

THE CLINICAL PSYCHOLOGIST



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

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PRESIDENT'S COLUMN

In Defense of Science and Controlled Clinical Trials.

Marsha M. Linehan, Ph.D., ABPP



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

Dear readers, consider the following quotations:

“A depressed patient can respond to psychotherapy or psychoanalysis if he [sic] is still reaching out for objects....If the patient is not reaching out for objects, his [sic] depression can only be treated with E.C.T. and perhaps drugs.” (*Wilner, 1966*).

“Turning to leucotomy [brain operation to sever the connections between the frontal lobe and underlying structures],...one can at least guarantee a relief of tension and obsessional rumination with very little of the general personality deterioration that used to happen with the old full operation.” (*Sargent, 1967*).

“...an operation [for obsessive-compulsive disorder] which in recent years has received much adverse publicity can...turn life ... from one of misery and anxiety into a much happier and fuller one” (*Carpenter, 1967*).

“The rate of improvement for the untreated [phobic] adult subjects is no different from the two studies of treated phobics....” (*Agras, Chapin, & Oliveau, 1972*).

“The prognosis [for obsessive-compulsive disorder] is generally regarded as not good.” (*Templer, 1972*).

As they say, “We have come a long way, baby!”

Several years ago, I was consulting at a case conference for a large group of psychologists and psychiatrists at a major teaching hospital in the United States. A 50 year old patient was presented who had had severe obsessive-compulsive disorder for all of her adult life. The story of the woman was tragic as OCD had made her life miserable. I asked my audience how many knew the exposure/response prevention treatment for OCD developed by Edna Foa and others—a treatment with very good evidence of effectiveness. Very few, perhaps four or five of over 50 people raised their hands. No evidence-based treatment had ever been applied. I have never forgotten that woman. Because of inadequate treatment, most of her life had been filled with misery. Her life can not be started over. Her past could not be repaired. Her excruciating suffering might have been alleviated if only someone treating her had known an evidence-based treatment. What if I had been this woman? That to me is the critical question. I know that I would have wanted someone to at least try a treatment with evidence of efficacy.

At another presentation several years ago, again at a large and very well known teaching hospital, I chatted on an elevator ride with a psychiatrist I had just met. He was in his fifties and had taken a sabbatical to obtain training in new treatments for serious and debilitating mental disorders. I asked him why. He was very well known. He had a large and lucrative private

(continued on page 2)

clinical practice. His reputation was impeccable. He told me that he had realized that there were new treatments more effective than the treatments he had learned and was currently providing. His commitment to effectiveness was greater than his commitment to his previous training. I have never forgotten that man. He had the courage to evaluate his own approach to treatment, to read the literature, to critically evaluate his own work, to buck his peer group who disparaged evidence-based treatments, and he changed. What if I had been this man? If I were asked to

throw out a lifetime of my own work because some other therapy was more effective, could I do it? I can only hope that I would emulate the man I met on the elevator.

One of the main reasons I ran for President of Division 12 was because of my ardent belief that the alleviation of mental and behavioral disorders requires the application of the scientific enterprise. Psychologists are uniquely trained to conduct the science and to apply the science that is needed to help those who suffer from severe disorders. I believe however, that we have undersold our-

selves as purveyors of effective mental health treatments and we have been undersold by others in the public arena.

I propose the following points for your consideration. These premises come from a professional lifetime both in the "ivory tower" but also consistently as a therapist treating highly suicidal and/or extremely dysfunctional individuals with complex multiple mental disorders. They also flow from the frustration I have experienced trying to "sell" psychological treatments, particularly for severe and/or life-threatening disorders, in multi-disciplinary settings. They come from teaching hundreds of workshops to mental health professionals, rarely filled with psychologists in the audience, who so often want me to tell them what to do but not how to think about or evaluate the science of what to do.

1. **Psychosocial (i.e., behavioral as opposed to biological) treatments developed primarily by psychologists have demonstrated impressive efficacy in treating a variety of mental disorders.** We now have exceptionally effective psychosocial treatments for a number of disorders: our own Division 12 not only developed a well thought-out set of criteria for determining which treatments could be considered efficacious, but then found that even with very rigorous criteria a large number of psychosocial treatments have been developed for depression, anxiety disorders and stress, drug and alcohol abuse, eating disorders, health related problems, marital distress, borderline personality disorder, schizophrenia and other severe mental disorders, and sexual dysfunction as well as a number of other disorders. Across many disorders, psychosocial interventions are as effective as and at times more effective than the best biological treatments. This is an amazing accomplishment for a field where there is little if any financial incentive for developing innovative and efficacious non-biological interventions.

2. **Psychologists by their broad training in both scientific methodology as well as normal and abnormal psychology are uniquely capable of advancing both the application of psychosocial treatments that already exist as well as developing and evaluating new more effective treatments.** The development of new treatments requires at a minimum a deep understanding of the prin-

ciples of the behaviors that one is trying to change. (I am using the word behavior here to refer to anything that moves, i.e., as in the behavior of the sun, the behavior of cells, the behavior of the mind, etc. Thus, emotions, cognition, biological responses, actions, etc., are all included under the rubric of behavior.) It is no accident that many, if not most, of the evidence-based psychosocial treatments have been developed by psychologists. Consider autism. Consider anxiety disorders. Consider borderline personality disorder. Consider drug addiction. Consider many more.

As treatment developers we have much to offer. Why? Unique to the mental health disciplines, psychologists are required to learn the scientific bases of both normal and abnormal behavior. Psychotherapy is a process of social influence; social psychology is the science of social influence. Psychotherapy is a process of change via new experiencing; the science of learning is the science of change due to experience. Psychotherapy is a relationship mediated by language. Ultimately, therefore, it is mediated by cognitive processing, a scientific field of its own. All behavior is biological; human biology is behavior. Psychotherapy changes biology. Neuropsychology is one of our fastest grown disciplines.

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3. The value of psychosocial treatments is seriously underestimated by both the public and by other health care professionals. It is stunning that, in spite of demonstrated efficacy of psychosocial treatments, medications for mental disorders are consistently both available and demanded by the public even when more effective psychosocial treatments are available. Why? Watch TV. Although I applaud advertisements that make real the suffering of depression and anxiety disorders, where is the public to get information that psychosocial treatments are as effective as biological treatments? Look at the recent data on the possible iatrogenic effects of anti-depressants for suicidal depressed adolescents. Where is the information that psychosocial treatments for depression are as effective without the side-effects of increased suicidality? Many more examples could be given.

4. **Controlled clinical trials, including randomized clinical trials and controlled single-subject designs of psychosocial interventions are our strongest calling card in getting in and staying in the top tier of recommended treatments for mental disorders.** We have to face it. To be in the market place we have to present data that is compelling to relevant stake holders. At the moment, randomized clinical trials are the currency that counts. No matter what we say or think, we will not get our treatments into the marketplace without data from clinical trials. I know that many psychologists do not agree that this should be necessary. But, whether we agree or not, convincing federal and state legislator and insurance companies to pay for our treatments requires evidence from clinical trials. We may be held to a higher standard than many treatments for non-mental disorders. We are not, however, held to a higher standard than biological treatments for mental disorders.

As noted by Lisa Onken, Chief of the Behavioral Treatment Development Branch at the National Institute on Drug Abuse, "The impact of psychosocial treatment, or psychotherapy, upon the lives of human beings who are suffering, cannot be underestimated. Science holds the key to developing the best psychosocial treatments." (Onken, 2002)

5. **Our ability to disseminate efficacious psychosocial treatments to the public will be**

seriously hampered, and perhaps already is, if we as a scientific profession do not speak with a united voice regarding the value of our own research enterprise. Think of the OCD woman I described above. Think of the severely disorder individuals you may have treated. If your child was depressed and threatening suicide would you want a non-evidence based treatment tried first? Obviously, if the evidence-based treatment does not work or for some other reason is inappropriate, one would want a therapist to switch to something else. But, that is not the question. The question is, what would you want tried first: a treatment with evidence that it works (and does not harm) or one applied by an experienced clinician but without any data that it works? What would you want your therapist to know: treatments that fit his or her theoretical orientation or treatments with scientific data that they work? That is our central question. I do not think we can make it in the market place of stake holder opinion if we remain as fractionated as we currently are with respect to the value of rigorous and controlled clinical trials.

It is 2007. Our starting place in advancing effective mental health care has moved ahead considerably from where we were in 1966-1972. □

I welcome your thoughts and comments. Please respond (linehan@brtc.psych.washington.edu)!

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The Open Access Movement

Simon A. Rego, PsyD

What is the "open access" movement? According to Peter Suber, a policy strategist for open access to scientific and scholarly research literature, the open access movement involves "the worldwide effort to provide free online access to scientific and scholarly research literature, especially peer-reviewed journal articles and their preprints." Surprised? While I am sure that for some of you this may be big news, in actuality, this movement can be traced back to the dawn of the Internet. Along the way, several stories related to this movement have made the news. For example, Google announced on December 14, 2004 that it planned to digitize and index millions of public-domain and copyrighted books (<http://books.google.com>), and Microsoft announced on December

"in actuality, this movement can be traced back to the dawn of the Internet."

6, 2006 that it had released a beta version of "Live Search Books" — an online search engine that searches a digital archive of books that includes collections from the British Library,

the University of California, and the University of Toronto (<http://books.live.com>). These mass digitization projects are being coordinated by a group calling themselves the Open Content Alliance (OCA; <http://www.opencontentalliance.org>). The OCA "represents the collaborative efforts of a group of cultural, technology, nonprofit, and governmental organizations from around the world that will help build a permanent archive of multilingual digitized text and multimedia content" and is currently making them available through the Internet Archive (<http://www.archive.org>).

It is in this spirit that I asked Dan Fishman, Professor of Clinical Psychology at the Graduate School of Applied and Professional Psychology of Rutgers University, to discuss the open access journal that he recently helped to develop and edits: *Pragmatic Case Studies in Psychotherapy* (PCSP; <http://pcsp.libraries.rutgers.edu>). Take it away, Dan.

"PCSP is an online, peer-reviewed journal of both case studies and articles on case method and its rationale. PCSP is freely available, is multi-theoretical,

and has a large, distinguished editorial board of over 65 individuals. To date it has published case studies involving: multimodal therapy; manualized exposure therapy for three American troops in Iraq with early symptoms of PTSD in reaction to experiences with IEDs; the balancing of supportive and insight-oriented, psychodynamic therapy; manualized, group, cognitive therapy for social phobia; and experientially-oriented hypnotherapy for fears of dying. Also case method articles have been published on employing an integrated set of normed measures to statistically assess the outcome of any particular case, and on the epistemological legitimacy of case study knowledge.

The online nature of PCSP offers three unique advantages for a journal about therapy case studies. First, unlike print journals that have arbitrary page limits, an online journal has virtually unlimited space. For each case study, this allows for publishing a full description of the rich, qualitative details of the case, together with commentaries by experts and comments by readers. Second, although there are clearly limitations in the capacity to generalize from a single case study, the collection of many such cases allows, via cross-case analysis, inductive generalizations to other, similar settings. This can happen by organizing case studies with similar presenting problems and intervention approaches into databases, akin to legal databases used by lawyers and judges. Since the larger the number of cases, the more powerful the capacity for generalization, the virtually unlimited space of an online journal is crucial for a case study journal/database like PCSP. Third, cross-case analysis is greatly facilitated by full-text searchability. This is only possible with a journal in electronic format, which is intrinsic to an online journal.

In addition, there are two general advantages that PCSP has like any online journal. The availability of non-proprietary, journal-publishing software and the relatively low cost of data storage allows for an online journal to be disseminated without any subscription cost, greatly increasing the accessibility and potential readership of its articles; and in an online journal, an article can be published and disseminated at the click of a button, substantially decreasing lags in publication time. Readers are encouraged to learn more about the PCSP journal by visiting the web site and to consider the submission of a case study manuscript." □

Show Me the Money!: Early Career Salary Setting

Katherine L. Muller, Psy.D.

Nothing, it seems, strikes fear in the heart of a psychology intern like negotiating a “reasonable starting salary” with a potential employer. At least this seemed to be the case last year when all four of my site’s psychology interns were looking for their first “out-of-internship” positions. They didn’t flinch when faced with the prospect of a giving a job talk, didn’t even bat an eye at relocating to another state for their first job. But the thought of being alone in a room with the “money person” to “talk numbers”—sheer terror! I don’t blame them. I remember the same feeling of fear and the worry that I might “overshoot” or

**“...don’t neglect
the ‘extras’ many
positions may offer.”**

early careerists, anecdotes from seasoned psychology vets, online tools, and my own two cents worth—to create a primer on early career salary issues.

Getting Started

A recent online survey reported that the median U.S. salary for a clinical psychologist with less than one year of experience was \$45,000 in 2006. Useful information? Well, maybe. But most of us will have to get much more specific in our research to arrive at a figure that fits our prospects. Experienced psychologists I spoke with echoed the need for geographic and setting-specific (medical center, university, private practice) guidelines to help you identify a salary range. Ideally, you should try to find out what others in similar positions at the same or similar sites are making. Be sure to account for years of experience when considering these numbers.

Many online resources can also assist you in the salary guideline search. A great place to start is the American Psychological Association’s Center for Psychology Workforce Analysis and Research (<http://research.apa.org/>). This site provides links to

a number of APA salary surveys in a variety of professional settings and by geographic region. One experienced psychologist recommended knowing this information “chapter and verse” when coming to the negotiating table.

Other online resources for job-related concerns and salary information abound. A few that may be helpful are:

- www.salary.com — a site that provides salary information for many different professions, including psychology
- www.monster.com — a popular job site with a great section on salary setting and negotiating tips
- perform a search for “cost of living calculator”—these tools, found on many financial and real estate websites, convert a salary amount into a comparable salary in a different location and report on cost of living differences among locales

Extra, Extra!

While salary is the often the most important area of compensation in a first job, don’t neglect the “extras” many positions may offer. Benefits such as funds for relocating, retirement fund matching, and conference reimbursement should be considered in the big financial picture. Some sites offer extras like tuition reimbursement, travel expenses, and credit union privileges (including fee-free bank accounts, low interest credit cards, and breaks on mortgage terms) that could mean monetary savings for you in the long run. These also may be areas that are more “negotiation-friendly” than salaries. My current employer offers a no-fee pharmacy benefit. This may not sound like such a great perk at first blush, but when I did the math on my family’s prescription co-pays and out of pocket costs, it was a striking annual savings. A recent trainee in our program was moving from New York to Philadelphia

Early Career (cont.)

for his first post-internship job. I suggested that he ask for reimbursement of the cost of his move. He asked and they immediately agreed—this reimbursement had a value of \$1000.00.

Cents and Sensibility

Don’t fall into one of the common traps of salary setting. Here are a few to avoid:

**“Don’t be afraid
to ask for what
you want.”**

• **Not Negotiating:** An established psychologist shared that she was “so desperate to get a job that I worried that if I negotiated I would lose out on opportunities”. Employers expect some level of negotiation when they offer you a position. Give them what they expect. Don’t be afraid to ask for what you want. The worst they can say is “no”.

• **The Contrast Effect:** Another veteran clinician and researcher noted that his first salary offer “felt like a giant step forward” when he compared it to what he was making as an intern. Remember that internship and

fellowship salaries tend to be low. Don’t let the “contrast effect” fool you into accepting the first salary amount offered just because it is more than your current salary.

- **Under-selling Yourself:** All of the psychologists who responded to my call for anecdotes cautioned against underestimating your worth and not playing up your strengths. As one psychologist so eloquently put it, “I should have realized that the people interviewing me actually wanted ME for the job”. Another urged new psychologists to “go in as if you have something valuable and marketable to sell, because it’s likely you do or you wouldn’t be interviewing”.

Many thanks to the psychologists who provided their words of wisdom for this column including Marty Franklin, Deborah Roth Ledley, and Simon Rego. Now, go forth and get paid, new psychologist! □

Drop me a line to share your experiences with salary negotiation: kmuller@montefiore.org.

Congratulations to Distinguished Student Award Winners!

D12 Members, I am pleased to announce the winners of Division 12’s Distinguished Student Awards:

Distinguished Service Award
Brian J. Hall, Kent State University

Distinguished Practice Award
Julia D. Buckner, Florida State University

Distinguished Research Award (co-recipient)
Martin Sellbom, Kent State University


Distinguished Research Award (co-recipient)
Amit Bernstein, University of Vermont

Recipients of the Student Awards will receive a ceremonial plaque, a \$200 honorarium contributed jointly by Division 12 and the *Journal of Clinical Psychology*, and a complimentary two year subscriptions to the *Journal of Clinical Psychology* and the *Journal of Clinical Psychology: In Session*.

Awards will be presented at the Division 12 Awards Ceremony at the Annual Meeting in San Francisco, California in August, 2007.

The Division of Clinical Psychology, 1965-1975

Donald K. Routh, PhD

 Clinical psychology in this era reflected national trends related to health research, civil rights, behavior therapy, and private clinical practice. The hiring of clinical psychologists by medical schools was fueled in part by the emergence of a golden era of research funding by the National Institutes

“Albee...believed that some of the most important roots of mental health problems are racism and poverty.”

of Health (NIH) from 1955-1968, led by its Director, physician James A. Shannon, supported by Senator Lister Hill and Representative John Fogarty. At least for a time, the federal government seemed to be willing to support practically any research project approved by peer review that might in some way contribute to the health of the nation, and the NIH budget expanded geometrically. Many clinical psychologists, trained

under the scientist-practitioner model, were able to qualify for such research grants or were employed by others who did. The president of the Division of Clinical Psychology in 1965-1966 was Ivan N. Mensh, the chief psychologist at UCLA, one of the largest health science centers in the country and a major recipient of NIH funding, then and now. Mensh once told the author that there were about 1,000 psychologists affiliated with the UCLA medical school either directly or as adjunct staff.

During the late 1960s Division 12 members such as Logan Wright (University of Oklahoma Health Sciences Center) and William Schofield (University of Minnesota Health Sciences Center) called attention to the increasing numbers of psychologists working in such medical school settings with physicians other than psychiatrists. Their efforts contributed to the development of new specialty areas such as pediatric psychology and health psychology in subsequent years. In 1968 the new Society of Pediatric Psychology was formed and became attached to Division 12's Section on Clinical Child Psychology.

A second national trend was the civil rights movement, which began with the impetus of the 1954 *Brown v. Board of Education* decision of the U.S.

Supreme Court and led to the Civil Rights Act of 1964 and the Voting Rights Act of 1965 passed by Congress under the administration of Lyndon B. Johnson. The president of the Division of Clinical Psychology in 1966-1967 was George Albee. Albee's previous studies of mental health manpower had convinced him that there were never going to be enough therapists to treat all the mental health problems in the population. Therefore, he became a lifelong champion of the alternative solution of developing strategies for the prevention of such problems. Albee's approach dovetailed with the civil rights movement and the emphasis of LBJ's "war on poverty" because he believed that some of the most important roots of mental health problems are racism and poverty. The president of Division 12 who followed Albee, in 1966-1967, was Florence Halpern. A practitioner and social activist, Halpern at age 68 journeyed from her home in New York to Mound Bayou, Mississippi, to set up

“More and more states had passed laws licensing psychologists for independent practice...”

services for poor black people during the 1960s. Division 12's next president, J. McV. Hunt (University of Illinois), who served in 1968-1969, was also very much in sympathy with both the civil rights movement and the "war on poverty." He had written a book influenced by Piaget's work emphasizing the importance of young children's experiences in fostering their intellectual development. Hunt's writings thus supported the development of the national Head Start movement, one of the most lasting innovations of the LBJ era.

The 1960s were also a time of several new developments in approaches to psychological treatment. In 1966, a new Division 12 section was formed that was ultimately called the Society for a Science of Clinical Psychology. It grew out of an influential conference on behavior modification held in Charlottesville, Virginia in 1962 and the publication of the first behavior therapy journal, *Behaviour Research and Therapy* by S. J. Rachman in 1963. Alan O. Ross, who

served as president of Division 12 in 1969-1970, has previously been mentioned in this History Column as the founder of the Division's Section on Clinical Child Psychology. During the time between his founding of this Section and his presidency of the Division, Ross had undergone a change in his views from a traditional psychodynamic approach to a behavioral one. Thus, he served as one of the first of many Divisional presidents who advocated behavior therapy and who took the position that all therapeutic methods should undergo rigorous empirical evaluation. (A subsequent Division president, Hans H. Strupp (1974-1975) certainly agreed with the need for rigorous evaluation of interventions but supported a more traditional, Freudian view of therapy.)

By the 1960s, many clinical psychologists were moving from academic positions into direct practice of their profession. More and more states had passed laws licensing psychologists for independent practice, and many state psychological associations clamored to get their practitioner members eligible for coverage by health insurance plans. Theodore H. Blau, who was Division 12 president in 1973-1974, was one of the first private practitioners to lead the Division (most of its previous officers had been academics). The interest in psychotherapy among psychologists was sufficiently strong that Section 2 (Psychologists Interested in the Advancement of Psychotherapy) outgrew section status and left Division 12 to form a Division of Psychotherapy (Division 29) in 1967, attracting thousands of members of its own.

As stated in a previous column, the Division 12 newsletter originated in 1947. By 1956 it had grown sufficiently that for the first time it had an editor (Elizabeth B. Wolf), who was not an elected Division officer. In 1966-1967 (Volume 20), the newsletter was given its present name, *The Clinical Psychologist*, by its editor Donald K. Freedheim. At this time, the publication expanded to include brief articles in addition to archival minutes, the presidential message, and committee reports. In 1968, editor Freedheim combined the newsletter with what became the APA journal *Professional Psychology*, which later became an independent publication not associated with the Division. □

The Association of Psychologists in Academic Health Centers is presenting its 3rd Conference: Psychologists in Academic Health Centers: Traditions and Innovations in Education, Science and Practice.

This stimulating meeting will be May 3-5, 2007 at the Radisson Hotel at the University of Minnesota in Minneapolis. The conference is designed to explore a broad range of topics of interest to psychologists affiliated with AHCs, including: clinical innovations, best practices; cutting-edge research; educational trends; opportunities and problems in the health-care system; emerging ethical challenges, and administrative, funding, faculty, and leadership issues in academic healthcare.

The meeting is likely to appeal to psychologists involved in clinical work, education, research, and administration throughout multiple departments in medical schools (e.g., Psychiatry, Pediatrics, Medicine, PM&R, Family Medicine, OB-GYN, etc.), as well as to psychologists in other AHC schools (e.g., Public Health, Nursing, Dentistry, Allied Health, Veterinary Medicine) and in affiliated teaching hospitals (e.g., VAMCs).

The conference will be informative and invigorating, with opportunities for mentoring and networking with psychologists who serve in diverse roles in health centers. Poster submissions are invited to showcase research in AHCs. An optional site visitor training workshop will be conducted by the Committee on Accreditation of the American Psychological Association at no cost for interested psychologists on May 3 before the conference begins.

We hope that you will consider attending this exciting conference. Further information and registration materials for the conference are available at: <http://www.apa.org/divisions/div12/sections/section8/index.htm>

William N. Robiner, Ph.D. ABPP
Richard J. Seime, Ph.D. ABPP
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Providing Clinical Mental Health Care to Puerto Rican Children and Families: Lessons Learned

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MetroHealth Medical Center

Case School of Medicine, Cleveland, OH

Puerto Ricans are the second-largest Latino group in the United States (U.S. Bureau of the Census, 2001). While nearly two-thirds of Puerto Ricans reside in the Northeast, a growing population is emerging in the Midwest (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). For example, Cleveland is one city where a growing number of Puerto Ricans reside, comprising nearly 75% of the local Latino population (U.S. Bureau of the Census, 2001). Given my linguistic skills and clinical position at the county hospital, I have seen a large number of Puerto Rican

“...it is important to document reasons for circular migration.”

children and families. Although I have learned a number of lessons through my clinical work with Puerto Rican children and families over the last 4 years, this summary will focus on one topic—the interplay between circular migration and family dynamics.

Unlike other Latino immigrant groups, Puerto Ricans have US citizenship status and are able to move back and forth between Puerto Rico and the United States, a pattern called circular migration (Rivera-Batiz & Santiago, 1996). Documenting this circular migration in clinical practice is important because it allows the clinician to identify and assess important issues that may have affected the child and the family, including the decision to move to the United States. Those issues may highlight the need to focus on different areas in counseling.

Family dynamics are one important issue that can contribute to circular migration. In my clinical experience, families (either entire family groups or subsets) may return to Puerto Rico after moving to the United States when an important family member (such as the grandparent) in Puerto Rico becomes ill. For immigrants without US citizenship or legal resident status, this option is challenging because

returning to the US is difficult. If a family member's health status is a reason for the return to Puerto Rico, it is informative to explore the relationship of that family member with the child and the parents.

One case in particular highlights why it is important to document reasons for circular migration. Carolina (a pseudonym) was a 12 year old Puerto Rican girl residing with her biological mother. They presented in my clinic because of maternal concerns of oppositional behavior and being disrespectful to her mother. During the assessment, the mother disclosed that they returned to Puerto Rico prior to the current move to care for the maternal grandmother, who had been sick and died about 1 year ago. Further exploration revealed that for several years during Carolina's childhood, the maternal grandmother had been Carolina's primary caregiver, and that Carolina had initially resisted the first move to the US and subsequent separation from her grandmother. As a result of this information, counseling focused on three fronts: providing Carolina with developmentally appropriate coping strategies and grieving her grandmother's loss, improving the quality of the parent-child relationship, and providing the mother with behavioral strategies to help manage Carolina's disruptive behavior. Without documenting the reasons for circular migration, the impact of the maternal grandmother's death might have been overlooked, and counseling may have focused exclusively on the behavioral strategies for the mother.

Working with Puerto Rican children and families is an exciting opportunity. These lessons will hopefully provide some insight for other clinical psychologists and trainees who may encounter Puerto Rican families in their clinical work. □

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The FDA Issues Safety Label Revisions for Stimulant Medications used to Treat ADHD: An Update

Timothy J. Bruce, PhD

As reported here previously, on February 10, 2006 the Drug Safety and Risk Management Advisory Committee to the U.S. Food and Drug Administration (FDA) advised the FDA to order black box warnings on all stimulant medications used to treat Attention Deficit Hyperactivity Disorder (ADHD), describing potentially fatal cardiovascular risks associated with their use. One month later, another FDA-com-

“Stimulants use at usual doses also risks the emergence of new psychotic or manic symptoms...”

missioned committee focusing on children’s medical issues recommended clearer warnings on ADHD drug labels, but stopped short of endorsing the, most serious, “black box” type recommended by the first panel. Both committees agreed that physician and patient education regarding cardiovascular risks needed improvement.

In August 2006, the FDA approved safety labeling revisions for several stimulants used to treat ADHD. The medications required to carry the warnings are *Dexedrine* Sustained-Release Capsules and Tablets (dextroamphetamine sulfate), *Focalin* and *Focalin XR* tablets and extended-release capsules (dexmethylphenidate HCl), *Metadate CD* extended-release capsules (methylphenidate HCl), *Methylin* chewable tablets and oral solution (methylphenidate), and *Ritalin*, *Ritalin SR*, and *Ritalin LA* tablets, sustained-release tablets, and extended-release capsules (methylphenidate).

The revised label warns of the risk for sudden death in patients with preexisting structural cardiac abnormalities and other serious heart conditions who use stimulants, as well as the medications’ potential to exacerbate some preexisting psychiatric disorders. Use of these products has also been linked to risks of treatment-emergent psychiatric effects and temporary growth suppression in children.

Reports of sudden death associated with use of CNS stimulants at normal doses in children and adolescents with structural cardiac abnormalities or other serious heart conditions prompted the first warning. The label will now read, “stimulant products generally should not be used in children or adolescents with known serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, or other serious cardiac problems that may place them at increased vulnerability to the sympathomimetic effects of a stimulant drug.”

Serious cardiovascular events (e.g., sudden death, stroke, and myocardial infarction) have also been reported in adults receiving stimulant drugs at usual doses. Although a causative role for the drug remains unclear, the new warning label notes that adults are more likely than children to have serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease, or other serious heart problems, and therefore, advises that adults with such abnormalities should also “generally not be treated with stimulant drugs.”

The label advises prescribers to obtain a careful history (including family history of sudden death or ventricular arrhythmia) and physical exam to assess for the presence of cardiac disease. If findings suggest such disease, further cardiac evaluation (e.g., via electrocardiogram and echocardiogram) is indicated. In addition, prompt cardiac evaluation is advised for any patient who develops symptoms such as chest pain upon exertion, unexplained fainting, or other symptoms suggestive of cardiac disease during stimulant treatment.

The warnings regarding the exacerbation of preexisting psychiatric conditions single out the risk stimulants may pose in inducing a mixed/manic episode in patients with bipolar disorder. Screening for Bipolar Disorder is advised for patients with comorbid depressive symptoms. The screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression.

Stimulants use at usual doses also risks the emergence of new psychotic or manic symptoms including hallucinations, delusions, or mania in children and adolescents without a prior history. The label advises that, “if such symptoms occur, consideration should be given to a possible causal role

of the stimulant, and discontinuation of treatment may be appropriate.” The warning cites results of a pooled analysis of multiple short-term, placebo-controlled studies, noting that, “such symptoms occurred in about 0.1% (4 patients with events out of 3482 exposed to methylphenidate or amphetamine for several weeks at usual doses).

The FDA notes that although there is no systematic evidence that stimulants cause aggressive behavior or hostility, such symptoms are observed in children and adolescents with ADHD and have

“These data suggest that children receiving chronic stimulant therapy every day for a year experienced a temporary slowing in growth rate...”

been reported in clinical trial and postmarketing data of some medications indicated for the treatment of ADHD. Accordingly, they advise that patients should be monitored for the appearance of or

worsening of aggressive behavior or hostility during initial therapy.

The risk of growth rate suppression is based on height and weight data collected in children aged 7 to 10 years who were randomized to receive either methylphenidate or nonmedication treatment for 14 months, as well as from naturalistic subgroups of newly methylphenidate-treated and nonmedication-treated children aged 3 years or older (out to 10 or 13 years). These data suggest that children receiving

chronic stimulant therapy every day for a year experienced a temporary slowing in growth rate (a mean of 2 cm (.8 inches) less in growth height and 2.7 kg (5.9 pounds) less in weight). The warning label advises that growth rate should be monitored in children during treatment with stimulants, noting that patients who are not growing or gaining height or weight as expected may need to have their treatment interrupted.

Finally, the label warns that in the presence of seizures, the drug should be discontinued. There is some clinical evidence that stimulants may lower the convulsive threshold in patients with prior history of seizures, in patients with prior EEG abnormalities in absence of seizures, and, very rarely, in patients without a history of seizures and no prior EEG evidence of seizures.

Although they highlight the concerns expressed by both previous advisory committees, the revised labels are not the black box type suggested by the first committee. As noted in our previous report, the individual on the original committee who made the motion for black box warnings said that he did so because he believed that anything less would not “get people to pay attention.” It will be interesting to see if any corresponding changes are witnessed in prescribing patterns, diagnostic prevalence, medical utilization, and the like related to ADHD and its treatment.

For those interested in the FDA’s safety information and adverse event reporting program visit: <http://www.fda.gov/Medwatch/index.html>. □

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:
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Please read the statements below by candidates for President-Elect, Council, and Secretary. Elections for these Division 12 offices will occur this Spring. Ballots will be mailed on April 15.

President Elect

Martin M. Antony, Ph.D., ABPP

Thank you for considering my candidacy for the position of President-Elect for the Society of Clinical Psychology. I have been a member of the Division since graduate school, and have been active in the Society for some time. My recent tenure as Editor of *The Clinical Psychologist* provided me with a window into most aspects of the Division and how it runs, including its strengths and areas for growth. As a member of the Publications Committee and the Board of Directors, I had an opportunity to work closely with the leaders of the association. If I am elected, I will set as my top priority to support and further implement recent recommendations by Division 12's Task Force on Identity. These include efforts to move evidence-based practice forward, advance the missions of our various sections, attract new members and retain our long term members, and enhance partnerships with other divisions.

I'd like to share with you some information about my background. I received my Ph.D. from the State University of New York at Albany. I am currently Professor in the Department of Psychology at Ryerson University, in Toronto. Previously, I was founding director of the Clinical Psychology Residency Program, founding director of the Anxiety Treatment and Research Centre, and Psychologist-in-Chief, all at St. Joseph's Healthcare, Hamilton, Ontario. I have also held academic appointments at McMaster University and the University of Toronto. I have published 20 books and more than 100 scientific papers, chapters, and other publications, primarily in the areas of anxiety disorders, cognitive behavior therapy, and evidence-based assessment. I have also held research grants from national and international funding agencies and have sat on editorial boards for seven scientific journals. In recent years, I served on the Boards of Directors for the Society of Clinical Psychology and the Association for Behavioral and Cognitive Therapies (ABCT). I also served as program chair for meetings of ABCT and the Anxiety Disorders Association of America. I have received career awards from the Society of Clinical Psychology (including both the David Shakow Award for Early Career Contributions and the Theodore H. Blau Early Career Award for

Outstanding Contribution to Professional Clinical Psychology), the Anxiety Disorders Association of America, and the Canadian Psychological Association. I am a fellow of the Society of Clinical Psychology, the American Psychological Association, and the Canadian Psychological Association. I am also a diplomate in clinical psychology.

As someone who has worked in academic departments, hospital settings, and private practice, I believe I can represent the interests of the broad and diverse membership of our Division. I look forward to the possible opportunity to serve you as President of Division 12. □

John C. Norcross, Ph.D., ABPP

My career has been devoted to integrating research, education, and practice in clinical psychology. I am a university professor, a private practitioner, a journal editor, a psychotherapy researcher, and an experienced leader. Whether it is teaching students, treating patients, conducting research, editing the *Journal of Clinical Psychology: In Session*, or serving professional associations, my central commitment is to synthesizing science, practice, and education. This synthesis, I am convinced, is the enduring and distinctive strength of clinical psychology.

My service to the profession traverses 25 years. In APA, I have been a Council Representative, member of the Policy & Planning Board, codeveloper of the APA Psychotherapy Videotape Series, and member of the Presidential Task Force on Evidence-Based Practices in Psychology. In Division 12, I have served on the Education & Training Committee and regularly contributed to *The Clinical Psychologist*. In Division 29 (Psychotherapy), I have served as president and chaired the task force that produced Psychotherapy Relationships That Work. Internationally, I have been president of the International Society of Clinical Psychology and an enthusiastic participant at worldwide conferences.

As a researcher, I have published more than 200 articles and 15 books in psychology, including *Psychologists' Desk Reference* (with Koocher & Hill), *Handbook of Psychotherapy Integration* (with Goldfried), *Insider's Guide to Graduate Programs in Clinical &*

Counseling Psychology (with Sayette & Mayne), *Evidence-Based Practices in Mental Health* (with Beutler & Levant), and *Systems of Psychotherapy* (with Prochaska). All of this is to say that I am prepared to effectively lead the Society of Clinical Psychology. (You can access my complete CV at <http://academic.scranton.edu/faculty/norcross>).

Succinctly stated, my priorities as president of Division 12 would cluster around 4 pivotal goals:

- Inclusion. APA's Society of Clinical Psychology should be an inclusive and welcoming place for clinical psychologists of all theoretical orientations, practice settings, and demographic characteristics. Recent initiatives to embrace diversity and increase membership must be continued. Division 12 should be a natural and valued home for a remarkably diverse cadre of clinical psychologists.

- Integration. I seek to narrow the historical rift not only between research and practice but also among disparate theoretical orientations. Our periodic surveys of Division 12 members repeatedly remind us that the modal orientation is integrative and that most of us are engaged in both practice and scholarship.
- International. Division 12 should proactively enlist doctoral-level clinical psychologists from around the world and reciprocally share services and publications. Globalization is upon us; let us join with our international colleagues.
- Interpersonal. I intend to make Division 12 a more interpersonally inviting organization. I will try to mend fences within the practice and research communities.

Call for Nominations

Division 12's 2008 Distinguished Contribution Awards:

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

This award honors psychologists who have made distinguished theoretical or empirical advances in psychology leading to the understanding or amelioration of important practical problems.

Award for Distinguished Scientific Contributions to Clinical Psychology

This award honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology

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

Call for Nominations

Division 12's 2008 Awards for Early Career Contributions to Clinical Psychology

David Shakow Award for Early Career Contributions

The recipient will be a psychologist who has received the doctoral degree in 1995 or later and who has made noteworthy contributions both to the science and to the practice of Clinical psychology. Letters of nomination should include the nominee's vita and a summary of his/her contributions.

Theodore Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology

This award is being funded by PAR (Psychological Assessment Resources) and American Psychological Foundation (APF), and began in 1998. The award will be given to a Clinical Psychologist who has made an outstanding contribution to the profession of Clinical Psychology. Given the difficulty of making such contributions very early in one's career, the award will be given to a person who is within the first 10 years of receiving his or her doctorate. The winner will receive \$2000

Send nominations to

Div 12, Box 1082, Niwot, CO 80544.

Candidates Statements (cont.)

I hope to be part of an inclusive, integrative, and proactive Division 12. Toward this end, I would appreciate your support of my candidacy for president-elect.

Finally, exercise your voice and vote in the election. Even if you vote for one of the other two excellent candidates for president-elect, please participate in the APA Society of Clinical Psychology. □

Robert Woody, Ph.D., JD

Colleagues in D12, having been the D12 Treasurer and on the Board of Directors, I know that I can provide the leadership necessary to meet the many challenges facing our Division. A prerequisite for leadership in D12 is being open-minded to the fact that clinical psychology is constantly changing and requires constructive efforts focused on assuring scientific principles are applied to shaping public policy, training, and practice.

Priority should be given to aggressive recruiting of diverse, high-potential students for training that will assure competence for modern-day issues, such as developing services for the poor and disenfranchised (e.g., chronically mentally ill), empirically-based assessments and interventions, expanded practice skills (e.g., psychopharmacology), contextual factors (e.g., rural versus urban), and research to refine theories and strategies.

Due to my diverse academic training and professional experiences, I support integrating research from non-clinical areas (e.g., cognitive, developmental, social, personality psychology and the neurosciences) into clinical psychology, and recognizing the benefits that are derived from mutual support between clinical, counseling, and school psychology.

My experience both as D12 Treasurer and the Florida Representative to the APA Council of Representatives created competency for handling financial matters. Stated bluntly, our Division must cope effectively with resource acquisition and utilization,

such as by strategic efforts to gain members and offer benefits that will cost less than the dividends.

My career includes being a private practitioner in both psychology (licensed in Michigan and Florida) and law (admitted in Florida, Michigan, and Nebraska), and concurrently being a professor (e.g., at SUNY at Buffalo, University of Maryland, Ohio University, and for the last 32 years at the University of Nebraska—Omaha). Also, in Nebraska, I am a former dean for graduate studies and research. Consequently, I bring a training and research perspective to practice issues. As an attorney, I have pretty much limited my counsel to psychologists and other mental health practitioners, helping them achieve effective practice management and defend against unwarranted allegations and micromanagement by licensing boards.

As President of the Florida Psychological Association and a member for years of its Board of Directors, I have heard the dismay expressed by practitioners, and have actively sought to confront decreasing revenues, illogical managed care, and unnecessary governmental regulations, and have promoted needed legislation. My years on the APA Ethics Committee buttressed my insights into how to maintain professional ethics and standards.

My degrees include: PhD (Michigan State), ScD (Pittsburgh); and JD (Creighton). I am an ABPP (Clinical and Forensic) and ABAP Diplomate. I did a postdoctoral year in clinical psychology at Maudsley Hospital in London, and graduated from the Group Psychotherapy Training Program at the Washington School of Psychiatry. With this background, it is obvious that I have an appreciation of different theoretical perspectives (e.g., cognitive-behavioral to psychodynamic, including family systems) and embrace interdisciplinary viewpoints.

I am ready to offer our Division high energy and commitment, and will appreciate your voting for my being your D12 President-Elect. □

activities, practices, and commitments are to the application of clinical knowledge to human welfare. As a member of Council, I will work to ensure that the Division remains strong; that we increase the appeal of the Division to the clinical members of APA, and that we better represent the broad range of views and prac-

Candidates Statements (cont.)

tices that constitute clinical psychology. I will work to foster the growth and development of our sections, because I believe that it is through the sections that these goals can be largely accomplished. We should actively work to expand the diversity of sections and to increase both their visibility and their voice within the Division leadership.

My career has been a blend of science, teaching, consultation, and practice. I have been a Director of Clinical Training in two major university programs and Director of two medical school internship programs. I have written and researched widely the nature of the psychotherapy relationship, and the fit of treatment to patients. My academic work has been guided by the traditions of psychotherapy research. As President of Division 12, I co-chaired a task force that identified research-informed principles to support and guide practice. The Task Force Report, *Principles of Therapeutic Change That Work* (with Castonguay, 2006) has been acclaimed by many as a more useful and sensible way to inform and guide practice than the use of manuals and theoretical models. □

Jean Lau Chin, Ed.D., ABPP

I am pleased to run as the Division 12 representative to APA Council of Representatives. I am a licensed psychologist with an extensive career as clinician, administrator, educator, and consultant for health and mental health services. Currently, I am Professor and Dean of the Derner Institute for Advanced Psychological Studies at Adelphi University in New York and can provide a strong perspective and advocate for clinical practice from these multiple vantagepoints. My scholarship includes having published 9 books and numerous publications and talks in the areas of clinical training, psychotherapy, cultural competence, and ethnic minorities; my latest book is on women and leadership. Within APA, I am in my last year as Council Representative for Division 35 – Women, and would welcome the opportunity to continue to serve the profession. I have experience in both divisional and state leadership within APA, was president of Section VI of Division 12, currently serve on BAPPI, and was member and chair of COPPS and CEMA in the past. I have also provided leadership and advocacy outside APA and psychology within health care and substance abuse. I bring a diverse set of skills and experiences that will serve Division 12 well if elected. I am committed to the integration of practice and science, and to issues of diversity as they relate to quality clinical training, prac-

tice, and research, and hope you will place your trust in my representing the Division well. □

Barry A. Hong, Ph.D., ABPP

I would like to seek a second term as one of the Council Representatives for Division 12. Serving on the Council of Representatives has been a great honor and an immense learning experience. I naively thought that much of the values and orientation of the Division 12 (science/practice model) were shared by the entire Association. I found that not to be true. In fact, it is a struggle to preserve that orientation, though the Association is often drawn to one of these extremes. I see Division 12 as a bridge to these divergent positions.

I believe that clinical psychology is struggling to reaffirm its identity and in the process is helping the Association to preserve its own. It is a tough time for APA and all professional organizations. I believe that I have been a strong representative and I would like your vote of confidence to continue. There are important, troublesome and often controversial issues which confront the Council. I believe that Division 12 needs to bring its best efforts and best people to these tasks.

Finally, I have a wide range of clinical, professional and administrative experience to be a Council Representative. I am a Professor of Psychiatry, Internal Medicine and Clinical Psychology at Washington University. I am the Vice-Chair of Clinical Affairs in Psychiatry and Chief Psychologist for Barnes-Jewish Hospital. I have been an Associate Editor of several journals include JCCP and have been a grant recipient and reviewer for NIH, HRSA, NIAAAA, NIA and NIMH funds. I presently serve as the principal investigator at Washington University for a large living lung and kidney follow-up study from the NIH. □

Steven E. James, Ph.D.

I would very much like to work with the Division's EC to create a more welcoming atmosphere for a wider range of clinicians in APA. I believe we can grow, especially with increased numbers of younger professionals, if we can show how membership is relevant to their personal and professional goals. One of the overarching tasks of a Secretary is to help the Division to understand how those outside perceive it and to portray the Division accurately and effectively to the field. As a President Emeritus of Divisions 44 (Lesbian, Gay, and Bisexual issues) and 45 (Ethnic Minority issues), and a current Trustee of the American Psychological

Council

Larry E. Beutler, Ph.D.

As a Past-President of two APA Division (12 and 29) and as a previous member of Council, I believe that I am prepared to help the Society of Clinical Psychology advance its goals before APA. Division 12 is the voice that speaks on behalf of those whose

Candidates Statements (cont.)

Foundation (APF), I am aware of many of the most pressing concerns felt by clinical psychologists not well represented in Division 12. As a long-time educator of graduate psychologists, I am familiar with the needs of younger professionals. I would like to bring these perspectives to the position of Secretary, along with my organizational and political skills honed both within service to the APA and as an associate dean and academic department chair of several years. Thank you for your consideration. □

Deborah A. King, Ph.D.

Having served on the Division 12 Board for four years as Section II (Geropsychology) Representative, I would be honored to continue to serve the Division as Council Representative. As a member of the Division's Finance and Nominations Committees, I witnessed the challenges arising from the declining membership of APA and all of its Divisions. Our future depends on our ability to attract and retain a diversity of new members from those entering the field. We owe it to those future generations to more clearly define the 'value added' of our profession in terms of the expert ability to develop, conduct and evaluate the application of psychological interventions to a diversity of populations.

As Associate Professor of Psychiatry and Director of Psychology Training at the University of Rochester Medical Center, I have integrated evidence-based treatments into our interdisciplinary educational and clinical care models. As Director of a HRSA-funded Graduate Psychology Education Program (GPE), I developed innovative training programs to provide accessible, culturally-responsive care to underserved elders in community centers, social service agencies, and primary care centers in the Rochester area. This experience impressed upon me the importance of developing new models of integrated care delivery, as well as the urgent need for a stronger evidence base regarding the effectiveness of such care with ethnic minority populations.

If elected as Council Representative, I will continue to vigorously pursue the advancement and integration of evidence-based practice and training. Having had 15 years of experience recruiting and nurturing young professionals as Training Director of both doctoral and postdoctoral programs, I will strive to bring new members to our Division. Lastly, I will continue to work with the Education Directorate to obtain enhanced federal funding for GPE and other

programs that support the development of future generations of psychologists. □

Scott S. Meit, Psy.D., ABPP, MBA

Greetings, fellow Division members! I am so pleased and honored to be a candidate for one of our Society's seats with the APA Council of Representatives. Good fortune and good mentoring have provided me with many opportunities and experiences which may appeal to multiple constituencies within the Society for Clinical Psychology. My intention is to serve diverse interests.

I am Vice Chair in the Department of Psychiatry and Psychology at the Cleveland Clinic. My career has included time in private practice and 15+ years in academic medicine. My specialty is primary care health psychology, and, as a former Professor of Family Medicine with West Virginia University, I have experience in practice, education, and scholarship. I have produced original research publications and have contributed to such seminal references as the Textbook of Family Medicine. It also is my privilege to serve on the editorial board of one of our Society's section journals, The Journal of Clinical Psychology in Medical Settings.

I bring considerable APA governance experience, having served two terms on Council as a state representative and a term on APA's Committee on Rural Health. Further, I recently was elected to a 3-yr term on APA's Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). A Fellow of Division 12, I also am board certified (ABPP) in both Clinical and Clinical Health Psychology. As a leader in psychology and health care, I was endorsed by APA and ultimately selected for a 2003 U.S. DHHS Primary Health Care Policy Fellowship. I also recently served on the Ohio Department of Mental Health Agency Review Team, providing policy input and assisting with transition for incoming governor-psychologist Ted Strickland. Finally, since APA is a \$100M enterprise, my business training and acumen can benefit the Association as well as our Division. □

Lynn P. Rehm, Ph.D., ABPP

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 for a strong scientist-practitioner perspec-

Candidates Statements (cont.)

ive. 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. I believe that I can represent the Division well. I have experience on Council, within APA, and within the Division. I am a past President of the Division and served on Council. I am also been president of The Society for the Science of Clinical Psychology, chair of CUDCP, Chair of BEA, President of the International Society of Clinical Psychology, and 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 the Director of two Clinical Psychology graduate programs. I am also a practicum supervisor and have had a small private practice for most of the last 35 years. □

John D. Robinson, EdD, MPH, ABPP

It is with honor and great pleasure that I have the opportunity to run for the Council of Representatives for Division 12. I have a long history of membership and involvement in the Division, a Fellow of the Division, served as Membership Chair and Fellows Chair for the Division, and hold an ABPP in Clinical Psychology. I have served on several APA gover-

nance bodies including chair of the APA Membership Committee. Currently, I am Vice President of the American Board of Clinical Health Psychology, Chair of the ABPP Ethics Committee, former Vice Chair of the Board of Psychology for the District of Columbia, and former President of the American Board of Clinical Psychology. In addition, I have been involved in the education and training of clinical psychologists for over 35 years and have held numerous faculty appointments. I am currently Professor of Psychiatry and Surgery at Howard University. My extensive experience as an educator, trainer, researcher, mentor, and practitioner qualify me to serve as the division's council representative with an understanding of all of these roles. My experience in the membership area on the division and APA level makes me even more aware of the challenges arising from decreasing membership. We must attract and retain members in order to secure our future. As an ethnic minority, I am acutely aware of issues of disenfranchisement.

If elected to Council, it is my goal to continue to pursue issues of inclusion, membership recruitment and retention, and representation of all members of the Society including ethnic minorities, graduate students, early career psychologists, LGBT, and others. Member recruitment and retention are the #1 goals of APA. I would be honored to have your support. □

Secretary

Linda K. Knauss, Ph.D., ABPP

I am the current secretary of the Society of Clinical Psychology. I have been impressed with the diverse accomplishments of this organization including: a conference on training in professional geropsychology; a conference of psychologists in academic health centers; and an outstanding series of publications. Science, practice, education, and training are all important issues to the Society of Clinical Psychology. We want to be responsive to the needs and interests of a wide variety of clinical psychologists, especially new professionals and students. It is critical that research and science provide the basis for therapeutic interventions. In addition, diversity and multicultural competence need to be an integral part of not only the work, but the thinking of clinical psychologists. I am committed to high quality clinical training, increased funding for research, advocacy efforts on behalf of

psychology, and support for the objectives of the Society of Clinical Psychology.

I am the Director of Internship Training and an Associate Professor at Widener University. I received my doctorate in Clinical Psychology from Temple University, and have authored several book chapters and journal articles on ethics. I have a private practice specializing in children, adolescents and families. I hold a diplomate in Clinical Psychology and am a Fellow of the Academy of Clinical Psychology. I have held many leadership positions at the regional, state, and national levels including: APA representative from Pennsylvania; Chair of the APA Child and Adolescent Caucus; Executive Committee of the APA Caucus of State, Provincial, and Territorial Representatives; President of Section IV of Division 12, Clinical Psychology of Women; Mentoring Award Chair of Section IV; President of the Pennsylvania

Psychological Association, Pennsylvania Psychological Foundation, and Philadelphia Society of Clinical Psychologists.

I would be honored to bring my experience and enthusiasm to another term as secretary of the Society of Clinical Psychology. □

Guerda Nicolas, Ph.D

Dr. Guerda Nicolas is a licensed clinical psychologist and full time professor at Boston College in the Lynch School of Education, Department of Counseling, Developmental, and Educational Psychology. She obtained her doctoral degree in clinical psychology from Boston University. She completed her predoctoral training at Columbia University Medical Center and her postdoctoral training at the New York State Psychiatric Institute (NYSPI) in the Department of Child Psychiatry. Her current research projects are on cultural adaptation of clinical intervention for ethnic minority adolescents, with a specific focus on Haitian adolescents, spirituality in the lives of adolescents, improving academic performance of ethnic minority High School students, and social support networks of Blacks.

I have been an active member of Division 12 for over 10 years and served on the Executive Committee of Section VI-Clinical Psychology of Ethnic Minorities for close to 10 years, as Membership Chair and the Newsletter Editor. In addition to my active membership in Division 12, 17, 35, 45, 53, and the Massachusetts Psychological Association, I am also a member of the APA Committee on Early Career Psychologists, Co-Chair of the Early Career Task Force, and the Federal Advocacy Coordinator of Division 35. As an early career psychologist, I believe that I have the energy, drive, wit, and compassion to serve the Division. As a multicultural (Haitian American) and multilingual psychologist (Spanish, French, and Haitian Creole), I will work to strengthen the visibility and sustainability of the divisions' connection to the various mental health professionals and organizations national and international level. I am fully aware of the importance of overseeing the division's missions and objectives as the secretary and I will make sure that I support the highest priorities of the division. I am honored having being nominated to serve the division and I look

forward to bringing my energy and experiences in achieving the mission and vision of the division. □

Danny Wedding, Ph.D., MPH

I direct the Missouri Institute of Mental Health, a research, policy and training center associated with the University of Missouri-Columbia School of Medicine. MIMH has around 110 employees and \$6M budget. Most of my own research has been funded by NIMH, NIDA and CDC.

I was trained as a clinical psychologist at the University of Hawaii and then completed a postdoctoral year of training at the University of Mississippi Medical Center. I've taught and conducted research in medical schools my entire career except for the two years I spent working for the U. S. Congress, first as a Robert Wood Johnson Health Policy Fellow with Senator Tom Daschle, and then as an APA Science Policy Fellow working for Congressman John Conyers.

I'm currently editing an online journal: *PsycCRITIQUES: Contemporary Psychology*—APA Review of Books. I've also recently published new editions of *Current Psychotherapies*, *Case Studies in Psychotherapy*, and a medical school textbook, *Behavior and Medicine*.

I previously have worked closely with the Society of Clinical Psychology as the Section Representative from the Association of Psychologists in Academic Health Centers (APAHC); I've now like to serve in a more significant role as the Secretary for the Society.

I'm especially proud of the series of books I edit (along with Larry Beutler, Ken Freedland, Linda Sobell and David Wolfe) for the Society titled *Advances in Psychotherapy: Evidence Based Practice*. Six volumes have been published to date, and we are projecting approximately 25 more. These books generate a significant royalty stream for Division 12; they also provide an important member service by packaging the best available science in small and inexpensive volumes that can be used by our members to obtain continuing education credit. In the role of Secretary, I would be able to monitor the continuing growth and contribution of the series. □

Section II: Geropsychology

Deborah A. King, Ph.D.

We have several important updates, representing the efforts of student and full Section members alike. Student representative Caitlin Holley, President Bob Intriери and President Elect Suzanne Meeks held a focus group at the recent Gerontological Society of America meeting in San Diego to generate ideas for making the Section more 'student friendly'. Thirteen students representing six schools attended and made important recommendations such as having informal programming relevant to students at the convention, the development of a virtual library of geropsychology resources, and changes in the geropsychology listserv to include more information on job opportunities.

Section members Karyn Skultety and Antonette Zeiss published an evidence-based review of treatments for depression in older adults in primary care settings (*Health Psychology*, Vol 25(6), Nov 2006, 665-674). Two treatment models were evident: Geriatric Evaluation Management (GEM) and integrated health care. Support was found for each model, with improvement in depressive symptoms and better outcomes than usual care. The authors recommend the use of interdisciplinary teams and more implementation of psychosocial treatments shown to be effective for older adults.

The Section Mentoring Committee, led by Amy Fiske, recently completed an informal review of mentoring programs and practices to serve clinical geropsychology trainees and professionals. The Committee is currently conducting a web-based survey of division members with an interest in geropsychology. The purpose of the survey is to learn about the kinds of mentoring experiences members have had and to gather ideas for new programs and services. Results of the survey will be posted on the Section's web page.

Visit our website at <http://www.geropsych.org/> for more information on clinical geropsychology!. □

Section III: Society for a Science of Clinical Psychology

E. David Klonsky, Ph.D.

I appreciate the opportunity to update the Division on the current activities of Section III, Society for a Science of Clinical Psychology. In January 2007 Daniel

Klein took over as SSCP President, Lee Anna Clark as President-Elect, and Elizabeth Hayden as Secretary-Treasurer. Antonette Zeiss will remain on the board as Past-President. We express our deepest gratitude to Denise Sloan who is rotating off the board after five years as Secretary-Treasurer, and to Jack Blanchard who has completed his term as Past-President.

Susan Mineka was awarded the 2007 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 for 2007 to support the pre-doctoral work of talented clinical psychology doctoral students.

Beginning in 2007 we plan to utilize ProfNet, a company that connects journalists and experts. We hope the service will serve as a means of focusing media attention on the need for evidence in clinical psychology, as well as provide SSCP members an opportunity to generate attention for important research findings and clinical issues.

We are also investigating ways to work with the APA continuing education committee to ensure that CE offerings are based in good science. This project is being conducted in collaboration with the Division 12 Committee on Science and Practice.

Finally, SSCP sent an observer to the Board of Educational Affairs (BEA)/Committee for the Advancement of Professional Practice (CAPP) Task Force to Review the APA Psychopharmacology Curricula and Related Policies meeting in November 2006 in order to inform the membership about current developments in post-doctoral training for prescription privileges. Additional information about SSCP can be found at our website, SSCPWeb.org. □

Section VI: The Clinical Psychology of Ethnic Minorities

Anabel Bejarano, Ph.D.

The new year brings with it a changing of the guard for Section VI. We are now under new leadership and with it, renewed energy. The following are our elected officers for 2007: Cheryl Boyce, President; Julia Ramos Grenier, President-elect; Helen Pratt, Treasurer; A. Toy Caldwell-Colbert, Section Representative to Division 12 Board (re-elected). Cheryl Boyce appointed the following officers: Mia Smith Bynum, Membership Chair; Elizabeth MacKenzie, Program Chair for APA

convention 2007. Committee chairs for the Awards and Mentoring committees will soon be appointed by Boyce. Our own Asuncion (Siony) Miteria Austria was elected Member-at-Large for the Division 12 Board. In addition, members of Section VI were appointed to Division 12's Diversity Committee, chaired by Gail Wyatt.

President Boyce's 2007 presidential theme is "Developmental Approaches to Clinical Psychology and Practice" which will highlight diverse approaches across the lifespan to include child, school-aged, adolescent, and older populations. She will focus on the mentoring of early career psychologists as Section VI continues to lead the way in maintaining an educational pipeline for ethnically diverse psychologists and those interested in issues that impact ethnically diverse communities. In keeping with this presidential theme, programming at convention 2007 will address developmental issues in mental health disparities research and interventions, and will include several panels on mentorship experiences and opportunities for clinical scientists of color. The various panelists will provide critical information regarding professional development issues and recommendations for psychologists of color.

Section VI's membership continues to grow. This growth will be further facilitated by recent changes in the criteria for membership. In order to join this Section, it is no longer required to be a member of APA nor a member of Division 12. We welcome student members and early career psychologists, and recognize that budgets are often limited at the early stages of one's career. Therefore, we have lessened the financial burden by not requiring multiple memberships in APA or D12. There has never been a better time to become a member of Section VI.

To keep abreast of our Section's activities and to become a member, please visit our website : <http://www.apa.org/divisions/div12/sections/section6/>. □

Section IX: Assessment

Norman Abeles, Ph.D.

Our section officers under the leadership of current President David Lachar have worked on refining our mission statement. Excerpts from the mission statement note that "while the vital importance of assessment is demonstrated in such specialized areas as forensic, neuropsychological and psychoeducational applications its importance is more broadly demonstrated in contemporary clinical practice as applied

in differential diagnosis, treatment planning and the measurement of treatment effectiveness. We believe that assessment plays an important role in all areas of applied psychology. We promote quality assessment and support excellence in assessment training and supervision at the graduate, internship and postdoctoral level.

In clinical practice we support third party reimbursement at appropriate rates performed by competent practitioners as well as proper practice standards administered by state psychology Boards. We encourage well designed research on psychometric foundations as well as the practical applications of assessment methods. We encourage test authors and test publishers to pursue the highest professional standards in their effort. We believe that increasing numbers of practitioners will seek to demonstrate assessment competence by such means as the board certification offered by the American Board of Assessment Psychology (ABAP Diplomate)."

In other news, our 2007 President is Robert P. Archer; President-Elect is Radhika Krishnamurthy and our new secretary is Mary Louise Cashel. David Lachar is Past President. Steven Smith continues as Treasurer. Jessica Foley is the student member on our Board. Our new membership chair is Fred Alberts. This past year Irv Weiner served as our Membership chair and we are very pleased to hear of his election as President-Elect of Division 12.

Section IX is planning to host an early morning coffee with Division 5 at the APA Convention in San Francisco in August.

In addition we are starting to work on developing a list serve and a website. We hope to make progress on this in 2007.

Section Dues are \$15. annually for members and a \$10 (one time fee) for graduate student members. For further information please contact Steven Smith at ssmith@education.ucsb.edu For your information here are the email addresses for our officers: President, Robert P. Archer: archerrp@evms.edu; President-Elect, Radhika Krishnamurthy rkrishna@fit.edu; Past President, David Lachar: David.Lachar@uth.tmc.edu; Secretary Mary Louise Cashel: mcashel@siu.edu; Treasurer: Steven R. Smith ssmith@education.ucsb.edu; Division representative, Norman Abeles: abeles@msu.edu; Membership chair, Fred L. Alberts: fred@33606.com. □

Lata K. McGinn, Ph.D.

Remembering Trauma

Richard J. McNally. Belknap/Harvard Press. Cambridge, MA. 2004

Reviewer: Dean McKay, Ph.D., ABPP, Fordham University

Since the year 2000, there has been a dramatic increase in publications related to trauma. From 2000 to 2006, there have been over 1800 book chapters and at least 200 books, devoted in whole or part to the topic. These texts range from self-help guides to clinical manuals to scholarly treatises. It is a daunting task to stay up on the latest literature in this area. Although one could say that this is a problem facing all 'generalists', the area of trauma and its treatment holds a special place in light of the complexities one faces in providing therapy. What is central and perhaps most difficult for the practicing clinician is dealing with memory of trauma. Making matters worse, the experimental and clinical literature regarding memory for trauma is heterogeneous, with variations in how traumatic memory is defined, what constitutes a traumatic memory, and whether traumatic memories can be 'repressed'.

Treating trauma survivors requires that one possess a combination of solid clinical skills and a working knowledge of the experimental literature on memory. While clinicians might not easily challenge the veracity of a client's reported traumatic experience, there is also compelling experimental evidence to show that memories are distorted, and in some cases, outright wrong. On the other hand we know from news reports and other media that terrible things do indeed happen to people, often with long lasting effect. Finally, clinicians face the important task of validating the concerns of clients without 'inserting' memories.

Richard McNally has synthesized a diverse literature in bringing us Remembering Trauma. Recognizing that there have been a number of highly controversial issues in the trauma literature, McNally summarizes the key points and lays waste to the rumor and hearsay. For example, the controversy around repressed memories and associated 'recovered memory therapy' is described from the perspectives of both psychological theory and politics/public policy as are other issues surrounding the effects of trauma on psychological functioning. For the practitioner, some of these controversies may be less well known, but are no less important. One of these controversies rose to the level of Congressional inquiry, when the American Psychological Association was under fire for a meta-analysis that appeared in Psychological Bulletin. The results of this meta-analysis suggested that adults who had been subjected to sexual abuse as children were virtually as well adjusted as their non-abused counterparts. Another important and no less contentious issue deals with the origins of multiple personality disorder and the more recent conclusion that individuals with this disorder lack a coherent single identity rather than multiple distinct ones. McNally also shows, from the experimental literature, how easily individuals can develop memories, even of events that are highly improbable.

While this is not a treatment guide, it is an important text for clinicians who treat trauma survivors. The myths and misconceptions associated with trauma are diverse. This book shines a bright light on these misconceptions, in clear and cogent terms. I consider it essential reading to therapists who regularly treat trauma victim to aid in conceptualizing their clients from a contemporary perspective. □

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Past issues of TCP are available at <http://www.apa.org/divisions/div12/clinpj.html>

Members present: Drs. Gerald Davison, Linda Sobell, Marsha Linehan, Irving Weiner, Linda Knauss, Robert Klepac, Barry Hong, Charles Spielberger, Annette Brodsky, Deborah King, David Klonsky, Gloria Gottsegen, Toy Caldwell-Colbert, Richard McKeon, Danny Wedding, Norman Abeles, Gerald Leventhal, Kathryn Yannick, and Ms. Lynn Peterson.

INTRODUCTIONS AND ANNOUNCEMENTS

The meeting was called to order by the President, Dr. Gerald Davison at 5:05 p.m. EST. A roll call was completed to identify all of the Board members present for the conference call. There were no changes to the agenda.

Minutes – June 2006

There were no additions or corrections to the minutes.

MOTION: To approve the minutes

ACTION: Passed unanimously

2007 Meeting Year Update

The next meeting will be held in Seattle, Washington on January 27-28, 2007. The Society of Clinical Psychology will be meeting at the Deca Hotel in the University district.

President-elect Designate Report

Dr. Irving Weiner said he was pleased to be elected. He is looking forward to working with the Board and has given much thought to his role. It was suggested that he appoint a program chair as soon as possible so that person can work with Dr. Alec Miller during this year.

FINANCE

Requirement of Scheduled Budget Reports from Sections

This is a reminder to the Sections to submit their budget reports. Ms. Lynn Peterson will send a sample report to each Section. The Division must submit these reports to APA.

Budget 2007

The Division had \$52,000 less in June 2006 than in June

2005. The proposed budget for 2007 has been sent to Ms. Lynn Peterson. The Finance Committee will meet the day before the Board meeting in January and will present the 2007 budget to the Board at the January meeting. The Division lost \$8,000 to \$10,000 by canceling the PDI.

COMMITTEE REPORTS

Awards

Dr. Barry Hong was thanked for serving as the chair of the awards ceremony at the APA convention. The deadline to nominate award candidates for 2007 is October 15, 2006.

Membership

The Division is still 2,000 members behind 1997. The 2,500 people who left the Division when Divisions 53 and 54 were formed have never been replaced. There are approximately 4,300 members of Division 12. The efforts to recruit students have been successful. There are 232 new student members. It is hoped that the students will remain Division members.

Nominations and Elections

Nominations for Division officers and APA Council Representatives are due by December 8, 2006. The ballots will be in *The Clinical Psychologist*.

Program

Dr. Alec Miller is working hard on the program. He has been in touch with Dr. David Tolin, the prior Program Chair. He has also been trying to collaborate with other divisions where possible. The program is on schedule. Program hours increased to four hours for Sections in 2007. After the convention, this will be reassessed.

Publications

Clinical Psychology: Science and Practice

The transition to Blackwell is going well. The Division has not gotten paid yet for this year. There is a guarantee of \$50,000. Ms. Lynn Peterson will follow-up on this with Blackwell. In 2007, members will be able to get the journal on line.

The Clinical Psychologist

Board of Directors Minutes (cont.)

Dr. Bill Sanderson said he has received good feedback so far on his first three issues. Attempts for interactions on the President's column were disappointing. There were some responses to the first column, but none after that. Dr. Jerry Davison received some personal notes on his columns. He encouraged the people who wrote to him personally to send their comments to TCP, but they chose not to do this. Having a spontaneous exchange has not been successful. One suggestion was to arrange responses in advance, by inviting people to respond.

Hogrefe Book Series Update

The series is going well, and is on schedule. CE questions on the books will be put on line January 1, 2007. The cost for this is \$14 to \$15 per hour and it will take four to five hours per book. The cost is similar to APA.

Website

Dr. Gerald Leventhal does not have access to the website. To make changes he must go through another person. In the near future he will be given limited access.

Finance Committee

The committee will meet before the January 2007 Board meeting.

Science and Practice

This committee is partnering with Section III. They had

a joint conference call focused on continuing education. The APA CE Committee reviews sponsors, but not programs. Section III and the Science and Practice Committee could review CE for scientific offerings and give feedback to the APA CE Committee. Recognition could be offered to CE providers for scientific content. It would be similar to a seal of approval for certain CE programs with scientific content. Scholarships could be offered for students and interns for CE with scientific content.

A question was raised about whether to also consider a broader agenda for the committee. The Science and Practice Committee needs a plan similar to the format of the Diversity Plan.

OTHER BUSINESS

Reports on the agenda that were not discussed on this call should be sent to Ms. Lynn Peterson by October 31, 2006 to be sent to the Board by email.

ADJOURNMENT

The meeting was adjourned at 6:05 p.m.

Respectfully submitted,
Linda K. Knauss, Ph.D., ABPP
Secretary

Applying for Fellow Status in Division 12

Fellows Applicants:

Individuals who would like to apply to Division 12 as "new" Fellows, (those who are not yet a Fellow in any other Division) should submit their application to the Division Central Office by December 1st of any given year. Notification will be in February of the following year. Ratification of the Fellows Committee's choices, however, must be done by APA's Membership Committee when they meet in August at the Convention. The Fellow status will begin the following January 1st.

For those who are already Fellows in another Division, but who would like to apply for this status in Division 12, applications should be sent to the Division Central Office by February 15th of any given year. Notification of outcome will be in April, with ratification by APA's Membership Committee in August.

Send all application to:
Fellowship Committee Chair
Div 12 Central Office
P.O. Box 1082
Niwot, CO 80544-1082

To request applications:
Tel: 303-652-3126
Fax: 303-652-2723
email: div12apa@attbi.com

Remembering what we know we don't know as Budding Psychologists

George M. Slavich, PhD

As we know, there are known knowns; there are things we know we know. We also know there are known unknowns; that is to say we know there are some things we do not know. But there are also unknown unknowns—the ones we don't know we don't know.

—Donald Rumsfeld, 02/12/2002

As budding psychologists, we are usually aware of what we know. Contained within this body of knowledge are details regarding our area of expertise, as well as information about the clinical and research skills that we possess. These facts, as Donald Rumsfeld might say, are the “known knowns”.

The opposite of known knowns, “unknown unknowns”, are the things that we don't know we don't know. This type of information is especially abundant, but by definition unknowable, when we meet a patient

“...it would have been useful and quite appropriate for him to remember that he knew he did not know the answer.”

for the first time or when we begin a new research project. Unknown unknowns, one might say, are the things that futures are made of; they are the facts that we (hopefully) come to know as we progress with a psychotherapy patient or with our program of research.

Known knowns and unknown unknowns are fascinating, but this column is about “known unknowns”, or the things that we know we don't know. Despite its novel-sounding name, known unknowns are nothing new. In fact, it was this type of information that Nisbett and Wilson (1977) highlighted in their classic article, “Telling more than we can know: Verbal reports on mental processes”. At the heart of their thesis was the argument that people often have little insight into their own cognitive processes, and that our judgments of cause and effect are frequently based more on our *a priori* hypotheses than on true introspection into our mental machin-

ery. By virtue of their account, the authors made the previously unknown known and in doing so taught us that we generally do not know much about the cognitive processes that underlie our judgments and behaviors... even though we might think we do.

The purpose of the present article is not to recap Nisbett and Wilson (1977), but to briefly describe how remembering what we know we don't know might be useful to us as budding psychologists. Two brief stories help illustrate this point.

First is the story about the superstar fifth-year graduate student who a friend of mine once interviewed for a clinical internship position. As my friend tells the story, everything was going well for the first half of the interview. My friend tends to ask difficult questions, but as she recalls, the interviewee fielded them with ease. The interviewee even managed to cite text directly from a hospital brochure as a means of conveying his interest in the position.

The catch to this story is that the interview eventually broke down when my friend asked the interviewee to describe how his research on emotion regulation might inform the development of an empirically-supported treatment for adolescents with bulimia nervosa. At this point, the interviewee could have acknowledged that the relation between emotion regulation and bulimia would be important to investigate in the future, or something along those lines, but instead he opted to answer the question—a question for which he did not really have an answer. In this moment, it would have been useful and quite appropriate for him to remember that he knew he did not know the answer.

The second story is thematically similar to the first, but with greater potential repercussions for not remembering the known unknowns. At the center of this story was a patient suffering from a severe bout of depression. He was admitted to an inpatient hospital program where I once worked and, after a two-week stay, the treatment team was still questioning his ability to keep himself safe. The nurse, citing her personal experience with depressed patients in the past, felt that he would not attempt suicide if released, but the psychiatrist, citing personal communication with the patient, disagreed.

One thing we know we don't know is the future, and in such situations, especially those involv-

ing patients, our success as clinicians is influenced greatly by the heuristics that we employ to make decisions. So, who made the better decision? The nurse's judgment appears to be sound at first, but in this example she is likely employing the “representativeness heuristic” (Kahneman & Tversky, 1973), where the probability that a particular individual is an actively suicidal patient, for example, is estimated by comparing information from that patient with

“...situations involving known unknowns represent excellent opportunities to learn.”

the contents of a stereotype for suicidal patients. This comparison is entirely valid, but it ignores data that are likely to be more pertinent to a true probability judgment, such as the patient's personal history, including his frequency of past suicidal attempts. These latter data, of course, were unknown to the nurse because she had not directly questioned the patient.

One take-home message from these two stories is that there are many benefits to remembering what we know we don't know. Although this is especially true for budding psychologists, I think the message remains relevant throughout the profes-

sional lifespan. After all, the pressure to know does not subside over time; if anything, it grows stronger as our expertise and responsibilities increase.

The silver lining in this tale is that, when correctly identified, situations involving known unknowns represent excellent opportunities to learn. In the case of the superstar interviewee, for example, remembering the unknown could have ignited an interesting discussion from which promising research ideas regarding emotion regulation in bulimia could have arisen; and with the depressed patient, remembering the unknown could have prompted a more comprehensive assessment of the patient by the treatment team. Both of these events occurred against a backdrop of pressure to pretend to know the unknown, but in such instances, remembering what we know we don't know may be even more important. It is only after remembering these instances, after all, that we attempt to find the relevant answers. □

References

- Kahneman, D., & Tversky, A. (1973). On the psychology of prediction. *Psychological Review*, 80, 237-251.
- Nisbett, R. E., & Wilson, T. D. (1977). Telling more than we can know: Verbal reports on mental processes. *Psychological Review*, 84, 231-259.

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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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.

THE CLINICAL PSYCHOLOGIST

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