VOL 61
Issue 1
WINTER
2008

THE CLINICAL PSYCHOLOGIST

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

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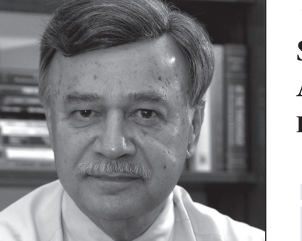
PRESIDENT'S COLUMN

Strength through Diversity: A Blueprint for Division 12

Irving B. Weiner, Ph.D., ABPP



Irving B. Weiner, Ph.D., ABPP
University of South Florida
President, Society of Clinical Psychology

As a candidate for Division 12 president, I expressed my conviction that the Society of Clinical Psychology should be an enjoyable and rewarding professional home for all clinical psychologists, whatever their theoretical orientation, area of specialization, or work setting. I have heard it said that the division cannot be all things to all people and should focus on pursuing a narrowly defined mission. I believe instead that we can and should be many things to a lot of people. Clinical psychology is a broad and diverse field of science and practice, and our division can best meet the needs and interests of its members by embracing a broad and diverse mission.

As testimony to our diversity, the *APA Directory* shows Division 12 members belonging to every one of the 55 current APA divisions, many of which address specialty areas within clinical psychology (e.g., Psychotherapy [Division 29], Clinical Child and Adolescent Psychology [Division 53]) or substantive areas with considerable relevance to the interests and work of clinicians (e.g., Personality and Social Psychology [Division 8], Developmental Psychology [Division 7). Thirty-one other divisions include more than 100 Division 12 members; of these 31 other divisions, 13 include more than 200 of our members, and six of these more than 300. This diversity reflects the fact that professionals pursuing many lines of basic and applied psychological science were initially educated and trained as clinical psychologists, and it is probably the case that most retain this core identity by referring to themselves as clinical psychologists, regardless of what other more specific terms they may use in describing their work (e.g., as a family therapist, a schizophrenia researcher, or an addictions specialist).

As the Society of Clinical Psychology, we must have a mission that is consonant with the diversity we represent: for example, a mission that includes (a) promoting the integration of science and practice in clinical psychology, together with fruitful collaboration among research scientists, scientist practitioners, and practitioner-scholars; (b) fostering effective education and training of clinical psychologists; and (c) advancing multicultural, advocacy, and public policy efforts related to clinical psychology. Such stated purposes, if properly framed and appropriately implemented, convey to our current members and to potential new members that we respect the perspectives of all clinical psychologists and welcome their participation in our Society.

Substantive diversity strengthens our division in three ways. First, by inviting and respecting a broad range of views, we expand our attractiveness as a professional home for our current

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ISSN 0009-9244

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members and for other clinical psychologists who consider joining us. A stable or expanding membership contributes in turn to maintaining our presence in the APA Council of Representatives, our program time during the annual APA convention, and a balanced budget. Second, by giving adequate consideration to multiple theoretical and practical perspectives, we increase the likelihood of arriving at informed judgments and undertaking constructive projects that benefit our members, the field of clinical psychology, and the broader society beyond. Third, by being recognized as a broadly rather than narrowly representative organization of clinical psychologists, we enhance our capacity to influence initiatives and developments not only within clinical psychology, but within organized psychology as whole and the arena of public policy as well. In concert with these objectives, I have identified *outreach* and *impact* as the main

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initiatives of my presidential year and in time will have more to say about each.

I would like in this initial column to announce my committee appointments effective January 1, 2008. Under our By-Laws, the president has the opportunity to appoint the chair and a certain number of new members to each of several standing committees. To promote continuity and benefit from their experience, I have asked the 2007 chairs of the following committees to continue serving in 2008: Barry Hong as Membership Chair; Jonathan Weinand as Education and Training Chair; Edward Craighead as Publications Chair; Danny Wedding as Governance Chair; and David Klonsky as Science and Practice Chair. Carole Rayburn, a 2007 member of the Fellowship Committee, will succeed Thomas Borkovec as chair of this committee in 2008.

As newly appointed committee members, I have asked Victor Molinari to be our Program Chair for 2008. To the Membership Committee, I have appointed Ronald Ganellen, Sharon Rae Jenkins, and one student member, Sean Sullivan; to the Education and Training Committee, Dorothy Holmes, Michael Lambert, Jeffrey Magnavita, and one student member, Sharie Fabregas; to the Publications Committee, William Gottdiener; to the Governance Committee, Steven James; to the Science and Practice Committee, Robert McGrath and Thomas Ollendick; and to the Fellowship Committee, Karen Calhoun, A. J. Finch, Adelbert Jenkins, and Luis Vargas.

For three other committees, the chair is designated by the By-Laws and members are appointed by the president. The Nominations Committee is chaired by our Past President, Marsha Linehan; my appointments to this committee are Stanley Messer, Lynn Rehm, Linda Sobell, and George Stricker. The Budget Committee is chaired by our Treasurer, Robert Klepac; my appointment to this committee is Norman Abeles. The Diversity Committee is chaired by the diversity representative on the Board of Directors, Asuncion Austria; my appointments to this committee are Linda Knauss and Felicisima Serafica.

During my year as President-Elect, I served on the Board of Directors together with my four immediate predecessors as President: Nadine Kaslow, Linda Sobell, Jerry Davison, and Marsha Linehan. I would like to express my appreciation for their leadership and many contributions to our Society. I hope that we can continue to prosper in the current year, and I wish the membership a happy and rewarding 2008.

Society of Clinical Psychology Fellowship Committee 2007

The Society Fellowship Committee, led by Fellowship Chair Thomas D. Borkovec, Ph.D., has approved the following individuals for Fellowship status, effective January 1, 2008:

Initial Fellows:

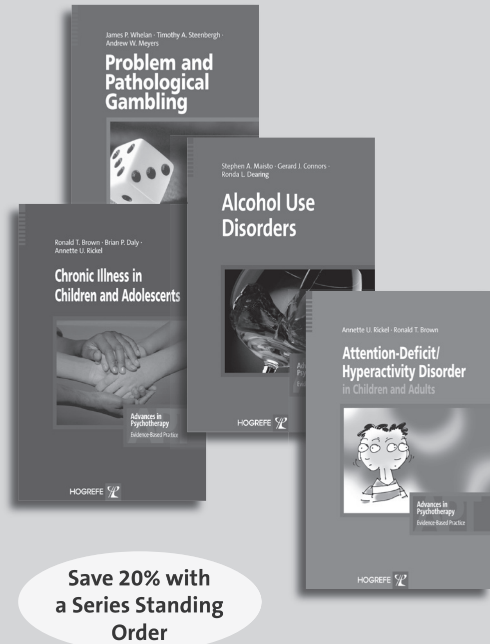
Frank L. Collins, Ph.D. • David J. Hansen, Ph. D.
Thomas Hadjistavropoulos, Ph.D. • Tatia M.C. Lee, Ph.D. • Arthur L. Robin, Ph.D.

We have received word that APA Membership Committee has approved these individuals. Council gave final approval in August.

Fellows Who are Already Fellows in Another Division:

Jeffrey M. Baker, Ph.D. • Lisa R. Grossman, Ph.D.
Frederick T.L. Leong, Ph.D. • Eduardo S. Morales, Ph.D.
Mindy S. Rosenberg, Ph.D. • Beverly E. Thorn, Ph.D. • Robert A. Zeiss, Ph.D.

The members of the 2007 Fellowship Committee are: **Gerald C. Davison, Ph.D., Charles J. Golden, Ph.D., Carole Rayburn, Ph.D., David Antonuccio, Ph.D., and Thomas D. Borkovec, Ph.D. Chair**



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In conjunction with the Society of Clinical Psychology (APA D12) a system of home-study continuing education courses has been developed for each book that an individual can complete on the web.

Current & Forthcoming Volumes at a Glance:

- Vol. 1: Bipolar Disorder by *Robert P. Reiser, Larry W. Thompson* (July 2005)
- Vol. 2: Heart Disease by *Judith A. Skala, Kenneth E. Freedland, Robert M. Carney* (August 2005)
- Vol. 3: Obsessive-Compulsive Disorder by *Jonathan S. Abramowitz* (January 2006)
- Vol. 4: Childhood Maltreatment by *Christine Wekerle, Alec L. Miller, David A. Wolfe, Carrie B. Spindel* (July 2006)
- Vol. 5: Schizophrenia by *Steven M. Silverstein, William D. Spaulding, Anthony A. Menditto* (August 2006)
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- Vol. 12: Social Anxiety Disorder by *Martin M. Antony, Karen Rowa* (February 2008)
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- Suicidal Behavior and Self-Injury by *Richard McKeon* (Publication date t.b.a.)
- Depression by *Lyn Rehm* (Publication date t.b.a.)
- Borderline Disorder by *Martin Bohus, Kate Comtois* (Publication date t.b.a.)
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The Readers Respond!

Simon A. Rego, PsyD

As I have stated since commencing my role as editor of the Internet Update section of *TCP*, I truly value your input as readers. Over the past two years, I have been pleasantly surprised by the number of emails sent to me after each issue is released, and have taken many of your comments and suggestions to heart when writing subsequent columns. With this in mind, I thought it would be fitting to allow you to get a glimpse at a few of the letters that readers recently submitted in response to my last two columns. In this column, I am including feedback from my column that appeared in the Summer 2007 issue ("Top 10 Psychology Websites"). For those who missed it, the issue (Volume 60, Number 2) is accessible online at: http://www.apa.org/divisions/div12/clinpj.html. In my next column, I will feature a commentary on my "call for civility" on listservers (Volume 60, Number 3) by James C. Coyne, Ph.D., Professor of Psychology in the Department of Psychiatry at the University of Pennsylvania School of Medicine. As always, feel free to submit your comments to me at dr.rego@gmail.com – they just may be included in a future column!

A glimpse at a few of the letters recently submitted

Monica Pignotti of Florida State University writes:

In the recent "Internet Update: Top 10 Psychology Websites," the author wondered why people were embarrassed to mention Wikipedia as a source of information they commonly refer to. This embarrassment is understandable, given that virtually anyone can contribute to Wikipedia, regardless of their qualifications and expertise in a given area. My own experience editing some of the articles has shown me that all too often, people who have a vested interest in a particular topic, especially when the topic is a novel therapy, will devote a great deal of time to a favorable presentation in such articles whereas others, who might be able to refute their claims are often too busy to keep up with the edits that are continuously being made. The result is often that the person who has the most time to devote to the article prevails.

Wikipedia has mechanisms for arbitration but this can be very time consuming and the person doing the arbitration does not necessarily have expertise on the topic. The goal of Wikipedia is balance and a "neutral point of view." Nevertheless, some of the articles feature references to promotional websites that are not caught for months, if at all. Additionally, sometimes references posted that run contrary to the agenda of proponents get deleted and that, too, isn't always corrected in a timely manner.

The idea of "balance" is also questionable when it comes to an accurate presentation of a particular topic. The facts on a particular topic might not necessarily support a middle ground position and thus, even when facts are accurately presented, contributors get accused of having an article that violates "neutral point of view" and lacks "balance."

While Wikipedia can be used as a way of obtaining references, readers are urged to carefully check references provided and critically question claims that are made, just as one ought to do with any other source of information.

Dylan Evans, a Clinical Psychologist at Townhill Hospital in Pietermaritzburg, South Africa writes:

I read your article on the "Top 10 Psychology Websites" and have taken up your challenge to create a psychology website with a similar format to digg.com. The site is called "PsychNews" (http://www.psychnews.co.za) and is finally ready. PsychNews is a website that gathers psychology news headlines from all over the web and presents them all on one website. The news headlines are updated hourly to provide new and interesting content every time you visit. PsychNews also lets you share your favorite psychology related web pages by submitting links to them. You can also explore what others have submitted, vote for what you like, and even discuss a topic by leaving comments. I would appreciate it if you let others know about the site as the more people who use it the more useful it will be to all of us.

Money Matters

Katherine L. Muller, PsyD

So, you've got the degree, a job, and you are pulling down what most would consider a "respectable income'. No worries, right? Wrong! In fact, being an early career psychologist means that you are confronting financial issues that you have not faced before and that you may not have anticipated. No need to panic. I'm no Suze Orman, but in this column, I will cover the facts about finances that I wish someone had told me about early in my career, or better yet, before my career even started!

Get a Good Accountant

A quick disclaimer: I don't have any family members who are CPAs. In fact, I remain somewhat cautious of folks of this ilk (no offense). However, now that I have found and worked with an accountant I trust, I can honestly say it was one of the best financial decisions I have made. I only consult with my accountant a few times a year: tax time, and via a few e-mails to make sure that I am on track for tax time. My first year of gainful psychology-related employment, I tried using one of those tax software products and was disappointed that it could not "compute" my interesting situation of full-time taxed income, part-time as-yet-untaxed income, and a few payments I received as a consultant. I then tried a generic, commercial tax preparer and found that she could not "compute" it either. I was thrilled when I entered the accountant's office, documents in hand, and he stopped my rambling explanation dead by saying, "I see. You had three sources of income, all taxable at different rates. This is very common in the work I do with clients who have private practices". (Cue "Hallelujah" chorus.) He has also been very helpful in arranging for estimated tax payments so I don't get hit with a huge payment come tax time (a common side effect of private practice work). My advice here is to ask for an accountant recommendation from a colleague whose work profile resembles your own and then set up a meeting to see if said accountant understands your financial situation.

Getting "Carded"

In the past, I toyed with the idea of designating a credit card for "business expenses", but I never did so until recently. I had two reasons for making the change. I realized that this would simplify itemizing expenses for my private practice work at tax time. In addition, my employer instituted a new requirement that we submit original credit card statements to get reimbursed for conference expenses. Having to turn in my Visa statement with the conference hotel fees as well as all of my holiday purchases from such various and sundry places as "Build-A-Bear Workshop" and "Victoria's Secret" was a little uncomfortable. Poring over twelve months of credit card statements come tax time and organizing them into a spreadsheet is almost as uncomfortable. I recommend that you pick one of those cards now and start using it only for business-related expenses to make life easier.

Readings and Resources

Oh, dear bank account, how do I empty thee? Let me count the ways: school loan repayment, licensing exam materials, licensing exam fees, association fees, and conference costs. Lest we forget those pesky things like rent, mortgage, car payments, and groceries! There are many expenses incurred in the early career phase, some that you don't know about until the bill arrives. Graduation means that you are no longer a student, hence, no more "student rates" for association fees and conference registrations. Sure, some associations offer "new professional" rates and this is certainly helpful for a few years, but these increased fees are something to plan for now. Then there's the phenomenon that I like to call the "end-of-year blow-out". Nope, this is not a great big year-end holiday discount, but instead an onslaught of dues and renewal payments that all hit around November and December, just as those holiday bills are mounting. In addition, many professional liability policy premiums are due in January. No earth-shattering solutions here, in fact, we're going old school- create a budget. This doesn't have to be a lifelong thing, but it can really help in those first few years when you are adjusting to having an actual income and incurring these increased expenses. Monitoring what's coming in and going out, as well as keeping track of what will be due each month, can help you avoid surprises. Other ideas for coping with early career financial burden include consolidating and/or refinancing school loans and taking advantage of discounts when available (e.g., "early bird" conference registrations, percentage-off discounts on liability premiums when certain continuing education requirements are met).

Early Career Column cont. on page 9

The Society of Clinical Psychology, 1995-2005

Donald K. Routh, PhD

This decade was one of consolidation of clinical psychology in the U.S., linkages to many colleagues abroad, recognition of internal diversity, and a continued fight for survival. The year 1996 represented the 100th anniversary of the founding of the first psychology clinic by Lightner Witmer at the University of Pennsylvania. Division 12 celebrated the occasion by presenting two Centennial Awards at the Toronto APA meeting, one to Paul E. Meehl and the other to Hans J. Eysenck for their outstanding contributions to the field. Eysenck, a British psychologist, is remembered for his 1952 paper questioning the efficacy of psychotherapy as compared to the spontaneous remission rate of untreated mental problems. Eysenck went on to be one of the principal promoters of behavioral therapies, including rigorous experimental evaluation of how well they worked. Meehl, of the University of Minnesota, is remembered, for example, for his APA presidential address, "Schizotaxia, Schizotypy, Schizophrenia," published in 1962, elaborating a theory of how genetic and environmental factors might combine to produce this disorder. The Centennial of clinical psychology was also celebrated in a 1996 symposium on the campus of the University of Pennsylvania, the proceedings of which were subsequently published by APA Press as a book entitled, *The Science of Clinical Psychology*. During 1998 Division 12 officially changed its name to the Society of Clinical Psychology. This did not change its legal relationship to APA but implied a degree of independence that the "Division" label had not conveyed.

International activities were numerous during this decade. Gerald P. Koocher, who was president of Division 12 in 1995, met with clinical psychology colleagues in Japan that year. As a subsequent APA president in 2006, Koocher has also been in the thick of psychology's attempted adjustments to international strife, including the controversial issue of psychologists' roles in the interrogation of enemy combatants. Lynn P. Rehm, who was president of Division 12 in 1997, arranged for its Board of Directors to meet in Mexico City, hosted by Juan Jose Sanchez-Sosa, Dean of Psychology at UNAM, the main university there. Rehm and Sanchez-Sosa had previously interacted as a result of the North American Free Trade Agreement (NAFTA). One aim of this treaty was to facilitate the movement of psychologists and members of other professions between North American countries. When I was president of Division 12 in 1998, the psychology world came to the U.S., so to speak. The International Association of Applied Psychology (IAAP) had its 1998 meeting in San Francisco, overlapping with the meeting of APA there. Division 12 used this occasion to sponsor the formation of a new group, the International Society of Clinical Psychology (ISCP), which has been meeting annually since that time. Routh and Rehm each later served as officers of ISCP as well as of the Division of Clinical and Health Psychology of the IAAP. Not to be outdone, Thomas P. Ollendick, when he was Division 12 president in 1999, arranged for its Board to meet in Halifax, Nova Scotia. Martin Anthony, editor of *The Clinical Psychologist* from 2002 through 2005, was employed by McMaster University in Hamilton, Ontario.

This decade brought unparalleled diversity to the leadership of Division 12. The Division had at least a handful of female presidents before, but during this 10-year period it had four of them: Karen S. Calhoun (2001), Diane J. Willis (2003), Nadine J. Kaslow (2004), and Linda C. Sobell (2005). Diane J. Willis was also the second individual of American Indian ancestry to serve as Division 12 president (the first one was Logan Wright, who served in 1981-82). In addition, during this decade, about half of the individuals receiving the Division's Award for Distinguished Scientific Contributions were women (Edna B. Foa, Lizette Peterson, Marsha Linehan, Lauren Alloy, and Lyn Abramson). In 2003, the Division instituted a new award for Distinguished Contributions to Diversity, named after Stanley Sue (of Chinese ancestry), its first recipient. Finally, in 2005 a new clinical research award was named after the late Samuel M. Turner, an African American.

Finally, this decade also involved a continued fight for survival by Division 12. Division 12 continued to be the one with the second highest membership totals within APA. However, the Division lost about 1000 members in the year 2000, when two of its sections decided to become APA divisions on their own:

History Column cont. on page 9

What to do Once Internship is Through: Finding the Post-Doc That's Best for You!

George M. Slavich, PhD

The clinical internship year can be stressful for many reasons. One reason not readily apparent when you begin the year is that by as early as November, you will likely be looking for another job! To ease the anxiety, let's examine some factors to consider when deciding whether a postdoctoral position following internship is right for you and, if so, what type of arrangement might be best.

Post-Doc vs. No Post-Doc: That is the (First) Question

The first question is whether you should consider a post-doc at all. If recent trends provide any indication, then the answer could well be yes: Approximately 50% of graduates recently surveyed were either currently completing or had just completed postdoctoral training, compared to only 10% of those surveyed in 1985 (Wicherski & Kohout, 2007). More striking, however, is how this percentage breaks down by subfield. For example, 88.9% of recent graduates in biological psychology pursued postdoctoral training versus 70.2% in the neurosciences, 57.1% in clinical neuropsychology, 45.2% in experimental psychology, 40.0% in cognitive psychology, and 26.9% in clinical psychology (Wicherski & Kohout, 2007). Thus, your decision to complete a postdoctoral fellowship (e.g., instead of going on the job market) may be informed best by your need for additional specialized training given your subfield of study.

Examine the factors when deciding whether a post-doctoral position is right for you

Postdoctoral Positions in Clinical Service versus Research

Within clinical psychology, the need for additional training pertains both to individuals seeking a career in clinical service as well as to those seeking a career in research. For individuals interested in clinical service, additional training can provide the supervised post-doctoral clinical hours that are required in order to be able to sit for the licensing exam. This training experience can also provide the time needed to develop a secondary specialization. If you are primarily interested in research, in contrast, additional training can help you extend your expertise in your primary field of study, expand your expertise to a secondary subfield of study, or allow you to write-up your dissertation or additional papers that might make you more competitive on the job market. Some postdoctoral appointments involve both clinical work and research, but the majority do not and instead have one primary focus, allowing little time, if any, for the other activity. Therefore, the type of postdoctoral position you choose will put you on a firm track for that type of job and make it more difficult, although certainly not impossible, to be highly competitive for the other type of job.

Postdoctoral Positions in Clinical Service

Length of appointment may be an important factor when choosing a postdoctoral position in clinical service. The average duration of these positions is 13 months, with 69% lasting one year and 10% lasting two years (Wicherski & Kohout, 2007). Postdoctoral fellowships in clinical service are divided most notably with respect to whether they are child or adult focused, but other factors are also important. When searching for the ideal postdoctoral experience in clinical service, you should ask about how long you will likely spend performing various clinical duties, including assessments, consultations, insurance reviews, report writing, supervision, and face-to-face individual, family, group, and milieu interventions. Postdoctoral fellows working in a hospital setting may also have the opportunity to instruct psychiatry residents, which may be attractive if you need to strengthen your teaching resume. Finally, when searching for your ideal position, you should ask about the levels of care within which you will likely work. The major levels of care are outpatient, partial hospital, residential, and inpatient, and it is best to have experience with all four.

Postdoctoral Positions in Research

Whereas the majority of postdoctoral fellowships in clinical service take place in a hospital or clinic, fellowships in research can occur in a variety of settings that include departments of psychology, medical schools, and research institutes. The average length of a postdoctoral

appointment in research is 23 months, with 54% lasting at least two years and 20% lasting longer than two years (Wicherski & Kohout, 2007). To find your ideal postdoctoral training experience in research, you should first consider how learning an additional methodology (e.g., psychophysiology, fMRI, ERP), studying a second population (e.g., children, adults, older adults), or mastering another design (e.g., epidemiological, cross sectional, experimental) would help you advance your program of research. The goal, then, is to locate an investigator who can provide you with the type of training that you desire.

Once you have located a potential mentor, it is useful to consider the amount of independence that you will have in your appointment. In the most restrictive type of arrangement, postdoctoral fellows work largely as project managers who carry out studies on behalf of their mentor. More independent than this arrangement type are those in which postdoctoral fellows work as independent investigators within their mentor's lab, collaborating with him or her on some studies, but primarily pursuing their own line of research. Lastly is the most independent of arrangements, in which fellows are hired as independent investigators within a particular research program or center. This type of appointment characterizes postdoctoral fellows who are hired onto National Institute of Mental Health training grants, which require only that a fellow pursues research on a particular topic (e.g., stress, depression, and disease). Amount of flexibility is often related to the source and purpose of the funding, so if you want to know how much leeway you will have in your appointment, try identifying whether the money is earmarked for a particular study, for you as an investigator, or for a larger program of research.

Final Considerations

The decision to complete a postdoctoral position inevitability involves the practicalities of life, so before you sign on the dotted line, know that you will not get rich completing a post-doc. The median annual salary for postdoctoral fellows in 2005 was $24,000 for those in clinical service positions that were paid for by client funds, $25,992 for those in clinical service positions that were paid for by other funds, and $36,000 for those in research positions (Wicherski & Kohout, 2007). Compare that with what you would earn if you entered the job market: about $60,000 per year if you land a research position and $63,555 per year if you land a clinical service position (Wicherski & Kohout, 2007). Thus, a final consideration involves examining the trade-off of making more money now versus gaining additional training so that you will be more competitive later.

Wicherski, M., & Kohout, J. (2007, November). *2005 Doctorate Employment Survey*. Retrieved December 30, 2007, from the American Psychological Association web site:
http://research.apa.org/des05.html#postdoctoral

Early Career Column (cont. from page 6)

Well, fellow early careerists, I'm spent (pun intended). I hope that you find some of these ideas helpful. I'd love to hear about other ways you are coping with early career financial issues. Please send your information and ideas to kmuller@montefiore.org.

History Column (cont. from page 7)

Clinical Child Psychology (the former Section 1, now APA Division 53), and Pediatric Psychology (the former Section 5, now APA Division 54). Division 12 has spun off a large number of related psychology organizations in the past, and these represent offspring of which it can be proud. Nevertheless, the potential budgetary deficits and loss of members with leadership potential had to be taken seriously. Given Division 12's history, the obvious solution was to add new Sections, and it did so. During the decade it added Section 7, Emergencies and Crises; Section 8, the Association of Medical School Psychologists, and Section 9, Assessment. As of the end of the decade, Division 12 had about 4,712 members. At the time, it was estimated that there were perhaps 10 times that many self-identified "clinical psychologists" in the U.S. A further source of membership loss for Division 12 in recent years has been that of retirements. The average age of members continues to inch up over time. As one of the final suggestions during her term, president Linda Sobell in 2005 requested that the Board consider establishing an additional Section, meant for Graduate Students and Early Career Psychologists.

Youths of Color: Strengths and Protective Factors

Billie Schwartz (schwarbi@bc.edu)
Boston College

The majority of research focusing on ethnic minority youths has focused on risk factors that negatively impact the lives of adolescents of color, with minimal focus on protective traits such as perceived social support from friends, family, and religiosity (Smetana, J., & Metzger, A., 2005; Cotton, S., Zebracki, K., Rosenthal, S., Tsevat, J., & Drotar, D., 2006). Researchers have posited that protective traits operate at three levels: individual, familial, and societal (Cited in Miller 1999: Garmezy, 1985; Gordon, 1995; Luthar & Zigler, 1991; Rutter, 1987). This brief summary highlights some of the main strengths of youths of Color with the hope that clinical researchers and clinicians will begin to integrate these areas in their work with youths of Color. Specifically, this summary provides information regarding racial socialization and racial identity, family and friend social support, and religion of youths of Color, but readers are urged to review the references for more details in each of these areas.

Many researchers have looked at whether ethnic identity may function as a protective factor for ethnic minority children and adolescents, in particular African American children and adolescents (as cited in Bennett, 2006). As Bennett (2006) defines, racial socialization typically involves teaching children to have pride in their race and the rich history of their culture. Peters (1985) and Stevenson (1994, 1995) have posited that racial socialization can mediate against negative racial messages in the environment, thus, giving inherent strength. Racial socialization in turn fosters racial identity.

An achieved racial or ethnic identity is defined as pride in one's ethnic heritage and a sense of self worth that embraces race, ethnicity, and culture, has been argued to facilitate coping strategies and social competencies related to self-esteem and self-efficacy (Helms, 2003; Arroyo & Zigler, 1995). For example, among African American children and adolescents, an achieved ethnic identity is believed to buffer from psychological distress as a result of living in a race-based society (Cross, Parkham, & Helms, 1991). Given the potential for racial identity to protect youths of Color from poor outcomes, it is important that more research be done in this area. Since racial socialization and racial identity are important factors in the development of racial identity, a closer look at the social network that may influence these factors is necessary.

This leads into the area of perceived social support from friends and family. The family is perhaps the most influential socializing agent for cultivating the child's attitudes, values, and overall emerging sense of self (Bennett, 2006). Findings from previous research demonstrate that the quality of parent-child relationship, parent-child communication, and peer support represent interacting social systems (i.e. protective traits) that are related to adolescent risk-taking behavior. Peers become important behavior referents in adolescence, and much research has documented the similarities in levels of risk behavior within peer groups (e.g. Boyer, Tschann, & Shafer, 1999; Romer et al., 1994). Hence, these two factors may also provide a layer of strength-building support for youths of Color.

The last protective trait to consider is religion. Religion, which has been shown to be an important influence in the lives of ethnic minority adolescents, is usually considered a protective factor against a host of negative health outcomes, and is often included in adolescent health outcomes research (Cotton et al., 2006). And, ethnic families, on average, report high levels of religious involvement (Steinman and Zimmerman, 2004). Researchers suggested that religion influences internalizing beliefs about immorality of risk behavior (as cited in Steinman and Zimmerman, 2004); influences peer groups (Burkett & Warren, 1987); improves family relationships (Bahr, Maughan, Marco, & Li, 1998); and increases involvement in prosocial activities (Buckhalt, Halpin, Noel, & Meadows, 1992; Zimmerman & Maton, 1992).

Currently, there is no known model highlighting the strengths of youths of Color. As a result, more research is needed in this area to highlight the positive protective traits that exist for adolescents in an environment that has, until recently, only looked for risks and negativity. I hope that this summary will ignite clinicians and researchers to examine more closely the positive aspects of youths of color.

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Join the Division 12 Public Education Media Campaign!

By Peter Kanaris, PhD and
Donna Rasin-Waters, PhD, Co-Chairs,
Public Policy Committee of Division 12,
Section 2 (Society of Clinical Geropsychology)

The Division 12 Board voted to fund a public education media project for members using a media intermediary, ProfNet. The goal of the media campaign is to increase public awareness of the value of psychology and the vital role that psychologists play. Additionally, it is our hope that over time we can favorably influence public policy makers in their support of legislation that facilitates science, education and mental health services in psychology.

The importance of media quotes, articles and appearances that educate the public about psychology and psychological research cannot be overstated. The media is currently very influential in shaping public perceptions and opinions. Unfortunately, the news is often sensationalized and laden with exaggeration and distortions. It remains important for psychologists to present responsible information, informed by social science, as a desperately needed service to the public. Further, the impact can only be measured over time through numerous appearances in a prolonged public education effort. Through the repeated presence of psychologists commenting on breaking news and feature stories, the public is allowed to get to know both the field of psychology and the important role that psychologists have to offer in research and practice. Psychologists have struggled to convey the applied value of their research and the importance of services to the population. The media remain a key vehicle for disseminating this knowledge. Again, as we inform the public our influence among policy makers is likely to grow.

It is important for psychologists to present responsible information, informed by social science, as a desperately needed service to the public.

Ways for Psychologists to Participate

Respond to media requests. At this level of participation merely send an email to me Donna Rasin-Waters at DrRasinWaters@aol.com with your name and media volunteer in the subject line requesting that you be included in the media volunteers emailing list. This list will be used to email directly to you any requests for interviews from the media that we receive. You can also select any to which you are interested in responding. You then simply follow the instructions in the request and respond directly to the writer/reporter. All we ask is that you send a follow-up email back to Dr. Rasin-Waters after you have done the interview so that we can keep track of our outcomes.

Create and submit media leads. Media leads are brief quotations provided by you "the expert" commenting on your work or a timely topic in psychology. For example, a research psychologist may share several observations about his/her most recent study. A clinical psychologist may comment on a current topic in psychology with which he/she is providing a relevant service. Through our media service these leads are distributed to many writers and reporters who can then pick them up for stories that they are working on.

For assistance in constructing a media lead, feel free to contact, Peter S. Kanaris at Drpit1@aol.com or Donna Rasin-Waters at DrRasinWaters@aol.com. It is only through a total effort, which is repeated and sustained over time that we can hope to have the kind of impact that truly provides a service to the public through education and public policy influence.

The Reasons We *All* Need to Care about What Happens to Medicare

By Donna Rasin-Waters, PhD

Whether researcher or practitioner, child and adolescent, adult or geropsychologists, we all need to be advocating for Medicare access and reimbursement. In recent years psychologists have faced multiple and more pronounced cutbacks in reimbursement to the Medicare program. Last year 10% cutbacks went into effect January 1, 2007. This year we narrowly missed another cutback in the same amount, but legislation went into effect providing a 6 month respite from another 10.5% cut to our rates and allowing a 0.5% increase instead. While the legislative pathway that

Federal Advocacy Column cont. on page 13

BOOK RECOMMENDATIONS

Lata K. McGinn, PhD—Section Editor

Cognitive Therapy for the Emotional Disorders

Aaron T. Beck, M.D.

Plume (1979)

Recommended by John H. Riskind, PhD, Professor of Psychology, George Mason University

Beck's *Cognitive Therapy of the Emotional Disorders* (1979) certainly deserves recognition as one of the all-time classics in the cognitive clinical literature. This book was published soon after his book on depression and was perhaps the first major extension of the cognitive formulation to anxiety disorders and other disorders. The focus of this book was on his conceptualization that "disorder specific" cognitive content was at the heart of each emotion disorder. As in Beck's other writings, the theoretical analysis was grounded in clinical material that pointed the cognitive phenomenology of patients with these disorders. It also suggested the link between different types of cognitive appraisals and innate action tendencies such as approaching, withdrawing etc. As such, this book reflects the influence of cognitive theories of emotion more generally as well as the interface between these cognitive theories of emotion and the cognitive therapy formulation.

Beck's proposal that a specific disorder-specific thought disturbance was central to each emotional disorder has been crucial to the development of cognitive therapy of depression, anxiety, and other disorders. Thus, this book helped to set out the rationale for cognitive specificity and in this way helped to outline the program of cognitive therapy research in the years to come. Since the exciting and pioneering time this book appeared, cognitive therapy has been expanded and demonstrated efficacy for the full range of psychological disorders including depressive and anxiety disorders, including more recently Panic and OCD and PTSD, personality disorders, eating disorders, medical problems and health anxiety, and even schizophrenia.

Although much has been written on cognitive therapy since this book was published in 1979, this seminal book continues to be one of my favorites because it offers readers the opportunity to observe Beck in the process of developing the cognitive formulation. It is necessary reading for seeing how the cognitive formulation was evolving in its crucial formative years. We can trace many of the most important developments in our discipline to the elaboration of the cognitive model that is evident in this book.

Federal Advocacy Column (cont. from page 12)

the APA Practice Organization have paved will help us attempt to restore the recent cuts it will take all of us working together to make it happen.

Medicare is the US government's health insurance program for older adults age 65 or older, persons with disabilities and end-stage renal disease. Medicare is roughly 10% of the entire Social Security Administration budget which funds the program. Currently covering about 40 million people, Medicare

Part A funds inpatient hospitalization and Medicare Part B covers physician and outpatient services. Psychological services are funded by Medicare Part B. President Lyndon B. Johnson signed the Medicare Bill into law in 1965. President Harry S. Truman was issues the first Medicare card in 1966 to honor his heroic efforts to pass a national health insurance program through Congress during his presidency.

So if one does not work with older adults why should one care about Medicare? Medicare is the benchmark for all insurance reimbursement. It is the model which is used as a starting point for both reimbursement and regulations. If a managed care or insurance company does not explicitly state charting and coding expectations, one can rest assured in an audit that Medicare standards will be expected. And it used to be the case that Medicare reimbursement rates were the benchmark from which insurance companies set their rates above. We all now know that with the age of managed care, the Medicare reimbursement rates are used by companies to set rates below that standard. That is the reason it is so important to fight cuts to the Medicare program.

Direct comments to: ***Donna Rasin-Waters,*** *PhD, D12, Federal Advocacy Coordinat or* ***DrRasinWaters@aol.com***

Psychopharm Update: Lilly Compound takes a "New Approach" to the Pharmacotherapy of Schizophrenia

Timothy J. Bruce, PhD

The September 2007 issue of Nature Medicine features results of a recent "proof of concept" clinical trial that the authors describe as a new approach to the pharmacotherapy of schizophrenia (Patil, Zhang, Martenyi, et al., 2007). The study, funded by Eli Lilly and Company and conducted in part by their researchers, reports that the investigational compound LY2140023 produced a statistically significant decrease in positive and negative symptoms of schizophrenia, a response comparable to that of Lilly's first-line antipsychotic, olanzipine (Zyprexa), and without the side effects common to olanzapine and other atypical as well as typical antipsychotics. LY2140023 is an oral "prodrug," meaning it is devoid of intrinsic biological activity. Once administered, however, it is metabolized to provide the active mGlu2/3 receptor agonist--currently labeled LY404039. The approach is new in the sense that current FDA-approved antipsychotics target dopamine or serotonin receptors. LY404039 is thought to work by reducing the presynaptic release of a different neurotransmitter, glutamate, at limbic synapses where mGlu2/3 receptors are expressed (Rorick-Kehn, Johnson, Burkey, et al., 2007)

A total of 196 participants were enrolled and randomly assigned to treatment with LY2140023 (40mg twice daily), olanzapine (Zyprexa; 15mg daily), or a sugar pill placebo. Olanzipine was used as an active placebo to control for side effects that a sugar pill is unlikely to produce. Participants were volunteers who had a primary diagnosis of schizophrenia and were judged to be symptomatically unstable. All participants were hospitalized, tapered off any pre-trial antipsychotic medications, and then treated in double-blind fashion for four weeks. In all, 118 patients (60%) completed the four weeks of planned treatment.

At the four-week follow-up, the LY2140023 and olanzapine groups showed statistically significant decreases in total and subscale scores on the Positive and Negative Syndrome Scale (Kay, Fiszbein, & Opler, 1987) relative to placebo, as well as on a clinician-rated global improvement measure. The authors note that the LY2140023 group reported fewer of the side effects usually associated with typical and atypical antipsychotics, such increased involuntary movement and weight gain, respectively. The placebo group experienced the highest rate of study discontinuation, reportedly due in large part to lack of efficacy. Discontinuation due to adverse events was not significantly different across groups. Treatment-emergent adverse events in the LY2140023 group, in order of prevalence, were insomnia, affective lability, nausea, headache, somnolence and blood creatine phosphokinase increase. In the olanzapine group, treatment-emergent adverse events included elevation in blood triglyceride levels, insomnia, weight gain, somnolence, akathisia, agitation and periodontitis. The authors indicated that more and longer-term studies are needed to confirm and extend these initial findings. Interested readers can find the article online, for a fee, here: http://npg.nature.com/reprintsandpermissions

Lilly's approach to targeting specifically the mGlu2/3 glutamate receptor follows from pilot studies using phencyclidine- (PCP-) induced hyper-locomotion as an animal model for psychosis in unaltered ("wild-type") and "knockout" rats (i.e., rats whose glutamate receptors had been ablated through genetic engineering). In these studies, olanzapine and LY404039 each showed the capacity to decrease PCP-induced locomotion in wild-type rats. In rats whose mGlu2/3 receptors had been knocked out, however, PCP-induced locomotion decreased only in response to olanzapine, not LY404039. The finding suggested that LY404039 decreases locomotion by effecting mGlu2/3 receptors specifically.

According to a recent New York Times article (Berensen, September 3, 2007) Lilly has begun another trial to determine the optimal dose range of LY2140023. It is expected to be complete in January 2009. If successful, a larger, Phase III trial is likely. Apparently, Lilly intends to develop the drug aggressively. Steven Paul, M.D., President of Lilly Research Laboratories, has said, "We are very actively working on this target and related targets because we believe that this mechanism is now validated" (p. 1). Although other agents that directly or indirectly modulate glutamate neurotransmission have been explored in schizophrenia previously

(Large, Webster, & Goff, 2005; Tuominen, Tiihonen, & Wahlbeck, 2005), none have demonstrated clinical efficacy in more than an adjunctive role (Goff, Herz, Posever, et al., 2005; Heresco-Levy, Javitt, Ebstein, et al., 2005; Kremer, Vass, Gorelik, et al., 2004).

For more on the glutamate hypothesis see: http://www.cnsspectrums.com/aspx/articledetail.aspx?articleid=1089

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Clinical Psychology Brochure

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

The cost is $15 per 50 brochures. Orders must be pre-paid.

For more information, contact:
Division 12 Central Office,
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CLINICAL UPDATE

William C. Sanderson, PhD—Section Editor

Note: This is a new column that will appear on occasion. I have solicited articles that provide a "bottom-line" update of a particular clinical area.

DBT for Suicidal Multi-Problem Adolescents

Jill H. Rathus, PhD,
Alec L. Miller, PsyD
and Bevin Campbell

Adolescent suicide is a major public health problem and accounts for at least 100,000 annual deaths in young people worldwide. In the United States, suicide was ranked as the third leading cause of death among the 10- to 14-year old and 15- to19-year-old age groups in 2000, preceded only by accidents and homicide. Moreover, suicidal youths tend to exhibit numerous co-existing problems, with the odds of medically-treated suicide attempts increasing exponentially for each additional problem behavior, such as smoking, violent behavior, high-risk sexual behavior, or substance abuse (Miller & Taylor, 2005).

Defining Adolescent Suicidal Behavior and Risk

Suicidal behaviors include completed suicide, suicide attempts and suicidal ideation. Many suicidologists also consider "non-suicidal self-injurious behavior" (NSIB) as falling into the larger spectrum of adolescent suicidal behaviors. In contrast to a suicide attempt, NSIB involves intentionally injuring oneself in a manner that often results in damage to body tissue, but without any conscious suicidal intent. Research has demonstrated that certain distal and proximal risk factors, when combined, increase the probability of suicidal behavior. The distal factors with the strongest link to adolescent vulnerability to suicide are prior suicidal behaviors, mental disorders, impulsive, disruptive, and anti-social behaviors, substance use, borderline personality disorder, chronic family disturbance, gender, homosexual or bisexual orientation, and ethnicity. Key proximal risk factors are stressful life events, childhood sexual and physical abuse, academic difficulties, functional impairment from physical disease or injury, suicide in the social milieu, and access to suicidal means. Those adolescents at high risk for suicidal behaviors tend to have multiple problems across cognitive, emotional, interpersonal, and behavioral domains of functioning.

DBT as a Treatment for Suicidal Multi-Problem Adolescents

Dialectical Behavior Therapy is a clinical intervention that was originally developed specifically for chronically suicidal patients. DBT views suicidal behaviors as learned methods of coping with acute emotional suffering when no other coping options are available. From a DBT perspective, two conditions set the stage for suicidal behaviors: 1) Individuals lack important interpersonal, self-regulation and distress tolerance skills; and 2) personal and environmental factors inhibit the use of skills the individuals may already have.

It is important to note that many of the factors placing adolescents most at risk for suicidal behaviors overlap significantly with the behavioral criteria for borderline personality disorder (e.g., impulsive and aggressive behaviors, substance use). Moreover, suicidal and other BPD criterion behaviors can be conceptualized as either attempts to regulate intensely painful emotions, or as direct consequences of emotional dysregulation. DBT views extreme emotional dysregulation as arising from a transaction between biologically-based emotional dysregulation and a pervasively invalidating environment.

The success of DBT in reducing suicidal behaviors in adults diagnosed with BPD has led many clinicians to use it with adolescents who are also at high risk for such behaviors. DBT is in many ways an ideal intervention for multi-problem suicidal youth, as it flexibly addresses suicidal behaviors, suicide risk factors, and co-morbid mental disorders. Most other empirically supported and manualized treatments developed for adolescents (e.g., other forms of CBT, interpersonal therapy) focus only on one major problem at a time (e.g. depression, interpersonal problems).

The theoretical orientation of DBT is a blend of three traditions: behavioral science, dialectical philosophy, and Zen practice. Behavioral science, providing a technology of behavior change, is countered by acceptance and tolerance (drawing on both Zen and Western contemplative practices). These poles are balanced in a framework of a dialectical world view. Dialectics holds that reality consists of polar opposites; the resolution or synthesis of tension between opposing positions (e.g., good and bad, parent and adolescent, client and therapist, etc.) produces change.

The overall structure of DBT is dictated by five essential functions that a comprehensive treatment program must fulfill: improving client motivation to change; enhancing client capabilities; generalization of new behaviors; structuring the environment to reinforce adaptive patient behaviors; and enhancing therapist capability and motivation. Adolescent DBT (Miller, Rathus, & Linehan, 2007) typically has five modes, designed to serve these essential functions: individual therapy, multi-family skills training group, telephone consultations with clients (and parents), family therapy, and therapist consultation meetings. DBT is conceptualized as occurring in four "stages". The first stage (which is the focus of most of the empirical literature on DBT) centers on four primary treatment targets: Decreasing life-threatening behaviors, decreasing therapy-interfering behaviors, decreasing quality-of-life interfering behaviors, and increasing behavioral skills.

DBT as originally described and evaluated included older adolescents and young adults in its sample, so using the standard treatment with adolescents is certainly an option. However, we and other practitioners have found that several modifications to the treatment are helpful for an adolescent population, based on developmental and contextual considerations. The most common adaptation is the inclusion of families in skill training. Relatedly, we offer inter-session phone coaching to family members who participate in the multi-family skills training group to further enhance their skills generalization as well. Other common adaptations include adding family therapy sessions as needed, abbreviating treatment length, simplifying skills handouts, including skills handout examples that are more relevant to teens, changing the "homework" label, adding new skills relevant to parent-adolescent problems, and orienting parents. In our work with DBT for adolescents, we have also added the adaptation of adolescent-specific "dialectical dilemmas."

In standard DBT, dialectical dilemmas are behavioral patterns exhibited by clients that are the product of emotional dysregulation. Individuals prone to emotional dysregulation often vacillate between polarized positions of behavioral extremes. These poles tend to overregulate or underregulate emotions, and in this sense such behavioral patterns can be understood as dialectical failures. The dilemma is thus the pull toward one extreme or the other; the synthesis between these extreme positions provides the solution to the dilemma. The dialectical dilemmas help sustain a broad range of dysfunctional behaviors, and these patterns of behaviors must be targeted in treatment if there is to be long-term change. Therefore, DBT has a set of secondary treatment targets. These secondary treatment targets involve finding syntheses of the client's extreme behavioral styles. At each polar extreme, there are two secondary treatment targets: one aimed at decreasing the maladaptive behavior, the other aimed at increasing a more adaptive response. The therapist attends to these secondary targets throughout the treatment, weaving them into behavioral analysis, insight strategies, and discussion of other issues as relevant. The standard DBT dialectical dilemmas are as follows: Emotional vulnerability versus self-invalidation; active passivity versus apparent competence; and unrelenting crises versus inhibited grieving. We have developed three adolescent-specific dialectical dilemmas: Excessive leniency versus authoritarian control; normalizing pathological behaviors versus pathologizing normative behaviors; and forcing autonomy versus fostering dependence.

Steps of DBT for Adolescents

When an adolescent is referred to a DBT program, the first thing that must occur is a comprehensive evaluation. An assessment procedure that we find helpful with this high-risk population in an outpatient setting includes evaluating suicide and NSIB risk, mental disorders, and eligibility for inclusion into the DBT program (Step 1); clarifying DBT Stage 1 target behaviors (Step 2); clarifying the feasibility of DBT for the specific adolescent client and family (Step 3); and developing an initial treatment plan, together with establishing some initial commitment to treatment (Step 4).

The pretreatment stage of orientation and commitment to DBT begins once suicide risk and diagnostic assessments are complete and the adolescent has been found to meet the inclusion criteria for the DBT program. Orientation and commitment begins with the adolescent alone. Once the process has been initiated with the adolescent, the therapist can bring in the parents and/or other participating family members and repeat some of the key elements. The development and maintenance of a therapeutic alliance with the adolescent are of critical importance in this initial stage and throughout treatment. Orientation is not simply a description of the treatment; rather, it aims to build motivation. A set of commitment strategies helps strengthen motivation as well.

Once the adolescent has been oriented and has expressed commitment to therapy, individual treatment with the adolescent can begin. All DBT strategies

(specified dialectical strategies, communication styles, commitment strategies, acceptance and change strategies) are employed in individual therapy, making this modality the most challenging to deliver competently. Intensive training in DBT, individual supervision, and intermittent observation of tapes by one's consultation team or individual supervisor all help improve adherence to the treatment model. The individual therapist in outpatient DBT is responsible for increasing the adolescent's motivation, inhibiting maladaptive behaviors, increasing the adolescent's skillful behaviors, and helping the teen to generalize them outside the therapy setting. One consideration for the individual therapist is that many multi-problem suicidal adolescents experience phobia of emotions. Thus, they tend to avoid content that induces affect in session in a variety of ways. This is one of several types of therapy-interfering behaviors that can make individual therapy with a suicidal adolescent extremely challenging.

Family therapy sessions, which are often scheduled on an as-needed basis, provide a context for the family members and the adolescents to interact in the presence of the therapist. We have found that validation skills need to be taught before behavioral analyses and problem-solving can be effectively initiated. Family sessions then become a unique opportunity for skills strengthening and generalization.

Like individual therapy, group skills training occurs weekly throughout the course of treatment. We strongly recommend that parents, guardians, or other caregivers be included in skills training sessions for adolescents. Skills training with adolescents in multifamily groups follows the same didactic behavioral format as outlined in Skills Training Manual for Treating Borderline Personality Disorder (Linehan, 1993). In our work with DBT for adolescents, we have shortened skills training content, both to fit within a shorter treatment length and to allow room for our new module, Walking the Middle Path. This module helps clients to balance change-oriented skills with acceptance-oriented skills. The module was developed to focus on issues that regularly required more attention in adolescent and family skills groups: The notion of dialectics in general, followed by specific examples of balancing validation (i.e., acceptance) with problem solving (i.e., change), and the adolescent-parent dialectical dilemmas and secondary treatment targets.

As in standard DBT, additional adolescent outpatient modes include telephone coaching and a weekly therapist consultation team meeting. This meeting aims to "treat" the therapist, helping the therapist to remain motivated and conduct effective treatment.

Conclusion

This article outlines DBT and its application to suicidal, multi-problem, adolescents. *Dialectical Behavior Therapy for Suicidal Adolescents* (Miller, Rathus, & Linehan, 2007) offers detailed information on this treatment adaptation. It is important to note that further reading and training in DBT are essential to be qualified to practice. Those interested should also read the original DBT texts *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (Linehan, 1993) and *Skills Training Manual for Treating Borderline Personality Disorder* (Linehan, 1993).

Given the number and complexity of the presenting problems of multi-problem suicidal youth, treatment approaches need to be comprehensive yet flexible enough to address the multiplicity of contributing factors. To date, there is no treatment with established efficacy for this population. For this reason many practitioners have found it useful to expand DBT to include adaptations for treating multi-problem suicidal adolescents. This multi-modal approach offers hope for those seeking effective interventions with this population, and randomized controlled trials of adolescent DBT are underway internationally.

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The Clinical Psychologist

Past issues of *The Clinical Psychologist* are available at **www.apa.org/divisions/div12/clinpj.html**

Section II: Society of Clinical Geropsychology

Deborah A. King, Ph.D.

As I write this column we are about to ring in the New Year. Looking back at 2007, this has been a very good year for psychology and geropsychology. For example, Section 2 member and past president Paula Hartman-Stein helped psychology gain an important role in defining quality care. At its fall meeting, the Ambulatory Care Quality Alliance (AQA) provided psychology voting privileges to decide the merits of quality improvement measures impacting medical practice. AQA has never before included psychology in the voting process. Dr. Hartman- Stein chaired the Phase I task group that recommended practitioners get bonus reimbursement for providing depression screening, cognitive screening, and patient co-development of treatment plans. Pending congressional approval, psychologists and other practitioners will be able to use the quality measures to gain bonus Medicare/Medicaid payment. A Phase II work group, chaired by Section 2 member Merla Arnold, is currently working on measures that will be proposed to AQA and the National Quality Forum (NQF) for 2009. Kudos to our Section 2 colleagues for putting psychology so solidly at the forefront of national quality improvement efforts!

Another important development was the work of APA President Sharon Brehm's 2007 Task Force on Integrated Health Care for Older Adults. The task force prepared a report, *Blueprint for Change: Achieving Integrative Health Care for an Aging Population,* which was recently approved by the APA Board of Directors. The Blueprint will now be forward to the APA Council of Representatives for consideration at its February meeting. The task force was co-chaired by Toni Antonucci, Ph.D., and Antonette Zeiss, Ph.D. We urge you to contact the council representatives of any APA Divisions you belong to and ask them to support this important document.

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, Ph.D.

In January 2008 Lee Anna Clark took over as SSCP President. For 2008, Dan Klein will remain on the board as Past-President, Elizabeth Hayden as Secretary-Treasurer, and David Klonsky as Representative to Division 12. Howard Garb is the new President-Elect. In addition, Mike Miller will continue as manager of the SSCPnet listserv, and Jack Blanchard will continue to manage our webpage, SSCPWeb.org

We engaged in a number of activities over the past year. We prepared and submitted to an American Psychological Society task force a "white paper" on the evolving role of Internal Review Boards. We also gave out several awards. Constance Hammen was awarded the 2008 SSCP Distinguished Scientist Award for her groundbreaking and enduring work on anxiety and fear, as well as her numerous other contributions to clinical psychology. In addition, we have given five dissertation awards to support the pre-doctoral work of talented clinical psychology doctoral students. Finally, Careen Farris won the 2007 SSCP poster award for her presentation entitled, "Alcohol intoxication influences perceptual processing of women's sexual interest cues."

Financially, the section is in good standing. 2007 income was $11,252.30, 2007 expenses were $9,085.05, yielding a year-end balance of $14,277.53. These totals do not include income from 86 members who have recently renewed by credit card. Finally, we are happy to report that the size of our membership has approximately doubled over the past year due to increased advertising efforts.

The Clinical Psychologist

A Publication of the Society of Clinical Psychology
Division 12 – American Psychological Association
ISSN: 0009-9244

Current annual institutional subscription rates are $30 domestic, $35 Canada, and $40 for all other foreign subscribers. Individual issues can be purchased for $10.

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Section VI: The Clinical Psychology of Ethnic Minorities

Anabel Bejarano, Ph.D.

As 2007 comes to a close, Cheryl A. Boyce, Section VI president, completes her presidency for the year. The 2008 presidency torch has been passed on to Eduardo Morales, PhD, Professor in the PhD Clinical Psychology program at CSPP/ Alliant International University, San Francisco campus.

As a final initiative in her presidency, outgoing president Dr. Cheryl A. Boyce started our "Pay It Forward" membership drive. Starting with a gift of membership to ten members, members have in turn granted membership to their students and colleagues, who in turn have granted membership to additional students and colleagues. Many students and early psychologists have already benefited from dues payment through the "Pay It Forward" membership drive. We hope that this will serve as model for members to reach out to fellow colleagues to increase membership and participation in 2008 exponentially!

Under the new leadership of Dr. Eduardo Morales, Section VI continues to progress and strengthen its commitment to increasing research and best clinical practice for racial/ethnic minorities. Section VI is proud that our new president is serving as co-chair along with Dr. Nolan Zane for the landmark meeting, "Culturally Informed Evidence Based Practices: Translating Research and Policy for the Real World" to be held in Washington, D.C. March 13-14, 2008 following the APA State Leadership Conference. For more information see http://www.reismanwhite.com/displaycommon.cfm?an=1&subarticlenbr=23.

The goals of the conference are to inform and stimulate interest and activity in generating impactful research and evaluation efforts in the development of evidence-based practices for ethnic minority populations; and to identify and refine strategies for effectively translating research on evidence-based practices into adaptations that can be effective for serving ethnic minority clientele and communities. Division 12 is serving as one of five organizing divisions for this conference along with Division 17 - Society of Counseling Psychology, Division 37 - The Society for Child and Family Policy and Practice, Division 42 - Psychologists in Independent Practice, and Division 45 - Society for the Psychological Study of Ethnic Minority Issues. In addition to these five organizing Divisions, 16 APA Divisions have officially communicated their sponsorship of this conference, for a total of 24 APA Divisions sponsoring this event as well as the National Latino Psychological Association, and Division 12 Section 6 APA (Clinical Psychology of Ethnic Minorities). The additional APA Divisions sponsoring are: Divisions 13, 15, 18, 20, 22, 27, 28, 29, 35, 38, 39, 40, 44, 48, 50, 51, 53, 54, and 56. Section VI has pledged support to serve as a sponsoring organization for the meeting as well. Several Section VI members, including Drs. Guillermo Bernal, Cheryl Boyce and Alfiee Breland-Noble have participated in the planning group. Members of Section VI will also be well represented in the plenary and workshop presentations.

We invite you to visit our website at http://www.apa.org/divisions/div12/sections/section6/ and to remember to "pay it forward" through membership and culturally informed clinical psychological science and practice.

Section VII: Clinical Emergencies and Crises

Marc Hillbrand, Ph.D.

On December 7th, 2007 we welcomed at new President-Elect (2008), Anthony Sprito, Ph.D., and a new Treasurer (2008-2010), Jennifer Muehlenkamp, Ph.D. Section VII is grateful to current Past President Alec Miller, Psy.D., and current Treasurer (and Section founder and first President) Phillip Kleespies, Ph.D. for their many years of service to Section VII and looks forward to their continued involvement as members of the Section VII Advisory Board.

A fact sheet summarizing the body of scholarly work on victimization and perpetration of violence in ethnic minority populations prepared by Liliana Cordero has been posted at http://www.apa.org/divisions/div12/sections/section7/homepage.html . The report is entitled *The Perpetration of and Victimization by Violence in Ethnic Minorities- Issues, Findings, and Considerations.* It highlights empirical findings that showed different patterns of covariation among violence, victimization, and various psychological variables in ethnic minorities. For instance, minority members appear to be particularly vulnerable to the effects of availability and advertising of alcohol, and more vulnerable to spinal cord injuries resulting from acts of interpersonal violence. Some ethnic groups demonstrate unique characteristics: for example, South Asian

women are very reluctant to reveal their victimization at the hands of their male partner outside the family circle. Some protective factors that exert their influence on Caucasians may have less impact on minority members (e.g., household income). Psychologists need this information in order to provide competent care across ethnic lines.

We look forward to an exciting program at the APA Convention in Boston. James Rogers, Ph.D., will deliver the Presidential Address, *Diversity perspectives on early psychological response to mass disasters.* Drs. Bruce Bongar and Larry James have invited Dr. Ariel Merrari, an Israeli psychologist, to discuss the psychology of terrorism.. Drs. Gutierrez, Brenner, Homaifar and Olson-Madden will highlight work being done by Veterans Administration psychologists in the area of veteran suicide prevention. Dr. Gutierrez will present on a feasibility study regarding the treatment approach put forth by Dr. David Jobes entitled the Collaborative Assessment and Management of Suicidality. The use of telemedicine technology to monitor suicidality in high risk patients will be discussed by Dr. Brenner. Drs. Homaifar and Olson-Madden will present on the outpatient suicide consultation service.

Section VIII: Association of Psychologists in Academic Health Centers

Ronald T. Brown, Ph.D.

Mentorship has become an increasingly important concept in the work setting. The Association of Psychologists in Academic Health Centers (APAHC) also considers mentorship to be especially important, particularly as some of our junior colleagues attempt to navigate through the corridors of academic health centers which frequently have their own cultures and unique set of values. It is therefore fitting that APAHC also contributes to the mentorship of our members for the purpose of easing the challenges that they may face in academic health centers that often are undergoing significant transformation in recent years.

First, given the unique aspects of a tertiary academic health center, many of our members who are still in their final stages of training often have important questions related to training at both the pre-doctoral or post-doctoral level. Questions often relate to issues of training including general versus specialty training and the expected career trajectory associated with both types of training. Their trusted advisors who typically reside in academic departments of psychology often are not familiar with academic health centers and some consultation outside of the ivory tower is often welcome by a trainee.

Frequently, our junior members encounter challenges associated with the unique governance structure and financial woes and priorities of academic health centers. Academic health centers often have their own unique set of political issues and customs that differ from other clinical and academic settings where clinical psychologists are employed. Many psychologists in academic health centers frequently are interested in increased involvement in academic governance within academic departments or for that matter the entire academic health system. Related to this are strategies for enhancing the role of psychology in these centers or the understanding of psychologists' potential contributions within the academic health care system. Thus, consultation with members of APAHC often serves as a valuable resource to our members in meeting those challenges that are encountered in their work in health care as well as issues involved in their careers and lifestyles.

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Our junior colleagues frequently face a litany of career development decisions including the choice and number of committee assignments as well as service assignments to their institutions. In addition, many academic health centers require a funded program of research and scholarship and thus are in need of strategies for launching a funded, programmatic research career. Related to this, several of our members are in need of strategies for establishing or joining a research network with others who work in their particular specialty area. Further, those who practice in academic health centers frequently are involved in the preparation of grant applications from both federal agencies and foundations and are often writing or rewriting manuscripts for publication in peer reviewed journals and chapters for books. At the same time our colleagues are responsible for very complex patient case loads as they attempt to navigate the formidable complexities of providing health care including reimbursement from the health care system in this country for psychological services.

For those members who are on a tenure track, a psychologist must prioritize all of the aforementioned activities as a junior faculty member. Given that academic health centers often serve many patients with complex illnesses and social problems, coupled with large training demands for psychology interns, medical students, and medical residents, our junior members often need assistance in prioritizing their responsibilities and making them manageable. Others who are employed in hospital settings that are affiliated with academic institutions are frequently in need of consultation with regard to obtaining faculty appointments. Some members need assistance as to whether a part-time faculty appointment is sufficient or whether voluntary faculty status will fulfill their needs as well as those of the hospital. Still at some academic health centers there may be resistance on the part of existing faculty in allowing the faculty appointments of non-physicians or other health professionals including psychologists. In the event that a psychologist encounters inequality with regard to gender or race, consultation also is often necessary. With regard to the practice of psychology among individuals with various chronic illnesses, many members have interest in clinical practice and the issues involved in this activity including licensure, garnering a referral source, issues with HIPPA, insurance for malpractice, and board certification. Finally, many of our other junior colleagues who are interested in national service to various associations including the American Psychological Association are in need of information pertaining to professional networking opportunities, involvement in national professional organizations, and attendance at national conferences.

APAHC is of the belief that consultation and mentorship are important ingredients necessary for professional development of our junior colleagues and trainees. After all, those daily decisions may shapes an entire career and lifestyle as a clinical psychologist. For the psychologist facing critical decisions, seeking information about career issues, or faced with unique challenges of an academic health center, consultation with other APAHC members can be a very valuable resource in making such decisions and facing these complex challenges.

For members interested in our consultation program, they may complete a Consultation Request Form which can be located on the Division 12, Section 8, APAHC web page. The form is short and obtains necessary information including current academic rank or job title, preferred model of contact (e.g., telephone or electronic mailing) and areas of interest (e.g., research, teaching, promotion and tenure, professional organizations). Once the form is accessed by APAHC we will assist in the identification of appropriate consultants as needed.

Section IX: Assessment

Norman Abeles, PhD.

Our section had another busy year. There was a section IX symposium at APA in San Francisco titled "Forensic Uses of of Psychological and Neuropsychological Tests. A poster session was also scheduled on Assessment of Children and adolescents. This was jointly sponsored with section 2. On Saturday of the convention we had a meet and greet social reception cosponsored with Division 5 of APA. There was a symposium on the MMPI-2 restructured form. Finally we had a co-sponsored poster session on the assessment of adults.

We also participated at the ABAP (American Board of Assessment Psychology) business meeting which was well attended. It is our understanding that the APA membership board had On its fall agenda a motion previously submitted concerning the listing of ABAP Diplomates in the APA membership directory.

Curent officers of the Section are Robert Archer, PhD, President and Steven R. Smith, PhD, Treasurer. Our membership chairperson is Fred L.Alberts, PhD and our student representative is Lisa Nowinski from UC Santa Barbara. Incoming President is Radika Krishnamurty, PhD rkrishna@fit.edu; Norman Abeles, PhD continues as the section Representative abeles@

msu.edu. For those of you interested in joining our section, please contact our membership chair, Fred Alberts fred@33606.com Section officers also discussed continuing efforts designed to encourage more Clinical psychology programs to promote advanced offerings in the area of assessment. We also noted with interest the APAP residential initiative on Integrated Health Care for older Americans and we look forward to seeing the work of this Task Force. It is our hope that the report will talk about the need for more assessments for older adults. APA and the American Bar Association recently published a handbook for lawyer titled "Assessment of Older Adults with Diminished Capacity. We hope that this will further stimulate interest in assessment of this population. Also in progress is an update of the 1998 APA Guidelines for the evaluation of dementia and age-related cognitive decline. It is our understanding that Division 20 will be involved in this effort.

JOB ANNOUNCEMENT: **ASSOCIATE DEAN**

Gordon F. Derner Institute of Advanced Psychological Studies

Chartered in 1896, **Adelphi University** is an institution of higher education for liberal arts and sciences offering undergraduate and graduate programs with the College of Arts and Sciences, the Honors College Adult Programs in University College, the Derner Institute, and the Schools of Business, Education, Nursing and Social Work. This co-educational university currently enrolls 8,000 students from 44 states and 60 foreign countries, with our main campus in Garden City on Long Island and centers in Manhattan, Hauppauge and Poughkeepsie. The University maintains a commitment to liberal studies in tandem with rigorous professional preparation and active citizenship.

The Gordon F. Derner Institute of Advanced Psychological Studies was founded in 1951 and became the first autonomous, university-based professional school of psychology in the nation in 1972. Today the Institute houses an array of programs emphasizing professional practice integrating psychological science and research through its undergraduate psychology program; M.A. programs in General Psychology, School Psychology, and Mental Health Counseling; APA accredited Ph.D. program in Clinical Psychology; and Postdoctoral programs in Psychotherapy and Psychoanalysis, Child and Adolescent Psychotherapy, and Marriage and Couple Therapy.

Responsibilities: Report to the Dean and work closely with the Dean in realizing the mission and goals of the Derner Institute. The Associate Dean helps to oversee the Ph.D. program including admission and recruitment of students, specific responsibilities for curricular issues, budget preparation and projections, faculty workloads and teaching assignments, mentoring faculty, student appeals, financial aid decisions, accreditation reports and visits, and other duties as assigned.

Qualifications should include: An earned doctorate in psychology, relevant administrative experience, credentials and experience to warrant tenure, scholarship in the field, evidence of commitment to research, teaching, practice, and service, experience in creating and sustaining programmatic innovations, knowledge of the re-accreditation process plus a record of effective collaboration, management, and communication skills.

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Society of Clinical Psychology Board of Directors Minutes Tucson, AZ September 15-16, 2007

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

Minutes – June 2007
MOTION: To approve the minutes as written
ACTION: Passed unanimously

2008 Meeting Year
January 26 – 27, 2008 Austin, TX, Omni Hotel
September 12-14, 2008 Jacksonville, FL,
Hyatt Regency

Committee Chair Attendance at Board Meetings
It was suggested that committee chairs attend one Board meeting per year. The best meeting to attend is in January. This would provide a mechanism to hold committee chairs accountable for the yearly goals of the committee. In the past, committee chairs attended Board meetings, but then there was not enough money to bring them to meetings. Also, committee chairs and Section representatives prepared written reports. There could be a consent agenda so it would not add time to meetings. Items that need a vote could be flagged. There was much support from Board members for having committee chairs at Board meetings.

MOTION: Relevant committee chairs will attend one Board meeting per year as determined by the Executive Committee.
ACTION: Passed unanimously

Committee chairs to attend the annual meeting: Finance; Diversity; Membership; Education and Training; and Science and Practice. (Finance and Diversity committee chairs are already on the Board).

The following committee chairs would only attend Board meeting if they hold another position on the Board: Governance; Awards; Fellowship; and Program.

Treasurer's Report
MOTION: To authorize a one time expenditure of $1,000.00 to allow the web master to make necessary changes.
ACTION: Passed unanimously

A discussion was held about changing the *TPC* to "on-line only." It will save the Division $22,000.00 per year.

MOTION: To offer the *TPC* "on-line only", but for those members who cannot access "on-line", they may request a hard copy from the central office.
ACTION: Passed unanimously

It is critical that every member of Division 12 be sent notification when the *TCP* comes out so they don't have to keep checking the web site. This information will be sent to members by announce-only list serve. The *TCP* will be archived on-line. It will be sent to members in PDF so they can download and print it.

Dr. Donna Rasin Waters, the Division Federal Advocacy Coordinator requested funds to attend the January, 2008 Board meeting.

MOTION: Invite Dr. Rasin Waters to the January, 2008 Board meeting and pay for her expenses.
ACTION: Passed unanimously

There was a request for funding from Dr. Mark Daniels for $1,500.00 to support the Society of Indian Psychologists' annual retreat and convention. In accordance with the Division policy, up to $500.00 could be approved.

MOTION: To give $500.00 to the Society of Indian Psychologists for their annual summer retreat and convention. This will be from the 2007 budget.
ACTION: Passed unanimously

Diversity Committee
The committee proposed two new awards. The first award is for Interventions and Assessment for Communities of Color. This award will recognize individuals who have contributed to the development and advancement of research and practice to communities of color or who have applied existing assess-

ment and/or treatment modalities effectively with these populations.

MOTION: To approve a new Division 12 award for Interventions and Assessment for Communities of Color.
ACTION: Passed unanimously

The second award would recognize distinguished psychologists of color and sexual minority psychologists whose lifetime contributions have advanced the fields of education, science, public interest and practice.

MOTION: To approve a new Division 12 award in each of four areas of psychology: Education, Science, Public Interest, and Practice to recognize distinguished psychologists of color and sexual minority psychologists whose lifetime contributions have advanced the fields of education, science, public interest, and practice.
ACTION: Not passed

MOTION: To approve a new Division 12 award to be given in any one of the following four areas of psychology: Education, Science, Public Interest, and Practice to recognize distinguished psychologists of color and sexual minority psychologists whose lifetime contributions have advanced the fields of education, science, public interest, or practice.
ACTION: Passed

The committee further recommended that Division 12 continue its presence at the biennial NMCS to highlight the Division's work on the implementation of research on culturally relevant evidence-based interventions.

MOTION: Division 12 will continue to maintain a presence at NMCS in perpetuity.
ACTION: Passed

MOTION: The Committee on Diversity chair or her/his representative should attend the CNPAAEMI (Council of National Psychological Association for the Advancement of Ethnic Minority Interests) meeting for recruitment and collaboration with psychologists of color whose training and experience are in clinical science and practice. This motion does not include any financial implications.
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 1st (Winter/Spring Issue – mails in early April)
May 1st (Summer Issue – mails in early July)
September 1st (Fall Issue – mails in early November);

Editor (2006 – 2009):

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Section 2

Section 2 continues to successfully use Profnet as a media platform to make psychologists accessible to the media. The Section contingency funds are used to help support this effort. The Section is asking the Division to support Profnet which costs $550.00 per year. This would make it possible for the entire Division to use Profnet, and the Section could use its contingency funds for training initiatives.

MOTION: Division 12 will support the use of Profnet as a media platform for the entire Division.
ACTION: Passed unanimously

Board members were asked to identify themes they would like to talk about to the media.

Section 6

The Section asked the Board for support of the Evidence Based Practice for Ethnic Minorities Conference which will be held March 13 & 14, 2008 in Washington DC immediately following the APA State Leadership Conference.

MOTION: To give $500.00 in the 2007 budget and $500.00 in the 2008 budget to support the Evidence Based Practice for Ethnic Minorities Conference.
ACTION: Passed unanimously

Discussion of Raising Dues

The Board discussed raising dues in a proactive way rather than waiting until there is a budget crisis. One consideration is whether Division 12 dues are higher than other parallel divisions. The dues increase would be used toward identity issues, the Strategic Plan on Diversity, and the Strategic Plan on Science. There will be more discussion at the January, 2008 Board meeting on how to use the money.

MOTION: Raise dues $1.00 per year for full dues paying members for five years and reevaluate.
ACTION: Passed unanimously

Addendum

In an email discussion by the Executive Committee in the fall of 2007, it was recommended that the award approved at the September Board meeting that was limited to “distinguished psychologists of color and sexual minority psychologists” be changed so that any distinguished psychologist could receive the award. The recommendation was sent to the Board for an email vote.

MOTION: To change the Division 12 award to be given in any one of the following four areas of psychology: Education, Science, Public Interest, and Practice to recognize any distinguished psychologist (not only distinguished psychologists of color and sexual minority psychologists) whose lifetime contributions have advanced the fields of education, science, public interest, or practice.
ACTION: Passed unanimously (by email on December 5, 2007).

ANNOUNCEMENT

With support from a grant by the Arcus Foundation National Fund, AFFIRM:

Psychologists Affirming Their Lesbian, Gay, and Bisexual (LGB) Family has been working on a project to enhance the training of graduate students in clinical psychology.

Voicing their concern about the lack of exposure to LGB issues in their training, graduate students have written to the APA Committee on Accreditation, urging them to recognize exposure to the literature on sexual minorities as an important part of the APA diversity requirement. AFFIRM has put together a carefully selected list of readings on LGB issues and sent them to Directors of Clinical Training, asking them to distribute it to their faculty. The topics covered include child/development, couples/family, ethics, psychopathology, and therapy.

In order to make these references available to an even larger audience, AFFIRM has also just posted them on its Web site, together with abstracts for each. To facilitate ease of use, a PDF can be obtained for each reading through PsycINFO, by contacting the author, or by emailing marvgoldfried@gmail.com.

You are invited to visit the AFFIRM Web site at: www.sunysb.edu/affirm. Go to “Announcements” for further information on the project, and then click on “Bibliographies.”

2008 Candidates' Statements

Please read the statements below by candidates for President-Elect, Treasurer, and Council Representative. Ballots will be mailed from APA on 4/15/08.

PRESIDENT-ELECT

Linda Wilcoxon Craighead, Ph.D.

I am running for president of Division 12 because I want this division to continue to play a major role in shaping the future of clinical psychology. My career has been devoted to integrating research, education and practice, and I am committed to the synthesis of these efforts. I received my Ph.D. from The Pennsylvania State University under the direction of Dr. Alan Kazdin. I have been training doctoral level psychologists my entire career, some more research-oriented and some more practice-oriented. My research focuses on improving the acceptability of interventions from the perspective of client and therapist as well as its effectiveness. We must not only develop effective interventions that practitioners can and will use. I maintain an active clinical practice to stay tuned in to the concerns of practitioners. I am now the Director of Clinical Training at Emory University and served in that role previously at the University of Colorado.

I now see our field as facing a unique set of challenges if we are to maintain the integrity of our discipline. As I see it, our profession was not able to take the lead in deciding how to respond to the significant increase in demand for professional services that was brought on largely by the success of clinical psychologists in developing more effective, affordable interventions that could be useful for a much broader range of mental and medical conditions than ever before. As market forces will prevail, alternative training models emerged, but the profession was not able to maintain control over the growth to insure that all the required, high quality training experiences remained predictably available. We are left in an untenable position, with no way to mandate a balance between the academic training and the internship training both of which are required for licensure. We also do not insure suitable postdoctoral supervision while related professions have clearly identifiable and predictable career tracks. This situation is not positive for currently practicing clinicians and it deters highly qualified young people from entering our profession. Most importantly, these deterrents likely have the most impact on individuals from more diverse backgrounds who the field most needs to attract. The costs of obtaining training and the unpredictability of achieving the outcome loom large in many individuals' career decisions. It is in our own best interest and it is our ethical obligation to resolve the current dilemmas in our training models so that we can continue to train highly effective practitioners as well as researchers. We also need to put forward coherent plans to document competency so that our professionals do not continue to struggle with different state licensing requirements.

Division 12 is a professional organization, which includes psychologists who are training or internship directors, psychologists who are active on state boards and those active in state associations. We can serve an important leadership role in addressing today's pressing issues. I believe these issues are important enough that I am willing to devote my time and energy to serving the division membership.

Marvin R. Goldfried, Ph.D. ABPP

I was traumatized by Paul Meehl when I was a graduate student. Meehl visited our clinical program, and I was among a small group of students that went out to dinner with him. This was a rare treat, especially since I had enormous respect for his insights on research, practice and the philosophy of science. At one point during the evening, someone asked him: "Dr. Meehl, to what extent is your clinical work informed by research?" Without any hesitation, he replied: "Not at all."

As someone who was struggling to adopt the identity of scientist-practitioner, I left this memorable dinner disheartened. I don't think I ever fully recovered. The challenge of how we can close the gap between research and practice has stayed with me all these years, and because I am attracted to challenges–my experiential colleagues would probably call it "unfinished business"–I have continued to be intrigued with the integration of research and practice.

Researchers and clinicians live in different worlds. As researchers, our lives are about convincing granting agencies to support our work and about publishing. As clinicians, our lives are about convincing insurance companies to support ongoing therapy sessions and about getting referrals. Although primarily an academic, I live in both worlds. In my role as Distinguished Professor of Psychology at Stony Brook University, I have been actively involved in therapy research and teaching. I have also expe-

Looking to relocate to the beautiful Northwest?

Psychology Practice Specializing in Anxiety Disorders, Lake Oswego, Oregon

The Anxiety Disorders Clinic (TADC) specializes in the evaluation and treatment of anxiety disorders in adults, adolescents, and children. Anxiety disorders affect 13 million people, surpassing substance abuse (10 million people) and depression (9.4 million people) as the number one mental health problem in the country.

TADC was established in 1985 by Ricks Warren, Ph.D., ABPP to provide the most current, evidence-based treatments for each of the anxiety disorders and related conditions. Clinic staff, in conjunction with the School for Professional Psychology at Pacific University, has pioneered in conducting effectiveness studies in a private practice setting, resulting in a rewarding national and international reputation. Studies have included panic disorder, OCD, PTSD, and social anxiety disorder.

TADC currently has eight staff members: five psychologists, two LCSWs and a marriage and family therapist. Psychopharmacological evaluations and medication management are provided by a consulting psychiatric nurse practitioner certified in psychopharmacology and other consulting psychiatrists. TADC has an extensive referral network of primary care physicians, pediatricians, and other medical specialists, as well as friends, family, and work associates of former clients.

TADC is located at 4550 S.W. Kruse Way in Lake Oswego, Oregon. The office building is located in one of the most desirable professional office areas in the Portland Metropolitan area, and each office space in the suite has a beautiful view of lush Northwest vegetation. Dr. Warren is selling TADC so he can move closer to extended family. For more information, see the TADC website at anxietydisordersclinic.com, contact Dr. Warren at (503) 635-8710 #1 or email *rickswarren@comcast.net*

www.anxietydisordersclinic.com

rienced the clinical world through my limited practice and my supervision of graduate students. Indeed, I am proud to have received honors in these two arenas, starting with my award in 1998 from Division 12 for Distinguished Scientific Contributions to Clinical Psychology. In 2000, I received the Division 29 (Psychotherapy) Award for Distinguished Psychologist. In 2001, I was awarded the APA Award for Distinguished Contributions to Knowledge, and in 2003 the Association for Advancement of Behavior Therapy awarded me for Outstanding Clinical Contributions.

In considering the relationship between psychotherapy practice and research, I have viewed my clinical work as providing me with the context of discovery. In my role as clinician, I have been able to garner clinical hypotheses that I studied under better-controlled research conditions, designed to verify what had been observed clinically. The findings from this empirical context of verification could then, in turn, readily be fed back to the clinical community.

My 1999 presidential address before the Society for Psychotherapy Research (SPR) in Braga, Portugal dealt with the need for the field to reach a consensus, but underscored the importance of having converging input from both the research and clinical communities. In articles appearing in such journals as Journal of Consulting and Clinical Psychology, American Psychologist, Clinical Psychology: Science and Practice, and Psychological Bulletin, I have argued for the need to develop additional research paradigms to supplement our current clinical trials methodology, which would involve greater clinical input, and which could have greater clinical validity. As President of Division 12, I do all I can to foster a closer interface between research and practice.

TREASURER

M. David Rudd, Ph.D, ABPP

It is a genuine pleasure to be nominated for the office of Treasurer of Division 12 and to have the opportunity to give a little something back to the Division. In particular, I'm excited about the chance to continue and expand the fabulous work of so many others to bolster the role of science in clinical practice and research. I currently sit on the APA council as a representative of the Texas Psychological Association. Additionally, I just completed my tenure as President of the Texas Psychological Association. As a dedicated academic with clear and consistent ties to the practice community, I think I would bring a unique and broad perspective to the Board. I'm currently chair of the Department of Psychology at Texas Tech University, but continue to be an active clinical researcher and practitioner, with the bulk of my work focusing on high-risk individuals. Consistent with my general philosophy about the importance of integrating science and practice, the vast majority of my work has attempted to answer simple and straightforward questions about risk in clinical settings. I've published consistently and extensively in the area, with almost every study having direct and specific implications for clinical practice, education, and training. Additionally, I've been willing to volunteer time in other settings in an effort to bridge the science-practice gap, serving as Chair of the Texas State Board of Examiners of Psychologists. I've also served previously as President of the American Association of Suicidology. I'm familiar with the inner workings of APA, organizational strategic planning and welcome the chance to serve with Division 12. I've spent my career pursuing the integration of clinical science into one of the highest need areas in day to day practice, suicidality. One of the most rewarding aspects of this work has been the chance to witness the positive and enduring life changes that result from good, practical science. I would be honored to have your vote.

Barbara Arneson Yutrzenka, Ph.D.

I am honored to be a nominee for Division 12 Treasurer. My credentials to serve in this position are embedded in the past 29 years of service to the profession as a clinician, scientist, administrator and advocate. After receiving my Ph.D. in clinical psychology from the University of North Dakota in 1981, I spent three years as director of the Emergency Services Unit within a comprehensive community mental health center outside of Richmond, Virginia. For the past 24 years I have been a faculty member in the Psychology Department at the University of South Dakota (which, I might add is the warmer of the two Dakotas!). I have directed our APA accredited clinical psychology program continuously for the past 20 years, which has involved managing budgets, advocating for/allocating resources, recruiting/retaining students and faculty, and encouraging/modeling/valuing diversity across all of these responsibilities.

I have been a member of APA and D12 for over 25 years. I have served as an officer in the South Dakota Psychological Association, as a Council of University Directors of Clinical Psychology Programs Board mem-

ber, and am currently on the SD Board of Examiners of Psychology. I am committed to the integration of science and practice as core to our discipline and am a strong proponent for increasing diversity in our science, practice, and presence/participation. I would welcome the opportunity to serve as your treasurer, to support the division's mission and to work collaboratively with the division's stakeholders to achieve its goals. Thank you.

COUNCIL REPRESENTATIVE

Deborah A. King, Ph.D.

As Professor of Psychiatry, Clinical Chief of Psychology, and Director of Psychology Training at the University of Rochester Medical Center, I have worked hard to integrate evidence-based treatments into our interdisciplinary educational and clinical care models. As Director of a Graduate Psychology Education Program, I developed innovative training programs to provide accessible, culturally-responsive care to underserved elders in the Rochester community. As Co-Director of an NIMH-funded "Program of Research and Innovation in Disparities Education", I work to bring more professionals of color into the psychology workforce. As a member of Sharon Brehm's 2007 Presidential Taskforce on Integrated Health Care for Older Adults, I helped formulate a "Blueprint for Change" to guide our field toward greater understanding of accessible, integrated care models for older adults. These experiences impressed upon me the importance of developing new research-supported approaches to care and health promotion for a diversity of underserved and ethnic minority populations.

I have served on the Division 12 Board for five years representing the Society of Clinical Geropsychology and serving as a member of the Division's Finance and Nominations Committees. I have witnessed the challenges arising from declining APA membership in general and I understand the importance of attracting and retaining a diversity of new members to our Society. If elected Council Representative, I will use my 15 years of experience as Training Director of APA-accredited programs to bring more early career psychologists into the Division. I will pursue initiatives to develop and disseminate research-supported interventions and to increase the evidence base regarding treatments for ethnic minority populations. I will advocate for increased federal funding of training programs designed to prepare the next generation of scientist practitioners to meet the needs of our diverse, aging population. I ask for your support in accomplishing these goals.

Richard M. Suinn, Ph.D.

It would be a pleasure to represent Division 12 to maintain its strong leadership presence at Council. My extensive experience enables me to immediately understand the complexities of Council, and to be an influential and respected voice. My uniqueness comes from experiences within every level of APA governance:

- Executive: APA president–which provided special insights in getting things accomplished,
- Special-focus Boards: chair of Education and Training Board and Board of Ethnic Minority Affairs, service on Publications/Communications and Policy and Planning Boards
- Specialized-committees: chair of the Committee on Ethics, Policy and Education, chair of two Commissions on diversity.

I have over 30 year's involvement in Divisions: helped found several Divisions and served on executive committees to foster Divisional growth and visibility. My latest activity for Division 12 was on its presidential-appointed Task Force on Diversity. My APA positions have been opportunities to initiate actions benefiting Divisions. For instance, as chair of APA's Membership Committee I was instrumental in recruitment innovations, an activity essential for Division 12 to retain its strength, influence and vitality.

I am truly a scholar/practitioner: publishing research on effective interventions, teaching core clinical courses on assessment and therapy, designing a new doctoral program in clinical psychology, supervising practicum, consulting with organizations, heading a Psychology Department. A licensed psychologist, I have been on the state's Board of Examiners, ABPP's Board of Directors, and an active participant in both the APA State and Divisional Leadership meetings.

I also have broader skills: I have been mayor of my city, and served as Olympic team psychologist and community advocate. As my perspectives have widened, the common element is a positive activism and commitment to getting things done. I would love to focus my energies and know-how for the Division's visions and goals and I ask for your support.

APA DIVISION 12 – SOCIETY OF CLINICAL PSYCHOLOGY

PROFESSIONAL DEVELOPMENT INSTITUTES • CE CREDIT • PRE-CONVENTION
AUGUST 13, 2008 • SAN FRANCISCO, CA • HILTON SAN FRANCISCO

FULL-DAY WORKSHOPS
WEDNESDAY, AUGUST 13, 2007 • 6 CE CREDITS

A. **Ethical Issues in Forensic Practice**
Alan Goldstein, Ph.D., P.C.

B. **Assessment of Personality Pathology with the SNAP**
Lee Anna Clark, Ph.D.

C. **Introducing the MMPI-2-RF (Restructured Form)**
Yossef S. Ben-Porath, Ph.D.

D. **Update on a Unified Treatment for Emotional Disorders**
David H. Barlow, Ph.D.

E. **Buried in Treasures: The Nature and Treatment of Compulsive Hoarding**
David F. Tolin, Ph.D., ABPP

HALF-DAY WORKSHOPS
WEDNESDAY, AUGUST 13, 2007 • 3 CE CREDITS

F. **Cognitive-Behavior Therapy for Schizophrenia**
Scott D. Temple, Ph.D.

G. **Individualities: Implications of Personality for Psychotherapy**
Nancy Mc Williams, Ph.D.

WORKSHOP	MEMBER	NON-MEMBER	STUDENT MEMBER	STUDENT NON-MEMBER
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B	( ) $180	( ) $200	( ) $100	( ) $120
C	( ) $180	( ) $200	( ) $100	( ) $120
D	( ) $180	( ) $200	( ) $100	( ) $120
E	( ) $180	( ) $200	( ) $100	( ) $120
F	( ) $90	( ) $100	( ) $65	( ) $75
G	( ) $90	( ) $100	( ) $65	( ) $75

*Fees are discounted **$10 per workshop** if check or credit card payment is received by **June 13, 2008***

CE CREDIT: CE credits are given for each workshop as listed above. The number of CE credits is equal to the number of contact hours. Full attendance at the entire workshop is prerequisite for receiving CE credit. **Partial credit may not be earned.**
The APA Division 12 is approved by the American Psychological Association to offer continuing education for psychologists. APA Division 12 maintains responsibility for the program.

CANCELLATION/REFUND POLICY: Full refund for cancellation by Division 12 because of inadequate enrollment or by participant before June 27. A 25% handling charge on cancellations between June 28 and July 11.
No refunds for cancellations received after July 12, 2008.

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Instructions to Authors

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

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

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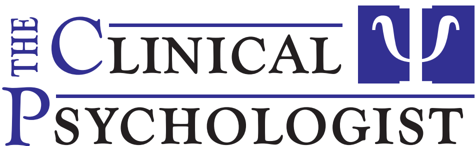
Articles published in *The Clinical Psychologist* represent the views of the authors and not those of the Society of Clinical Psychology or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.



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

Non-profit Organization
U.S. Postage
PAID
Boulder, CO
Permit #537

Canada Goods and Services Tax
Registration No. 127612802

The Clinical Psychologist is printed on paper that meets or exceeds EPA guidelines for recycled paper.
Printed in the USA