thompson, Ph.D. for winning the 2007 M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology. Dr. Gallagher-Thompson's award address at the 2007 Convention is entitled "Culture Counts in Intervention Research: Issues and Recommendations for Working with Dementia Family Caregivers."

Section 2 President Forrest Scogin, Ph.D. edited a Special Section on "Evidence-Based Psychological Treatments for Older Adults" in the March 2007 issue of *Psychology and Aging*. This project represents a second-generation effort to continue the work of Margaret Gatz, Ph.D. and colleagues (1998) who used the criteria developed by the Society of Clinical Psychology (Chambless et al., 1996) to develop the original review of evidence-based approaches for older adults. The Special Issue contains articles on the psychological treatment of geriatric anxiety (Ayers and colleagues), insomnia in older adults (McCurry and colleagues), behavioral problems in dementia (Logsdon and colleagues), and caregiver distress (Gallagher-Thompson and colleagues). A previous article on evidence-based treatments for depression in older adults was published in 2005 by Scogin and colleagues in *Clinical Psychology Science and Practice*.

Finally, many Section 2 members are working on Dr. Sharon Brehm's APA Presidential Task Force on Integrated Healthcare for Older Adults. The Task Force is making recommendations for how psychologists can work with other health care professionals to ensure appropriate and effective health care for the increasing number of older adults. In addition to a symposium presented at the 2007 Convention, the primary product will be a report: "Blueprint for Change: Achieving Integrative Health Care for an Aging Population". The Task Force is Co-Chaired by Toni Antonucci, Ph.D., and Antonette Zeiss, Ph.D. Other Task Force members include Greg Hinrichsen, Ph.D., Deborah King, Ph.D., Peter Lichtenberg, Ph.D., Martita Lopez, Ph.D., and Jennifer Manly, Ph.D. Norman Abeles, Ph.D. is Chair of the Advisory Panel.

Visit our website at <http://www.geropsych.org/> to join our Section or get more information on clinical geropsychology!

### Section III: Society for the Science of Clinical Psychology

**E. David Klonsky**

We are pleased to update the Division on the activities of Section III, Society for a Science of Clinical Psychology. Daniel Klein is

SSCP President, Lee Anna Clark President-Elect, and Elizabeth Hayden Secretary-Treasurer.

We invite Division members to attend several SSCP programs that will take place at this summer's APA convention. Sue Mineka, winner of the 2007 SSCP Distinguished Scientist Award, will give her award address titled "Integrative perspective on risk for mood and anxiety disorders: Preliminary evidence from a longitudinal study of adolescents." Dan Klein will give his Presidential Address on "The classification of depressive disorders in DSM-V: The case for a two-axis system." In addition, Emily Durbin will chair a symposium on "Developmental psychopathology of internalizing and externalizing disorders." The symposium will include talks by John Abela, Eric Youngstrom, and Ted Beauchaine.

SSCP has begun to use ProfNet, a company that connects journalists and experts. Donna Rasin-Waters, Chair of the Division 12 Public Policy Workgroup, has been instrumental in making this happen. Interested members of SSCP regularly receive and can respond to inquiries from journalists on topics relevant to psychology. The service will serve as a means of focusing media attention on issues in clinical psychology of interest to SSCP members. We have already had success in this regard and encourage other Sections to make use of the service as well.

SSCP is assisting a Division 12 task force on strengthening and promoting clinical science. At the direction of Marsha Linehan in her role as President of Division 12, the dual charge of this committee is to promote clinical science in the field and help Division 12 better serve the needs and provide a home for clinical scientists.

### Section VI: The Clinical Psychology of Ethnic Minorities

**Anabel Bejarano, Ph.D.**

Under the leadership of Cheryl A. Boyce, Section VI continues to progress and strengthen its infrastructure. Our Executive Committee is now complete. Courtney Ferrell from NIH is chair of the Mentoring Committee; and Melanie Domenech-Rodriguez from Utah State University is chair of the Awards Committee. Communication among our Executive Committee members is now facilitated with a new EC listserve.

The upcoming APA convention Section VI program will showcase presentations that reflect Boyce's presidential theme highlighting mentoring and an initiative promoting early career psychologists. The Presidential Symposium "Developmental Issues in Mental Health Disparities Research and Interventions", will be chaired by Boyce. It will include "Developmental Research Issues for the Study of Racial/ Ethnic Minority Families" (Boyce), "Depression and Suicide among Diverse Adolescents" (Sean Joe), "Preventing Anxiety and Violence in Racially Diverse Communities" (Michele Cooley), and "Culturally Relevant Family Based Interventions for Violence and Substance Abuse" (Phillipe Cunningham) with Charlene LeFauve as discussant. Gail Wyatt will chair "Diversity within Science and Practice

of Clinical Psychology Diversity” Discussion Hour, with participants Boyce, Stanley Huey, Guillermo Bernal, Steven Lopez, and Nadine Kaslow as discussant. The Rodney Clark Memorial Symposium for Early Career Clinical Science will be chaired by Norman B. Anderson and will include “The Clinical Scientist of Color’s Roadmap to Securing the Proper Mentoring: One Woman’s Circuitous Journey” (Alfiee M. Breland-Nobel), “Planting Seeds: Addressing Mental Health Disparities Through Mentorship and Service Learning” (Monica Mitchell), Getting the Most out of Your Mentors to Build an Academic Research Career (Stanley Huey), Implementing a Career Plan Through Mentorship: Vision, Hard Work, & Serendipity (Anthony Chambers), Finding a Clinical Scientist Mentor where you Least Expect it (Courtney Ferrell), and Mentoring: Nurturing Careers and Advancing the Discipline (Jessica H. Daniel). Gail Wyatt, will give an invited plenary entitled, “You Should Know What I Know: The Empirical Basis for Understanding Sex Today”.

Section VI is proud to co-sponsor a conference organized by a Task Force of Division 45, Society for Psychological Study of Ethnic Minority Issues, on Evidence Based Practice in Psychology, to be held in Washington, D.C. March 13-14, 2008 following the annual APA State Leadership Conference.

And last, but certainly not least, Section VI is excited and optimistic as we organize our feedback to Division 12 and all of its sections on implementing goals on Recommendations for Increasing Diversity within the APA Division 12. We trust that our recommendations will serve as a blueprint for actions that all sections and Division 12 will be able to follow.

We invite you to visit our website: <http://www.apa.org/divisions/div12/sections/section6/>

## Section VIII: Association of Psychologists in Academic Health Centers

**Ronald T. Brown, Ph.D., ABPP**

Over the past several months, the Association of Psychologists in Academic Health Centers (APAHC) has been quite busy in planning our third national conference that will take place from May 3 to May 5, 2007 in Minneapolis, MN. APAHC will be convening a formal assembly for psychologists employed in academic health centers that is specifically designed to assist them in understanding the transformation of academic health centers and strategies for insuring their roles as indispensable contributors and leaders in health science centers. The conference is designed specifically to inspire psychologists to innovate, originate, challenge, and expand professional opportunities and responsibilities within academic health centers. The conference title, Psychologists in Academic Health Centers: Traditions and Innovations in Education, Science, and Practice, reflects its unique relevance to psychologists in medical schools, schools of health professions and nursing as well as teaching hospitals. We are most excited about this stimulating conference that will connect psychologists in academic health science centers across the nation.

This year, the conference will employ three themes that

are designed to promote systemic thinking for the purpose of developing training, research and clinical service within interdisciplinary health sciences centers. Specifically, the conference in Minneapolis will be organized around three distinct tracks including Professional Development Issues in Academic Health Centers. Specifically, the track will focus on administrative skills, compensation issues for professional psychologists, building effective programs, maintaining professional viability in a competitive health care and research funding market place, ways to secure reimbursement for services and new diagnostic coding developments. As academic health sciences centers are increasingly under increased pressures for cost containment, this track should be of interest to many.

The second track, Contemporary Roles for Academic Health Sciences Center Psychologists: Education, Research, and Clinical Opportunities will focus on the distinctive competencies of psychologists in academic health centers, the interface between psychologists and physicians in areas such as competencies, evidence-based practice, research utilization of the Institute of Medicine Report on Behavioral Science Teaching/Medical School Curriculum and funding issues for research activities. Particularly in this current time of “evidence-based medicine”, it will be important to understand the important role of research and competencies in clinical practice within a health sciences center. In addition, a track entitled, New Horizons: Emerging Opportunities in academic health science centers will focus on emerging issues including the impact of the predicted physician shortage on opportunities for psychologists, genomics, and the most efficacious models of psychology in basic research and clinical practice delivery systems. This latter track promises to be especially important as it will highlight new roles for clinical psychologists in academic health sciences centers in both research and clinical practice.

In addition to the aforementioned tracks, an especially innovative feature of the conference is that each morning of the conference there will be an early career mentoring breakfast meeting that is designed to match participants at the meeting with mentors, in small groups in accordance with specialty interests or specified mentorship needs. Specifically, these meetings will provide consultation and valuable networking opportunities for psychologists who are recently beginning their careers in academic health science centers. Particularly for those psychologists recently beginning their careers, these activities will serve an important role in enculturating recently trained clinical psychologists to academic health sciences centers and their indispensable roles in such centers.

The third national conference that is specifically designed for psychologists practicing in health sciences centers promises to be especially stimulating and will serve to update these individuals in education, science and practice. Featured speakers at the conference include Nadine J. Kaslow, Ph.D., ABPP, Anne E. Kazak, Ph.D., ABPP, Brick Johnstone, Ph.D., ABPP, Cheryl King, Ph.D., ABPP among several other prominent clinical psychologists across the nation. In addition continuing education credit will be available for conference participants at no extra cost. ■■



## ***Division 12 Award Criteria: Deadline October 1, 2007***

Note: At the June, 2004 BD Meeting, the BD voted that no voting member of the Division 12 Board of Directors will be eligible to receive awards from the Division while serving their term.

Send award nominations for 2008:

**Marsha Linehan, Ph.D., Chair**  
**2008 Awards Committee**  
*c/o Division 12 Central Office, P.O. Box 1082*  
*Niwot, CO 80544-1082*  
Email: div12apa@comcast.net  
Deadline: October 1, 2007

### **Theodore Blau Award:**

The "Theodore H. Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology" will be given by the Division of Clinical Psychology 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. (\$1,000 is awarded to the winner), and the American Psychological Foundation (an additional \$1000 to the winner).

### **David Shakow Award:**

The "David Shakow Early Career 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. Letters of nomination should include the nominee's vita and a summary of his/her contributions. (Up to \$500 for travel to the APA Convention is awarded.)

### **Distinguished Scientific Contribution Award:**

Honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology.

### **Florence Halpern Award for Distinguished Professional Contributions:**

The Florence Halpern award for distinguished professional contributions honors psychologists who have made distinguished advances in psychology leading to the understanding or amelioration of important practical problems and honors psychologists who have made outstanding contributions to the general profession of clinical psychology.

### **The Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology** (created 2003):

Will be given by Division 12 (Society of Clinical Psychology) 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.

### **The American Psychological Foundation Theodore Millon, Ph.D. Award**

Division 12 is to administer the American Psychological Foundation's new Theodore Millon, Ph.D. Mid-Career Award in Personality Psychology. The American Psychological Foundation (APF) Theodore Millon, Ph.D. Award will be conferred annually (from 2004 through 2008) to an outstanding mid-career psychologist engaged in advancing the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. A scientific review panel appointed by Division 12 of the American Psychological Association will select the recipient upon approval of the APF Trustees. The recipient will receive \$1,000 and a plaque. Nominees should be no less than 8 years and no more than 20 years post doctoral degree. Nominations should include a cover letter outlining the nominee's contributions to science of personality psychology (in one or more of the areas of personology, personality theory, personality disorders, and personality measurement) and a copy of an abbreviated curriculum vitae. Self-nomination is permitted. One or two letters in support of the nomination are also encouraged.

### **Outstanding Clinical Educator Award**


This award will be conferred annually to a psychologist displaying excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty. It will recognize those individuals who have been outstanding in supporting, encouraging and promoting education and training, professional and personal development, and career guidance to junior colleagues. Qualities that can contribute to good mentoring are advisor/guide in research related to clinical psychology, advisor/guide in clinical practice related to clinical psychology, advisor/guide in education and teaching related to clinical psychology, advisor/guide in public policy related to clinical psychology, acting as a successful role model, fostering the development of talents, acting as an advocate and guide, "friend" with concern for students and junior colleagues as people and support of their personal development, supportive on both a personal and professional level and long-term commitment to mentoring. This award seeks to recognize those individuals who truly go out of their way to mentor more junior colleagues, honoring them for efforts which often go unnoticed—but not unappreciated.





# Division 12: Developing a New Identity

Linda C. Sobell

 Over the past year, a Task Force on Identity has been meeting. The members of the task force were: Mitch Prinstein, Lynn Rehm, Ed Craighead, Toy Caldwell-Colbert, Karen Calhoun, David Barlow, Tom Ollendick, Irv Weiner, Lynn Peterson, Linda Sobell. The reason for the Task Force was to identify pressing issues for the Division and to provide recommendations for future goals for our Division. Many of the issues/concerns facing Division 12 are also facing APA and other divisions. Our Division also faces some unique concerns.

Our report was submitted at the Winter 2007 meeting a few weeks ago and approved unanimously. Now the hard work begins as we go forward to seek ways to address the six issues/concerns. However, as we proceed, the Board wants to also ask the membership for their input.

The overarching concern centers on the Division's mission and goals for the next decade. The Task Force identified the following 6 major issues/concerns:


1. Sections within Division 12 need to feel an identity with the division— How do we ensure that the sections within the Division feel an identity with the division? We need a very clear agenda to advance the mission of the sections using the full force of Division 12 over and above inviting sections to send a representative to the Division 12 board (e.g., Division 12 resources allocated to joint promotion of section-division goals, making the division more valuable to the sections; ask sections what they need from the Division; ask what they need to further promote the division). The goal would be to help sections, while at the same time having them help the Division realize our collective goals.
2. Moving evidence-based practice forward: Given that we cannot be all things to all people, the Division needs to focus on our cross-cutting strengths such as focusing on health and mental health delivery that is evidence-based and that is transportable to the professional community. Division 12 could take the lead on taking APA's Evidence Based Practice (EBP) document to the next level. There are multiple advantages associated with taking the initiative in moving EBP forward. In the early 90's, Division 12 focused on empirically supported treatments, now it is time to go beyond that and focus on EBP that incorporates idiographic approaches to clinical care in combination with the more nomothetic activity of identifying and promulgating empirically supported treatments. Using a model that is unique in the world, Division

12 can forge ahead with an agenda that many clinical psychologists in other divisions might be eager to join. (Further discussion supporting this is noted below in the supporting documentation section.)

3. Attracting new and young members and retaining long-time members. Use new Section 10 to help us disseminate our changing values. It is important to have Divisional activities that are exciting and invigorating to clinical psychologists across the professional life-span.
4. Enhanced attention to diversity issues in the profession. Use new member at large for Diversity on the Board, the Diversity Committee, and Section 6 to help disseminate our changing values and emphasis. Seek a commitment and action plan from each Section and division Committee that fosters the recommendations of the Diversity Committee's Strategic Plan for Diversity in the Division. Address clinical training expectations that foster the APA Multicultural Guidelines within the field of clinical psychology.
5. Partnering and Connecting with Other Divisions: We are not well connected with other divisions. Develop a "Coalition of Divisions" where Division 12 can do things collaboratively with other divisions to have shared benefits among members by keeping the focus on clinical psychology rather than a specialty. (Further discussion supporting this is noted below in the supporting documentation section.)
6. Connecting with, engaging, and applying the resources of the broad diversity of our members from practitioners to scientists to educators in order to promote clinical psychology.

Summary: If we as a division are to advance the mission of clinical psychology, we need to be more welcoming. We need to bring ALL stakeholders to the table and to welcome all facets of clinical psychology including recognizing the breadth of experiences and backgrounds of our own members. The success of this will be in the numbers we can bring to the table to advocate for policy issues and needed change.

(For those interested, a longer report can be requested that contains additional documentation supporting the recommendations).

Comments and suggestions from Division members are welcomed (sobell@nova.edu). 



## Society of Clinical Psychology Board of Directors Minutes Seattle, Washington January 27-28, 2007

Submitted by Linda K. Knauss, PhD.  
Secretary, Society of Clinical Psychology

### President's Agenda

1. It is important for clients/consumers to have access to treatment that works. Psychologists can not treat everything, but can be effective with a lot. Dr. Marsha Linehan created a Task Force in conjunction with Section III and the Science and Practice Committee. The purpose of the Task Force is to update the evidence based practice list and create a mechanism to keep it updated regularly.
2. There is an absence of voter representation on the Division 12 Board. The Division has 4,000 members who elect the Board. Sections have 1,000 members, but half the votes on the Board are Section representatives. Dr. Marsha Linehan would like to discuss how votes are allocated.
3. Appointment of committee chairs – Some committee members have been on the committee long enough to become chair, but that is not how the committee chairs are selected. People serve as committee chairs for only one year. In this Division the president appoints his/her own team. One suggestion is for each president to appoint three committee chairs, and chairs would serve for three years. This will be more effective.
4. Does the Division want to increase membership at all cost, or should the Division remain small and passionate? What relationship do we want with APA?
5. Sections need a system where the Section representatives can get all required reports completed on time.
6. Monthly Executive Committee conference calls will be held to formulate policy and think through issues to present to the Board.

### Minutes – October 2006

MOTION: To approve the minutes as corrected.  
ACTION: Passed unanimously

### 2008 Meeting Year

Dr. Irving Weiner outlined two initiatives for his presidential year.

#### 1. Outreach

This initiative is to expand the diversity of the Division beyond racial and cultural diversity to include the diversity in clinical psychology. There are many types of psychologists. The goal is to reach out to more people.

#### 2. Impact

Dr. Weiner would like the Division to play a more influential

role in APA consistent with the size of the Division and the importance of clinical psychology.

Dr. Weiner has contacted the presidents-elect of other APA divisions which also have a significant number of Division 12 members. He would like to meet with them at the APA Convention. Thus far 20 people have responded. This is consistent with the goal of forming coalitions with other divisions that is included in the Identity Task Force Report.

The next meeting of the Board will be in Tucson, Arizona on September 14-16, 2007.

### National Multicultural Summit

Division 12 presented a symposium on culturally relevant evidence based practice. The symposium was very well attended. There were over 100 people and standing room only. The Multicultural Summit was sold out, and people were turned away. Drs. Asuncion Miteria Austria and Judith Worrell, Division 12 members were honored as elders.

Dr. Nadine Kaslow requested that her hotel room for the night before the symposium on culturally relevant evidence based practice be paid for by the Division because the Division requested the symposium for the Multicultural Summit.

### Finance Committee Meeting Report

The Board policy regarding late submission of reimbursement was reviewed and reconfirmed. Any request for reimbursement filed more than 90 days after the expenses were incurred will be referred to the Board of Directors for a decision on whether reimbursement should be authorized and paid. Original receipts are required for reimbursement. Credit card monthly summaries are not adequate.

The committee reviewed the financial history of the Professional Development Institutes (PDI's), and recommended to offer PDI's again at the 2007 APA Convention in San Francisco. In addition to the financial concerns, a central part of the mission of the Division is a commitment to dissemination of effective interventions and concepts. The committee recommended that this and alternate means of dissemination be discussed after the outcome of the 2007 PDI program is known. The PDI's have been losing money even before being cancelled in New Orleans. Some reasons for this include: APA offers CE during the convention, there is other competition for CE before the convention, and the Division is not allowed to offer CE during the convention.

The Finance Committee reviewed the 2006 budget and drafted the 2007 budget.

MOTION: To give \$500 to the Interdivisional Task Force on Child Mental Health  
ACTION: Passed unanimously  
MOTION: To approve \$200 for Dr. Nadine Kaslow's hotel room  
ACTION: Passed unanimously

## Abbreviated Minutes (cont.)

### Awards

The award recipients were confirmed by an email vote of the Board.

Distinguished Science – Dr. Larry Beutler  
Halpern (Professional) – Dr. Richard Rogers  
Shakow Early Career – Dr. Michael Zvolensky  
Blau Early Career – Dr. Melissa Kuhajda  
Stanley Sue Diversity – Dr. John Robinson  
Sam Turner Clinical Research – Dr. Deborah Beidel  
Theodore Millon – Dr. Aaron Pincus  
Clinical Educator Award – Drs. Paul Pilkonis and Marsha Marcus

Voting members of the Board are not eligible for these awards.

### Public Policy

Future plans include: 1) There will be an advocacy column in each issue of *The Clinical Psychologist*. Dr. Donna-Rasin-Waters will be responsible for this. 2) There will be a list on the Division 12 website of where we will contribute. 3) Dr. Donna Rasin-Waters requested funds to attend the January 2008 Board meeting. This will be considered at the fall meeting. 4) Dr. Donna Rasin-Waters will work on the federal advocacy list serve.

### Identity Task Force Report and Action Steps

The issues faced by Division 12 are faced by other divisions also. To advance we need to be more welcoming and bring all stakeholders to the table. It is important not to lose the momentum of the Task Force.

MOTION: To accept the report of the Identity Task Force  
ACTION: Passed unanimously  
MOTION: To thank the Identity Task Force for their work.  
ACTION: Passed unanimously

The Identity Task Force Report identified six concerns. Dr. Linda Sobell recommended assigning two people to each concern to develop action steps to bring to the Board at the next meeting for discussion. Dr. Linda Sobell will chair this process.

### Identified Concerns

1. Deb King and Richard McKeon (Sections need to identify with the Division)
2. David Klonsky and Linda Sobell (Moving evidence based practice forward)
3. Sean Sullivan and Barry Hong (Attracting and retaining new and young members)
4. Siony Austria and Nadine Kaslow (Enhanced attention to diversity issues)
5. Irv Weiner and Linda Knauss (Partnering and connecting with other divisions)
6. Donna Rasin-Waters and Norm Abeles (Promoting clinical psychology)

### Reimbursement for APA Council Representatives

Since APA has changed the reimbursement policy for Council members during the APA Annual Convention to pay for two nights at the convention hotel rather than one, the Division needs to change its policy for consistency.

MOTION: To reimburse APA Council Representatives for one day's expenses (hotel and meals) in addition to the two days APA covers.  
ACTION: Passed unanimously

### Request for Funds 2007

\$500 for Child Task Force  
\$200 for hotel room for Dr. Nadine Kaslow  
\$400 from Education and Training for ½ of stipend  
\$800 for APA Representatives (4) to pay for one night's stay at APA convention  
\$200 for Dr. Donna Rasin-Waters to State Leadership Conference  
\$400 for Web site (Increase from \$1,600 to \$2,000)

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\$2,500 Total

MOTION: To adopt the 2007 budget.  
ACTION: Passed unanimously.



## INSTRUCTIONS FOR ADVERTISING

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

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

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

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


### Submission deadlines for advertising and announcements:

February 1<sup>ST</sup> (Winter/Spring Issue – mails in early April)  
May 1<sup>ST</sup> (Summer Issue – mails in early July)  
September 1<sup>ST</sup> (Fall Issue – mails in early November);

### Editor (2006 – 2009):

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# Division 12 APA Program: August 2007

 San Francisco is certainly an interesting city to visit. It may appear slightly less interesting, however, after you review the extremely stimulating Division 12 Program offered at the upcoming APA Convention. This year's program includes invited and presidential addresses, symposia, paper and poster sessions, discussion and conversation hours, and a clinical supervision roundtable. Sessions ranging from psychotherapy, psychological assessment, psychopathology, and training in clinical psychology, also emphasize culture, ethnicity, and developmental stage. In addition, the latest results from the most cutting-edge research trials will be presented.

While you can certainly read the complete program schedule below, I wanted to highlight just a few sessions to whet your appetite. First, Dr. Marsha Linehan's Presidential Address will certainly be a huge draw and no student will want to miss her more informal conversation hour. Dr. Albert Bandura and Dr. Jackie Persons will both undoubtedly provide outstanding invited addresses. Dr. Aaron T. Beck will receive the Section VII Lifetime Achievement Award while Albert Ellis will receive a tribute of his own provided by many of his protégées and chaired by Dr. Jon Carlson. Division 12, in collaboration with several other APA Divisions, will offer two poster sessions pertaining to the psychological assessment of children, adolescents and adults. The intent of this interface is not only to select the highest quality posters but also to provide a larger more integrated forum for professional networking in this specialization. In addition, we are excited to offer the first, and hopefully not the last, clinical supervision roundtable. Marsha Linehan (behavioral), Nancy McWilliams (psychodynamic), and Evan Imber-Black (family systems), will be presented difficult cases by audience members and then share their clinical wisdom from differing theoretical orientations.

Please join us for the D12 Awards Ceremony scheduled on Saturday (8/18/07) from 5-550pm. If you stay a little longer, you can be sure not to deny yourself some fun with your D12 colleagues and students at the Social Hour from 6-650pm.

I look forward to seeing you there.

*Alec L. Miller, PsyD*

*Division 12 Program Chair*

## FRIDAY, 8/17

### Section X Invited Address

Before and After Internship: How to Thrive as a Budding Psychologist  
8/17 Friday 8:00AM-9:00AM  
Moscone Center, Room 238  
*Edmund Neuhaus*

### Symposium: Identifying and Applying Evidence-Based Mental Health Practices

8/17 Friday 9:00AM-10:50AM  
Moscone Center, Room 2022  
*Todd A. Glover, Felice Reddy, Alissa A. Taylor, Brad J. Nakamura, Daniel L. Ullman*  
Discussant: *David H. Barlow*

### Discussion: Reflections on Immigrant Women as Professionals, Clients, and Collaborators—A Panel Presentation

8/17 Friday 9:00AM-10:50AM  
Moscone Center, Room 3003  
Chair: *Elizabeth Davis-Russell*  
Discussant: *Rajeswari Natrajan, Leena Banerjee, Lucia Lopez-Plunkett, Mathew Calkins, Shruti Poulsen*

### Symposium: Psychology and Aging Policy—Advocating for America's Growing Aging Population

8/17 Friday 9:00AM-10:50AM  
Moscone Center Room 3004  
*Diane Elmore, Donna Rasin-Waters, Suzann Ogland-Hand, David Powers*  
Discussant: *Michael A. Smyer*

### Symposium: Forensic Uses of Psychological and Neuropsychological Tests

8/17 Friday 10:00AM-10:50AM  
Moscone Center Room 301  
*Robert Archer, Yossi Ben-Porath, Eric Zillmer*

### Symposium: Corruption of Science and the Sacrifice of Academic Freedom

8/17 Friday 11:00AM-12:50PM  
Moscone Center, Room 307  
*David Antonuccio, William G. Danton, David Healy, Gretchen LeFever, Aubrey Blumsohn*  
Discussant: *David D. Burns*

### Poster Session: Psychological Assessment of Children and Adolescents—Understanding Behavior and Adjustment

8/17 Friday 12:00PM-1:50PM  
Moscone Center, Halls ABC  
*Pvel Blagov, Reginald Adkisson, Joo Young Lee, Sonya Padilla, Carey Heller, Leonor Avila*

### Symposium: Prevention of Child and Adolescent Disorders

8/17 Friday 12:00PM-1:50PM  
Moscone Center, Room 303  
*W. Edward Craighead, Robert McMahon, Ron Prinz, Eirikur Arnarson, Ellen Flannery-Schroeder*  
Discussant: *Philip C. Kendall*

### Symposium: Empowerment Intervention for Abused, Suicidal, Low-Income African American Women

8/17 Friday 12:00PM-1:50PM  
Moscone Center, Room 310  
*Nadine J. Kaslow, Dawn Llardi, Amy Leiner, Sarah Dunn, Carli Jacobs*

### Invited Address: Society for the Science of Clinical Psychology Career Award Integrative perspective on risk for mood and anxiety disorders: Evidence from a longitudinal study of adolescents

8/17 Friday 1:00PM-1:50PM  
Moscone Center, Room 2001  
*Susan Mineka*

### Section X Conversation Hour

Staying on your path when it's a whole lot easier to jump off.  
8/17 Friday 1:00PM-1:50PM  
Moscone Center Room 2008  
*George Slavich, Marsha M. Linehan*





## Division 12 APA Program: August 2007

Symposium: Future Directions for Psychosocial Interventions Research in Late-Life Mental Illness—Recommendations from an NIMH Workshop  
8/17 Friday 2:00PM-2:50PM  
Moscone Center Room 309  
*George Niederehe, Patricia Arean*

Discussion: Tribute to Albert Ellis  
8/17 Friday 2:00PM-3:50PM  
Moscone Center, Room 303  
Chair: *Jon Carlson*  
*Nicolas Cummings, William Glasser, John Norcross, John Minor, Arthur Freeman, Robert Albert, David Burns, Elliot Cohen, Bill Knauss, G. Alan Marlatt*

Section II Presidential Address: [Scogin]  
Training professional geropsychology: Climbing Pikes Peak.  
8/17 Friday 3:00PM-3:50PM  
Moscone Center, Room 2010  
*Suzanne Meeks, Forrest Scogin*

### SATURDAY, 8/18

Section IX with Division 5 Breakfast and Assessment [Social Hour]  
8/18 Saturday 7:00AM-8:50AM  
San Francisco Marriott Hotel  
Golden Gate Salon C1

Section III Presidential Address: (Klein)  
Clarification of Depression Disorder in DSM-V: The Case of a Two-Axis System  
8/17 Saturday 8:00AM-8:50AM  
Moscone Center, Room 2007  
*Daniel Klein*

Symposium: Results of the REVAMP Chronic Depression Trial  
8/18 Saturday 8:00AM-9:50AM  
Moscone Center, Room 2018  
*Bruce Arnow, Barbara Rothbaum, Rachel Manber, Danaiel Klein*  
Discussant: *Robert J. DeRubeis*

Symposium: Perfectionism and Psychopathology  
8/18 Saturday 8:00AM-9:50AM  
Moscone Center, Room 309  
*Anna Bardone-Cone, Gordon Flett, Patricia DiBartolo, Kenneth Rice*  
Discussant: *Martin Anthony*

Symposium: Introducing the MMPI-2 Restructured Form  
8/18 Saturday 8:00AM-9:50AM  
Moscone Center, Room 310  
*Yossi Ben-Porath, Auke Tellegan, Paul Arbisi, Martin Selbom, Allan Harkness*

Invited Address: M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology  
8/18 Saturday 9:00AM-9:50AM  
Moscone Center, 2009  
*Forrest Scogin, Delores Gallagher-Thompson*

Discussion: Diversity Within Science and Practice of Clinical Psychology  
8/18 Saturday 9:00AM-9:50AM  
Moscone Center, Room 3002  
*Gail Wyatt, Cheryl Boyce, Stanley Huey, Guillermo Bernal, Steven Lopez*  
Discussant: *Nadine Kaslow*

Division 12 Invited Address: [Persons]  
How do I know if I am helping?  
8/18 Saturday 9:00AM-9:50AM  
Moscone Center, Room 303  
*Marsha Linehan, Jacqueline Persons*

Poster Session: Psychological Assessment of Adults I—Understanding Behavior and Adjustment  
8/18 Saturday 11:00AM-12:50PM  
Moscone Center, Halls ABC

Poster Session: Psychological Assessment of Adults II—Measuring Cognitive Abilities and Deficits  
8/18 Saturday 11:00AM-12:50PM  
Moscone Center, Halls ABC

Section VII Presidential Address: [Rudd]  
Science and risky patients: The good, the bad and the ugly.  
8/18 Saturday 2:00PM-2:50PM  
Moscone Center, Room 2020  
*James Rogers, M. David Rudd*

Symposium: Depression Prevention Program—Specific or Nonspecific Effects:  
8/18 Saturday 2:00PM-2:50PM  
Moscone Center, Room 3003  
*Eric Stice, Patrick Poessel, Paul Rohde*

Symposium: Rodney Clark Memorial Symposium for Early Career Clinical Science  
8/18 Saturday 2:00PM-3:50PM  
Moscone Center, Room 303  
*Norman Anderson, Alfie Breland-Noble, Monica Mitchell, Stanley Huey, Anthony Chambers, Courtney Ferrell, Jessica Henderson*

Invited Address: [Bandura]  
Moral disengagement in the perpetration of inhumanities.  
8/18 Saturday 3:00PM-3:50PM  
Moscone Center, Rooms 306 and 308  
*Marsha Linehan, Albert Bandura*

Division 12 Awards Ceremony  
8/18 Saturday 5:00PM-5:50PM  
San Francisco Marriott Hotel  
Golden Gate Salon C2  
*Marsha Linehan*

Division 12 Social Hour  
8/18 Saturday 6:00PM-6:50PM  
San Francisco Marriott Hotel  
Golden Gate Salon C2

### SUNDAY, 8/19

Symposium: Cognitive Vulnerability Risk Models in Anxiety Disorders—Beyond Threat Appraisal  
8/19 Sunday 8:00AM-8:50AM  
Moscone Center, Room 2004  
*David Castro-Blanco, Safija Jovic, Michael Dugas, Amy Krain*  
Discussant: *Holly Hazlett-Stevens*

Paper Session  
Meta-analysis of computer based CBT for anxiety  
8/19 Sunday 8:00AM-8:50AM  
Moscone Center, Rooms 202/204/206  
*Gregory Gahm*

Division 12 Presidential Address: [Linehan]  
Getting from A to Q: Taking treatments from the ivory tower and making them work in the real world.  
8/19 Sunday 9:00AM-9:50AM  
Moscone Center, Room 303  
*Gerry Davison, Marsha Linehan*

Symposium: Internalizing and Externalizing Disorders of Childhood and Adolescence—Perspectives from Developmental Psychopathology  
8/19 Sunday 10:00AM-11:50AM  
Moscone Center, Room 2004  
*Theodore Beauchaine, John Abela, Eric Youngstrom*

Discussion: Clinical Supervision Roundtable  
8/19 Sunday 10:00AM-11:50AM  
Moscone Center, Room 303  
Chair: *Alec Miller*  
*Marsha Linehan, Nancy McWilliams, Evan Imber-Black*  
Poster Session: Clinical Psychology II—Child and Adolescent, Specialized Populations, and Other Topics  
8/19 Sunday 11:00AM-11:50AM  
Moscone Center, Halls ABC  
*Gilles Trudel*

Invited Symposium: Developmental Issues in Mental Health Disparities Research and Interventions



## Division 12 APA Program: August 2007

8/19 Sunday 11:00AM-11:50AM  
Moscone Center, Room 3001  
Cheryl Boyce  
Discussant: Charlene LeFauve

Symposium: Home-Based ERP for Refractory OCD Through Live-Training Model

8/19 Sunday 11:00AM-11:50AM  
Moscone Center, Room 3007  
Chair: Johan Rosqvist

Amy Jenks, Allison Osborn, Lauren Hollrah, Mike Haderlie, Jay Wilkenson

Paper Session

Effects of Ethnicity and Culture on Diagnosis and Psychological Adjustment

8/19 Sunday 12:00PM-12:50PM  
Moscone Center, Room 2001

Deidre Anglin, Janie Hong

Paper Session

Dual relationships and the psychologist's inner circle: Ethical decision making concerning multiple relationships with family and friends.

8/19 Sunday 12:00PM-12:50PM  
Moscone Center, Room 276

Susan Haydar

Section VII Invited Address: Lifetime Achievement Award to Aaron Beck

8/19 Sunday 12:00PM-12:50PM  
Moscone Center, Room 3018

David Rudd, Aaron Beck

Symposium: Diversity in Academic Health Centers

8/19 12:00PM-1:50PM  
Moscone Center, Room 2008

John Linton, John Robinson, Asha Ivey

Symposium: Treatment of Adolescent Suicide Attempters (TASA)—A new Intervention

8/19 Sunday 12:00PM-1:50PM  
Moscone Center, Room 303

Barbara Stanley, Kelly Posner, Scott Compton, Beth Kennard, Mary Cwik  
Discussant: John Curry

Poster Session: Clinical Psychology I—Adult Populations

8/19 Sunday 1:00PM-1:50PM  
Moscone Center, Halls ABC

Section VIII Invited Address: APAHC Award Recipients' Presentations

8/19 Sunday 1:00PM-1:50PM  
Moscone Center, Room 3009

Cheryl King, David Antonuccio, Danny Wedding

Discussion: Current Directions in Understanding and Responding to Nonsuicidal Self-Injurious Behavior

8/19 Sunday 1:00PM-1:50PM  
Moscone Center, Room 3018

M. David Rudd, Matthew Nock, Jennifer Muehlenkamp, David Jobs

Paper Session

Conducting competent child protection evaluations

8/19 Sunday 1:00PM-1:50PM  
Moscone Center, Rooms 258/260

Dawn Blacker

Section VII Business Meeting: (Business Meeting)

8/19 Sunday 3:00PM-3:50PM  
San Francisco Marriott Hotel  
Golden Gate Salon A3

Section II Business Meeting: (Business Meeting)

8/19 Sunday 3:00PM-3:50PM  
San Francisco Marriott Hotel  
Golden Gate Salon B1

Section VIII Business Meeting: [Business Meeting]

8/19 Sunday 3:00PM-3:50PM  
San Francisco Marriott Hotel  
Golden Gate Salon C3

### MONDAY, 8/20

Paper Session

Asperger Disorder, learning disabilities, and the Rorschach: A dual profile.

8/20 Monday 8:00AM-8:50AM  
Moscone Center, Rooms 258/260  
Hagit Shimoni

Symposium: Navigating the Internship Application Process—Applying, Interviewing, and Matching

8/20 Monday 8:00AM-9:50AM  
Moscone Center, Room 2003  
George Slavich, Joyce Chu, Sean Sullivan

Discussion: Cognitive Therapy for Suicide Prevention in Special Populations

8/20 8:00AM-9:50AM  
Moscone Center, Room 276  
Sunil Bhar, Paul Grant  
Discussant: M. David Rudd

Symposium: Dissemination of Evidence-Based Psychological Treatments in the Veterans Health Administration

8/20 Monday 9:00AM-9:50AM  
Moscone Center, Rooms 228 and 230  
Bradley Karlin, Ira Katz, Candice Monson, Gregory Brown  
Discussant: Antoinette Zeiss

Symposium: Anger and Posttraumatic Stress Disorder—New Insights Into the Relationship

8/20 Monday 10:00AM-11:50AM  
Moscone Center, Room 2022  
Ulrich Orth, Raymond Novaco, Leslie Morland, Claude Chemtob  
Discussant: Andreas Maercher

Discussion: Challenges in the Development of Multicultural Clinical Psychologists—Tales From the Front

8/20 Monday 10:00AM-11:50AM  
Moscone Center, Rooms 252/254/256  
Kumea Shorter-Gooden  
Discussant: Amila Chandrapala, Jessica Eldridge, Amalia Guerrero

Symposium: Assessing Competencies in Psychology Training—An Objective Structured Clinical Exam (OSCE)

8/20 Monday 12:00PM-12:50PM  
Moscone Center, Rooms 228 and 230  
Richard Zwig, Gregory Hinrichsen, Elizabeth Kachur, Richard Zweig, Kathleen Byrne  
Discussant: Nadine Kaslow

Symposium: Do Cognitive and Psychodynamic Supervisors Actually Have Something in Common?

8/20 Monday 12:00PM-1:50PM  
Moscone Center, Room 200  
Edward Shafranske, Judith Beck, Joan Sarnat  
Discussant: Edward Shafranske, Carol Falender



### The Clinical Psychologist

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# APA DIVISION 12 – SOCIETY OF CLINICAL PSYCHOLOGY

PROFESSIONAL DEVELOPMENT INSTITUTES • CE CREDIT • PRE-CONVENTION  
 AUGUST 16, 2007 • SAN FRANCISCO, CA • HILTON SAN FRANCISCO

FULL-DAY WORKSHOPS • THURSDAY, AUGUST 16, 2007 • 7 CE CREDITS

- |  |  |
|--|--|
| <p>A. <b>Recent Developments in MMPI-2 Interpretation: The Restructured Clinical Scales and New, Restructured Form, the MMPI-2-RF</b><br/>Yossef S. Ben-Porath, Ph.D.</p> <p>B. <b>Treating Victims of Mass Trauma and Terrorism</b><br/>Larry E. Beutler, Ph.D.</p> <p>C. <b>Movies and Mental Illness: Using Films to Understand Psychopathology</b><br/>Danny Wedding, Ph.D.</p> <p>D. <b>Mentoring Women and Ethnic Early Career Academic Psychologists (ECP)</b><br/>Helen Pratt, Ph.D.</p> <p>E. <b>Dialectical Behavior Therapy for Borderline Personality Disorder</b><br/>Anthony P. DuBose, Psy.D.</p> | <p>F. <b>Psychological Interventions for Patients with Heart Disease</b><br/>Judith A. Skala, RN, Ph.D. and<br/>Kenneth E. Freedland, Ph.D.</p> <p>G. <b>Diagnosis and Treatment of Obsessive-Compulsive Disorder</b><br/>Jonathan Abramowitz, Ph.D.</p> <p>H. <b>Advances in Evidence-based Treatment for Bipolar Disorder</b><br/>Robert Reiser, Ph.D.</p> <p>I. <b>Improving Therapy Outcome by Monitoring Process and Outcome</b><br/>Jacqueline B. Persons, Ph.D.</p> |
|--|--|

WORKSHOP	MEMBER	NON-MEMBER	STUDENT MEMBER	STUDENT NON-MEMBER
A	( ) \$180	( ) \$200	( ) \$100	( ) \$120
B	( ) \$210	( ) \$230	( ) \$130	( ) \$150
C	( ) \$210	( ) \$230	( ) \$130	( ) \$150
D	( ) \$180	( ) \$200	( ) \$100	( ) \$120
E	( ) \$180	( ) \$200	( ) \$100	( ) \$120
F	( ) \$210	( ) \$230	( ) \$130	( ) \$150
G	( ) \$210	( ) \$230	( ) \$130	( ) \$150
H	( ) \$210	( ) \$230	( ) \$130	( ) \$150
I	( ) \$180	( ) \$200	( ) \$100	( ) \$120

Workshops B, C, F, G, and H include the book form Hogrefe and Huber Series valued at \$30

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## Instructions to Authors

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

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

Inquiries may be made to the editor:  
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## THE CLINICAL PSYCHOLOGIST

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