

THE CLINICAL PSYCHOLOGIST



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

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EDITORIAL

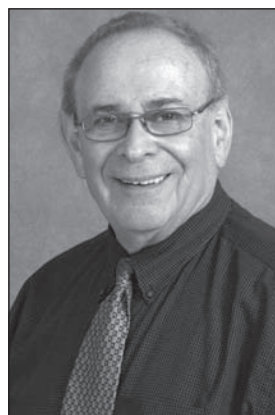
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2010 Election Special: Division 12 Candidate Statements (page 21)



By **Marvin R. Goldfried,
PhD, ABPP**
**Stony Brook University
President, Society of
Clinical Psychology**

PRESIDENT'S COLUMN

Building a Two-way Bridge between Practice and Research

One of the long-standing problematic themes in clinical psychology has involved the gap between research and practice. John Norcross, Past-President of the Society of Clinical Psychology, has been a strong advocate of the need to close this gap. In assuming the presidency in 2010, my goal is to help us work toward some resolution of this unfortunate and long-standing state of affairs. One step in that direction is that the Society's theme for the forthcoming APA convention in August will be on building a

two-way bridge between practice and research.

As I have indicated in the past, this strained alliance between research and practice has plagued me ever since graduate school. A particularly distressing event during my graduate career occurred when Paul Meehl—a very strong advocate of the need for empirical evidence in clinical psychology—visited our program. I had read virtually everything he had written, I was particularly fortunate to be among the small group of graduate students to sit with him at dinner. At one point during the evening, somebody asked: “Dr. Meehl, to what extent does research inform how you practice clinically?” Without hesitation, Meehl replied: “Not at all!” As someone who was aspiring to become a scientist-practitioner, I was crushed. Indeed, I continue to be effected by this some 50 years (!) later.

Depending on your theoretical orientation, you might say that I am either fixated, continue to have unfinished business, or have failed to extinguish my emotional response to his comment. Whatever your formulation might be, my concern about the practice-research gap continues to exist. A major difference, however, is that there now exists a body of evidence—coming from basic research, randomized clinical trials (RCTs), and process research—that can inform how we practice clinically. To be sure, there may be some limitations in extrapolating research findings to the clinical setting. Still, we know far more now than we did in the past. What is perhaps most significant now is that the field of psychotherapy can no longer make claims without pointing to collaborative evidence. Although pressures for accountability have existed over the past few decades, the emphasis on empirically supported treatments (ESTs), evidence-based practice, pay for performance, quality assurance, and the existence of practice

(continued on page 2)

President's Column (*continued*)

guidelines have inexorably moved the field of psychotherapy toward accountability.

In the 1970s, The National Institutes of Mental Health shifted its emphasis to rely more on the medical model of psychological problems. What had previously been called "outcome research" was renamed "randomized clinical trials," and the "target behaviors" that had been the focus of outcome research was

replaced by DSM "disorders." All this, of course, was modeled after the research paradigm associated with drug trials in medicine. Although many have lamented about this shift to a medical model, there is an aspect of this paradigm that can have important implications for closing the research-practice gap in psychotherapy.

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EDITORIAL

Milton Strauss, PhD (Editor) and Guerda Nicolas, PhD (Associate Editor): *The Clinical Psychologist*

 This is a time of transition for *The Clinical Psychologist* in many ways. As you may recall, this is the last issue to appear in print as well as in electronic format. In the future, the TCP will be available only electronically. It is also a transition in editorship. We hope to maintain Bill Sanderson's success in making TCP informative about the broad range of issues in clinical psychology, with emphasis on topics relevant to both practitioner and academic communities.

You will see a number of changes in section and column editors in this issue. There is also a new column on ethical issues, edited by Jeff Younggren, and an extension of the Internet Update to cover electronic issues more broadly as Technology Update. We hope to have the full slate of columns back in the Spring issue.

As we journey through these changes together, we welcome your comments and suggestions of ways that we can make the TCP even more useful to you. We welcome brief manuscripts (10-12 pages) for consideration for publication. TCP is a newsletter for all section members and so submissions should be of broad interest.

TCP is a tool for communicating with colleagues in our field and we welcome your participation. Please submit comments, suggestions and manuscripts to the editor, Milton Strauss, at milton.strauss@gmail.com.

Thank you.

Milton Strauss, Editor

Guerda Nicolas, Associate Editor 

The Clinical Psychologist

Past issues of *The Clinical Psychologist* are available at:

www.div12.org/clinical-psychologist


President's Column (continued from page 2)

Once a drug has been approved by the Food and Drug Administration (FDA) as a result of randomized clinical trials, practitioners have the opportunity to offer feedback to the FDA based on their experience using it in clinical practice. As a way of building a two-way bridge between research and practice, the Society of Clinical Psychology will be establishing a mechanism whereby practicing therapists can provide feedback on the basis of their clinical experiences using ESTs.

We have just completed pilot work on a Web-based survey that will allow practicing clinicians offer their clinical experiences in conducting empirically supported treatments. Our preliminary efforts in doing this will focus on the treatment of panic disorder with cognitive behavior therapy—at present the primary intervention that has been shown to have empirical support. This survey will provide practicing therapists the opportunity to share their clinical experiences about those variables that they

have been found to limit and enhance the successful reduction of panic. The results of the survey will be posted in on our Web site, and Web sites of other relevant organizations will have links to it. I invite you to take this very brief survey at: www.div12.org/panic.

Not only will the posted findings of the survey allow practicing clinicians to compare their experiences with those of others, but it will also provide researchers with clinically relevant questions in need of empirical investigation. Although we will be starting with a survey on the treatment of panic disorder, the goal is to expand this to other clinical problems that have been the focus of empirically supported treatments. I will keep you posted on our progress.

Meanwhile, I welcome hearing your thoughts and suggestions about this initiative, either directly (marvin.goldfried@sunysb.edu) or through postings on the Society's listserv (Div12APA@lists.apa.org). 



Keep Up with the Advances in Psychotherapy Evidence-Based Practice

Developed and edited with the support of the Society of Clinical Psychology (APA Division 12)



Series Editor: *Danny Wedding*
Associate Editors: *Larry Beutler, Kenneth E. Fredland, Linda Carter Sobell, David A. Wolfe*

The Series:

This series provides therapists and students with practical, evidence-based guidance on the diagnosis and treatment of the most common disorders seen in clinical practice – and does so in a uniquely “reader-friendly” manner. Each book is both a compact “how-to” reference on a particular disorder, for use by professional clinicians in their daily work, and an ideal educational resource for students and for practice-oriented continuing education.

The books all have a similar structure, and each title is a compact and easy-to-follow guide covering all aspects of practice that are relevant in real life. Tables, boxed clinical “pearls,” and marginal notes assist orientation, while checklists for copying and summary boxes provide tools for use in daily practice.

Main features of the volumes:

- **Authoritative:** Written and edited by leading authorities
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**Advances in
Psychotherapy**
Evidence-Based Practice

HOGREFE




What do Clinicians Want? An Investigation of EST Training Desires

Rebecca E. Stewart

Dianne L. Chambless

University of Pennsylvania

 Almost 15 years ago, the Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures (1995) intensified American psychology's focus on the identification and dissemination of empirically supported treatments (ESTs). Nonetheless, evidence suggests that efforts to promote ESTs have had minimal impact on the practice of front-line clinicians (Arnow, 1999; Becker, Zeyfert, & Anderson, 2004; Crowe, Mussell, Peterson, Knopke, & Mitchell, 1999; Goisman, Warshaw, & Keller, 1999; Haas & Clopton, 2003; Mussell et al., 2000; Stewart & Chambless, 2007; von Ranson & Robinson, 2006) and dissemination of ESTs has emerged as an important area for study. Several authors have pointed to graduate education and internship as a particularly opportune time in which to train practitioners and convey the value of ESTs (Aarons, 2004; Crits-Cristoph, Chambless, Frank, & Brody, 1995; Stewart & Chambless, 2007). However, increasing graduate students' exposure to ESTs does not address the important and pressing issue of how to train those clinicians who are already in practice.

Unlike graduate students, practicing clinicians have wide discretion in how they spend their continuing education efforts. Post-graduate training is rarely compensated for clinicians in private practice, and some evidence indicates that the time and resource demands of EST training can deter commitment (Riley et al., 2007; Stewart & Chambless, 2009). Practitioners might be more receptive to learning ESTs if training were made available for disorders of particular interest to them. The purpose of the present investigation was to determine those disorders for which clinicians would like to learn an EST. Such information should be useful for planning EST dissemination and training efforts for practicing clinicians

Method

Participants and Procedure

Questions for this research project were incorporated

into a survey instrument used by Stewart and Chambless (2009) to investigate the barriers to EST dissemination. Using mailing labels purchased from APA, we sent a cover letter and survey to a randomly selected sample of 4,000 members of the American Psychological Association (APA) who specify themselves as practitioners in private practice. Front-line clinicians practice in a number of settings, including, for example, community agencies and hospitals as well as private practice. To achieve greater sample homogeneity in light of limited resources, this study was limited to private practitioners. Eight envelopes were returned to the sender due to faulty mailing addresses. Of the 1277 respondents, 28 were unusable (i.e., participants returned blank surveys indicating they did not have time, were not currently in practice, or had retired). We had a total of 1249 useable responses to the mailing, for an effective response rate of 32%.

Measures

A questionnaire was developed comprising 29 self-report items. Two sections comprising 8 of these items were employed in the primary analyses reported in this article. The first section assessed practitioners' demographic information, theoretical orientation, years of clinical experience, graduate school emphasis on empirical research on psychotherapy outcomes (on a 1 = *Never* to 10 = *Always* scale), primary employment setting, current average number of weekly psychotherapy hours, and number of weekly psychotherapy hours desired. The desired hours shortfall was calculated as the difference between participants' desired weekly hours and current average number of weekly hours. In Section 2, participants read a definition of ESTs and some examples of ESTs representing a variety of theoretical orientations for depression, panic disorder, borderline personality disorder, and bulimia. Clinicians were then asked to write in a disorder for which they would like to pursue additional training.

Results

Sample Characteristics

Of the practitioners, 60% were female. The mean age of the sample was 55.28 ($SD = 8.44$, range = 29-80). In terms of highest professional degree, 83% of the

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Implementation Research Institute (IRI)

New NIMH funded training institute invites applications

The Center for Mental Health Services Research (CMHSR) at Washington University in St. Louis invites you to apply to the Implementation Research Institute (IRI).

Funded by a five-year R25 grant from the National Institute of Mental Health, this unique interdisciplinary training program will help you launch a research career in implementation science. Over two years, the IRI provides IRI Fellows with experiential learning, didactic training, faculty mentoring, and support for pilot research and NIH grant writing—all focused on helping participants shape a research project for competitive external funding.

What is the IRI? The IRI was established to advance the field of implementation science in mental health by enhancing the career development of early to mid-career investigators. IRI participants will join a learning collaborative of implementation researchers for two years, spending one week each summer at a week-long institute at the CMHSR, and receiving individualized mentoring to help them shape a research agenda in implementation science and prepare a competitive research grant proposal.

Who should apply? We invite applications from ambitious PhD/MD investigators, with demonstrated experience and enthusiasm in the study of mental health services, who wish to conduct ground-breaking research in the area of implementation science.

Applications should be submitted electronically by February 28, 2010.

For more detailed information and application instructions, including the FAQ page, visit <http://cmhsr.wustl.edu/Training/IRI/Pages/ImplementationResearchTraining.aspx>, or contact Sally Haywood, MPA, Director of Administration at shaywood@wustl.edu; (314) 935-5741.

practitioners had earned a Ph.D., 14% a Psy.D., and 3% an Ed.D. Practitioners had an average of 21.6 ($SD = 8.36$, range = 2-50) years in practice. They saw patients an average of 24.65 ($SD = 11.13$, range = 5-65) hours a week. The large majority (95%) of the practitioners worked in private practice. The two most common self-described primary theoretical orientations were cognitive-behavioral (46%) and psychodynamic (23%). An additional 19% reported themselves as eclectic, 5% described themselves as humanistic/experiential, 3% subscribed to family systems, and 4% chose the category other as their primary theoretical orientation.

Selected Disorders for EST Training

In an open-ended format clinicians were asked to indicate a disorder for which they held interest in EST training. The first author (RES) reviewed and codified all responses. The most frequently cited disorder was post-traumatic stress disorder (18%). Depression (14%) was the second most commonly mentioned disorder, followed by anxiety disorders broadly mentioned (8%). The *other* category (12%) included 31 disorders and presenting problems that each comprised 1% or less of responses. See Table 1.

Predictors of Selected Disorders

What clinicians are interested in what disorders? We used a multinomial logistic regression predicting chosen disorder from our biographical variables to address this question. To conserve power and limit our dependent variable to an interpretable number of categories, we collapsed across disorders and summarized them as mood, anxiety, and personality disorders. Psychotherapy research emphasis in graduate school, years in clinical practice, average hours of week, and average desired hours shortfall were entered as continuous variables. Theoretical orientation and gender were entered as categorical variables. To avoid small cell sizes, we included only the three theoretical orientations to which participants most frequently subscribed. In the overall model, theoretical orientation (psychodynamic ($n = 284$) versus eclectic ($n = 234$) and CBT ($n = 586$) practitioners) was the only significant predictor for both the personality/anxiety disorder contrast (OR = 0.56, 95% CI = 0.33, 0.94, $p < .05$) and the personality/mood contrast (OR = 0.42, 95% CI = 0.24, 0.76, $p < .005$).

To further probe this effect, we conducted a series of nine 2 (orientations) by 2 (disorder) chi-squares. Within mood and personality disorders, 57% of psychodynamic

practitioners selected mood disorders instead of personality disorders versus 75% of eclectic practitioners and 76% of cognitive behavioral practitioners. This difference was significant. There were no significant differences between cognitive-behavioral and eclectic practitioners on their selection of mood versus personality disorders. The results were similarly significant for anxiety and personality disorders: 76% of dynamic practitioners selected anxiety disorders over personality disorders versus 86% of eclectic practitioners and 86% of CBT practitioners. Again, there were no significant differences between cognitive and eclectic practitioners on their selection of anxiety versus personality disorders. There were also no significant differences on selection of anxiety versus mood disorders for any of the theoretical orientations. See Table 2.

Discussion

Our sample comprised mostly highly experienced clinicians. For what disorders would such clinicians like to learn an EST? Clinicians most frequently cited PTSD, followed by depression and anxiety disorders broadly mentioned. We do not have enough information from this study or any previous data against which to compare the current data to make strong conclusions about why this is the case. It is likely that the ongoing conflicts in Iraq and Afghanistan, as well as the high rates of PTSD identified in returning soldiers (Hoge, Terhakopian, Castro, Messer, & Engel, 2007) have increased interest in PTSD and the effects of trauma. Moreover, broad media coverage of these topics has raised awareness of not only PTSD, but also potentially of ESTs for PTSD.

We were also interested in which clinicians were interested in which disorders. The only significant clinician variable that predicted selected disorder was theoretical orientation. Cognitive-behavioral and eclectic practitioners were more interested than psychodynamic practitioners in Axis I disorders (i.e., mood and anxiety), whereas psychodynamic practitioners held more interest in personality disorders than did practitioners of other orientations. To our knowledge, there is no empirical work examining whether practitioners of varying orientations work with clients from different diagnostic categories. Nonetheless, it is conceivable that cognitive-behavioral therapists may be more likely to see patients with well-defined mental disorders (i.e., Axis I disorders) and pursue training in disorders most commonly seen in their practice. In contrast, psychodynamic psychotherapy is traditionally consid-

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Wanted: Clinicians' Feedback on Treating Panic Disorder

Once a drug has been approved by the Federal Drug Administration (FDA) as a result of clinical trials, practitioners have the opportunity to offer feedback to the FDA on any shortcomings in the use of the drug in clinical practice. The Society of Clinical Psychology, Division 12 of the American Psychological Association, is in the process of establishing a mechanism whereby practicing psychotherapists can report their clinical experiences using empirically supported treatments (ESTs).

This is not only an opportunity for clinicians to share their experiences with other therapists, but also can offer information that can encourage researchers to investigate ways of overcoming these limitations. We are starting with the treatment of panic disorder, but will extend our efforts to the treatment of other problems at a later time.

Our Web site provides the opportunity for therapists using cognitive-behavior therapy (CBT) in treating panic to share their clinical experiences about those variables they have found to *limit the successful reduction of symptomatology*. Although research is underway to determine if other therapies can successfully treat panic, CBT is the only approach at present that is an EST. However, in order for the field to move from an EST to an evidence based treatment that works well in practice settings, we need to know more about the clinical experience of therapists who make use of these interventions in actual clinical practice. By identifying the *obstacles to successful treatment*, we can then take steps to overcome these shortcomings.

Your responses, which will be anonymous, will be tallied with those of other therapists and posted on the Division 12 Web site at a later time. The results of the feedback we receive from clinicians will be provided to researchers, in the hope they can investigate ways of overcoming these obstacles.

The survey, which should take 10 minutes, can be found at:

<http://www.surveymonkey.com/s/KX3MBZJ>

ered a treatment focused on character change, alleviation of unconscious conflicts, and increasing insight (Strupp, 2001), and it is possible that psychodynamic therapists might be more likely to treat clients with personality disorders and therefore hold more interest in training in these disorders. It is important to note, however, that there are fewer ESTs for personality disorders than for Axis I disorders. ESTs have only been identified for borderline and avoidant personality disorders (Chambless & Ollendick, 2001). Borderline personality disorder comprised 80% of the specific personality disorders mentioned in this study. Thus, ESTs do exist for the personality disorder nominated most frequently by clinicians in this sample.

One limitation of this study is that the sample may not be representative of practicing psychologists. Not all doctoral-level psychologists join APA, and doctoral level psychologists are only one group among those who provide mental health services. Moreover, because only 32% of the sample responded, there is no way to know if the responses can be generalized to describe the initial sample. It is possible that clinicians who respond to a survey describing an EST may be more sympathetic to EST dissemination than non-responders, who may have disregarded the survey given its focus. A second limitation of the present study is our use of questions about attending a specific EST workshop as a proxy for willingness to gain training in ESTs in general. Although our study indicates willingness to attend one

particular workshop, it may not be measuring practitioners' willingness to commit themselves to the amount of training, supervision, time, and monetary demands that may be required when learning a new EST.

The current study provides information on EST training desires, specifically the disorders in which clinicians are most interested. More research is needed on clinician desires for EST training and what sort of training would be relevant and applicable to their practices. More information gleaned from practitioners would encourage a productive collaboration between clinicians and researchers, and help inform effective dissemination strategies to increase the training and adoption of ESTs among clinicians already in practice.

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Investigation continued on page 10

TABLE I
Selected Disorders for EST Training by Percentage (N = 1241)

Disorder	Number of participants	Percentage of Total Responses
Post-traumatic stress disorder	219	18
Depression	176	14
Anxiety	98	8
Borderline personality disorder	87	7
Generalized anxiety disorder	84	7
Eating disorders	84	7
Bipolar disorder	82	7
Missing	77	6
Obsessive-compulsive disorder	64	5
Panic disorder	46	4
Asperger's/Autism disorders	32	3
Social phobia	27	2
Attention-deficit disorder/Attention-deficit hyperactivity disorder	22	2
Other	143	12



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TABLE 2
Chi-square results for theoretical orientation and disorder selection

	N	χ^2	p	Φ
Personality v. Mood Disorders				
Dynamic v. CBT	259	10.20	.001	-.20
Dynamic v. Eclectic	150	4.39	.04	-.17
CBT v. Eclectic	243	0.24	.63	-.03
Personality v. Anxiety Disorders				
Dynamic v. CBT	445	6.30	.01	-.12
Dynamic v. Eclectic	282	4.62	.03	-.13
CBT v. Eclectic	425	.022	.88	.007
Mood v. Anxiety Disorders				
Dynamic v. CBT	548	1.67	.20	.06
Dynamic v. Eclectic	324	.06	.81	.01
CBT v. Eclectic	548	1.02	.31	.04


Arthur M. Nezu, PhD, ABPP

Looking Back to Move Forward

Arthur M. Nezu, PhD, ABPP

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 As the incoming chair of Division 12's Committee on Diversity (CoD), I thought it to be important to provide some history about the CoD in order to place it in context and provide for a renewed starting point as we look to the future.

In 2005, under the leadership of Division 12 President Linda Sobell, the Board of Directors (BoD) approved a motion to establish a task force "to consider the issues of cultural diversity within the Division in a thoughtful, planned, and committed way." Later that same year, the BoD further approved motions to establish a *standing* committee on diversity, as well as create a voting Member-at-Large position who would

serve both on the board and as the chair of the CoD, while being elected by the Division's general membership. The first chair was Gail Wyatt who, along with her committee, provided an excellent and detailed blueprint by which to better integrate diversity within Division 12 (e.g., increase attention to culturally congruent and empirically validated treatment strategies, increase diversity in the research conducted, attract and retain new members who represent diverse populations). The next chair, Siony Austria, continued to make the trajectory of progress flow in a positive direction. All involved are to be highly commended for their successful efforts.

I am now honored to continue in this tradition and hope to fill what are "huge shoes." But, to quote a famous politician—"it takes a village." To that end, it is great that many of the same members will continue to serve on this committee. But, I am hoping for an even

Update on the Committee on Diversity continued on page 12

ANNOUNCEMENT

An invitation to join the Society for Psychotherapy Research

As current president of the Society for Psychotherapy Research (SPR), I invite you to join this international society dedicated to the advancement of scientific knowledge about psychotherapy and behavioral change, the society brings together researchers, clinicians, and students from a variety of theoretical orientations (e.g., cognitive-behavioral, humanistic, integrative/eclectic, interpersonal, psychodynamic, systemic) and professional backgrounds (e.g., psychiatry, psychology, social work). The primary mission of SPR is to foster the development and dissemination of scientifically rigorous and clinically relevant studies related to the outcome of psychological interventions, the process of change, and the characteristics of clients and therapists associated with change. For further information about the society, please visit our web site at <http://www.psychotherapyresearch.org/>

Louis Castonguay, President SRP
Fellow, Division 12




Donna Rasin-Waters, PhD—Section Editor

The APA Public Policy Advocacy Network

Donna Rasin-Waters, PhD

Division 12 Federal Advocacy Coordinator

 It is crucial for psychologists to become active in advocacy at the federal level simply because legislation that is passed by Congress affects each and every one of us. The Public Policy Advocacy Network (PPAN) of the American Psychological Association offers information to enhance understanding about current public policy initiatives that are critical to psychology. The APA Government Relations Office has a simple sign-up process that enables one to receive legislative updates and take action on major policy issues being followed by the Education, Public Interest and Science Directorates. Please join the Public Policy Advocacy Network by direct link at <http://www.apa.org/ppo/ppan/aboutppan.html> or by logging onto www.apa.org and searching for Public Policy Advocacy Network.

In addition to receiving periodic legislative alerts and news from PPAN, there is a wealth of information to assist psychologists in understanding Federal Advocacy at the PPAN site. Under the heading Capitol Hill Basics one can find a summary of how the legislative process works. Tips are also provided regard-

ing the most effective way to communicate with one's U.S. Senator and Representative. Other helpful resources are *Advancing Psychology in the Public Interest: A Psychologist's Guide to Participating in Federal Policymaking* and *Advancing Psychology Education and Training: A Psychologist's Guide to Federal Advocacy*. For those who want to become even more active and possibly visit representatives, APA can offer information and assistance to make your visit as successful as possible.

In addition to legislative updates and important news that is relevant to psychology one can also follow links to make contact with Representatives on a variety of issues important to psychology. Sample letters are available making it fast and easy to respond to your Representatives on an issue. However, please take a moment to personalize letters as it increases the effectiveness.


Collectively we all need to take part by informing Congress about psychology and how it is relevant to federal policy-making, particularly as healthcare reform moves forward. While APA advocates for psychology regularly, the most important aspect of advocacy comes down to us, the constituents. So let me encourage each and every psychologist to exercise the right and privilege as citizens to impact public policy-making related to our field. Please mark time on your busy calendar to visit the PPAN site.

—drrasinwaters@aol.com 

Update on the Committee on Diversity (continued from page 11)


larger village—you the members of Division 12. As such, I would like to take this opportunity to request: (a) any and all feedback about the committee's work; and (b) brief articles that would appear in the Diversity Column of TCP (see previous issues for examples of the type and length of articles we are seeking). If you are part of an educational, health services, or organizational setting where you were successful in achieving goals commensurate with the CoD, I would especially appreciate hearing from you in the form of a brief paper.

Finally, I also have the honor of being the incom-

ing editor of the *Journal of Consulting and Clinical Psychology*. I mention this because of my stated commitment to increase the presence in this journal of high quality articles focused on diversity, broadly defined (see December 2009 issue of the *Monitor*, p. 74). So, please join me at the start of this new decade in a renewed effort to increase and better integrate diversity within clinical psychology across multiple venues (e.g., Division 12 offerings at annual conventions of APA, increased focus on diversity with APA's and Division 12's publications). 

New column: Technology Update

Zeeshan Butt, PhD

 For the past three years, Dr. Simon Rego has written the Internet Update for TCP. In this space, he explored a number of interesting topics on the intersection of the internet with clinical psychology. As the incoming section editor, my first action will be to rechristen the column the “Technology Update” in an effort to expand its scope a bit.

My name is Zeeshan Butt, an early career psychologist and faculty member at Northwestern University. I have become increasingly interested in the ways technology may reshape the work of the clinical psychologist. Hopefully with your input, I will focus future Technology Updates on practice-related issues, clinical intervention, and clinical research. In this issue’s column, I will address the increasing use of technology in psychological testing.

Testing is a cornerstone of clinical psychology. Good tests used appropriately lead to accurate and meaningful assessments. Formal, systematic testing of patients can help identify psychological strengths and weaknesses, can serve as a useful gauge of treatment success, and/or can identify teaching moments where health promotion interventions can be implemented. So how has technology impacted testing and assessment? Allow me to paint three broad brushstrokes.

Ease of administration.

One fairly basic way that testing may benefit from technological advances is in the digitization of testing material. Whether these are items on a self-report inventory or stimuli for a cognitive test, use of such computer-assisted testing can help the test administrator focus more on the testing environment while ensuring that examinees have standardized test presentation. However, some computerized tests are simply computerized versions of existing tests, and so the end-user must evaluate whether there is any value added to the new mode of administration, which may come at a higher cost.

Ease of scoring.

Most computerized tests now go beyond simple digital test presentation and also have provisions to record and score examinee responses in the testing platform itself. This has the obvious advantages of significantly reducing human error in recording answers and the conversion of raw to more interpretable scores. This is a win-win for the examiner and the examinee. However, with this ease of data processing and storage come higher-tech concerns regarding data safeguards. (Future columns may address issues related to standards of data storage/encryption, testing data in electronic medical records, and the like.)

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ANNOUNCEMENT

Mental health services after natural disaster trauma

Division 12 Members with interest in providing mental health services after natural disaster trauma might consider joining the **Disaster Relief and Response Special Interest Group** of Division 56, the Trauma division. This SIG provides a forum for discussions on best practice and dissemination of research in the area of post natural disaster trauma. If interested, please contact Angeleque Akin-Little at drsakinlittle@netzero.net.



New paradigms.

Perhaps the most exciting technological advances in psychological testing have less to do with burnishing the old gold and more to do with making new paradigms of testing a reality. Let's briefly consider three new paradigms:

Measurement. Unlike classical test theory, *item response theory* (IRT) estimates measurement properties of individual items and provides an estimate of precision for all levels of the assessed concept. While classical test theory describes scores against group-specific norms, IRT models the probability of a particular item response to the examinee's underlying symptom, or trait, level. In most traditional testing situations, examinees are given fixed-length tests that may contain questions that are inappropriate for the sample being tested (i.e. they endorse none or all of the symptoms). Because IRT models estimate examinee symptom or trait levels based on the pattern of responses to items, and not simply the sum score, it becomes possible to estimate the examinee's level using any set of items from a calibrated "bank" of self-report or performance-based items. In turn, this approach lends itself to the development and application of computerized adaptive tests (CAT). In a CAT an examinee is presented items based on their responses to the previous item based on a computerized algorithm. At each item administration, the algorithm estimates the examinee's symptom or trait level and an associated standard error. CAT-administered assessments may allow for briefer assessments, more efficient assessments, and assessment of more domains of interest compared to traditional psychological tests. Historically, while CAT assessments have not been technologically practical for real-world applications, this is quickly changing as evidenced by NIH initiatives such as the Patient Reported Outcomes Measurement Information System (*nihpromis.org*) and the Toolbox for the Assessment of Neurological and Behavioral Function (*nihtoolbox.org*).

Data collection. Other technological advances have made possible the use of *real-time assessment* via for e.g. PDAs, pagers, and text messaging. Broadly speaking, real time assessment, or ecological momentary assessment, include efforts to sample and/or monitor psychological states outside of the laboratory setting. Numerous health

organizations have recommended "routine" monitoring of symptoms and psychosocial problems to ensure overall good quality of patient care. Despite the potential benefits, this is seldom performed in clinical practice. Increasingly, we are seeing the application of information technology resources to facilitate real time assessment at home or in the clinic with minimal burden on clinicians and patients. Such assessments may provide the detailed and specific knowledge necessary to allow for early and accurate identification of symptoms to the clinical team, which may improve symptom burden and allow for better psychological care.

Interface. *Virtual reality* technology is an advanced form of human-computer interface that allows examinees to engage with a computer-generated environment in a relatively naturalistic manner by the integration of real-time computerized graphics and sensory input devices. Continuing advances in VR technology along with equipment cost reductions have led to the development of more usable, useful, and accessible VR systems that may be useful for a wide range of psychological/cognitive assessment questions. One attractive aspect of VR is that it holds promise for assessment in more ecologically-relevant (albeit virtual) settings than more traditional psychological tests. VR applications have been shown to be increasingly promising assessment tools in clinical psychology, neuropsychology, and rehabilitation.

Caveat emptor

Technological advances have certainly pushed psychological testing into new areas, allowing for applications that can ease the burden of testing for both the examinee and the psychologist. However, a technological advanced test does not necessarily equal a psychometrically desirable test. There remains a burden on developers to provide data on the reliability, validity, and clinical utility of their platforms. And likewise, clinicians and researchers will be compelled to be active consumers as they make decisions on which tests to use.

Please feel free to send me a note if you would like to see a specific topic addressed in a future column or if you have any other related thoughts you'd like to share. I can be reached most easily by e-mail at z-butt@northwestern.edu. ☞

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Evolution of the Concept of a Right to Effective Treatment

Donald K. Routh, PhD

 In recent years the leadership of the Society of Clinical Psychology has moved toward the opinion that all people have a right to effective treatment for mental health problems. This means two things: that the effectiveness of such treatments should be rigorously evaluated, and that the public should have access to such treatments. Both of these issues are pertinent to the present national debate concerning the health care system in the United States.

Lightner Witmer, who is commonly considered to be the founder of the field of clinical psychology, was interested in providing treatment for certain kinds of problems, particularly children's slow progress in school. However, Witmer did not engage in any formal evaluation of such interventions. In fact, he recommended certain treatments, for example the surgical removal of a child's adenoids, which in retrospect seem unlikely to remediate a child's academic difficulties.

During the first half of the 1900s, the field of clinical psychology focused more on assessment, particularly the use of the Binet test, than it did on intervention activities of any kind. During those years Freudian psychoanalysis emerged as the predominant type of psychotherapy, essentially swamping all other approaches. Psychoanalysts at that time, including those who were also psychologists, were not known for their interest in formal evaluation of their treatment efforts. The curative value of psychoanalysis was assumed on the basis of observations that people with neurotic problems who sought such treatment were then observed to improve.

In 1952, Hans Eysenck published a paper that proved to be a bombshell. Using data from insurance companies, he argued that people with mental health problems tended to recover from them just about as well whether they received psychotherapy or not. This paper suggested the need for controlled studies in which patients were randomly assigned to receive psychotherapy or to a non-treatment control group. Eysenck's suggestion that psychotherapy might not be an effective treatment was in agreement with the equivocal

outcome of the early example of a random clinical trial of psychotherapy known as the Cambridge-Somerville Youth Project, carried out in the 1930s.

Eysenck advocated a radical solution to what he saw as the ineffectiveness of psychotherapy. He suggested that psychologists ignore Freud and develop their own treatment approaches. Indeed, this is what happened, leading to the development of what became known as behavioral and cognitive therapies. In the era following World War II, particularly beginning in the 1960s, several varieties of therapy based on psychological research and theory developed. Their advocates, including Joseph Wolpe, Aaron T. Beck, and B. F. Skinner, all encouraged their followers to engage in rigorous evaluation of such treatments.

In 1993, the Society of Clinical Psychology officially took cognizance of the growing emphasis on controlled research on mental health interventions. In that year it sponsored a task force, chaired by Dianne Chambless, on "empirically validated" or "empirically supported" interventions and began to publish lists of treatments that met rigorous evaluative criteria.

The concept of a right to effective treatment is important not only to psychology but also to medicine and other fields, and its significance is not just for the United States but the whole world. A landmark in this domain is the 1972 book by Scottish physician and epidemiologist Archie Cochrane, *Effectiveness and Efficiency: Random Reflections on Health Services*, making the case for random trials in evaluating a wide variety of medical and social interventions. Cochrane had been a medical officer in the British army during World War II. As a prisoner of war, he long had to serve as the only physician for soldiers of many nationalities under extreme conditions. He once had to deal with a diphtheria epidemic among the prisoners, with no resources for treating it. To his surprise, about the only deaths that occurred were due to gunshot wounds caused by some of the German guards. In other words (as Eysenck tried to tell his fellow psychologists), human beings have amazing powers of recovery from illness. Cochrane's first personal experience with what was in effect a random controlled trial came in his use of yeast supplements (obtained with his own funds via the black market) to treat half of a group of starving prisoners with

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edema (swelling of the legs above the knee). The yeast was thus proved to be an effective treatment. After the war, Cochrane was especially impressed by the random trials done by Bradford Hill establishing the efficacy of streptomycin for tuberculosis.

Cochrane came to believe not only that all treatments should be proved to be effective but that all effective treatments should be free to patients. He was thus a wholehearted supporter of the post-war development of the National Health Service in Britain. Cochrane was also a fierce critic of treatment bias. At one point he had helped arrange a clinical trial of the effectiveness of special cardiac units in hospitals as compared to home treatment of patients with heart attacks. In early report of the results, he led a group of cardiologists (who were committed to the idea of the special hospital units) to believe that the trial favored such care. They argued that it would be unethical not to stop the research immediately. He then told them the actual results (which favored home treatment) and

chided them for not advocating equally strenuously for the immediate discontinuation of the use of the cardiac units.

After Cochran's death, a further innovation was the development of what is now called the "Cochrane Collaboration" (www.cochrane.org), an international enterprise with units not only in Britain but also in France, Italy, Brazil, and other countries. These units carry out systematic "meta-analyses" and keep track of random trials underway all over the world. They are thus in a position to advise clinicians concerning the most effective treatments for patients in any diagnostic category (including those with mental health diagnoses). The Cochrane units can also provide similar advice to various national health services as to what treatments they should support financially. As psychologists who wish to be reimbursed for their services, we should therefore pay careful attention to the conclusions within this new domain of "evidence-based" medicine. ■■

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,


P.O. Box 1082, Niwot, CO 80544-1082

Tel: 303-652-3126 / Fax: 303-652-2723

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Can I Keep a Secret?

Jeffrey N. Younggren, PhD

 The rights to privacy and the confidentiality are believed by many to be the two most valued ethical principles in mental health care both of which find their roots in moral principles relevant to medicine. In their pure form, these concepts insure that patients can secure care without fear of losing control of where that information goes (confidentiality) or losing control of the right to control access to that information (privacy) (Beauchamp & Childress, 2008). However, while many hold the central tenants of these concepts to be sacred to effective healthcare, as with all philosophical concepts, in their pure form they can collide with other, and arguably equally valuable, moral principles. As a consequence, exceptions exist throughout ethics codes (APA, 2002) and the law where the application of these concepts is compromised because professional bodies, courts and/or elected officials have placed a higher value on the competing principles like the welfare of society or beneficence obligations to others. What is key here is that psychologists must be familiar not only with the essence of how to apply the principles of privacy and confidentiality, but also with their exceptions.

Privacy rights are frequently waived when an individual engages in behaviors that are inconsistent with an expectation of privacy. Under these circumstances information can usually be shared with others. Examples of these types of exceptions to privacy rights include when a patient places their mental health at issue in a legal proceeding, fails to pay the psychologist's bill or chooses to sue their psychologist for damages. In these examples the subsequent conduct that was not a part of the original agreement, or conduct that is inconsistent with the tenants of that agreement, changes the rights to privacy. However, as with all things, this does not necessarily mean that the person's right to privacy is completely null and void. It may not be and it could allow access to information that is circumspect and limited. Consequently, great care must be exercised by those who are placed in a circumstance where they might violate a patient's rights to privacy because they believe that their patient has behaved inappropriately.

Confidentiality concepts have also been modified by both ethics and the law. Many of the codes of ethics of various health care professions have explicit in them exceptions that allow for sharing of information under unusual circumstances where confidentiality collides with other moral principles. In addition, across the United States laws have been enacted or rulings have been made that have limited confidentiality rights. For example, child abuse reporting and duty to protect laws have clearly modified confidentiality by stating that the rights of children and others to exist in a safe environment, free from harm by others, supersedes the right to confidentiality. So serious is this right to safety that a psychologist who fails to fulfill these obligations may face civil or, in the case of child abuse, criminal action. Some states have further modified confidentiality by requiring that professionals report colleagues to the state licensing board who have behaved unprofessionally. In so doing, these states have placed a patient's right to privacy below that of the society's right to access competent healthcare professionals.

Psychologists may also confront conflicts between laws and ethical principles when the law compels the disclosure of something that the psychologist believes was not intended to be disclosed. The best example of this would be when information was shared with a psychologist by a patient prior to that patient's demise. While the intention of the deceased may have been that the information should never be shared with anyone, the death of that individual usually transfers the authority to consent to another individual. However, while this might be consistent with the law, it might not be consistent with the psychologist's sense of ethics or beliefs about how the intention of the deceased should still be honored. In these types of circumstances the legally correct answer and the morally correct answer could be in clear conflict with each other.

Finally, confidentiality and privacy rules can become very complex when working with minors. While there is little question that minors have some confidentiality rights the limits of those rights can become quite murky when psychologists are dealing with parent's requests for information about their minor child. Generally parents are thought to have the right to access the treatment information on their

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children secondary to parental rights. However, exceptions, once again, do exist to this. First, some states have decided that confidential disclosure does occur when the issues being addressed in the treatment of the minor deal with alcoholism, drugs, pregnancy and/or sexual trauma. Consequently, in these states, parents would not necessarily be able to access their child's information because privacy laws prevent this. In addition, parent's rights to information are impacted directly by the purpose of the request for that information. Consistent with HIPAA (U. S. Department of Health and Human Services, 2006) and case law (Harder v. Anderson, Arnold, Dickey, Jensen, Bullickson, and Sanger, LLP and Pini, 2009), parents can be denied access to a child's records if they are not operating in the best interests of the minor child.

Psychologists would be well advised to be aware and cautious when there is a conflict between the law and ethics. While these ethical principles are generally believed to be clear, directive and sacrosanct, there are many exceptions to them that could truly put the individual psychologist into professional jeopardy. In

truth, the answer to the title question, "Can I keep a secret?" is "Usually." Given the lack of certitude in this answer, it would be wise to consult with a knowledgeable colleague or an experienced attorney when one is confronted with questions about privacy and confidentiality.

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ANNOUNCEMENT

Graduate Student Scholarships To Be Offered for Teaching the Psychology of Men Continuing Education Program at the APA San Diego Convention

Teaching the Psychology of Men will be a Continuing Education Program during the APA Convention in San Diego. Seven scholarships will be awarded to graduate students who want to attend the workshop free of charge. Issues related to the psychology of men and masculinity are increasingly identified as important areas in psychology and therefore how to teach courses in this new area has become important and timely.

The purpose of this introductory workshop will be to assist psychologists in developing course work on the psychology

of men using the theoretical and empirical literature on men and masculinity. Participants will learn basic knowledge on how to create a psychology of men course or how to infuse this content into existing courses on gender or the psychology of women.


The teaching faculty for the workshop include: James M. O'Neil, Ph.D, University of Connecticut; Christopher Kilmartin, Ph.D, Mary Washington University; Michael Addis, Ph.D, Clark University; and Mark Kiselica, Ph.D. The College of New Jersey.

Information about the graduate student scholarships, how to apply, criteria for selection, and the deadline date can be obtained by emailing Jim O'Neil, Chair, Committee on Teaching the Psychology of Men, Society for the Psychological Study of Men and Masculinity (SPSMM), Division 51 of APA, at: jimoneil1@aol.com.

Registration For APA Continuing Education Programs Begins May 1, 2010: Call 1-800-374-2721, ext. 5991
Online Registration at apa.org/ce

Section II: Society of Clinical Geropsychology

Brian D. Carpenter, PhD

 In the Section's continuing efforts to advance education, Amy Fiske from the Mentoring Committee and Jennifer Zimmerman chaired a symposium at the November meeting of the Gerontological Society of America entitled, "Mentoring Across the Geropsychology Career: Perspectives from the Experts." The session was designed to provide information for both mentors and mentees, tackling mentoring at various levels of training. Presenters included Bob Knight, who spoke on doctoral-level training, Michele Karel, who shared her experience in internship and postdoc training, Peter Lichtenberg, who discussed mentoring junior faculty, and Keith Whitfield, who provided a perspective on diversity in the mentoring relationship.

The Section's John Santos Geropsychology Respecialization Program consulting service has been gaining momentum this year. The program maintains a list of practicing geropsychologists who are willing to provide consultation to licensed psychologists who wish to master the 13 competency areas of clinical geropsychology that were identified in the Older Boulder Conference. The list is available on our website and also distributed by the Counsel of Clinical Geropsychology Training Programs. Currently the list is 18 professionals in 10 states (and Canada!). If you're interested in adding your name to the list, contact Jon Rose, Jonathon.Rose@VA.Gov or 650-493-5000 x64334.


If you're looking for resources related to the intersection of diversity and geropsychology, take a look at the new report on *Multicultural Competency in Geropsychology*, available at <http://www.apa.org/pi/multicultural-competency-geropsychology.pdf>. The report, compiled by Deb DiGilio and other members of the APA Committee on Aging, features recommendations for geropsychology practice, research, training and public policy, and it includes a comprehensive list of print and web-based resources.

At the November business meeting of the Council of Professional Geropsychology Training Programs (CoPGTP), Bob Knight reported that CoPGTP has applied to join the Council of Chairs of Training Councils, which would provide a voice for geropsy-

chology training in this group guiding education. In addition, he reported that recognition of geropsychology as a specialty was inching ahead. CoPGTP has its own excellent website rich with resources, including many documents regarding geropsychology competencies: <http://www.uccs.edu/~cpgtp/>

Section III: Society for a Science of Clinical Psychology

David F. Tolin, PhD, ABPP

 Thomas Ollendick is the new President of SSCP; the 2010 elections brought us President-Elect Varda Shoham, Secretary/Treasurer David Smith, At-Large Representative Bethany Teachman, and Student Representative Rebecca Brock.

SSCP is requesting nominations for its Distinguished Scientist Award. Past awardees have included such luminaries as William Iacono, Susan Mineka, Richard McFall, Richard McNally, Lyn Abramson, Steven Hollon, Marsha Linehan, Alan Marlatt, Alan Kazdin, Thomas Borkovec, Peter Lewinsohn, Edna Foa, David Barlow, Martin Seligman, Stanley Rachman, Hans Strupp, Walter Mischel, Gordon Paul, Paul Meehl, and Albert Bandura.

We are also now accepting applications for SSCP Dissertation Grant Awards. Awards will be in the amount of \$500 and it is anticipated that up to 5 grants will be funded. Eligibility requirements and application instructions can be found at www.SSCPweb.org. Applications must be received by November 17, 2009 and notification of awards will be made in January 2010.

Our 2009 student representatives Ashley Pietrefesa and Frank Farach have designed a website for SSCP's student members. A link to the website, www.sscpstudents.org, is on the homepage of SSCP's main website (www.SSCPweb.org) for easy access. The website contains student-related news, research awards and grant postings, links to professional development websites and online research tools, descriptions of current SSCP student projects, and SSCP membership information.

Since 1974, SSCP has published an Internship Directory for students. Going beyond the APPIC directory, the SSCP Directory contains information about an internship site's research expectations and oppor-

tunities, availability of funds for research, publications by interns that result from research involvement during the training year, research facilities/technology, and training in empirically supported interventions, and more. The new edition of the Directory was edited by Lea Dougherty, Greg Kolden, and Rebecca Brock, and is available at www.sscpstudents.org.

The Executive Board of SSCP recently issued a resolution regarding psychologists' involvement in torture practices. The resolution, as well as a background information paper, were published in *The Scientist-Practitioner* and can be viewed on our web site (www.SSCPweb.org).

Section IX: Assessment

Norman Abeles, PhD




Is assessment in the public interest? Many practitioners see assessment as part of their practice and do not really think about the public interest implications. One of my colleagues informed me of the recent Supreme Court hearing in the case of Holly Wood versus Allen. Mr Holly Wood had killed his girlfriend and had been convicted of killing her and was then sentenced to death. On appeal to the Supreme Court Wood's attorney argued that the sentencing jury was not informed of Wood's mental deficiency nor was there mention of his IQ which was between 59 and 64. In a prior decision by the US supreme Court in the case of Atkins versus Virginia, the Supreme Court ruled that the death sentence should not be applied to individuals who are considered mentally retarded because this violated the 8th amendment of the US constitution and constituted cruel and unusual punishment. In the case of Holly Wood, the report on his mental status indicated that he could discern right from wrong. Counsel argued that the issue was not so much whether Wood could discern right from wrong and could assist in his own defense but whether or not the jury should have been made aware of his mental status and low intellectual functioning in the sentencing phase of the decision. Parenthetically, the US Supreme Court recently ruled that a defendant in a death sentence case was entitled to a new sentencing hearing because the jury was not made aware of the individual's limited ability to read, had brain abnormalities and suffered as a child from physical abuse and had heroic military service (Porter v McCullum). In the Wood case a major issue was whether or not his mental state was withheld

from the jury accidentally or whether this was a strategic decision by his counsel.

This is not the place for me to discuss these issues in detail but I will do so at a later date. This topic clearly suggests the impact of assessment on our legal system and appears to be clearly in the public interest.

In other Section IX issues, elections are under way for president-elect and membership chair. Candidates for President are Yossef S. Ben-Poreth, PhD, and Mark A. Blais, PsyD. Membership chair candidates are Sharon Jenkins, PhD, Lisa Rapport, PhD, and Dustin Wygant, PhD.

The theme of the 2010 symposium at APA will be the integration of different types of assessment data.

In other news I have been informed that the American Board of Assessment Psychology has begun an online Journal and welcomes submissions according to the Editor, Alan Raphael, PhD. Contact the website at www.assessmentpsychologyboard.org or araphael@assessmentpsychologyboard.org. 

JOIN A DIVISION 12 SECTION

Division 12 has seven sections covering specific areas of interest.

- Clinical Geropsychology (Section 2)
- Society for a Science of Clinical Psychology (Section 3)
- Clinical Psychology of Women (Section 4)
- Clinical Psychology of Ethnic Minorities (Section 6)
- Section for Clinical Emergencies and Crises (Section 7)
- Section of the Association of Medical School Psychologists (Section 8)
- Section on Assessment (Section 9)
- Graduate Students and Early Career Psychologists (Section 10)

To learn more, visit Division 12's Section web page:

www.div12.org/division-12-sections

DIVISION 12 CANDIDATE STATEMENTS

Candidates for President:

J. Gayle Beck
David A. Wolfe

Candidates for Secretary:

Barbara A. Cubic
John C. Linton

Candidates for Council Representative (2 positions):

Larry E. Beutler
Janet R. Matthews
Helen D. Pratt
Lynn P. Rehm
Irving B. Weiner



Candidate statement for President: J. Gayle Beck

Clinical psychology is a diverse field; diverse with respect to the types of activities that are involved, the content area, and the ways that each of us defines our approach to the field. This diversity at times threatens to divide our field, particularly at points when we fail to understand or appreciate each others' activities and perspectives. If elected as President of Division 12, my goal will be to continue with efforts designed to bridge the gap between various perspectives of clinical psychology. Connecting with previous presidential initiatives, I would like to form a working committee that considers how to enhance doctoral training in empirically-grounded forms of therapy. Recognizing that our scientific foundation is what separates clinical psychology from some other areas of mental health intervention, this committee will focus on ways to infuse empirical training together with clinical wisdom into psychotherapy training, irrespective of theoretical orientation. Although each graduate program has its unique approach to training and curriculum, I would like to develop a series of guidelines to support training in clinically sophisticated empirically-grounded interventions, with children, adolescents, adults, and seniors, including training on the integration of empirical data within case conceptualization, selection of interventions based on this grounded formulation, and education in evaluating the impact of therapy as a form of feedback to the therapist.

During my career, I have primarily worked within university settings and have focused on strengthening doctoral education using the scientist-practitioner model. For over 20 years, I have run a clinic intended to provide free or low-cost services to help-seeking adults, in exchange for their research participation. I have also maintained a private practice during much of my career in order to keep alive my clinical skills, to strengthen my contribution to the local community and to stay current in my training and supervision of doctoral students. I obtained my doctoral training at SUNY-Albany; following internship at Rutgers/Robert Wood Johnson Medical School, I accepted a faculty post at the University of Houston, where I worked from 1984 to 1993. I joined the clinical faculty at SUNY-Buffalo and remained there until 2008, when I accepted the Lillian and Morrie Moss Chair of Excellence at the University of Memphis. Throughout my career, I have published research on the psychopathology of adult anxiety disorders and on effective interventions, taught core clinical courses on psychotherapy and research methods, assisted in re-vamping graduate training curricula, supervised practicum, consulted with various external organizations, served as a reviewer for federal and private grants, served as Associate Chair of a Psychology Department, and served in a variety of leadership positions for the Association of Behavioral and Cognitive Therapies, Division 38 (Health Psychology) and Division 12. I would love to focus my energies and know-how for the Division's visions and goals and I ask for your support.



Candidate statement for President: David A. Wolfe

It is a pleasure to be considered for the position of President of Division 12. I chose to run for this position because I thoroughly enjoy working with my colleagues on the many issues facing our Division and the profession. I trained in clinical/community psychology at the University of South Florida and have been in academic research and part-time clinical practice for 30 years (my practice relates to child abuse and neglect, and includes all age groups). I served for five years in the capacity of elected Councilor to an international organization



(International Society for Prevention of Child Abuse and Neglect), and I am a Past President of Division 37. I am aware of the nature and importance of the workload of this task. I also have past administrative experience as Director of Clinical Training, and I am currently a Professor at the University of Toronto and Director of the Centre for Prevention Science. Since 2007 I have been Editor-in-Chief of *Child Abuse & Neglect*.

I wish to serve as President to advance the profile of Division 12 and its ten sections throughout APA. The size of Division 12 is both a strength and a challenge, and I wish to examine more closely how we can increase communication and coordination among the sections. I would also like to establish a bridge between scientists and practitioners, and reach out to early career psychologists to increase their interest and commitment with APA and Division 12. Other issues facing our Division stem from the need to work more closely with other related APA divisions that share our goals and membership, and to review and modify training and internship requirements and opportunities.



Candidate statement for Secretary: Barbara A. Cubic

I am enthusiastically running for Division 12 Secretary. My APA service includes: Continuing Education Committee (2 yrs); Council of Chairs of Training Council (3 yrs); and Division 12 Program Chair/Co-Chair for the 2008-2012 APA Conventions. For Section 8 (Association of Psychologists in Academic Health Centers), I am President-Elect and Editor of the *Journal of Clinical Psychology in Medical Settings* and was Secretary, Track Leader for the 3rd National conference and Continuing Education Coordinator for the 3rd and 4th National conferences.

I recognize psychologists in different settings and at different stages of career development join Division 12 for different reasons. I have been a faculty member at the Eastern Virginia Medical School since 1992 and serve as Co-Director for the Psychology Internship, Director of Student Mental Health, Director of Continuing Education and Director of the Center for Cognitive Therapy. I teach undergraduate medical students, psychiatry and family medicine residents, and clinical psychology graduate students and interns. I have provided multiple national presentations on

educational competencies, integrated care and eating disorders. I have obtained three HRSA GPE grants to train psychologists in integrated care and two grants for child psychology workforce development from Virginia.

I have a keen interest in evidence-based clinical intervention, am committed to training our next generation of psychologists, and have a scholarly track-record in professional issues. I am a founding fellow and Certified Cognitive Therapist by the Academy of Cognitive Therapy. I have numerous publications, including providing the instructor's resources and manuals for *Current Psychotherapies* (5th through 9th editions), often the first book used to introduce undergraduate students to psychotherapy.

I am a decisive thinker, goal directed, and skilled at collaboration. I can bring new perspectives to Division 12 and will ponder leadership decisions carefully. I would be proud to serve as Division 12 Secretary.



Candidate statement for Secretary: John C. Linton

I'm currently Professor and Vice Chair of the Department of Behavioral Medicine and Psychiatry at the West Virginia University School of Medicine in Charleston. I received my doctorate in clinical psychology at Kent State University, and have been a scientist practitioner since, having run training programs, treated patients and conducted research throughout my career. A recent scholarly work was the *Handbook of Obesity Intervention for the Lifespan* (Springer) with Larry James.

My introduction to organized psychology was through Division 12, first serving on the board as director of the Post Doctoral Institutes for five years, and Fellows Committee chair for seven, then doing the usual tour of duty at APA, serving on Council several times, as well as the Ethics Committee, CRSPPP, CAPP and Public Information. I helped to found Division 38, served as editor of *The Health Psychologist* for 15 years, and most recently completed a two-year term as president of the Association of Psychologists in Academic Health Centers, which is a section of Division 12,

I'm board certified through ABPP in Clinical and Clinical Health Psychology, and serve on the ABPP Board of Trustees. I received the Heiser Award for Advocacy in Psychology a number of years ago, am a Fellow of

APA through Division 12 and a number of other divisions, and was honored this year to receive the Lifetime Achievement Award from the National Register.

I share your dedication and fidelity to Clinical Psychology, and if given the choice, would do it all again the same way. After many years away, returning to the board of the Society of Clinical Psychology as your secretary is a privilege I would gratefully embrace.



Candidate statement for Council Representative: Larry E. Beutler

Larry E. Beutler, Ph.D. is the Wm McInnes, Distinguished Professor and former Chair of the PhD Programs at Palo Alto University's Pacific Graduate School of Psychology. He is formally the Director of Training and Professor of the Counseling/Clinical/School Psychology Program at the University of California in Santa Barbara. He is a Consulting Professor of Psychiatry and Behavioral Sciences at Stanford University School of Medicine and Professor Emeritus at the University of California, and has been a practicing clinician since 1972. Dr. Beutler is the past Editor of the *Journal of Clinical Psychology* and the *Journal of Consulting and Clinical Psychology*. He is a fellow of the American Psychological Association and the American Psychological Society. He is the Past-President of the Society for Clinical Psychology (Division 12 of APA), a Past President of the Division of Psychotherapy (APA), and a two-term Past-President of the (International) Society for Psychotherapy Research. He has been a member of council for three terms since 1976 and was a candidate for President of APA in 2002-2003. He is the author of approximately 400 scientific papers and chapters, and is the author, editor or co-author of twenty-two books on psychotherapy, psychopathology, depression, and drug abuse.



Candidate statement for Council Representative: Janet R. Matthews

Janet R. Matthews, Ph.D., ABPP, is Professor of Psychology, Loyola University New Orleans and a Fellow of Division 12. I am honored to be nominated for one of our representatives to APA's Council. I have a long history of Division 12 service starting over 25 years ago with the original

Section 2 (continuing professional development) where I was secretary-treasurer. I have served as president of both Section IV and Section IX and as Secretary of the Division. At various times I have served on the Division's Finance Committee, Fellows Committee, and Nominations and Elections Committee, as well as being one of our representatives to the APA Council. I also have a long history of service to APA through various boards and committees. I am currently serving in my final year on APA's Board of Educational Affairs where I am chair. I believe my broad background within the division gives me a good picture of our membership and its interests while my background of APA service has taught me about the Council process and procedures so I will be ready to represent the Division if elected to this position. Given the breadth of our membership, it is important to have representatives who can look at APA policy issues from many different perspectives before voting on them. It is also important that our delegation to the APA Council be able to work well with each other and share their concepts on issues relevant to our Division. I have been described by colleagues in psychology governance as someone who works well with others. At this crucial time in APA's development, I would like to be able to speak in this forum for Division 12 and would therefore appreciate your vote.



Candidate statement for Council Representative: Helen D. Pratt

My name is Helen D. Pratt, Ph.D. I am a graduate of Western Michigan University (WMU) in Kalamazoo, MI. and a licensed psychologist. I currently serve as the Director of Behavioral and Developmental Pediatrics in the Pediatrics Program at Michigan State University/Kalamazoo Center for Medical studies, Kalamazoo, MI. I hold two academic appointments: professor of Pediatrics and Human Development at Michigan State University (Kalamazoo Campus) and adjunct professor of psychology at WMU. Although I have never served at the Division level, I have been a dedicated and member of Section 6 Clinical Psychology of Ethnic Minorities since 1998, serving as secretary; president (elect, president, immediate past), treasurer. I also am a member of Section 4 Clinical Psychology of Women and have served as secretary and newsletter editor. I currently

Division 12 Candidate Statements (continued)

serve as Treasurer of Section VI and Newsletter Editor for Section IV. My activity level in Divisions 25 and 45 has been minimal (reviewing articles, attending presentations and workshops) but I remain a member to support their missions. I am asking for your vote and the honor to serve as a Council Representative.



Candidate statement for Council Representative: Lynn P. Rehm

I am pleased to be running for Council Representative for Division 12. Council is the policy making body of APA and the Division needs to be well represented from a strong scientist-practitioner perspective. The Division is in a position to balance the needs of science and practice, as well as education and public interest. Division 12 is a microcosm of all of the interests of APA and as such should play a central role in guiding the association for the benefit of all. Council is a place where the extreme voices are often the loudest, and thus there is a need for representatives who can see both sides of issues and move Council forward in rational directions. We are in precarious financial times, and yet we are also in a period of important national opportunities for psychology. We must be well represented in health care reform, and our science must be recognized in expanding national science initiatives.

I believe that I can represent the Division and APA well. I have experience on Council, within APA, within the Division, and in the discipline of psychology broadly. I am a past President of the Division and served on Council. I have been president of the Society for the Science of Clinical Psychology, chair of Council of University Directors of Clinical Psychology, Chair of Board of Educational Affairs, President of the

International Society of Clinical Psychology, and I am currently President of the Clinical and Community Division of the International Association of Applied Psychology. I am an academic who has been on NIMH research review groups and a clinician and educator who has been the Director of two Clinical Psychology graduate programs. I have been a practicum supervisor and had a small private practice for most of the last 35 years.



Candidate statement for Council Representative: Irving B. Weiner

I value the opportunity I have had to serve on the Division 12 Board of Trustees from 2002-2005 as Section IX (Assessment Psychology) representative and from 2006-2009 as president-elect, president, and past president. I remain firmly committed as I was then to promoting and maintaining the Society of Clinical Psychology as an enjoyable and rewarding professional home for all clinical psychologists, whatever their theoretical persuasion, special areas of interest, or preferred work setting. I also continue to embrace the Society's mission of integrating science and practice in clinical psychology. My practitioner bent is evidenced in the books and chapters I have published on methods of psychodiagnosis and psychotherapy, and my scientific commitment is demonstrated by my lifelong career as a university faculty member and my writings on assessment research methods, as well as by my current presidency of APA Division 5 (Evaluation, Measurement, and Statistics). I am eager to resume working on behalf of Division 12 as a member of our board and also, drawing on my experience, to provide strong representation of our interests and concerns in the APA Council of Representatives. ♣

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:

Winter issue: January 3
Spring issue: April 1
Summer Issue: July 1
Fall issue: October 1

Editor:

Milton Strauss
milton.strauss@gmail.com

Award Winners for 2010

The Society for Clinical Psychology is pleased to announce the following recipients of Division 12 awards:

SENIOR AWARDS

Award For Distinguished Scientific Contributions To Clinical Psychology:

Steven D. Hollon and Linda C. Sobell

Florence Halpern Award For Distinguished Professional Contributions In Clinical Psychology:

Irving B. Weiner

Stanley Sue Award For Distinguished Contributions To Diversity In Clinical Psychology:

Armand R. Cerbone

Toy Caldwell-Colbert Award For Distinguished Educator In Clinical Psychology:

Jessica Henderson Daniel

MID CAREER AWARD

American Psychological Foundation Theodore Millon Award:

Brent W. Roberts

EARLY CAREER AWARDS

Theodore Blau Early Career Award For Distinguished Professional Contributions To Clinical Psychology:

E. David Klonsky

David Shakow Early Career Award For Distinguished Scientific Contributions To Clinical Psychology:

Bunmi O. Olatunji

Samuel M. Turner Early Career Award For Distinguished Contributions To Diversity In Clinical Psychology:

Cortney Warren

GRADUATE STUDENT AWARDS

Practice:

Winslow Gerrish

Seattle Pacific University, Seattle, Washington

Service:

Emily Engle

Long Island University, CW Post Campus

Research:

Rebecca Kathryn McHugh

Boston University. 



To see a list of past award winners,
visit www.div12.org/awards

Abbreviated Minutes: Society of Clinical Psychology January 2010

Motion: To approve the September, 2009 minutes.
Passed.

Motion: The Society must maintain a minimum of \$330,000 in reserves. By an affirmative vote of the Board in any given year a maximum of 5% of the projected operating expense can be taken from the reserves in that year.
Passed.

Motion: To allow the investment subcommittee, with the approval of the Executive Committee, to invest up to 10% of the Fidelity savings in a more moderately aggressive program.
Passed.

Motion: To increase division dues by \$2 for cost of living for 2011.
Passed.

Motion: Board approves, in principle, a two-for-one rate of membership, pending the approval of the membership committee.
Unanimous.

Motion: The Board immediately approve \$1000 from the 2009 budget to pay for COR representative's past travel.
Unanimous.

Motion: Put \$400 for membership in Council of Specialties in the 2010 budget.
Passed.

Motion: To approve the 2010 ballot.
Passed.

Motion: To approve the student award winners selected by the 2010 Awards Committee.
Passed.

Motion: The Society of Clinical Psychology (APA

Division 12) reaffirms its conviction that all APA-accredited clinical psychology programs should post on their websites specific data about their program outcomes for the past five years as a matter of academic integrity as well as an APA accreditation requirement. The Society is particularly concerned about some programs failing to post the percentage of their students securing APA- or APPIC-accredited internships. Compliance with the existing policy should be routinely monitored by CoA, and program infractions should result in appropriate actions. The Society looks forward to a response from CoA on this matter.

Motion: That the Task Force on the Public Perception of Psychologists be sunsetted.
Passed.

Motion: To advise Dr. Marks the Society endorses the the Common Language Project and allow the Div 12 logo to be used.
Failed.

Motion: That the D12 ECP Summer Fellowship be created.
Passed.

Motion: A position statement of the Society of Clinical Psychology (Division 12 of the American Psychological Association).

The Society of Clinical Psychology is firmly committed to identifying and promulgating treatments that work. Indeed, the Society was among the first organizations in mental health to compile a list of empirically supported treatments on the basis of supportive results from randomized clinical trials (RCTs). As scientific knowledge and research designs mature, and as researcher-practitioner collaborations increase, we have reached a point where it is desirable and feasible to extend the research methods used and the constructs investigated. A multiplicity of sophisticated research strategies, including but not limited to RCTs, now allows us to improve the effectiveness of psychological treatments.

To advance this broad view, the Society of Clinical

Abbreviated Minutes continued on page 27



OFFICERS (Executive Committee)

President (2010) Marvin R. Goldfried, Ph.D.*
President-elect (2010) Danny Wedding, Ph.D.*
Past President (2010) John C. Norcross, Ph.D., ABPP*
Secretary (2008-2010)
Treasurer (2009-2011) M. David Rudd, Ph.D.*

COUNCIL OF REPRESENTATIVES

Representative (1/08-12/10) Larry Beutler, Ph.D.*
Representative (1/08-12/10) Lynn P. Rehm, Ph.D.*
Representative (1/09-12/11) Richard M. Suinn, Ph.D.*
Representative (1/10-12/12) Deborah King, Ph.D.*

EDITORS (*Members of the Board without vote*)

The Clinical Psychologist - Milton Strauss, Editor and
Guerda Nicolas, Associate Editor
Clinical Psychology: Science and Practice - (2004-10) Philip
Kendall, Ph.D. ABPP
Web Editor - (2009-2011) Sammy Banawan, Ph.D.

SECTION REPRESENTATIVES TO THE DIVISION 12 BOARD

Section 2: Society of Clinical Geropsychology (10-12)
Brian Carpenter, Ph.D.*
Section 3: Society for a Science of Clinical Psych. (09-11)
David Tolin, Ph.D.*
Section 4: Clinical Psychology of Women (08-10) Lynn
H. Collins, Ph.D.*
Section 6: Clinical Psychology of Ethnic Minorities (10-
12) Guillermo Bernal, Ph.D.*
Section 7: Emergencies and Crises (10-12) Marc

Hillbrand, Ph.D.*

Section 8: Assoc. of Psychologists in Academic Health
Centers (10-12) Barry Hong, Ph.D., ABPP*
Section 9: Assessment Psychology (08-10) Norman
Abeles, Ph.D., ABPP *
Section 10: Graduate Students and Early Career
Psychologists (08-10) Brian Hall*

MEMBER AT LARGE

Arthur M. Nezu, Ph.D.* (10-12)

* = Voting Members of Board

DIVISION 12 CENTRAL OFFICE

Lynn G. Peterson, Administrative Officer
(not Board member)
PO Box 1082, Niwot, CO 80544. 303/652-3126.
303/652-2723 (fax) div12apa@comcast.net 📠

To learn more about
the Society of Clinical
Psychology, visit our
web page:
www.div12.org

Abbreviated Minutes (*continued from page 26*)

Psychology defines the mechanisms of psychotherapy as those factors, processes, and interventions that are designed to effect and maintain beneficial changes in client/patient functioning. These change mechanisms include treatment methods, participant characteristics, the quality of their interactions (relationships), the context and culture in which the interventions occur, and other contributors yet to be discovered. This inclusive and evidence-based definition is designed to ensure that: 1) research on psychotherapy and the designation of empirically supported therapies consider treatment

methods as well as the participants, their relationship, and contextual factors; 2) a wide variety of research methods are used as appropriate to the questions asked; and 3) research increases our understanding both of the cross-cutting/common and unique principles on which effective treatments rest and enhance the optimal use of participants, interactional, cultural, and technical factors in effecting change.

Motion: That the deficit budget of \$8000 be passed.
Passed. 📠



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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 sixth edition of the Publication Manual of the American Psychological Association (2010). An electronic copy of a submission in Word format should be sent as an attachment to e-mail. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries and submissions may be made to the editor at milton.strauss@gmail.com.

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.