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DIVISION 12 OFFICERS

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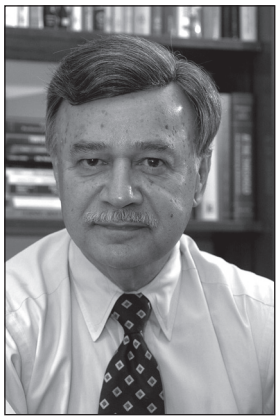
PRESIDENT'S COLUMN

Strength through Unity: A Third Blueprint for Division 12

Irving B. Weiner, Ph.D., ABPP



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

In my first column as Division 12 President, I wrote about diversity as a source of division strength—diversity that derives from making the Society of Clinical Psychology an enjoyable and rewarding professional home for all clinical psychologists, whatever their theoretical orientation, area of specialization, or work setting. In my second column, I emphasized participation as a companion source of division strength—participation that consists of the active engagement of a diverse membership in division activities and pursuits. In this the last of my columns, I want to stress unity as a third blueprint for sustaining our strength and achieving our goals.

But how, one might ask, can unity coexist with the active participation of a diverse membership? Answering this question begins with some further examination of our diversity. Troublesome diversity in clinical psychology is most often identified as a gap between science and practice that we must seek to bridge. Ever the optimist, I regard this gap as less daunting than many of our colleagues fear, and the distinction between science and practice as less discrete than many suggest. After all, scientists can and should be concerned with practical applications of what they learn from their research. Practitioners can and should function as what George Stricker has called the local clinical scientist, a psychologist who approaches clinical work with scientific attitudes toward objective observation and the formation, confirmation, and rejection of hypotheses.

On the other hand, there is more to our professional diversity than being scientists or practitioners. For many clinical psychologists neither science nor practice is the primary area of their interest and contributions to the field. Some of us identify ourselves and are most productive as educators who teach, train, supervise, write textbooks and manuals, and in other ways disseminate psychological knowledge and concentrate on preparing the next generation of clinical psychologists. Others are devoted mainly to administration and make their mark as program directors, department heads, or organization leaders.

So we do speak with many voices, particularly when we factor in diverse theoretical perspectives, differing preferences for methods of assessment and intervention, and a mix of ethnic and sociocultural backgrounds. To prosper and grow, however, we need also to speak in one voice, and I would like to identify four ways in which, by so doing, we can combine unity with the active participation of a diverse membership.

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First, whatever disagreements we may have among ourselves, we must display tolerance rather than animosity, and we must refrain from demeaning or disrespecting carefully conceived convictions and well-intended practices of our colleagues, no matter what reservations we may have about them.

Second, we can speak in one voice by endorsing evidence-based professional practice as defined by our parent organization, the American Psychological Association (APA). In so doing, we must recognize that evidence is for our purposes thrice defined: by relevant and dependable research findings, by professional expertise gleaned from cumulative clinical experience, and by adequate attention to the needs, preferences, and values of the patients and clients we serve. In this endorsement we must also recognize that assessment

and intervention are professional practices and, as such, fall within the APA guidelines for evidence-based professional practice. Accordingly, evidence-based assessment and evidence-based treatment are identified jointly by research findings, clinical expertise, and patient characteristics, and not by any one of these considerations to the exclusion or minimization of the others.

Third, we can speak with one voice by endorsing more generally the policies and procedures of our Society and those promulgated by the APA. This does not mean that we agree fully with all of these policies and procedures, nor does it preclude our recommending changes in those policies and procedures with which we take issue, nor does it restrict individual freedom to express contrary points of view. What it does mean, however, is that we work together as a Society to advance our mission and within APA to support its efforts. If we believe that some organizational change is needed, we take constructive steps to promote this change. We do not precipitously desert the organization in protest, nor do we engage in public derision of its actions.

Fourth and finally, we can speak in one voice for our Society of Clinical Psychology by taking every possible opportunity to inform our professional colleagues, our students, and the public at large of the valuable purposes we serve: discovering and disseminating knowledge about the nature of people and their personal capacities and limitations; identifying and encouraging useful applications of this knowledge; and advocating for the support of the educational and training activities, research endeavors, and practice reimbursements that maintain clinical psychology as a respected discipline and rewarding profession.

As a coda to the first two parts of my blueprint for Division 12 strength, diversity and participation, let me note in closing that those who attended our awards ceremony at the recent APA meeting in Boston were able to share with me the pleasure of seeing a microcosm of diverse engagement in action. Colleagues from all eight of our varied sections participated in presenting and receiving awards; the participants were a multicultural group of senior, mid-career, early career, and graduate student psychologists; and we all spoke in one voice in honoring the recipients for their accomplishments and contributions to clinical psychology. I encourage all of you who attend future APA meetings to put this awards ceremony on your schedule.

Simon A. Rego, PsyD—Section Editor

Is your email HIPAA compliant?

Simon A. Rego, PsyD

An ongoing debate in many circles is whether email has simplified or complicated life. No matter which side of this debate you're on, one thing appears certain: email is here to stay. In fact, as information technology continues to improve and grow, it is becoming increasingly easy to use email as a primary means of transmitting data.

While rapid improvements in information technology may be seen by many as a blessing (e.g., allowing massive files such as photographs, music files, and even movies to be sent and received), when applied to the healthcare industry, these advances in technology have created complications and increased the risk of loss, unauthorized use, and disclosure of sensitive health information (HIPAA Security Guidance, 12/28/2006).

As most of you are likely aware, in 1996 the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") established, for the first time, a set of national standards for the protection of certain health information (Office for Civil Rights Privacy Rule Summary, 2003). The U.S. Department of Health and Human Services issued the Privacy Rule in order to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Rule eventually took effect in April of 2003. What some of you may not be aware of, however, is that the HIPAA regulations are actually divided into four standards or rules: Privacy, Security, Identifiers, and Transactions and Code Sets (Privacy Data Protection Project, University of Miami School of Medicine, 2006).

The Security Rule[1] took effect in April of 2005. Unlike the Privacy Rule, which applies to protected health information (PHI) in "any form or medium," the Security Rule covers only PHI that is created, stored, transmitted, or received electronically by covered entities ("ePHI"). This would include any information that identifies an individual and relates to either: (a) the individual's past, present or future physical or mental health; (b) the provision of health care to the individual; or (c) the past, present or future payment for health care. According to HIPAA, there are 18 Identifiers that should not be included with ePHI unless you have permission. These identifiers include the individual's name, date of birth, telephone or fax numbers, email address, Social Security number, and any address information more specific than the person's state.

The Security Rule is divided into three safeguards (Administrative, Physical, and Technical), which are in turn divided into two specifications that define what a covered entity must do (Standards) and describe how it must be done (Implementation). It should be noted, however, that while some implementation specifications are required (i.e., must be implemented), others are classified as "addressable" – meaning some choices exist for how they can be handled. Of particular relevance to this column are the Technical Safeguards, as these specify the transmission security policies, procedures, and processes that must be developed and implemented to prevent unauthorized access to ePHI that is being transmitted over an electronic communications network (e.g., the Internet).

According to a HIPAA Security Guidance document (dated 12/28/2006), possible risk management strategies for data transmission include: (a) prohibiting transmission of ePHI via open networks (e.g., the Internet); (b) prohibiting the use of offsite devices or wireless access points (e.g. hotel workstations) for non-secure access to email; (c) using more secure connections for email; and (d) implementing and mandating appropriately strong encryption solutions for transmission of ePHI. Of note is the statement that "SSL should be a minimum requirement for all Internet facing systems which manage ePHI in any form, including corporate web-mail systems" (HIPAA Security Guidance, 12/28/2006).

Also of note is that all covered entities must comply with the Security Rule. Covered entities include health plans, health care clearinghouses, and health care providers who transmit any ePHI. Covered entities that do not comply with the Security Rule requirements are subject to a number of penalties – including civil penalties (e.g., $100 per violation, up to $25,000 per year for each requirement violated) and criminal penalties (e.g., from $50,000 in fines and one year in prison up to $250,000 in fines and 10 years in jail). So, if you are one of the increasing number of health care providers turning to email as a means to communicate and transmit sensitive information, I ask you: Is your email HIPAA compliant? As always, feel free to send me your suggestions or comments (dr.rego@gmail.com).

[1]For a more detailed review of the HIPAA Security Rule, go to www.cms.hhs.gov and click the link under "Regulations and Guidance" for HIPAA Educational Materials.

Katherine L. Muller, PsyD—Section Editor

Project "Runaway"

Katherine L. Muller, PsyD

I recently made a list of the writing, presenting, clinical, and administrative tasks that I am ostensibly "working on". I looked it over, rearranged it by due date, and then fought the urge to immediately run away from it all to a tropical island. I am suffering from project overload. I am overcommitted, underdelegating, and, quite honestly, overwhelmed. My desire to be productive, help others, and, hopefully, make a name for myself, has exceeded my abilities. I'd bet that I am not alone.

While preparing this column, I contacted a number of colleagues for pearls of wisdom about managing early career clinical and academic "project overload". Interestingly, I only heard back from the more established psychologists. I am guessing that for the early careerists in my sample, responding to me was yet another task on an already-too-long to-do list! The folks who did respond offered some great advice and coping strategies. These seemed to fall into two categories: action and attitude.

Action

When I was a year into my first postdoctoral job, I was invited to teach a night class at a university in the next state. It was easily a 70-mile drive each way. I was so eager to do some teaching that I immediately said yes. I spent 10 weeks going back and forth, with my boss commenting each time I left early to make the drive, and had to function the day after each class on about 4 hours sleep. One of my veteran psychologist contributors told me that early in his career he learned to, "never accept a new project until at least 24 hours pass'. As new psychologists, we may have the urge to jump at any and all opportunities, despite the impact they may have in other areas of our lives. After 24 hours, I still may have said yes, but I would be doing so after a bit more consideration. I may have also been able to challenge my automatic fearful thoughts that, "I better take this offer because I may never get the chance again".

My desire to be productive, help others, and, hopefully, make a name for myself, has exceeded my abilities. I'd bet that I am not alone.

A few of the psychologists who sent me ideas talked about the role of "collaboration" in finding balance in your project load. They advised new psychologists to create networks to share projects. For example, one psychologist described inviting other faculty members and even students to co-author book chapters and articles so she didn't have to do all of the work. Collaboration was also cited as a way to keep motivation up and be accountable for project deadlines and due dates. Essentially, a shared burden didn't feel quite so heavy.

One of the actions contributors did not recommend was running away. They noted that "avoidance and procrastination make things worse". In fact, they advocated dealing directly with overcommitment and pressure to commit to new projects. Despite departmental and/or supervisor pressure, you can still use your assertiveness skills. They recommended practicing saying "no" to some projects early in your career so you are able to have this skill as part of your repertoire for the future.

Attitude

A lot of the advice I received about coping with early career overload touched on the importance of one's attitude or "philosophy" about work projects. Comments here ranged from "realize that something has to give" and "to be successful, there must be some sacrifice in your personal life" to "now is all the time you will ever have" (a quote, interestingly enough, from a running magazine) and "view your time as a commodity of which you have a finite amount". While these specific attitudes may not be a perfect fit for you, clarifying what you value will likely guide your project management strategies. You may be willing to have less personal and leisure time early in your career. If so, be honest with yourself and consider putting it on paper, so that doubts do not creep in the next time a project is offered. Remember that you can shift your priorities

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as your career develops and your personal life changes, just be sure that you are monitoring where your priorities are at any given time to make project decision-making easier.

One of the most useful pieces of "attitude" advice I received referred to the utility of "radical acceptance" when it comes to managing projects early in your career. These strategies came from a therapist who utilizes acceptance techniques with his psychotherapy patients and began applying them to his own work. He talked about how indecision and guilt, about doing too much or too little, would tend to creep in. Instead of trying to strike an unrealistic "perfect balance", he accepted that these mixed feelings would occur along the way and tried to "live with them" rather than fighting them.

I hope that this advice serves you well in digging out from under your pile of projects—or, better yet, in preventing the pile-up to begin with. Please share any other ideas and strategies that you have by e-mailing me at: kmuller@montefiore.org. Many thanks to contributors Dr. Bill Sanderson, Dr. Alec Miller, Dr. Simon Rego, and a few others who chose to remain nameless, for the excellent suggestions.

SOCIETY OF CLINICAL PSYCHOLOGY FELLOWSHIP COMMITTEE 2008

The Society Fellowship Committee, led by Fellowship Chair Carole A. Rayburn, Ph.D., has approved the following individuals for Fellowship status, effective January 1, 2009:

Initial Fellows:

Thomas E. Brown, Ph.D. • Michael Butz, Ph.D. • Kenneth L. Lichstein, Ph.D. • Karen Schmaling, Ph.D.

We have received word that APA Membership Committee has approved these individuals. However, Council must give final approval in August.

Fellows Who are Already Fellows in Another Division:

Manuel Barrera, Jr., Ph.D. • Robert Colligan, Ph.D. • Richard H. Cox, Ph.D. • Gerald Devins, Ph.D.
Edward A. Dreyfus, Ph.D. • Gary Elkins, Ph.D., ABPP • Charles F. Emery, Ph.D. • Robert Frank, Ph.D.
Meyer D. Glantz, Ph.D. • Robin Gurwitch, Ph.D. • Carroll W. Hughes, Ph.D. • Robert Hutzell, Ph.D.
Harriette Elizabeth King, Ph.D. • Michael J. Murphy, Ph.D., ABPP • A. Rodney Nurse, Ph.D.
Natalie Porter, Ph.D. • Lisa A. Serbin, Ph.D. • Jeffrey C. Siegel, Ph.D. • Gregory Taylor Smith, Ph.D.

The members of the 2008 Fellowship Committee are:

David Antonuccio, Ph.D., Thomas D. Borkovec, Ph.D., Gerald C. Davison, Ph.D., Alfred J. Finch, Ph.D., Adelbert Jenkins, Ph.D. and Carole A. Rayburn, Ph.D. Chair

Donald K. Routh, PhD—Section Editor

Early Outreach: The EOAA Committee

Bonnie R. Strickland
President, 1982-83

Section Editor's note: *Now that I have essentially completed my survey of the history of Division 12 and its forbears, I began thinking of what to do for an encore. My solution, as approved by TCP Editor Sanderson, was to ask various former presidents of the Division from a few decades ago to give their own perspectives on the organization or the field.*

As I opened my old files on Division 12's Equal Opportunity and Affirmative Action Committee, I was struck by the mimeographed papers and the smell of musty ink. These were the days before the routine use of copying machines and computers. These were also the days when women and minorities were scarce within the governance structure of the Division or APA. Title VII, the Civil Rights Act prohibiting discrimination in employment on the basis of race or sex, was scarcely a decade old. Homosexuality as a mental disorder had only been removed from the DSM in 1973 but a year later, the Supreme Court would still uphold Virginia's sodomy laws.

I was Chair of the new Committee. The charge was, "To address issues of concern about discrimination in Clinical Psychology which occur on the basis of sex, ethnic background, or alternative life styles."

Following the turbulent decade of the sixties, women, ethnic minorities, and gay men and lesbians began to press for more attention to their interests and their rights. This was especially true for women in APA and in the Division. Although there had been several important advocates of women's rights associated with the history of Division 12, such as Helen Bradford Thompson Woolley, Leta Hollingworth, and Judith Worell, very few women had been involved in leadership in the governance structure. Several groups began to push for an increased representation of women in psychology. The Association for Women in Psychology was established in 1969, a Committee on Women was appointed within APA and Division 35, now the Society for the Study of Women, came into existence. Division 44, the Society for the Psychological Study of Gay, Lesbian and Bisexual Issues and Division 45, the Psychological Study of Ethnic Minority Issues were well into the future. And, to their credit, officers and members of Division 12 began to push for increased diversity in the Division and an Ad Hoc Committee on Equal Opportunity and Affirmative Action was appointed in 1975.

At that time, Hans Strupp was President of the Division and its 13 person Executive Committee consisted of 11 Caucasian men plus Florence Halpern and Logan Wright of Native-American heritage. Three women had been President of the Division since its inception in 1945 and a very few others had served as Council Representatives or Secretary-Treasurer. Reaching back to 1917 when the Clinical Section of APA was established, 4 women presided over the organization giving us a total of 7 women Presidents in the almost 60 years prior to 1975. From 1958 when Awards were begun, only four of the 34 recipients were women (8.5%).

I was Chair of the new Committee and members were William Anderson, Emily Davidson, Carole Rayburn, Laura Toomey and Diane Willis. Allan Barclay was the Liaison from the Executive Committee. The charge to the Committee was "To address issues of concern about discrimination in Clinical Psychology which occur on the basis of sex, ethnic background, or alternative life styles." These concerns included the degree to which women and ethnic minorities were pursuing degrees in Clinical Psychology, the degree to which they faced discriminatory action in clinical training programs, the availability of jobs, employment satisfaction and/or reasons women and minority group members fail to complete academic or professional programs or remain in professional positions. More specifically the Committee was asked to investigate the degree to which women and minority group members were represented in the membership, the governance structure, and the award structure of the Division. We were further charged with identifying areas within Clinical

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Psychology that may contribute to discriminatory practices of a sexist or racist nature including 1) evaluation and assessment, 2) psychotherapy, counseling, and guidance, 3) definitions of psychological adjustment.

A bold, daunting and impossible charge to a small, Ad Hoc Committee with a budget of $500 and no email. This was also before the days that APA had the technology and the resources to begin to collect needed data and share it with us. For example, the Division had 4016 members but no information as to gender or minority breakdowns. Being naïve but enthusiastic, we set about our task. Since Division Officers would often say they didn't know women and minorities to appoint to various responsibilities, we first developed a Talent Bank of Women. We also tried to identify people of diverse ethnic heritage. Unfortunately, we did little to advance the interests of gay, lesbian, bisexual, and transgendered people in the Division although Evelyn Hooker had received an Award in 1974 for her contributions as an advocate for "sexual minority persons." Part of this occurred because in these early days, few psychologists were openly "out" as a sexual minority person. Additionally, many of the activities that could have been undertaken in the Division occurred within the Association of Gay Psychologists, established in 1973 and eventually Division 44, the Society for the Psychological Study of Gay, Lesbian, and Bisexual Issues.

By 1983, 7 of the 16 member Executive Committee were women and I was President of the Division. But it would be almost 20 years before another woman, Karen Calhoun, served in that office.

As we had hoped, the make up of the Division's Executive Committee began to change. Logan Wright appointed Samuel Turner Editor of The Clinical Psychologist in 1981. Turner went on to be elected as Council Representative in 1987 and Diane Willis joined him as a Council Representative in the same year. By 1983, 7 of the 16 member Executive Committee were women and I was President of the Division. But it would be almost 20 years before another woman, Karen Calhoun, served in that office. In the last 8 years, however, 5 of the Division Presidents were women. The percentage of women who have received Awards in the Division has improved to 20%. Sadly, only two people of ethnic minority status have ever been President of the Division and only one has ever received an Award.

Perhaps the most important contributions our EOAA Committee made were helping to establish two new Sections in the Division. The Section on the Clinical Psychology of Women (Section 4) came into being in 1980 and the Section on Ethnic Minority Clinical Psychology (Section 6) was established in 1986. Sections elect someone to serve as a Representative to the Executive Committee, receive program time at the APA Convention and have a built in continuity that a Committee does not have.

The EOAA Committee was blessed with many strong, active members and was in existence through the mid 1980's when most of its work was taken on by Sections 4 and 6. Currently, over a third of the Division members are women and 15% are ethnic minorities. A Diversity Committee for the Division was appointed in 2005 and a Diversity Column appears in each Newsletter. We still have much to do but our outreach to women and minorities over the last 30 years was made infinitely easier through the activities of the initial EOAA Committee.

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Thinking about Licensure is the Thing to Do; The Earlier You Start, the Sooner You'll be Through

George M. Slavich, PhD

The life of an early-career clinical psychologist is marked by a number of important professional requirements. First are the coursework, preliminary examination, and dissertation requirements; then, the clinical hours and supervision requirements. With all of these demands in mind, it is easy to focus on the present and delay thinking about the future. For many budding psychologists, though, what looms ahead is the licensure application process, and understanding the process now can save you a lot of time and money later. Here's what you need to know:

The Initial Decision

Think licensure is not relevant to your professional development? Think again. States originally drafted licensing laws in part to identify well-trained practitioners of psychology. However, federal grants that fund research involving clinical populations generally require a licensed clinical psychologist to be available to respond to psychiatric emergencies. Many of the roles that academicians in clinical psychology fulfill, such as providing licensed clinical supervision, also require a license. For this reason, getting licensed is also helpful if you aspire to one day become a Director of Clinical Training in a graduate, internship, or post-doc program. Becoming licensed as a psychologist is thus required of individuals planning for a career in direct clinical service, but may also be necessary for those considering jobs that involve clinical supervision or research.

Knowing Your State's Requirements

States differ greatly with respect to their licensure requirements. It is therefore helpful to begin to collect information on each state in which you eventually might seek to establish yourself. This information can be obtained by contacting the respective licensing boards directly (for an online directory, see http://www.asppb.org/about/boardContactStatic.aspx). The major requirements for each state are also listed in the Handbook of Licensing and Certification Requirements database, which is maintained by the Association of State and Provincial Psychology Boards (http://www.asppb.org).

Clinical Hours

All states require applicants to complete supervised clinical hours. However, the precise number of hours, exactly when in one's professional career these hours need to be completed, and the required ratio of clinical hours to supervision hours differs greatly across states. In Iowa, for example, applicants must complete a minimum of 1,500 supervised hours, but there is no time limit or specification for when these hours need to be accrued. In California, in contrast, two years (3,000 hours) of supervised clinical experience are required, at least one year of which (1,500 hours) must be accrued following completion of all doctoral requirements or conferral of the doctoral degree, whichever is first. Furthermore, each year must be completed within a 30 consecutive-month period, and if both years are completed post-doctorally, they must be done within a 60 consecutive-month period. As you can see, the regulations can either be relatively general or very specific.

As mentioned previously, the required ratio of clinical hours to supervision hours also differs by state. The ratio in Massachusetts, for example, is 16:1; in California, it is 10:1. To make sure that all of your clinical hours can eventually be counted toward licensure, review the regulations of the relevant licensing boards as soon as possible.

Training and Coursework

In addition to completing a certain number of supervised clinical hours, many states require applicants to document that they have received training in topic areas that are relevant to the practice of psychology. Some common topics include: Ethics, History of Psychology, Research Methods, Statistics, Biological Bases of Behavior, Cognitive-Affective Bases of Behavior, Social Bases of Behavior, Individual Differences, Human Sexuality, Child Abuse Assessment and Reporting, Detection and Treatment of Alcohol and Other Chemical Substance Dependencies, Spousal/Partner Abuse Assessment and Intervention, and Aging and Long-Term Care. The ear-

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lier you know which topics you will need to cover, the better, because it is easier and less expensive to fulfill these training requirements while you are affiliated with an academic program (i.e., while in graduate school, on internship, or in a post-doc position). In most cases, such requirements can be met by attending relevant courses or seminars at your institution. In order to count toward licensure, however, you must possess formal documentation of having attended the courses. A listing on an official transcript will typically suffice. If the title of the course is not informative, though, or if the course is not listed on a transcript, then another description of the training experience will be needed (e.g., a syllabus or catalogue description), accompanied by a signed letter that confirms your attendance and documents the total number of hours being certified.

Banking Your Credentials

Given this description thus far, two challenges of getting licensed may be apparent. First, as time passes, it sometimes becomes increasingly difficult to contact past supervisors and to obtain documents that will be necessary for the licensure application process. Second, because of differences in licensing laws across states, moving from one state to another can be complicated once you are licensed.

To help with these two issues, you should begin to bank your credentials as soon as possible. This may be done with the help of one of two services: the Association of State and Provincial Psychology Board's Credentials Bank (ASPPB; http://www.asppb.org) or the National Register of Health Service Providers in Psychology's National Psychologist Trainee Register (http://www.nationalregister.org). A third option is to become credentialed by the American Board of Professional Psychology (ABPP; http://www.abpp.org), which grants board certification in 13 specialty areas. The ABPP currently has a $25 Early Entry Option for students, and getting credentialed makes future certifications and mobility much easier.

The Exams

The final step toward getting licensed involves taking the necessary exams. These, again, differ by state. Thirteen states require an oral exam. Others, however, have dropped this element and require only the Examination for the Practice of Professional Psychology (EPPP), a standardized 200-question computer-administered test, in addition to a jurisprudence exam, which differs slightly by state. Generally speaking, it is a good idea to take these exams as soon as possible to make sure the material is fresh in your mind. The earliest point at which you can sit for these exams, however, also differs across states. To determine when you can begin this final step of the licensure application process, contact the relevant licensing boards directly or search ASPPB's Handbook of Licensing and Certification Requirements database (http://www.asppb.org), which maintains a listing of answers to this exact question by state.

Timothy J. Bruce, PhD—Section Editor

Ethical Considerations in Discussing Medications with Clients: Part II

Timothy J. Bruce, PhD

This column continues our look at ethical considerations involved in discussing medications with clients. In Part I of this series, it was noted that there are common roles and responsibilities that non-prescribing mental health service providers are routinely asked to assume regarding medication use by their clients (Bentley & Walsh, 2000). They include educating clients and family members about medication use including, for example, its effectiveness relative to other treatment options, common side effects, and how medication may interact with other interventions; consulting and collaborating regarding a client's possible need for medication, referral to a physician, as well as working regularly with the physician and client; advocating and assisting clients and family members in working with their physicians; and monitoring and reporting positive and negative effects of the medication on the client and communicating these to the physician, client, or both. It was noted that responsibilities such as consulting, collaborating, monitoring, and reporting ask psychologists to form relationships with prescribers. Relevant to that action are Principle B of the APA Ethical Guidelines (APA, 2002) regarding Fidelity and Responsibility and Standard 3.09: Cooperation With Other Professionals. Principle B states that, "…Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct" (p. 3). Standard 3.09 states, "When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately" (p. 9). Key to both the principle and standard is that the relationship is formed to serve the client's best interest. Noting that prescibers and psychologists use different interventions, often guided by different therapeutic models, and sometimes targeting different outcomes, the potential for conflict or other undesirable outcomes exists.

Does the psychologist have an independent ethical duty to warn the client?

An example of such a conflict was offered in which a psychologist had a client who was on phenelzine sulfate (Nardil) and failing to follow the dietary restrictions, an action that risks a potentially fatal hypertensive reaction. The physician was informed about the patient's behavior but determined that the risk was low and that the Nardil should be continued. The question was posed, "Does the psychologist have an independent ethical duty to warn the client?" Although the ethical standard on professional relationships would suggest that the psychologist should do what is in the best interest of the client's welfare, which would seem to be to inform the client of the risk, the question raises the issue of the psychologist's competence to make this risk assessment and act upon it. In this case, the ethical standards regarding competence become pertinent. For example, Standard 2.01 regarding Boundaries of Competence states, "Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (p. 4). Consideration of competency standards would suggest that unless there is clear evidence that the physician has made an erroneous risk assessment (e.g., misunderstood the severity of the client's noncompliance), the psychologist should defer to the competence of the physician to make the assessment. Clearly, a goal here is try to develop good collaborative relationships with physicians so that concerns such as these can be discussed explicitly, toward the goal of mutual understanding and agreement, and thus best serving the client's welfare. It is fair to say that in day-to-day practice the quality of these relationships falls on a continuum, highlighting the relevance of guidelines regarding good documentation (e.g., Standard 6.01, Documentation of Professional and Scientific Work and Maintenance of Records).

Competency standards are invoked whenever psychologists assume the responsibility of educating their clients. One educational responsibility required of psychologists derives from the guideline to obtain informed consent to therapy: "When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is fea-

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Donna Rasin-Waters, PhD—Section Editor

A Powerful Voice

Donna Rasin-Waters, PhD,
Division 12 Federal Advocacy Coordinator

As many of you may be aware and whether we all like it or not, our media often drives public policy. How does this happen? When the media picks up on issues and stories, such as the recent outcry about the lack of mental health services for our returning veterans, these stories and the op-ed responses by the public are carefully monitored by our representatives' staff on Capitol Hill. There is nothing that moves our Congress more than issues that are intertwined with human stories, and our media outlets are full of such stories. So when one story triggers a cascade of other similar stories we will often find that Congress will become mobilized to respond and take action. The media outcry about the mental and behavioral health issues that our veterans may be facing upon return from the war has resulted in a funding boon for VA mental and behavioral health services.

So what can the role of psychologists be in all of this? In January, 2008 our Division Board approved funding for a media intermediary, ProfNet, from which I receive daily feeds or lists of questions by journalists who would like to hear from experts. I sort through these queries several times a day to find questions that may be appropriate for psychologists to respond to. To date 56 volunteers from our Division 12 Public Education Media Campaign have responded to 35 media queries on a wide range of topics including depression, parenting, sexuality, eating disorders, family issues, personality and dementia, to name a few. We have responded with both our clinical and scientific expertise and have appeared in numerous media outlets including the following: Mature Living, Prevention, Parents Magazine, The Hartford Herald, Yoga Life, The Boston Globe, The American Medical Association's Physician Magazine and many other smaller, local media outlets. There has been one radio interview that aired in Pittsburgh. We have also sent out several media leads to which journalists looking for a new story can respond.

Please join us in this effort. When psychology is quoted in the media we have an opportunity to shape what the media reports on, as well as disseminate our expertise and science to the community at large. Remember, the media is a powerful voice on Capitol Hill.

Psychopharm Update *(continued)*

sible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers" (APA, p. 14-15). A common question asked by clients of psychologists concerns other treatment options and selection considerations, including the option of medication. Although informed consent standards do not specifically guide psychologists to know and discuss all viable treatment options, this expectation has been called into question in the legal arena (King & Anderson, 2004; Littrell & Ashford, 1995) most notably by the case of Osheroff versus Chestnut Lodge (Klerman, 1990). More on that next edition in the final installment of this series.

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Lata K. McGinn, PhD—Section Editor

Principles of Therapeutic Change That Work

Louis G. Castonguay & Larry E. Beutler (Eds).
New York: Oxford University Press.
ISBN:13 978-0-19-515684-3

Recommended by Marvin R. Goldfried, Ph.D.
marvin.goldfried@sunysb.edu

There has been increasing pressure in recent years for psychotherapy researchers and clinicians to reach some consensus about what works clinically—a conclusion that involves a combination of research findings and clinical expertise. Based on randomized clinical trials—what we used to call outcome studies—lists of empirically supported treatments have been specified, usually defined operationally by a treatment manual. And although this has clearly marked a step forward in our search for consensus, these multifaceted treatment packages no doubt include active ingredients along with elements based more on the author's conceptual framework than actual evidence.

The decision by Division 12 to specify empirically supported treatments prompted Division 29 (Psychotherapy) to establish a task force to complement this initiative by specifying empirically supported therapy relationships that work. In their book Principles of Therapeutic Change That Work, Louis G. Castonguay and Larry E. Beutler—both award-winning psychologists—have taken a more novel approach to consensus by focusing on those principles underlying therapy treatments and relationships. Both of them seasoned researchers and clinicians, Castonguay and Beutler established a task force sponsored by Division 12 and the North American Society for Psychotherapy Research that would specify variables associated with change that were based on research findings—rather than on a person's favorite theoretical variables.

The book, which is an outgrowth of the task force's efforts, is divided into four sections: dysphoric disorders, anxiety disorders, personality disorders, and substance use disorders. Each grouping presents change principles associated with (a) the techniques used, (b) the therapy relationship factors, and (c) the characteristics of both the client and therapist.

Some of the principles contained in the book are common to all clinical problems. For example, one such common principle is: "Clients who have been diagnosed with a personality disorder are less likely to benefit from treatment than those who have not" (p. 355). Certain principles were found to be unique to certain clinical problems, such as: "Therapists working with a specific personality disorder may increase their effectiveness if they receive specialized training with this population" (p. 356). Some principles are more prognostic in nature: "Client's expectations are likely to play a role in treatment outcome" (p. 357). Still others are related to the process of change: "Therapy outcome is likely to be enhanced if therapy addresses interpersonal issues related to clinical problems" (p. 363).

What is particularly noteworthy is that because these principles are data-based, they are not limited to any given theoretical orientation and thereby have the potential of leading the field on to a more mature phase in its 100 year development. Indeed, this volume represents an important step in the history of therapy, and has the potential to dramatically change how we think about therapy clinically and to inform us about the kind of research that is needed. As such, it represents an exciting beginning.

An article co-published in *The Independent Practitioner* **and** *The Clinical Psychologist*

The Research-Practice Gap: Clinical Scientists and Independent Practitioners Speak

John C. Norcross, E. David Klonsky, & Heather L. Tropiano (correspondence can be sent to norcross@scranton.edu)

Editor's note: *This article is being published concurrently in The Independent Practitioner (Division 42 Newsletter) and The Clinical Psychologist (as a result, this article is in the public domain; it is not copyrighted). The authors believe simultaneous publication in the two newsletters will mark a movement toward interdivisional cooperation and intraprofessional rapprochement. As you will see, the two expert panels were drawn directly from the Division 12 and Division 42 memberships. –WCS*

The research-practice gap in professional psychology probably predates Genesis. The Boulder Conference of 1949 envisioned that "the relationship between research and practice is intimate and synergistic" (Stricker, 1992, p. 543), that research and clinical practice would ideally work to make each other stronger, to advance the field. However, as Parloff (1980, p. 279) lamented many years ago, practice and research "have emerged, developed, and flourished in essentially untrammeled independence of each other. They have grown along parallel lines, and, like well-mannered parallel lines, they have only rarely touched."

The research-practice gap persists and may have deepened over the years. The gap has been variously characterized as an "anaclitic depression" (Parloff, 1980), an "incommensurable paradigm" (Stricker, 1997), and a "strained alliance" (Goldfried & Wolfe, 1996)." Writing on the widening gap, Tavris (2003, p. xiv) opined that today:

> calling it a "gap" is like saying there is an Israeli-Arab "gap" in the Middle East. It is a war, involving deeply held beliefs, political passions, views of human nature and the nature of knowledge, and—as all wars ultimately involve—money, territory, and livelihoods.

Beutler and colleagues (1993, 1995) conducted two surveys of mental health practitioners to determine how they use and where they obtain research. In all, 80% of practitioners responded that they read research articles, but only 35% of those articles were published in research journals. Most practitioners identified a theoretical or practice-oriented journal as the one most recently read. Similarly, books were read frequently, but 51% of the books were practice-oriented and 33% were popular trade books. Beutler and colleagues also found that clinicians find research literature more important than researchers find clinical literature.

In their 1995 study, Beutler and colleagues asked 221 scientists and 144 practitioners to indicate their preferred means of information communication. Practitioners favored communication of scientific findings through professional newsletters, while researchers favored communication of clinical practices through research articles. The differences were most pronounced between clinical scientists and independent practitioners.

In this context, we decided to ask nationally recognized clinical researchers and independent practitioners, separately, to address the research-practice gap in professional psychology. In this study, 11 clinical scientists and 13 independent practitioners nominated, in their own words, the reasons for the research-practice gap as well as what can be done to narrow that gap. We have asked that the respective newsletters of our experts' organizational homes—The Independent Practitioner (Division 42) and The Clinical Psychologist (Division 12)—simultaneously publish the results in an effort toward interdivisional cooperation and intraprofessional rapprochement.

Delphi Poll

We employed a modified Delphi poll to facilitate consensus among our experts. The Delphi uses a series of carefully designed questionnaires interspersed with information summaries and feedback from preceding responses in order to facilitate consensus on complex questions.

Our study entailed four sequential steps, each applied to separate Delphi polls of independent practitioners and clinical scientists. First, we identified experts in the science and practice of psychology and invited them to participate. For the clinical scientists, we contacted 14 experts who were current or former members

of the APA Society of Clinical Psychology or its sections and who represented diverse theoretical orientations; 11 agreed to participate. For the independent practitioners, we invited the 24 former presidents of the APA Division of Independent Practice (42); 13 agreed to participate. Table 1 lists the names of the expert panelists.

Second, we developed an open-ended questionnaire to solicit opinions related to our dual aims—reasons for the gap and means to narrow it. We asked our panels of experts to answer these two broad questions:

- There has long been a gap between the science and practice of psychology. For example, some clinical scientists feel that the practice of psychology is largely uninformed by research, and some practitioners feel that clinical research is not relevant to their practice. What do you think are the main reasons for the scientist-practitioner gap?

- In your opinion what can be done to help bridge this gap? What practical and realistic steps can be taken? Your suggestions could be micro-level, macro-level, or in between, and can be directed at political entities, academic psychologists, practicing psychologists, educators, and/or other relevant institutions.

Third, we took their verbatim responses to these questions and condensed them into discrete items, preserving the exact language whenever possible, and disseminated them (without identifying their authors) to participants. The panelists were asked to rate each item on two dimensions: agreement with the response on a scale where 1 indicated "strongly disagree" and 5 indicated "strongly agree"; and importance of the response where 1 indicated "not important" and 5 indicated "very important." We included the second rating because one may agree strongly with a statement but believe it is not particularly important.

Fourth, we identified expert consensus as median ratings indicative of both strong agreement (4 or higher on 5-point-scale) and high importance (4 or higher on the 5-point scale). In addition, at least 75% of the expert panelists had to agree on that particular item, as reflected in ratings of 3, 4, or 5 for the clinical scientists, and 4 or 5 for the independent practitioners in light of their increased homogeneity in practice setting and theoretical orientation.

The following reasons for the research-practice gap and recommendations for bridging that gap all achieved expert consensus by this definition. Of course, consensus does not imply unanimity; not all panelists endorsed the emergent group consensus.

Reasons for the Research-Practice Gap

From their original pool of 23 suggestions, the clinical scientists consensually endorsed 6 reasons for the gap.

- Large numbers of psychologists are trained in professional schools, or as MA psychologists, where the training does not emphasize the value of science.

- APA has been so concerned about alienating its practitioner "base" that is has mostly been unwilling to take a stand against questionable clinical practices.

- Clinicians are not trained to use science in their clinical work, e.g., set measurable treatment goals, monitor progress, use the scientific literature to identify therapies.

- In PhD programs, clinical and research training are often separate. Thus, students do not see many models of scientific practice, and many researchers do not do clinical practice and integrate what they learn there into research.

- Scientists and practitioners utilize different epistemologies: one side believes in experimental control and the other in personal experience (e.g., I've seen it work so it works).

- Reading research and learning evidence-based treatments is time consuming, humbling, hard, and places demands of time and energy that are not attractive to practitioners.

From their separate poll of 29 suggestions, the independent practitioners consensually endorsed 6 reasons for the gap.

- There is little dialogue between scientists and practitioners.

- Data compiled in "laboratory" studies are not easily transported to practice.

- Scientists do not understand that the therapeutic relationship is the glue of effective therapy.

- Practitioners' main focus is to serve clients, and few have the time or skills to conduct research.

- Most researchers do not translate their findings in ways that practitioners find relevant to their practice.

- A lack of shared purpose; clinical scientists do not work with practitioners as equal partners to improve services.

Although impossible to directly compare the results of the two expert panels since each panel independently nominated and rated items, we observe impressive convergence on several points. Both panels noted that scientists and practitioners insufficiently engage and learn from each other, and that the demands of practice leave little time to engage in research. In addition, clinical scientists suggested that many clinical training programs do not value science, whereas practitioners suggested that the scientific research often does not translate well to clinical work.

Suggestions for Bridging the Gap

From an initial pool of 25 suggestions, the independent practitioners consensually identified 9 of them. These were:

- Make research more relevant to the needs of practitioners.

- Disseminate research findings in more accessible ways for practitioners; e.g.., psychologist's version of WebMD.

- Publish research findings in traditionally practitioner publications.

- Be sure that practitioners aren't scared off by research but rather see it as necessary to providing high quality service to their patients.

- Create better partnerships that occur throughout all career phases, e.g., create mentoring relationships of practitioner and researchers.

- Encourage master sessions, perhaps at APA conventions, in which researchers address practitioners about practical psychotherapy and practitioners inform researchers about the problems of integrating research into psychotherapy.

- Give greater attention to the value of ecological validity of clinical research.

- Provide grants for supporting researchers and practitioner partnerships.

- Involve more practitioners in developing interventions.

From their separate pool of 21 distinct recommendations, the clinical scientists achieved consensus on 5 suggestions for bridging the gap:

- Insist on rigorous (not lip service) quality improvement processes to be used in ALL clinical services. Doing so is improving medicine and should be applied to us too.

- Provide better tools to make evidence-based practice easier.

- Develop high-quality CE offerings that are scientifically-based and that teach practitioners how to think clearly and critically about research evidence.

- In line with research on outgrouping and superordinate goals, put clinicians and researchers together on the task of psychotherapy research.

- Educate consumers about how to identify whether their psychologist is a scientist-practitioner by giving them a checklist of things to ask for, including goal setting and progress monitoring.

Here too there appears to be impressive convergence between the scientists and practitioners. Both panels recommended making research findings more accessible and relevant to practitioners. The clinical scientists recommended doing so via continuing education courses, whereas the practitioners favored publishing research findings in practitioner publications, developing a psychologist version of the WebMD website, and holding "master" sessions at conventions in which researchers and practitioners present to each other. Both panels also agreed that scientists and practitioners should more often work together in the evaluation and development of psychotherapies, perhaps via the development of grant mechanisms to support such endeavors.

Closing Observations

The practice-research gap in professional psychology

has a long and undistinguished history. Realistically, the gap will not close in the immediate future. At the same time, there is perhaps unprecedented consensus in the field that psychological practice must be based on the best available evidence (APA, 2006; Norcross, Hogan, & Koocher, 2008). This consensus presents a unique opportunity to revisit the gap, listen to each other, facilitate rapprochement, and make progress. We hope this interdivisional report represents a small contribution to that endeavor. In the end, all of us—practitioners, researchers, and consumers—stand to benefit from the sophisticated integration of science and practice.

Table 1. Panel of Experts

Clinical Scientists

Richard R. Bootzin, PhD

Marvin R. Goldfried, PhD

Steven D. Hollon, PhD

Scott O. Lilienfeld, PhD

Richard M. McFall, PhD

John C. Norcross, PhD

William O'Donohue, PhD

Jacqueline B. Persons, PhD

Kenneth J. Sher, PhD

John R. Weisz, PhD

Drew Westen, PhD
(contributed to first round only)

Independent Practitioners

Jeffrey E. Barnett, PsyD

Jean A. Carter, PhD

Lillian Comas-Díaz, PhD

Michael F. Enright, PhD

Alan D. Entin, PhD

Carol D. Goodheart, EdD

Jana N. Martin, PhD

Stanley Moldawsky, PhD

Michael J. Murphy, PhD

Robert J. Resnick, PhD

Elaine Rodino, PhD

Richard M. Samuels, PhD

Karen M. Zager, PhD

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Section II: Society of Clinical Geropsychology

Deborah A. King, Ph.D.

As of August 2008, the Society of Clinical Geropsychology had 262 paid members, 44 of whom were students. The Society held its annual election of new officers in June; taking office in January 2009 are President-Elect David Powers, and Secretary Karyn Skultety. Karyn retires as our newsletter editor, and is succeeded in that role by co-editors Brian Yelchin and Sherry Beaudreau. Our members are busy with many exciting initiatives, including the work of the Committee on Education and Training which is led by Erin Emery. Erin is working with the Council of Professional Geropsychology Training Programs (COPGTP) Task Force on Geropsychology Competency Assessment on the evaluation of a geropsychology competencies assessment tool, which builds on the competencies established during the 2006 Pikes Peak Conference on Training in Professional Geropsychology. Interested individuals can contact Erin at erin_emery@rush.edu for a copy of the tool. The Society's other initiatives include the work of the Mentoring Committee, chaired by Amy Fiske, to analyze responses to a recent mentoring survey and prepare a proposal to support research training in geropsychology. As well, the Diversity Committee, chaired by Angela Lau, is preparing a comprehensive list of resources on research and clinical work with diverse older adults and the Public Policy Committee, led by Donna Rasin-Waters, continues important legislative advocacy efforts. Donna regularly submits media leads pertaining to older adults and mental health using the media platform Profnet. Contact Donna at drrasinwaters@aol.com if you are willing to help with this important effort. The Society has a new website coordinator, Laura Phillips, who will be working to update and upgrade our website to showcase all of our initiatives. Finally, we want to thank Caitlin Holley and Sarah Yarry for their dedication to the Society and their work as student representatives. We are sad to see Caitlin retiring from her role as Student Rep but welcome Shannon Foster from the University of Colorado, Colorado Springs.

Our members are busy with many exciting initiatives.

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

Section III: Society for the Science of Clinical Psychology

E. David Klonsky, Ph.D.

Lee Anna Clark is SSCP President, Dan Klein Past-President, Howard Garb President-Elect, Elizabeth Hayden Secretary-Treasurer, and David Klonsky Representative to Division 12. We would like to update the Division 12 membership on a few developments.

As part of our efforts to increase student involvement in our section, our two student board members, Frank Farach (Yale University) and Ashley Pietrefesa (Binghamton University), have developed an SSCP website specifically for students. An initial version of the site can be found at http://sscpstudents.org, and the site is expected to expand rapidly over the coming months. We encourage interested students to visit the website and get in touch with Frank and Ashley with suggestions about getting involved and helping determine how SSCP can serve the needs of clinical psychology students. Annual student membership in SSCP costs only $10.

In addition, we are discussing plans for updating our directory of predoctoral clinical psychology internships. The most recent version, compiled by William Horan and Jack Blanchard and completed in 2004, contains more than 500 pages of detailed information on internship sites in the United States and Canada. An electronic version of the directory is available at our website, www.SSCPweb.org, as one of the links under "Professional Training and Employment."

Finally, for the first time we have made our newsletter, "Clinical Science," available to the public. Previously the newsletter was password-protected and only available to SSCP members. The newsletter can be accessed through our website (www.SSCPweb.org).

Because my term as Representative to Division 12 is ending this will be my last section update in The Clinical Psychologist. However, I look forward to continuing to work closely with both SSCP and the Division as Chair of the Division 12 Committee on Science and Practice and as Editor of the Division

12 Website on Research-Supported Psychological Treatments (www.PsychologicalTreatments.org).

Section VII: Clinical Emergencies and Crises

Marc Hillbrand, Ph.D.

The 2008 APA Convention offered a wide array of Section VII offerings. Jim Rogers gave an inspiring Presidential Address entitled "Diversity perspectives on early psychological response to mass disasters". He articulated a rich conceptual framework to think about diversity in general, and more specifically about diversity as it applies to disasters. Bruce Bongar chaired a symposium in which Larry James and Ariel Merari presented the latest scientific findings on suicide terrorism. They described the psychological make-up of the typical would-be suicide bomber as well as common recruitment scenarios used by terrorist organization. Peter Gutierrez and his VA colleagues reported on recent clinical developments in suicide prevention that target veterans. They presented data from a pilot study using David Jobes' Collaborative Assessment and Management of Suicidality (CAMS) with VA patients. Phil Kleespies, David Rudd, David Veerhagen and Dean Kilpatrick offered a continuing education workshop on at-risk adolescents. Phil Kleespies gave an overview of behavioral emergencies, David Rudd spoke on suicide risk with adolescents, David Veerhagen on violence risk and adolescents, and Dean Kilpatrick on risk for victimization with adolescents.

Other presentations by Section members illustrate the breadth of topics that fall under the Section VII umbrella. They ranged from Leverage, the treatment relationship and treatment participation (McNiel et al.), Positive behavioral support programming in forensic practice (Colwell et al.), Refining interventions to improve engagement and outcomes among suicidal youths (Spirito et al.), and Benefits of electronic medical records in managing inpatient suicide risk (Hillbrand et al.)

Section VII recognized the pioneering work in suicide prevention of one of its heroes, Donald Meichenbaum. One of the founders of Cognitive Behavior Therapy, he was voted one of the ten most influential psychotherapists of the century by North American clinicians in a survey reported in the American Psychologist. He was honored with the Section VII Lifetime Achievement Award. Jayoung Choi was also recognized with the Section VII Graduate Student Research Award for her work on the cultural validity of the College Student Reasons for Living Inventory with Asian American college students.

Section VIII: Association of Psychologists in Academic Health Centers

Ronald T. Brown, Ph.D.

Section 8, the Association of Psychologists of Academic Health Centers (APAHC) is especially excited about its official journal, the *Journal of Clinical Psychology in Medical Settings* (JCPMS). The *Journal* is published on quarterly basis and fulfills a significant gap in the literature since psychologists who are employed in health sciences centers typically require skills in addition to those that are taught in departments of psychology or provided in traditional continuing education workshops for psychologists. In an effort to meet the ever increasing needs of its members, Barbara Cubic, Ph.D., Editor of JCPMS has been busy developing a vision for the *Journal* such that it meets the needs of APHAC members as well as psychologists who are either employed or consult in academic health science centers. The *Journal* has and will continue to devote itself to meeting psychologists' professional knowledge and providing them with the empirical knowledge necessary to assist them in remaining up to date on the most recent knowledge necessary to function competently and effectively in a health sciences center.

A recent issue of the *Journal of Clinical Psychology in Medical Settings* (March, 2008) illustrates how the journal serves those who are employed in a health sciences center. This special issue was devoted to those professional dilemmas and skills necessary to address the common challenges faced by practicing psychologists in academic health centers. This special issue included a paper on the challenges for Ph.D. level faculty in medical school departments and the changing educational needs of psychologists in academic health sciences centers (Schweitzer & Eells, 2008). An important question was addressed by Belar (2008) as to whether psychologists are in need of additional training including greater medical knowledge, basic science and additional psychological science (Belar, 2008). In a related area, Zeiss (2008) reviewed the integration of mental health services and primary

care. In addition, Kaslow and her colleagues delineated those competencies necessary for psychologists in academic health science centers (Kaslow, Dunn & Smith, 2008). Of particular interest is the article by Cubic and Gatewood (2008) that addresses the issue as to whether psychologists can assist physicians in meeting competencies of their own medical accreditation bodies. Finally, Bennett-Johnson (2008) delineated specific research paradigms that have been successful in fostering research success within academic health science centers.

As a follow-up to the Zeiss (2008) paper on the integration of mental health care in the primary care setting within VAs, the March, 2009 issue of the *Journal* (with guest editor, Rodger Kessler) will feature a series of articles pertaining to collaborative endeavors among psychologists and other health care providers in a variety of primary care settings. Included within this important series of articles, will be models of integrated health care serving the military, cultural awareness in primary care settings, and issues pertaining to the economic outcome of collaborative endeavors.

We anticipate that psychologists who are employed in health science centers, especially early career psychologists, will benefit from the articles in the *Journal of Clinical Psychology in Medical Settings*. We welcome your contributions to the *Journal of Clinical Psychology in Medical Settings* including your suggestions and submissions. Submissions may include reviews of the literature, empirical studies, and commentaries that are thought provoking. Any submissions or suggestions may be sent directly to the Editor of the *Journal* at cubicba@evms.edu.

Section IX: Assessment

Norman Abeles, PhD.

In my summer column I noted the late breaking news that Section IX members will receive the Journal "Assessment" edited by Dr. Ben-Porath as a benefit of membership. I recently received my copy of the journal. Thanks should go to our former Section Representative, now President of our Division, Irv Weiner. Robert Archer, Past President of our section and our current President, Radhika Krishnamurthy were also very helpful. If have forgotten anyone I will update you in my next column.

At the recently concluded APA convention in Boston we had an active program including a "meet and greet" breakfast for the assess community of Divisions 5 and 12 (Section IX). The President of Division 5 (Neal Schmitt) was there as were many others including graduate students. We also had a display of selected student posters focused on assessment. We had a number of symposia including one on understanding, practicing and teaching therapeutic assessment. Participants were Constance T. Fisher, Stephen E. Finn, Deborah Tharinger and Radhika Krishnamurthy. Another symposium dealt with current directions in psychological assessment practice, research and training. Participants were Paul A. Arvisis, Robert Archer and Radhika Krishnamurthy. The section IX Distinguished Assessment Award was presented to Dr. David Lachar. Another award winner was Norman Abeles who received an APA Presidential citation in recognition of his service to psychology and to APA over five decades. In assessment related activities, APA and the American Bar Association will soon publish a handbook for psychologists dealing with the assessment of older adults with diminished capacity.

JOIN A DIVISION 12 SECTION

Division 12 has seven sections covering specific areas of interest.

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

To learn more, visit Division 12's Section web page:
www.apa.org/divisions/div12/div12.html

Call for Nominations for Divison 12 Leadership Positions

Dear D12 colleague:

It's that time of year to sharpen your pencils and submit your nominations for Division 12 leadership positions. We depend on you to nominate individuals for these positions in keeping with the Division's nomination process. This year we will collect ballot nominations electronically via the Internet. We are moving more closely toward a complete electronic system because it *is* a tremendous cost-saver for the Division.

The process will work like this: on October 1 you will receive an email indicating that this is the call for Nominations Ballot for Division 12. In the body of that email you will have a link that is specific to you and your email address. When you click on the link, you will be taken directly to the ballot. Once there, you have the opportunity to type in your choice for the following positions: president-elect, APA council representative, and member-at-large/chair of the diversity committee.

This system is easy, fast, and secure. If you choose not to vote at the time that you receive the initial email or if you accidentally delete the notice—never fear—you will receive a reminder email in about 2 weeks. The entire nominations process will take about 6 weeks and will end on midnight November 15. Last year's nomination turnout was strong; we hope that this year's nomination turnout will be even stronger. We thank you in advance for your help in the nomination process.

If you would prefer to be mailed/emailed a paper ballot, please contact the Lynn Peterson at Central Office. You can reach her at
Division 12 Central Office,
P.O. Box 1082, Niwot CO 80544,
Tel: (303) 652-3126
Fax: (303) 652-2723,
Email: div12apa@comcast.net

Call for Nominations for Divison 12 Awards

The Society of Clinical Psychology (APA Division 12) invites nominations and self-nominations for its 2009 awards. Women, ethnic/racial minorities, and members of other underrepresented groups are particularly encouraged to apply.

Please see below for information about the various awards given by Division 12. The deadline for awards nominations is November 1, 2008. The awards will be presented at the 2009 APA Convention.

Send nominee's name, recent vita, and a concise (1-2 page) typewritten summary of his/her achievements and contributions to:

Irving Weiner, Ph.D., Chair,
2009 Awards Committee
c/o Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082
Email: div12apa@comcast.net

Division 12's 2009 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.

Division 12's 2009 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.

Theordore 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 ones 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 $2,000.

Division 12's 2009 Award for Mid-Career Contributions to Clinical Psychology

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

This award will be conferred annually (from 2008 through 2012) to an outstanding early or mid-career psychologist engaged in advancing the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. A scientific review panel appointed by Division 12 of the American Psychological Association will select the recipient upon approval of the APF Trustees. The winner receives $1,000.

Division 12's 2009 Award for Distinguished Contributions in Applied Clinical Research

Samuel M. Turner Clinical Research Award

This award will be conferred annually to a psychologist who has made distinguished contributions in applied clinical research.

Division 12's 2009 Award for Outstanding Clinical Educator Mentoring

Toy Caldwell-Colbert Outstanding Clinical Educator Award

This award will be conferred annually to a psychologist for excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty. It will recognize those individuals who have been outstanding in supporting, encouraging and promoting education and training, professional and personal development, and career mentoring to junior colleagues.

Division 12's 2009 Awards for Diversity

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.

Contributions to Interventions and/or Assessment for Communities of Color in Clinical Psychology Award

This award recognizes individuals who have contributed to the development and advancement of research or practice to communities of color or who have applied existing treatment modalities effectively with these populations.

Lifetime Award for Distinguished Contributions to Diversity in Clinical Psychology Science and Practice

This award will be given in any one of the four areas of psychology: Education, Science, Public Interest, or Practice. This award recognizes distinguished psychologists whose lifetime contributions have advanced the

fields of education, science, public interest, and practice with ethnic and sexual minority populations. The nominees for any of these awards should be a senior psychologist who has made outstanding contributions in the promotion of diversity in clinical psychology as in leadership and positive influence in the education of students of color and sexual minority students; or who has made theoretical or empirical contributions to basic or applied research; or has identified solutions to social problems and enduring dedication to community needs; or development or delivery of services that are focused on ethnic and sexual minority populations.

Student Awards

The Society of Clinical Psychology (APA Division 12) is pleased to announce three awards for graduate students in clinical psychology.

The Division 12 Education & Training Committee will determine the award recipients. Please send nomination materials for student awards to Jon Weinand, Ph.D. via electronic mail: Jweinand@grhs.net. Deadline for receipt of nominations material is October 30, 2008. Awards will be announced by January 2009, and presented at the Division 12 Awards Ceremony at the annual APA meeting (you need not attend the APA meeting to be an award recipient.)

The Distinguished Student Research Award honors a graduate student in clinical psychology who has made exemplary theoretical or empirical contributions to research in clinical psychology. Clinical research contributions can include quantity, quality, and/or innovations in research. The recipient will be a person who is a matriculated doctoral student in clinical psychology (including pre-doctoral interns) and who is a student member (affiliate) of Division 12. Nominations should include a copy of nominee's curriculum vitae and two letters of support detailing the nominee's contributions to research in clinical psychology.

The Distinguished Student Practice Award honors a graduate student in clinical psychology who has made outstanding clinical practice contributions to the profession. Clinical practice contributions can include breadth and/or depth of practice activities, innovations in service delivery, and/or other meritorious contributions. The recipient will be a person who is a matriculated doctoral student in clinical psychology (including pre-doctoral interns) and who is a student member (affiliate) of Division 12. Nominations should include a copy of nominee's curriculum vitae and two letters of support detailing the nominee's contributions to the practice of clinical psychology.

The Distinguished Student Service Award honors a graduate student in clinical psychology who has made outstanding service contributions to the profession and community. Service contribution can include development of creative educational programs or other novel activities in the advancement of service, working to increase funding for agencies, volunteer time, working on legislation regarding mental health, general mental health advocacy; as initiating outreach to underserved communities or substantive involvement in efforts to do such outreach. The recipient will be a person who is a matriculated doctoral student in clinical psychology (including pre-doctoral interns) and who is a student member (affiliate) of Division 12. Nominations should include a copy of nominee's curriculum vitae and two letters of support detailing the nominee's service contributions to the profession and community.

Recipients of the student awards receive a plaque, a $200 honorarium contributed jointly by Division 12 and Journal of Clinical Psychology (JCLP & JCLP in-session), a complementary two-year subscription to JCLP & JCLP in-session, and one year subscription to Clinical Psychology: Science and Practice.

To learn more about the Society of Clinical Psychology, visit our web page:
www.apa.org/divisions/div12/homepage.html

Call for Nominations: Division 12 Web Editor

The Society of Clinical Psychology has recently created the position of Web Editor. The Web Editor will be responsible for the design, content, and maintenance of our website (www.apa.org/division/div12/homepage). The Web Editor must possess the technical skills for website management and familiarity with the content that our website should include. Content familiarity can be acquired on the job, with guidance from our Central Office and Board of Directors.

The position of Web Editor is open now and will be filled as soon as an appropriate candidate is identified. The anticipated term for this position is 3 years (2009-2011), and the annual honorarium is to be determined.

The Division 12 website is an integral part of our publication program. The work of the Web Editor, like the work of our journal (Clinical Psychology: Science and Practice) and newsletter (The Clinical Psychologist) editors, will operate under the oversight of our Publications Committee.

Serving as our Web Editor will provide excellent opportunities for involvement in Division 12 activities, collaboration with the division's leadership, and use of professional skills in enhancing the utility of the website.

Nominations, including self-nominations, should be sent electronically to Ms. Lynn Peterson at div12apa@comcast.net. Persons interested in the Web Editor position should include an abbreviated CV and a brief description of their qualifications for it.

Society of Clinical Psychology Board of Directors Minutes

Division 12 Board Conference Call Minutes

June 10, 2008

Call to Order, Dr. Irving Weiner, President

Members Present: Irving Weiner, Nadine Kaslow, Asuncion Austria, Norman Abeles, Bob Klepac, Lynn Collins, Danny Wedding, Jon Weinand, Marc Hillbrand, Eduardo Morales, Brian Hall, David Klonsky, Ed Craighead, Brad Karlin, Larry Beutler, Marsha Linehan, Lynn Peterson, Lynn Rehm.

Members Absent: John Norcross, Ron Brown, Linda Sobell, Deborah King (Brad Karlin standing in), Barry Hong

Introduction of Board/Agenda changes - Dr. Weiner
Dr. Weiner discussed bylaws changes. These changes will be sent out via email to all members.

The Minutes from the meeting Jan 25-27, 2008, were approved.

2009 Meeting Year Update

The Board will meet at the Crown Plaza in Philadelphia, Sept 12-13, 2009.

Finance – Treasurer's Report – Dr. Robert Klepac

1. Like many APA divisions, there has been a loss in membership. Both student membership and full membership has declined.

2. The EC has recommended an Investment Committee (a subcommittee within Finance Committee) be created. At the next meeting of the Finance Committee in September, this subcommittee will bring forward a proposal for how the Society should handle investments.

3. There is a requirement for scheduled budget reports from Sections. The Section Representatives have a responsibility to make sure that the Section Treasurers submit these reports. There will be a discussion of the role of Section Representatives at the September meeting.

Reports

Awards – Dr. Marsha Linehan reported on current award nominees. There was a discussion on the number of awards, the few nominations currently put forward for the awards, and the entire award process.

Publications Committee – Dr. Ed Craighead

Clinical Psychology: Science and Practice
The two publishers, Wiley and Blackwell have merged. The integration has not affected CP:SP. However, the "Synergy" website platform for the on-line journal has been changed. The new platform will be operational by January 1, 2009. Library subscriptions have remained steady, and we now have 2,600 libraries that get the journal via consortia agreements. There were 2,074 subscriptions in 2006 and 2,582 in 2007.
The journal's impact factor has gone up, and it is now 18th out of 86 mental health journals.

There are 91 "on-line only" subscriptions of our approximately 4500 members, and many of these subscribers are students. The Society is charged $11 per on-line only subscription, as compared to almost twice that for the hard copy, so this option should be marketed heavily before the start of next year.

The Journal Editor, Phillip C. Kendall, has a term expiring in 2010; he has served as editor for ten years and has made a substantial contribution to the success of the journal. Dr. Craighead discussed the possibility of renewing the contract with Wiley/Blackwell, as well as other options the Society might pursue. The new editor will be responsible for the first issue in 2011. This means he or she should be receiving manuscripts in early 2010. A final decision should be made at the September 2009 meeting; therefore, advertising for a new editor should begin in early 2009.

The Clinical Psychologist – Dr. Bill Sanderson
The Summer issue is ready, and it includes the com-

plete schedule for the upcoming convention in Boston.

Hogrefe & Huber book series update/ABCT endorsement – Dr. Danny Wedding
The board approved the concept of Hogrefe working with ABCT and to negotiate a discounted rate for ABCT members similar to those discounts D12 members receive. This may help with membership recruitment. Almost all books in the series to date have received stellar reviews.

Science & Practice Committee – Dr. David Klonsky

The website for the S&P committee is up and available. The Board discussed the language currently being used and whether or not "Psychological Disorders" should be changed to "Mental and Behavioral Problems"?

New criteria are needed to establish what practices are designated as evidence based.

Clinical Science Taskforce Subcommittee Report: This subcommittee was appointed to convert the report's recommendations into actionable items for a vote. The subcommittee was headed by John Norcross and included David Klonsky, Nadine Kaslow, and Larry Beutler. The subcommittee developed five actionable items based on the report and these actionable items that were approved by unanimous voice vote.

Education & Training – Dr. Jon Weinand

The committee has identified three students who will be receiving awards in Boston.

Professional Development Institutes 2008: There are six workshops scheduled; however, only 20 individuals have signed up to date. Dr. Weinand discussed the possibility of discontinuing the series.

Task Force on Educational and Conference Planning – Dr. Jon Weinand

There is a need to support teaching of early career psychologists. 44% of Division 12 membership is over 50 years old; younger people may be more comfortable adopting new educational technologies. At least 35% of members are independent practitioners and do not have a specific home in the division. 6.8% of members are PsyD's; 5-10% of the PDI workshop attendees are members of the Society.

Specific recommendations of the task force include the following: (a) have a convention within the convention; (b) have a theme for each conference (e.g., anxiety); (c) continue to focus on science to practice themes; (d) have D12 Sections develop their own convention spin-offs; (e) utilize a competency based model for assessing CE learning; (f) work with APA CE committee to develop skill based workshops to take the place of didactic lectures; (g) link CE with listserves so learning can continue after a workshop; (h) combine CE activities and social activities (e.g., "Meet the Presidents" sessions).

Fellowship Committee – Dr. Weiner for Dr. Carole Rayburn.

Four initial fellows have been approved and 19 current fellows have been approved. All of the nominees for D12 fellowship were approved.

Diversity Committee – Dr. Asuncion M. Austria

Dr. Austria thanked the board for the inclusion of diversity in the new, revised mission statement, and thanked several specific board members for their support for diversity issues. She emphasized the need to recruit more ethnic minority members to enhance diversification in the Division, and encouraged continued participation in the multicultural summits. Dr. Austria recommends that the D12 Outstanding Clinical Educator award be named in honor of Dr. Toy Caldwell-Colbert. It was decided that this discussion should be postponed until September.

Task Force Reports

1. Task Force Report on Strengthening and Promoting Science in Clinical Practice – there was a motion to endorse the report passed unanimously.

Section Reports

1. Section 2 – Dr. Deborah King. Dr. King was unable to participate in the call, but submitted a written report for Board review.

2. Section 3 – Dr. David Klonsky. Dr. Klonsky updated

the Board on the activities of the Society for a Science of Clinical Psychology.

3. Section 4 – Dr. Lynn Collins. Section 4 is trying to decide how to honor the memory of Toy Caldwell-Colbert.

4. Section 6 – Dr. Eduardo Morales. Dr. Morales reported on the multicultural summit; it was a great success. They are working on using IT to keep communication streams open, and to enhance activities such as mentoring.

5. Section 7 – Dr. Marc Hillbrand. The group's initial focus was on interpersonal violence, suicidality and victimization. Over the years, the Section has come to put more emphasis on suicide and suicidality. They aim to return to a greater balance between these areas of interest.

6. Section 8 – Dr. Ronald Brown. No report.

7. Section 9 – Dr. Norman Abeles. Section 9 members now receive the journal Assessment as a member benefit.

8. Section 10 – Brian Hall. Our student section remains active and engaged.

Council Reports – Division 12 Council Representatives.

Dr. Larry Beutler reported that there is a continuing effort to get minority psychology groups represented on Council. Psychology's response to the problem of torture continues to be debated on the floor of Council.

The group agreed to leave the journal fee at $30 for the time being; further discussion will occur in September.

The meeting adjourned at 5:30 pm EST.

Respectfully submitted,

Danny Wedding
Secretary

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)

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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 disc 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.