

THE CLINICAL PSYCHOLOGIST



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

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Gerald C. Davison, PhD
University of Southern California
President, Society of Clinical Psychology

PRESIDENT'S COLUMN

Graduate Education in Clinical Psychology and the Empirically Based Practices in Psychology Report

Gerald C. Davison, PhD

*Education is the kindling of a flame,
not the filling of a vessel.*

Socrates



In my first column (TCP Spring Issue, 2006), I discussed two issues that strike me as important in the EBPP report from APA (www.apa.org/practice/ebpreport.pdf), namely (a) the definition of evidence and the role of clinical observation, and (b) the sometimes unacknowledged role of theories and paradigms in how we understand our clinical practices and research. In this second column I offer for your consideration some implications that I believe the EBPP document has for education and training in clinical psychology.

Education, not Training

But first some terminology and a statement of bias: I wish we would do away with the title "director of clinical training" and other similar designations that emphasize training rather than education. Training refers to teaching people specific skills, like how to score a Rorschach, time-sample behavior, assess intelligence with the WAIS, conduct a structured interview like the SCID, phrase empathic statements to patients, draw up an anxiety-hierarchy, challenge a biased way of processing information, encourage a patient to make alterations in maladaptive schemas, and ad infinitum. It is obviously important for our students—and for independent practitioners and teachers—to acquire these skills but....

I believe that doctoral programs in clinical, whether they award the Ph.D. or Psy.D. degree, should concentrate much more on education. By this term (which comes from the Latin, educere, to lead forth, draw out) I mean the encouragement of critical and independent thinking in the process of mastering relevant bodies of knowledge. Sometimes I tell the first year clinical students at USC in my course on psychological intervention that my main purpose is to get them to worry. I don't mean that they should become diagnosable as suffering from GAD or otherwise be dysfunctional! I do mean that I want them to reflect carefully and critically on what they read, hear, and say; learn how to play today's science game well and to see its relevance for responsible application (practice); and examine both established and innovative approaches in assessment and intervention with a Missourian "show me" attitude. Not with a nihilistic cynicism but with a modesty and skepticism that befit a true scholar.

Inside:
Division 12
APA Program

(continued on page 2)

President's Column (cont.)

The Liberal Arts

These considerations have their roots in the liberal arts and the college experiences most of our graduate students have had. The liberal arts provide breadth of knowledge and perspectives, encouraging the student to reflect on and appreciate the complexity of human experience, on the role that the humanities, the social sciences, and the natural sciences play in our efforts to understand our world. Most importantly, "Liberal education teaches the importance of tempering profound convictions with a measure of tolerance and a judicious sense of humility." (Freedman, 2003, p.

58). Such study, which I believe is of overriding importance in the education of clinical psychologists, requires students to engage in areas of inquiry they might not have elected voluntarily. It encourages students to become generally well educated people who can think across a spectrum of disciplines, who question what is known, how it was learned, and why it might change over time.

These acquired abilities, these habits of careful, analytical critical thinking are the keys to all kinds of intellectual and professional success, particularly at the higher levels of professional achievement, where judgment and

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imagination, analysis and synthetic thinking are prized over specific training in the customary ways of doing business. These habits of thought can also, I would suggest, facilitate creativity and wisdom because of the achievement of a broad historical and philosophical context for applied activities. For example, a civil engineer involved in building a bridge would do well to appreciate the history of the region and the various cultures and beliefs of the population, in addition to understanding soil mechanics and physical and engineering principles.

Doctoral Study and Breadth

In an article I published last year, I discussed the way our graduate students are educated and I offered some opinions on problems I see in how we select and educate them:

...a liberal arts education provides undergraduate psychology majors—who account for the vast majority of applicants to our doctoral programs—with a suitably broad historical, social, and philosophical context for their specialty study of psychology. But...when students apply to graduate psychology programs, the primary focus of admissions committees is, I believe, on statistics, research methods, psychology content courses, and especially involvement in psychological research to the virtual exclusion of non-psychology work and intellectual interests that can provide...[a] broad context [for understanding the human condition]...

Once they enter a doctoral program in clinical or counseling psychology, the de-emphasis on topics not tightly linked to psychology becomes even stronger. When Ph.D. programs required comprehensive examinations, including history and systems, there was some assurance that students would gain a modicum of exposure to the larger historical, social, and epistemological context of the study of the human condition. But [I believe that] students are not being encouraged or required to appreciate the macro factors that influence their subject matter (Davison, 2005, p. 1062).

I have long believed in the importance of a solid liberal arts education as the foundation for all fields of graduate and postgraduate specialization. Whether it makes the more hard-nosed amongst us uncomfortable or not, both researchers and clinicians—to the

extent that there are sharp differences between them—have to be *Menschenkenner*, people who know and understand people, including themselves. I believe that a broad education—in addition, no doubt, to some inborn abilities of empathy and interpersonal sensitivity—can contribute to the ability to figure out the vagaries of human conduct and how most effectively to devise ethically proper methods of change.

My concerns extend well beyond clinical psychology education and training. Increasing and earlier specialization in such domains as cognitive (neuro)science and behavioral neuroscience imposes more and more demands on students and makes it difficult for them to avail themselves of graduate-level coursework in areas such as social, clinical, and developmental psychology. Indeed, many of my nonclinical colleagues question the very relevance of study in these areas to the research and scholarly goals of their students. I disagree with this position. It is ironic that most of today's leading senior psychological neuroscientists are themselves products of doctoral programs that emphasized broad and general education in psychology as a useful context for their specializations. Who can say that the graduate level study of psychopathology, for example, could not play a heuristic role in the research of a nonclinical graduate student? The same can be said for coursework in areas such as social and developmental psychology. One cannot know from where good ideas may develop. Of course the importance attributed by clinical psychology to what is sometimes called "core psychology" has been integral to sound doctoral education and has been for many years central to APA standards for accreditation.

Where Do Our Theories Come From?

The generation of a theory is perhaps the most challenging part of the scientific enterprise—and one of the least understood. It is sometimes asserted, for example, that a scientist formulates a theory simply by considering data that have been previously collected and then deciding, in a rather straightforward fashion, that a given way of thinking about the data is the most economical and useful.

Although some theory building follows this course, not all does. Bold directions, paradigmatic shifts, if you will, go beyond what extant data and theorizing tell us. Aspects too seldom mentioned in science and application are creativity and the excitement of finding a novel way to conceptualize things. A theory sometimes seems to leap from the scientist's

head in a wonderful moment of insight. New ideas suddenly occur, and connections previously overlooked are suddenly grasped. What formerly seemed obscure or meaningless makes a new kind of sense within the framework of the new theory or paradigm. How this happens has intrigued students of science and the arts for many hundreds of years. I am myself certain that such fertility of imagination is not nurtured by a narrow study of a specialized domain of inquiry and application.

As Kurt Lewin said many years ago, there is nothing more practical than a good theory. And in the epistemology that most of us adopt, one characteristic of a good theory is that it is testable, and one characteristic of a good scientist is that he or she does not become so invested in a given theory or paradigm that the search for disconfirming information ceases and that the person spends their time either not thinking about the utility of their theoretical models or actively avoiding opportunities to find shortcomings in their conceptual frameworks and core assumptions. We should not fall in love with our theories and for me that goes back to my initial suggestion that we should not construe doctoral education in clinical psychology as primarily a training enterprise.

Patient Characteristics, Culture, and Preferences

These thoughts are, I believe, pertinent to a key section of the EBPP report, namely "Patient Characteristics, Culture, and Preferences." In that section the task force discusses such things as the need for clinical psychologists to understand and respect the range of social and cultural factors that affect patients and that should be considered in assessing patient needs and wishes as well as planning treatments that are acceptable to the patient. An awareness of and sensitivity to cultural and ethnic differences is readily acknowledged to be of critical importance in developing a comprehensive understanding of the person and how most effectively and ethically to intervene. Developmental factors also need to be borne in mind, such as the different ways patients at different stages of life express their difficulties. In fact, one could add that the clinician needs to have an understanding of the very kinds of problems people have that vary significantly across the lifespan. Macro variables also must be incorporated into the clinician's understanding of the patient. For example, what are the economic conditions that might be influencing the patient in negative ways or that might provide a support for therapeutic change?

The methods of gathering assessment data on our patients and research subjects and the principles of change that we seek after/create in our efforts to improve the human condition are embedded in a larger context than the functionalist rules we work with as scientists. Said differently, the topography of our subject matter cannot be overlooked in our quest for knowledge.

Concluding Comment

A report last year from Harvard on general education (http://www.fas.harvard.edu/curriculum-review/gen_ed_report_05.pdf) provides a useful review and analysis of the diverse and evolving conceptions of and practices in general education. What comes to my mind in reading the report is the sometimes overlooked importance of the liberal arts to the nourishment of the human spirit, to the meaning that each of us constructs not just to get through the day—though that is often a challenge in itself in certain times and places—but to forge over time a life worth living. This transitions to my third and final presidential column, in which I will explore the implications of the EBPP report for the questions of ethical decision-making by therapists, the choice of goals in treatment, questions of meaning and values—the kinds of challenges that confront clinical psychology on many levels and in many domains, matters that must not be ignored in the education and training of clinical psychologists and other mental health service providers and researchers. The report asserts that patients' values are of paramount importance and should be the primary guide in the design and content of therapeutic intervention. I'm not sure it's as straightforward as that. □

Note


1. Everything in this column is the author's own opinion and does not reflect the opinions or policies of Division 12 or of the American Psychological Association.

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And now to reiterate what I said at the end of my first column: Bill Sanderson has agreed to publish as many comments on this column as space allows in the next issue of TCP. If you are interested in having your response included, email a paragraph of no more than 200 words to William. C.Sanderson@Hofstra.edu. Early replies will be given preference and the deadline is 9/1/06.

Response to Dr. Davison's First Column: Invitation to Auseinandersetzen

 I appreciate Dr. Davison's support for the work of the APA Presidential Task Force on Evidence-Based Practice and his thoughtful questions. In this brief response to his invitation to auseinanderzusetzen about the Task Force Report, I offer some additional context about the work and clarify a few points.

The APA Council of Representatives, including all Division 12 representatives, adopted the recommended policy statement on Evidence-Based Practice in Psychology (EBPP) in 2005. The Report (Task Force, in press), which provides the basis and references to support the policy, is available at www.apa.org/practice/ebpreport.pdf and will be published this year in the *American Psychologist*. Taken together, these documents give APA a unified voice to advance psychology's efforts toward improved funding for clinical research and education, health care legislation that serves the public need, and reimbursement for psychological services in the marketplace.

The Report makes it clear what should be accepted as evidence. APA endorses multiple types of research evidence that contribute to effective practice, because different research designs are better suited to address different types of questions. The Report delineates nine categories, from clinical observation and basic psychological science (in the context of discovery) through efficacy research (in the context of verification) and meta-analyses conducted to synthesize results from many studies and estimate effect sizes. No one claims that a single clinical observation is equivalent to a \$5 million controlled research study. In an integration of science and practice, the Report describes psychology's fundamental commitment to sophisticated EBPP and takes into account the full range of evidence psychologists and policy makers must consider.

In discussions that may be fostered by Dr. Davison's comments about "coherence" and the creation of "optimal" therapeutic conditions, it is important not to confuse clinical expertise with clinical pref-


erence. They are not the same. The Report presents clinical expertise as the prism through which one integrates relevant research, clinical data obtained over the course of treatment, and the patient's characteristics and preferences, in order to obtain good outcomes. Multiple components are described.

The APA Task Force heard many points of view and found substantive common ground. An extension of the effort to convey opportunities for rapprochement may be found in *Evidence-Based Psychotherapy: Where Practice and Research Meet* (Goodheart, Kazdin, & Sternberg, 2006). We are all participants in how EBPP will be shaped in the future; discussion in *The Clinical Psychologist* by clinicians, educators, and researchers is another positive step forward. □

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American Psychological Association.

Carol D. Goodheart, Ed.D.
Chair, APA Presidential Task Force
on Evidence-Based Practice

 To earn epistemological respect, practitioners' documentation of their work must go beyond "business as usual" clinical reports to create systematic and peer-reviewed case studies, defined by a variety of methodological quality controls. Such case studies can provide a qualitative, contextually elaborated, holistic description of the clinical patterns and processes of what transpires in the individual therapy case --complementing the discrete-variable-oriented, quantitative data that emerges from experimental research. Moreover, analyses across similar types of such cases can yield inductive, "bottom up," evidence-based generalizations that complement the deductive, "top down," evidence from experimental studies. Some of the case study methodological controls I have employed in my work include requiring: (a) a write-up that takes place within a standardized, explicit analytic framework which logically separates descriptive clinical material from theory, which shows the logical links between clinical material and theory, and which facilitates comparisons among cases; (b) a write-up that


contains extensive, illustrative quotes from therapy transcripts which provide the basic data upon which inferences are based; (c) a write-up that contains third party observers and interpreters for reliability; and (d) a write-up that contains the use of standardized, quantitative questionnaires before, during, and after therapy so as to place the individual case in a normative framework for comparison with similar types of clients. (For more on this approach to writing up case studies, see the peer-reviewed, open-access, e-journal I edit, *Pragmatic Case Studies in Psychotherapy*, at: <http://pcsp.libraries.rutgers.edu/> .)

To achieve adequate rigor, I suggest that a properly coherent treatment strategy be defined as one that both links systematically to previous research and documents explicitly the therapist's reasoning, thus making this reasoning open to outside critical analysis. These characteristics are captured in Peterson's (1991) Disciplined Inquiry model of practice, which my colleagues and I have incorporated into the criteria for the publishable, systematic case studies in our journal, *Pragmatic Case Studies in Psychotherapy* (see above). Specifically, in the Peterson model, the practitioner is required to set forth: (a) a clinical description of the client's problems and goals; (b) a discussion of the guiding theoretical conception being used to understand the client's problems and to plan treatment for them, together with a scholarly analysis of how the guiding conception is supported by previous empirical and clinical research; (c) a description of assessment information and a conceptual analysis of how the case formulation derives from applying the guiding theoretical conception to the assessment data; (d) a description of the therapy process and a conceptual analysis of how and why it relates to the guiding conception and the formulation, incorporating into the analysis data for empirically monitoring the therapy process; and (e) qualitative and normatively quantitative outcome data. □


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Daniel B. Fishman
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 Professor Davison appropriately points out that the observations made by clinicians are (by definition) empirical and therefore not to be excluded from evidence-based practice. Such observations may be limited by their anecdotal nature, subjectivity, limited quantifiability, and resistance to nomothetic study, but they are still empirical. The greater danger, it seems, lies in an over-reliance on a new brand of empiricism that values large datasets of quantifiable observations for the purpose of statistical inferences. Such naïve empiricism has often led us to put our trust in statistical data, only to be confronted later with a flurry of studies with conflicting findings, and then left with a wasteland of research that is abandoned. One example I pointed out in a recent book of mine relates to the comorbidity of pain and depression. After decades of "empirical" research, it has been revealed that these comorbidity statistics range anywhere from 0% to 100%. Epidemiological data in other areas are also riddled with wide discrepancies, and research on psychotherapy outcome is hardly free of marked conflicting findings. Against this backdrop, we may benefit from listening more closely to the clinician and the participant rather than the statistical data alone. □

Ephrem Fernandez, Ph.D.
Southern Methodist University

 I have read with great interest this paper about the need for greater empiricism in clinical psychology and especially in psychotherapy. Unfortunately, the word "empiricism" means different things to different people, ranging from "experiential" to "controlled." The most important aspect of a scientific endeavor is not empiricism but "replicability." That is why 40 years ago (1964) I started the laboratory method in both evaluation and interventions, using standard operating procedures that would be replicable by someone else somewhere else. Since then, I have also argued that as long as psychotherapy is based on talk, it will be very difficult if not impossible for psychotherapy to advance to a scientific position because talk is not a replicable medium of communication. That is why there are about 400 different types of psychotherapy. I would even argue that there are as many psychotherapies as there are psychotherapists because they are not replicable within themselves and among themselves.

As talk remains the major if not the sole

medium of communication, there is no way that psychotherapy will advance. It will remain stuck in the quagmire of the status quo. Another more repeatable and less costly medium of communication will take over face-to-face, talk-based psychotherapy, and whether psychotherapists like it or not, it will be writing, as is the case in science, law, business, and yes, medicine. □

Luciano L'Abate
Professor Emeritus
Georgia State University



What should pass as evidence?

As mentioned in the article, the meaning of the word "empirical" is "based on experience." Reports from clinicians should be given the same respect as conclusions drawn from research designs because they provide different types of experience and evidence. Research experience provides nomothetic evidence about how best to treat a given population as opposed to clinical experience which provides idiographic evidence about how best to treat a given individual. Reports from research designs show what treatment may be most effective, while reports from clinicians help show the nuances in treating the individual in a real world setting. It has been argued that clinical experience may be subject to theories and biases; however, the same could be said for research evidence. Research experience is subject to theories and biases when deciding what to study, how to study it, and how to measure it. Both clinical and research experience are valuable because they provide different types of evidence; both should be integrated into Evidenced-Based Practice.

Paradigm free?

When developing a coherent treatment strategy or when understanding a person suffering from a disorder, clinicians are not free of their own theories and

paradigms. This should not be a problem. Theories and paradigms are used by scientists and professionals in medicine, physics, business, history, and most every other field of study. Theories and paradigms are used by both children and adults in understanding and interacting with the world. The problem is not letting theories and paradigms guide practice, the problem is when a clinician is unwilling to alter his or her theory based on evidence. If a theory based treatment strategy or understanding of the person does not work for a client, the clinician should reconcile her or his theory and come up with a new strategy that does work for the client. Treatment strategies and understandings of clients do not have to be theory free as long as the theory is in line with the existing evidence and the ongoing dynamics present during treatment with the client. □

Joshua Swift BS. & Nick Wisdom B.S.
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I could not resist Gerry Davison's invitation to Auseinandersetzen about the APA Task Force on Evidence Based Practice. Unfortunately I quickly found myself stuck fast in a "conceptual filter." Repeated references to people with problems as "patients" greatly determined the boundaries of the discussion for me--which then could not be considered "from all possible angles." If we must accept the view that a person "has a disorder" and that we study "the disorder the person has" we are bound by the strangling constraints of the medical model. I cannot drink enough wine to Auseinandersetzen with this clasp around the "heart of psychology". □

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Get to Know Google

Simon A. Rego, PsyD



Welcome back! Those of you who read my inaugural column last issue might recall that my intent is to use this column to focus on areas in which clinical psychology and the Internet intersect. For this issue, however, I have decided to violate my mission in order to start with something basic: Google (www.google.com).

While I am sure that by now all of you have heard of the little [search] engine that could, largely via word of mouth, grow into what is now the third most visited site on the web, many of you may not be aware

“...Google has also introduced many features over the years that extend its capabilities to well beyond that of just a search engine site.”

of some of the commands that Google allows that can make your searching more efficient and productive. For example, did you know that Google searches on words in the order they are entered? So, the entry “clinical psychology”

will generate different results (about 66,200,000) than “psychology clinical” (about 65,100,000).

Let’s review just a few of the commands that you can use to help with your searches: *intitle:* This tells Google to search for just words found in web page titles. For example: *intitle:top graduate schools*. Similarly, *inurl:* tells Google to search only in the URLs of webpages. For example: *inurl:anxiety*. In addition, people are increasingly making information available online in the form of Word documents, Adobe Acrobat (PDF) files, and PowerPoint slide shows. The command *filetype:* tells Google to bring back only files created with the matching extension. For example, entering *filetype:doc depression treatment* will return only Word documents on the subject of depression treatment. Finally, for those of you who are grammatically challenged, the command *Define* tells Google to find definitions of words. For example, entering *define:unconscious* will return definitions of unconscious found on the web. For the complete list of these types of syntax search elements see: www.google.com/help/operators.html.

Those of you who are not impressed by syntax

commands might be surprised to know that Google has also introduced many features over the years that extend its capabilities to well beyond that of just a search engine site. These include a map generator (patients can get a map and directions to your clinic by entering your clinic’s US street address, city, state, and/or zip code into the search box) and news alerts (enter a topic you are interested in and Google will email you when it finds a new story on it). For those of you on the go, there is a flight tracker that allows you to check the status of your US flight by typing the airline name and flight number. For those who make a lot of online purchases, there is a package tracker that allows you to check the delivery status of your package by entering the tracking number. And while you are shopping for the latest text on cognitive therapy, you can use Froogle to search and compare prices at sites across the Internet. I am particularly fond of Google Scholar, and often find myself using it before PubMed. For those not familiar with it, Google Scholar allows users to “search the scholarly literature across many disciplines and sources, including: peer-reviewed papers, theses, books, and abstracts, from academic publishers, professional societies, preprint repositories, universities and other scholarly organizations.” Google is constantly adding new features (the latest include a book search that allows users to search the full text of books, a currency converter, and a Q&A that allows users to get quick answers to straightforward questions), so it pays to check back from time to time.

Finally, those of you who pay attention to detail may have noticed in my first column that my email address was at Google’s Gmail. Gmail is a free, search-based webmail service that includes more than 2,713 megabytes (2.7 gigabytes) of storage - and counting. The real strength of Gmail, however, is that it contains a built-in search engine that quickly finds any message an account owner has ever sent or received! This means there is no need to file messages in order to find them again. And when Gmail displays an email, it automatically groups all the replies to that email, so users can view a message in the context of what Gmail calls a “conversation.” If you hate to delete messages or are not the most organized, I highly recommend trying it. I hope you have enjoyed these pointers. As always, your comments are welcome! Feel free to email me at (where else?): dr.rego@gmail.com. □

“If Only I Knew Then What I Know Now...”: First Job Edition

Katherine L. Muller, Psy.D.

In this issue's column, I shared my thoughts about what I learned during my first five years as a psychologist. This time around, I thought I would consult with veterans in the field of psychology for wisdom and advice for early career psychologists. We've all said it at one time or another—"If only I knew then what I know now". My hope is that early career psychologists reading this may benefit from what these folks know now that they didn't know then!

I asked a number of psychologists who have been out of graduate school for more than 5 years (some for many more than 5 years!) to share the most important bits of advice they would give to psychologists in the early phase of their careers. I received so many responses, with amazing detail and breadth of information, that I will be able to provide multiple "editions" of their wisdom in this column. For this first edition of "if only...", we'll look at pearls of wisdom about one's first job in the field of psychology.

Location, Location, Location. It's not just a key theme in the field of real estate. The geographic location of your first professional position can be incredibly important. One respondent emphasized the pressure new psychologists often feel "to get, and accept, an offer for a first job"; regardless of where the job may be located. Because of this preoccupation with landing a job, other concerns like cost of living and proximity to supports like friends and family may move to the back burner. Once in the position, however, the reality of where you are may hit- and it may not be pretty. One psychologist reported spending a difficult ten months in a place that was a "terrible match" for her interests and priorities. Though the job may have fit the bill professionally, the location prevented her from achieving her personal goals and pursuing other "quality of life" interests like favorite free-time activities and socializing. Her recommendation is that new psychologists consider these issues before and during the job search- not after accepting an offer.

Know Thy Mentor

We all know that having a mentor can be very important to our career path. But, as multiple respondents echoed, the mentor you "end up with" may not be the one you and your career need. The allure of working at a prestigious site or with an esteemed individual in the field may be hard to resist. The psychologists I surveyed cautioned individuals not to be blinded by "fame or name" and instead look for a mentor who will help you develop your career, both with them and without them. One

respondent recommended that new psychologists find out as much as they can about potential mentors before committing to work with them. She suggested not only finding out about a potential mentor's "productivity and scholarship" but also "their generativity and generosity".

Personal Care "Items"

The topic of first-job advice that garnered the most attention in the feedback I received was "personal life". Specifically, respondents emphasized the need to have, and maintain, one of these. Researchers and clinicians alike recognized a tendency to put "personal interests on hold" when first entering the field as a professional. Many cited their whole-hearted intent to get back to personal pursuits once "the career got going", but most found themselves caught in the cycle of "pump(ing) out papers" or adding "just one more patient" to their practice caseload. A few mentioned that they "neglected" the other areas of their lives in pursuit of their career goals. One psychologist shared the insight that career pursuits are "a marathon, not a sprint, and if you go out too fast, you're more liable to develop cynicism and burnout". The overwhelming recommendation here: "There is much more to life than work and your work will be much more successful if you are happy in life!"

Some of the advice and recommendations reviewed here may seem like common sense; many of you may believe that you know all of this already. But my contributors wisely recognized the all-too-common disconnect between "knowing" and "doing". Their suggestions for ensuring that you "do" included "scheduling down time" and actively balancing work and personal interests. They advised early career psychologists to look closely at their choices and speak with peers and "non-psychology" folks to get feedback on their first-job plans. To a colleague who is a driven, 60-hour-per-week post-doc fellow, your first-job option of moving across the country to work at a 60-hour-per-week post-doc fellowship may seem entirely reasonable. To a friend or family member with a steady 9-5 job that allows for free time, flexibility, and hobbies, your plan may seem ridiculous. Take both views into account.

I hope the feedback from these "former" early career psychologists is helpful for those of you in the process of finding your first job- and for those of you looking for your next position! I would like to thank the following psychology "veterans" for their thoughtful feedback and advice for this edition: Dr. Deborah Roth Ledley, Dr. Martin Franklin, Dr. Alec Miller, Dr. Simon Rego, and Dr. Joan Cook. Your wisdom, hard-earned in many cases, is very much appreciated. If you'd like to weigh in on first job concerns, or any other issues impacting early career psychologists, please feel free to drop a line to: kmuller@montefiore.org. Your sage advice may be included in a future column. □

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The Division of Abnormal and Clinical Psychology, 1945-1955

 In my initial column, I described the three organizations that preceded Division 12 of the American Psychological Association, covering the years from 1917 to 1945. With that background, I can now proceed to describe how Division 12 itself was founded. In the 1930s, organized psychology in the United States had divided itself into two parts, the American Psychological Association (APA), and the American Association for Applied Psychology (AAAP); at that time the APA had come to represent the science of psychology, while AAAP represented its professional aspects, including clinical psychology. Many clinical psychologists belonged to both organizations, of course.

World War II brought with it the demand for national unity in order to defeat Germany and Japan. Under the circumstances, it did not make sense for a field like psychology to be divided, and a movement emerged to combine APA and AAAP. The resulting organization was the new APA of 1945, which kept its previous name but now adopted the organizational structure of the AAAP and represented both the science and the profession of psychology.

It was decided that the new APA would have a number of divisions to appeal to the interests of its various members. Logically, this plan began with a Division 1, for those interested in general psychology. A new Division 11, titled "Abnormal Psychology and Psychotherapy," was devised as an interest group presumably for those interested in the academic and research parts of the field. Division 12, "Clinical Psychology," was a carry-over from the AAAP Clinical Section, for those more interested in practice. In the end, the prospective members of Divisions 11 and 12 saw that they had much in common and decided to combine these two organizations, calling the resulting hybrid the "Division of Abnormal and Clinical Psychology" and keeping the number of Division 12.

World War II resulted not merely in such organizational changes within the subdisciplines of psychology. It mobilized the medical community as well and produced unprecedented cooperation and good feeling between psychology and psychiatry in the service of the mental health needs, first of the armed forces, and second of the veterans returning to civilian life. William C. Menninger was the chief psychiatrist of the Army and Robert Felix (also a psychiatrist) the Director of the new National Institute of Mental Health (NIMH). James Grier Miller, a PhD and MD (psychology and psychiatry), was a key figure in the reorganized Veterans Administration (VA). Soon after the war, the VA and the NIMH approached the APA with plans for financial support of graduate education in clinical psychology.


The memorable 1949 conference in Boulder, Colorado on training clinical psychologists was funded by NIMH and was attended by 70 prominent psychologists. This conference came up with the well-known scientist-

practitioner model of PhD training in clinical psychology, and the APA devised a system for accrediting such graduate training programs, including internships. In 1945, the first psychology licensing law was passed by Connecticut, and in 1947 the American Board of Examiners in Professional Psychology (ABEPP, later simply ABPP) was founded to recognize advanced levels of clinical competence. The modern field of clinical psychology as we know it was thus launched in the post-World War II era, not only in the USA but also in the United Kingdom and several European countries. In each country, clinical psychology was part of an expanded government health care system.

As noted above, Division 12 began functioning in 1945. Its newsletter (later called *The Clinical Psychologist*) was begun in 1947, at first edited by psychologists who also served as either secretary or president of the Division. The psychologists who served as president of the Division in those years played important roles in the events just described. Edgar A. Doll, president in 1945-46, represented a sort of holdover from prewar days. He had served as the chief psychologist of the Vineland Training School in New Jersey and was well known for devising the Vineland Social Maturity Scale, an index of social competence in the diagnosis of mental retardation. Laurance F. Shaffer, president in 1946-47, had headed the Psychological Corporation and was the first APA-appointed editor of what became the premier journal of clinical psychology, the *Journal of Consulting and Clinical Psychology*. David Shakow, president in 1947-48, had headed the Committee on Training in Clinical Psychology, whose plans were later endorsed by the Boulder Conference. A noted researcher on attentional processes in schizophrenia, he later served as chief psychologist for the NIMH. David Wechsler, president in 1948-49, devised the famous Wechsler scales of intelligence, still the standard assessment procedures in this domain for both adults and children. Carl Rogers, president in 1949-1950, was a pioneer in research on psychotherapy and an advocate of the role of the clinical psychologist as a psychotherapist. Norman Cameron, a PhD-MD (psychology and psychiatry) was an influential researcher and writer in the domain of psychopathology, known for his description of the nature of paranoid thinking. Samuel J. Beck, president in 1951-52, was a virtuoso in the administration and interpretation of the Rorschach inkblot test, considered during this era to be a crucial part of the clinical psychologist's assessment battery. O. Hobart Mowrer, president in 1952-53, was a major figure in the area of learning theory, so important in psychology in this era, and not incidentally, a co-author of treatment for bedwetting in children, subsequently well validated empirically. William A. Hunt, president in 1953-54, had done important research in psychopathology and also had served as the chief psychologist in the U.S. Navy in World War II. Finally, Harold M. Hildreth, president during 1954-55, played a major role as a clinical psychologist in the VA. He earned the gratitude of many clinical psychologists by demanding that those hired by the VA have doctoral degrees. □

Family Connection among Haitians: A Buffering Agent

Angela M. DeSilva and Kelly L. Subrebost
Boston College

 The experience of connection to family is a critical source of support and resilience for any individual (Sameroff & Suomi, 1996). For racial minorities and immigrants in the United States, family connection is a particularly critical variable to understand given the role that it plays in coping with the stressors associated with racism and/or the adjustment to a new country and culture. Not only can family support for ethnic and linguistic minorities be a source of strength for these individuals, but strong family connections may also contribute to their overall mental health.

Studies examining the role of family connections and mental health among ethnic minorities have found

“...higher levels of family cohesion and family support have been associated with lower levels of suicidal ideation...”

significant positive outcomes (Harrison-Hale, McLoyd, & Smedley, 2004). For example, among African Americans, higher levels of family cohesion and family support have been associated with lower levels of

suicidal ideation (Harris & Molock, 2000), depression (Becker & Schmalting, 1991), and anxiety (White, Bruce, Farrell, & Klier, 1998). Similar findings have been reported in Latino and Asian immigrant families, which stresses the significance of strong family support on the mental well-being of individual family members (Cumsille & Epstein, 1994; Gil & Vega, 1996; Kimbrough, Molock, & Walton, 1996).

Despite the large number of Haitian immigrants in the United States the dynamics and structure of Haitian families have not been investigated (Buddington, 2002). Considering the rapidly increasing number of Haitian families immigrating to the United States and the paucity of research concerning them, it becomes important to investigate Haitian family structures and functions in the United States, particularly to gain insight about Haitian families and their effect on the mental health of family members.

In order to enhance our understanding of Haitian immigrant families, the current report provides: (a) descriptive information about family char-

acteristics (household composition, family proximity, family get-togethers, and family correspondence) of Haitian immigrants; (b) a summary of family support (family contact, connection, and stress) for Haitian immigrants; (c) a report on the relationships among family characteristics and family support; and (d) an assessment of whether family characteristics and family support indicators predict self-esteem and depression in Haitian immigrants. This in-depth examination will provide mental health researchers and clinicians with ideas regarding how to integrate such data into intervention and treatment delivery for this population.

A total of 150 Haitian adults (91 women and 59 men) were recruited from community centers, churches, and neighborhoods in Haitian communities in the Boston area. The mean age of participants was 40.72 years ($SD = 12.6$ years, range = 22-82). Ninety-three percent ($n = 141$) of the participants were born in Haiti and the majority (83%, $n = 115$) reported Creole (the native language of Haiti) as their first language, although all participants were able to speak English. The mean age of immigration to the United States was 27.42 ($SD = 26.47$, range = 11-94) and almost all of the participants (99%, $n = 148$) reported that their parents were born in Haiti.

The Neighborhood and Family Questionnaire (NFQ; Belle 1981) was used to examine both the family characteristics and the family support of this sample. Nugent and Thomas's (1993) Self-Esteem Rating Scale (SERS) was used to measure self-esteem, while the CES-D (Radloff, 1977) was used to measure depressive symptoms.

Descriptive statistics were used to provide a basic understanding of the characteristics of Haitian immigrant families (e.g., the number of people living in a house, the number of family get togethers participants attend). Pearson Product Moment correlations were calculated to assess the relationships between Haitian participants' family characteristics, family support, and mental health. Lastly, hierarchical regressions were run to determine whether family support is predictive of Haitian mental health.

Overall, the results obtained in the current study suggest that Haitian immigrants have a notably different family experience than Haitians remaining in Haiti. While results obtained in this study suggest that Haitian immigrants, like native Haitians, live with both kin (related by blood or marriage) and non-kin relatives, the frequency with which they have regular contact or gatherings with relatives decreases upon

Family Connection among Haitians: A Buffering Agent (cont.)

arriving to the United States. Another difference is the relatively high levels of stress that Haitian immigrants report experiencing from their families. One possible explanation for this finding is that Haitian families are negotiating a new environment for their family in the United States while simultaneously supporting immediate or extended family abroad in Haiti (Zephir, 1996).

Despite these differences in family structure, the results of this study point to the continuing benefits of family life for Haitians who live in the United States. This is evidenced by the results showing a positive association between family connection and self-esteem and a negative relationship with depression symptoms. In a similar vein, family stress is associated with poorer mental health, specifically with higher levels of depressive symptoms and lower levels of self-esteem. Thus, similar to other ethnic and linguistic minority groups (Price, Dake, & Kucharewski, 2001), family is a source of strength for Haitian individuals.

Within the present sample, family connection was viewed as a resource that helped to buffer against the onset of depression. Since family plays such a significant role in the lives of many Haitians, engaging family members in care and treatment is necessary (Colin & Paperwalla, 1996). Incorporating family members in the treatment process can lead to a more trusting relationship with the provider, leading to increased treatment adherence and compliance. □

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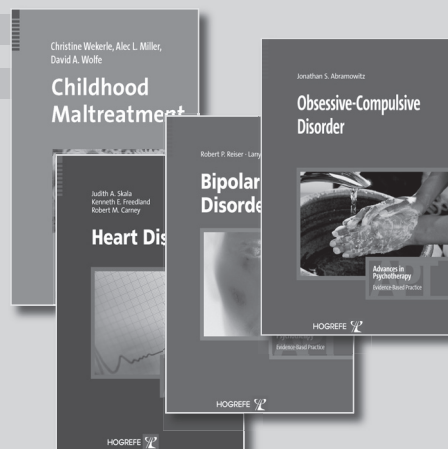
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Black Box Behavior Therapy for Stimulant Prescribing

Timothy J. Bruce, Ph.D.

University of Illinois College of Medicine

 On February 10, 2006, the Drug Safety and Risk Management Advisory Committee to the U.S. Food and Drug Administration (FDA) voted 8 to 7, with one abstention, to urge the FDA to order black box warnings, the most serious of alerts, on all stimulant medications used to treat ADHD. The warnings would describe potentially fatal cardiovascular risks associated with their use. Data reported to the FDA between 1999 and 2003 on some 676,000 ADHD patients using stimulant drugs showed 25 reports of sudden death, including 19 children ages 7 to 16, and 54 reports of non-fatal cardiovascular or cerebrovascular adverse events, 26 of them in minors under 18.

A month later, another FDA-commissioned committee focusing on children's medical issues revisited this issue. Although not voting, this group recommended clearer warnings on ADHD drug labels, but stopped short of endorsing the "black box" type recommended by the earlier panel. Both committees agreed that better physician and patient education regarding cardiovascular risks was needed.

It is interesting that the intent of the first meeting was not to make recommendations regarding warning labels per se, but to "focus on research approaches that could be used to study whether drugs approved for...ADHD...increase the risk of adverse cardiovascular outcomes" (DSaRM, p. 11). And that committee spent most of their time accomplishing their intended charge. They noted that the adverse events were discovered through reviews of the FDA's passive surveillance system, MedWatch, in which individual case reports of events are recorded. They thoroughly discussed the strengths and weakness of data collected through MedWatch. They noted, in particular, that MedWatch data are not reliable enough to accurately assess incidence, nor are they complete enough to rule-out confounds such as the possibility that pre-existing cardiovascular conditions may have accounted for the adverse events. They considered detailed methodological issues and generally acknowledged that data from better-controlled studies were needed to support the conclusion that the link between the drugs and the adverse events is causal. And, they recommended specific study strategies that would improve confidence in addressing the questions around risk.

So how did the committee go from accomplishing its original charge to recommending warning labels?

And why did the majority recommend black box warnings, warnings usually reserved for those instances when a risk, "is very clearly established as causal" (DsaRM, p.197)? In fact, the decision to vote on black box warning labels was not planned. Rather, it was a motion made by a member of the committee who practices as a cardiologist, but clearly knows the first step in behavior change, "What I was really trying to accomplish is to elevate the warning high enough to make people think twice before they give the drugs to an adult with symptoms that maybe are pretty marginal. Is that good public health policy? To say that before you give a 50 year-old a drug that increases heart rate and blood pressure you ought to really think pretty hard about it? And, the only way you get people to pay attention is when you put it in a black box. It just doesn't seem to get there if you don't do something pretty dramatic, and that is why I made the motion the way I did. It is because I want to cause people's hands to tremble a little bit before they write that script, and the only way I know to do that is to get their attention with a black box. Now, that is the reality" (DsaRM, p.223).

Many of those who voted "Yes" expressed concerns regarding the overdiagnosis of ADHD in children and adults and in the overprescribing of stimulants for the problem. Approximately, 2.5 million children and 1.5 million adults take these medications. The most common comment from those voting "No" was that there were other mechanisms for reporting uncertainty regarding risk than using the most serious, black box warning. The recommendation for a black box warning was not to communicate a causal link between stimulant use and adverse cardiovascular events, but rather to warn of a serious but uncertain risk and to prompt prescribers to think about it before they diagnose ADHD and treat it with stimulants.

Of course, the content, motives, and group processes inside these committees was more complex, informative, and thoughtful than this news summary can capture. If you are interested in the details, you can read the verbatim transcripts of the two commissions' hearings at www.fda.gov. Although a little lengthy, they do provide an interesting insight into decision making that influences public health policy.

The FDA is planning a new study of ADHD drugs based on recommendations of the two advisory committees. Those results are expected sometime next summer. They have yet to act on the different recommendations regarding the warnings. So it remains uncertain whether black box behavioral therapy will actually change prescribing behavior. □

BOOK RECOMMENDATIONS


Lata K. McGinn, PhD — Section Editor

The Psychology of Religion: An Empirical Approach

**B. Spilka, R.W. Hood, B. Hunsberger,
and R. Gorsuch**

Guilford: New York. 2003

Reviewer: Robert L. Leahy, PhD

 Although psychologists are often associated with secular humanism and have sometimes taken an anti-religious position, there is increasing interest in the role of values, spirituality and traditional community in the lives and welfare of people. Notable anti-religious positions have been taken by

“Religion, community, ritual and prayer have significant roles in the lives of people—often to their benefit.”

Freud and Ellis, yet the role of values, virtues and even “ultimate concerns” has become a major part of what is now called “positive psychology”. What is the

nature of religious commitment and practice and how is it related to psychological well-being? The authors of *The Psychology of Religion* provide us with an exhaustive survey of this field—one that serious psychologists might find valuable.

Religion plays a major role in the lives of most

of our clients. For example, 97 % of Americans believe in God and 90% of people pray—with the United States ranking at the top of all nations in religious belief and participation. In fact, some have argued that the concept of God is hardwired into our brain. But there is wide variation as to what “God” personifies. For example, factor analyses reveal a range of clusters, including a punitive, harsh, benevolent, impersonal or an omnipotent God.

Research demonstrates that the practice of religion is associated with significant health benefits, positive social relationship values, and higher levels of marital and sexual satisfaction. Studies also show that older individuals report less fears of dying, that meditation slows down brain waves, and that prayer is often a significant means for gaining a sense of peace.

There are excellent reviews of the vast literature on religion and coping, mysticism, conversion, and other topics that will give pause to anyone who believes that religious participation is an escape from reality pursued by irrational and sick people. Religion, community, ritual and prayer have significant roles in the lives of people—often to their benefit. It may be that our recent interest in “positive psychology” may draw upon the wisdom that has been here for quite some time. This book will help the reader understand how religion can, in some cases, play a positive role in healing the suffering and establishing meaning in the lives of their patients. □

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Section II: Geropsychology Submitted by Deborah King


 Members of Division 12, Section 2 and Division 20 are hard at work finalizing plans for the National Conference on Training in Professional Geropsychology, to be held June 8-11th, 2006 at the Antlers Hilton in Colorado Springs. Conference Co-Chairs Michele Karel, Ph.D. and Bob Knight, Ph.D. note that the conference is especially timely given the rapid growth of the older adult population, the projected increase in rates of mental disorders, and the shortfall of psychologists trained to provide geropsychology services. Conference participants will be 50 delegates representing invited organizations or “at large” delegates invited to apply via broadly distributed e-mail announcements. Participants will develop aspirational educational models to inform geropsychology training at the graduate, internship, postdoctoral and post-licensure levels. Outcomes will include publication of the recommended models of geropsychology training, as well as the various pathways for obtaining specialized preparation for work with older adults.

Visit our website at www.geropsych.org for more information on clinical geropsychology!

Section III: Society for a Science of Clinical Psychology Submitted by E. David Klonsky


 We are in the midst of another exciting and active year here at SSCP and are pleased to share some of our activities with the Division 12 membership! The SSCP webpage has undergone a substantial overhaul. The redesigned webpage—which resides at SSCPweb.org—describes the Section's history and current activities. In addition, the website features links of interest to clinical psychology professionals and students, including the SSCP Directory of Clinical Psychology Internships.

Section VI: The Clinical Psychology of Ethnic Minorities Submitted by Anabel Bejarano

 Section VI members will be involved in various APA convention activities. Gordon N. Hall will


receive the Stanley Sue Award from Division 12, and participate in a symposium on research training for ethnic minority undergraduates (Division 45). John D. Robinson, will chair a meeting of the APA Membership Committee, and continue as Chair of this committee for the remainder of the year. Milton A. Fuentes, will be discussant on a symposium chaired by Y. Evie Garcia, titled Bicultural Couples—When Diverse Worldviews Merge (Division 42). Janet Matthews, member of the Presidential Task Force on Mentoring, will participate in programs illustrating mentoring across three generations, including “senior” mentor Stanley Sue. She will participate in a Town Hall meeting as member of APA's Policy and Planning Board. She is also discussant for a symposium on the role of state associations in the post-Katrina relief efforts (Division 31). Anabel Bejarano will present on trauma among minority youth (Division 42) and on cultural competence with international women (Division 35). Guerda Nicolas will participate on a symposium on spirituality, religion and psychotherapy (Division 42).

Section VIII: Association of Psychologists in Academic Health Centers Submitted by Danny Wedding

 We will be hosting a national conference in Minneapolis in 2007. The conference theme is Psychologists in Academic Health Centers: Traditions and Innovations in Education, Science, and Practice. The dates of the conference are May 3- May 5, 2007. The format for the conference will be plenary sessions and working groups centered around the themes of education, science, and practice. We anticipate a conference that will prove invaluable for attendees as we those address issues most important and critical to shaping the future of psychology in academic health science centers.

The National Conference Chair is Rick Seime, Mayo Clinic and the local arrangements Chair is Bill Robiner, University of Minnesota Health Science Center. A program committee is already hard at work developing the program. The local arrangements will include a comfortable and reasonably priced venue right on the University of Minnesota campus. Look for more information coming soon.

Congruency is Key: A Model for Professional Development in Clinical Psychology

 After clinical internship interviews, people always want to know what they asked. The answer, I found out, depends greatly upon where you interview. At one site, I met with three interviewers, and the focus was largely on clinical experience and competence. At another site, I met with four interviewers and received only one question about clinical experience; the remainder revolved around research interests and experience.

Many of the questions interviewers asked seemed similar to what one might find in an intern-

“...the goal is to prioritize training opportunities that have the highest degree of congruency with your target image.”

ship interview preparation book. The rest, however, were completely unpredictable. The most difficult question I received was of this latter sort. It came from an unexpected source (an administrative assistant) at an unexpected time (while eating lunch). After biting into an apple, she asked, with a slight

grin, “What do you want to be when you grow up?” That question seemed easy enough to field, but the follow-ups were not. Getting more serious, she continued with, “How would you say your past training relates to your professional goals?” And then, “How will being here help you achieve those goals?”

Sometime later, I learned that the assistant had a substantial say about how interviewees were ranked by the program, which explains her evaluative line of questioning. Still, though, I could not help but be impressed with her assessment strategy. It required me to describe and substantiate my professional identity, and it made me ask myself questions that are relevant, I believe, for all budding psychologists. How are our past experiences, present training needs, and future goals related to one another? And what is the underlying principle that guides our decision to pursue some training opportunities and

not others?

With the rest of this column, I would like to discuss the model I have used to answer these questions. It is called the “Congruency Model of Professional Development” (See Figure 1), and it begins with a simple question: What is your target image? Do you plan to become a forensic psychologist who works in the government sector, a scientist-practitioner who works in a private practice, or a clinical scientist who works in a psychology department? The more specific the target image, the better (e.g., a clinical scientist, interested in the etiology of eating disorders, who works in a psychology department).

Once you have established a target image, the ongoing task becomes one of prioritizing. We engage in a variety of activities, and these may be categorized into at least four domains: research, teaching, clinical work, and professional activities. In the Congruency Model, the goal is to prioritize training opportunities that have the highest degree of congruency with your target image. Let’s look briefly at each of these major domains to see how the Congruency Model works, assuming that the target image centers on wanting to become a clinical scientist.

Research

Conducting research is critical for developing clinical scientists, but opportunities are ubiquitous. Deciding which opportunities to pursue is easy within the context of the Congruency Model, where the first task is to develop a “burning question” or a set of related “burning questions.” These are questions that you need to answer; that keep you awake at night. If you already have the knowledge and skills necessary to answer your burning question(s), then you are doing great; if not, then consider prioritizing research endeavors that meet this need.

Teaching

Competent teaching, I believe, is the second most important skill budding clinical scientists can develop. Within the Congruency Model, ideal opportunities are those that are both highly congruent with your target image and synergistically related to your research. Instructing your own course is the most intense way to gain teaching experience, but other opportunities exist, including paid and unpaid teaching assistant positions and lectureships. If these posi-

Congruency is Key: A Model for Professional Development in Clinical Psychology (*cont.*)

tions are not officially available in your department, consider approaching a professor and ask to unofficially assist with a course.

Clinical Work

The third component of the Congruency Model is clinical work experience, and opportunities in this area should be prioritized based upon the extent to which they broaden your clinical competence while simultaneously informing your research and teaching.

"...Engagement in such activities demonstrates dedication to the development of clinical psychology..."

Accruing clinical hours is often the goal, but clinical hours are not necessarily a game of "more is better." Good supervisors, for example, will remind you not to overlook the quality of those hours. Quality in this sense can be assessed by eval-

uating how much supervision is provided, whether the opportunity is congruent with your target image, and to what extent the opportunity informs your teaching and research.

Professional Activities

Professional activities are the final component of the Congruency Model and these can take many different forms, including: positions on departmental committees, leadership roles in psychological asso-

ciations, and positions as a journal or grant reviewer. Engagement in such activities demonstrates dedication to the development of clinical psychology and exhibits a commitment to public service in the interest of the profession. As with all other opportunities, the more congruent the professional activity is with your target image, the better!

Concluding Comments

That assistant was on to something when she asked me what I want to be, and I think a good answer to this question has never been more necessary. The prevailing trend in the internship match process explains why: in 2002, 15% of applicants failed to match on "match day," and the percentage has increased from there, to 18% in 2003, 20% in 2004, 21% in 2005, and 23% in 2006. The beginning of each academic year brings with it an opportunity to reprioritize the various activities in which we engage, and with statistics like these, informed prioritizing is becoming increasingly necessary.

My thesis in the present discussion has been that when considering how to prioritize, congruency is key. For optimal advancement, your target image should be congruent with your future goals, and the specific activities you pursue should be congruent with your target image. The product of such congruency is a sensible story that you can tell to anyone in order to convey and substantiate your professional identity. □

Clinical Psychology Brochure

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

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

**For more information, contact:
Division 12 Central Office,
P.O. Box 1082,
Niwot, CO 80544-1082.
Tel: (303) 652-3126.
Fax: (303) 652-2723
Email: div12apa@comcast.net**



DIVISION 12 SPONSORED CONTINUING EDUCATION WORKSHOPS

will be offered this year in New Orleans, LA, at the New Orleans Marriott Hotel,
August 9, 2006, just prior to the APA Convention.

Full-day Workshops, Wednesday, August 9, 7CE Credits

A. Second Annual Military Clinical

Psychology Symposium: Posttraumatic Stress Disorder—Innovations in Research and Practice

Matt Friedman, MD, LCDR Gary Hoyt, Ph.D., Steven Southwick, MD, Andy Morgan, MD, LTCOL Rick Campise, Ph.D., COL Tom Williams, Ph.D., Ann Rasmussen, MD, CAPT Morgan Sammons, Ph.D., Heidi Kraft, Ph.D.

B. Recent Developments in MMPI-2 Interpretation: The Restructured Clinical Scales and Non-K-Corrected Profile

Yossef S. Ben-Porath, Ph.D.

C. Treating Victims of Mass Trauma and Terrorism

Larry E. Beutler, Ph.D.

D. Movies and Mental Illness: Using Films to Understand Psychopathology

Danny Wedding, Ph.D.

E. Surviving the Politics of Academia: How to Get Tenure and Promotion

Helen D. Pratt, Ph.D.

F. Dialectical Behavior Therapy for Borderline Personality Disorder

Anthony P. DuBose, Psy.D.

G. Psychological Interventions for Patients with Heart Disease

Judith A. Skala, RN, Ph.D., and
Kenneth E. Freedland, Ph.D.

H. Diagnosis and Treatment of Obsessive-Compulsive Disorder

Jonathan Abramowitz, Ph.D.

I. Advances in Evidence-based Treatment for Bipolar Disorder

Robert Reiser, Ph.D.

* Workshops C, D, G, H, and I include the book from Hogrefe and Huber Series valued at \$30

WORKSHOP REGISTRATION FORM

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

Complete and return this Registration Form with your check, money order, or credit card information. All payments must be in U.S. dollars. Make checks payable to: Division 12 PDI. Send to: Division 12 PDI, P.O. Box 1082, Niwot, CO 80544-1082. Registrations are accepted on a first-come, first-served basis and will be confirmed by mail. Visa/MasterCard registrations may be made by telephone (303) 652-3126 (8a.m. to 5p.m. MST) or fax (303) 652-2723 anytime. Fees are discounted \$10 per workshop per day if check or credit card payment is received by June 16, 2006. Full refund is given if a workshop is cancelled by Division 12 and for registrant cancellations received before June 30. A 25% handling charge is imposed on cancellations received between July 1 and July 14. No refunds can be given for cancellations received on or after July 15, 2006.

Name _____ Highest Degree _____ Div. 12 Member: Yes No

Address _____

City _____ State _____ Zip _____

Tel. No. (with area code) _____ Email _____

Credit Card: MC/Visa Card Number: _____ Exp. Date: ____/____/____

TOTAL ENCLOSED _____ Signature: _____

CONTACT CENTRAL OFFICE FOR MORE INFORMATION: Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. Tel. (303) 652-3126 Fax (303) 652-2723 www.apa.org/division/div12/homepage



DIVISION 12 APA PROGRAM—August 2006

Division 12 will offer a range of poster sessions, symposia, and panel discussions that address this year's theme of "Empirically Supported Practice, Clinically Relevant Research." Psychotherapy, psychological assessment, and training in clinical psychology are all emphasized. In addition, the location of the conference in New Orleans will allow attendees ample opportunity to learn about the psychological, academic, and institutional effects of Hurricane Katrina from those who have worked directly in the aftermath of the disaster.

David F. Tolin, Ph.D.
Division 12 Program Chair

Thursday, August 10, 2006

Invited Symposium: Ethics and the Practice of Psychological Assessment

8/10 Thursday: 8AM – 9:50AM

Morial Convention Center, Meeting Room 262

Barbara A. Van Horne, Robert T. Kinscherff, Jerry J. Sweet, Thomas D. Oakland, Lynda D. Field, Mary Alice Conroy

Symposium: Serious Mental Illness in Long-Term Care Settings

8/10 Thursday: 8AM – 9:50AM

Morial Convention Center, Meeting Room 266

Kathy Hyer, Marion Becker, Adam Rosenblatt, Victor A. Molinari

Symposium: Best Practices for Competent Supervision in Practicum

8/10 Thursday: 9AM – 10:50AM

Morial Convention Center, Meeting Room 354

Kim D. Lassiter, Victor Pantesco, Judy Hyde, Brian L. Lewis

Poster Session: Psychotherapy and Psychopathology

8/10 Thursday: 10AM – 10:50AM

Morial Convention Center, Halls E & F

Symposium: Ethical Online Psychotherapy? Progress, Problems, and Possible Solutions

8/10 Thursday: 10AM – 10:50AM

Morial Convention Center, Meeting Room 271

Michelle G. Newman, Jo Ann Oravec

Invited Address: Update on the FDA Warning Signs About Antidepressants and Suicide in Children and Adults

8/10 Thursday: 11AM – 11:50AM

Morial Convention Center, Meeting Room 275

Kelly Posner

Symposium: Online Clinical Research – Advantages, Challenges, and Ethical Issues

8/10 Thursday: 11AM – 11:50AM

Morial Convention Center, Meeting Room 279

Heidi E. Keller, Robin M. Mathy, Mary S. Tramel

Symposium: Incorporating Research and Systemic Data Collection in the Practicum

8/10 Thursday: 11AM – 12:50PM

Morial Convention Center, Meeting Room 271

Terry M. Pace, Bonny J. Forrest, Barbara M. Vollmer, Eric M. Sauer

Workshop: Innovative Strategies Integrating Mindfulness with CBT for Treatment of GAD

8/10 Thursday: 1PM – 2:50PM

Morial Convention Center, Meeting Room 278

Lobsang Rapgay

Discussion: Critical Discussion of APA's Evidence-Based Practices in Psychology Report

8/10 Thursday: 2PM – 2:50PM

Morial Convention Center, Meeting Room 273

Marsha M. Linehan, Stephen D. Hollon, Drew Westen, John C. Norcross, Bruce E. Wampold

Discussion: Recent Advances in Negative Symptom Research – Translation into Psychosocial Interventions

8/10 Thursday: 2PM – 3:50PM

Morial Convention Center, Meeting Room 260

William P. Horan, Ann M. Kring, Paul M. Grant

Symposium: Trauma and Resilience in Survivors of Hurricanes Katrina and Ivan

8/10 Thursday: 3PM – 3:50PM

Morial Convention Center, Meeting Room 266

Mary Alice Mills-Baxter, David DeBoer, Lynne M. Roetzer



DIVISION 12 APA PROGRAM (cont.)

Friday, August 11, 2006

Symposium: Training for Ethical and Multicultural Competencies in the Practicum

8/11 Friday: 8AM – 9:50AM

Morial Convention Center, Meeting Room 262

Erica H. Wise, Tony Cellucci, Sonia R. Banks

Section II (Clinical Geropsychology)

Presidential Address

8/11 Friday: 9AM – 9:50AM

Morial Convention Center, Meeting Room 274

Robert C. Intrieri

Discussion: Aftermath of Hurricane Katrina Through the Eyes of Displaced and Affected Predoctoral Interns – Reflections of Maslow's Hierarchy of Needs

8/11 Friday: 9AM – 9:50AM

Morial Convention Center, Meeting Room 353

Jason A. Hankee

Symposium: Rising From the Floods – The Effects of Katrina on Academic Health Center Training Programs

8/11 Friday: 9AM – 9:50AM

Morial Convention Center, Meeting Rooms 267 & 268

Diane Z. Franz, James R. Gay, Jill H. Hammer

Invited Panel Discussion: Who Teaches Assessment to Clinical Psychology Graduate Students? A Survey of their Opinions

8/11 Friday: 2PM – 2:50PM

Morial Convention Center, Meeting Room 265

David Lachar, Lisa J. Rapport, Janet R. Matthews,

Jessica Foley

Symposium: Measuring Child and Adolescent Outcomes in Divergent Settings and Populations

8/11 Friday: 2PM – 2:50PM

Morial Convention Center, Meeting Room 271

Phillip L. Nelson, Jared B. Cooper, Jonathan C. Cox,

Jennifer A. Cannon

Symposium: Cognitive-Behavioral Therapy with Culturally Diverse Populations

8/11 Friday: 2PM – 3:50PM

Morial Convention Center, Meeting Room 253

Christopher Martell, Pamela Hays, Angela W. Lau,

Cheryl M. Paradis

Section IX (Assessment Psychology)

Business Meeting

8/11 Friday: 3PM – 3:50PM

Morial Convention Center, Meeting Room 265

David Lachar

Symposium: Pikes Peak Models for Training in Professional Geropsychology

8/11 Friday: 3PM – 4:50PM

Morial Convention Center, Meeting Room 261

Bob G. Knight, Michele J. Karel

Division 12 Award Ceremony

8/11 Friday: 4PM – 5:50PM

New Orleans Marriott Hotel

Carondelet Room

Symposium: Great Ideas of Clinical Science

8/11 Friday: 4PM – 5:50PM

Morial Convention Center, Meeting Rooms 238 & 239

Scott O. Lilienfeld, James M. Wood, Allan R. Harkness,

Stephen S. Ilardi, Gerald C. Davison

Symposium: Black Immigrant Experience – Implications for Clinical Work

8/11 Friday: 5PM – 5:50 PM

Morial Convention Center, Meeting Room 253

Angela M. DeSilva, Kelly L. Subrebst, Rachel R. Singer

Division 12 Social Hour

8/11 Friday: 6PM – 7:50PM

New Orleans Marriott Hotel

Carondelet Room

Saturday, August 12, 2006

Symposium: Innovative Practice Methods in Geropsychology

8/12 Saturday: 8AM – 8:50AM

Morial Convention Center, Meeting Room 254

Paula Hartman-Stein, Donna Rasin-Waters

Symposium: Children of Hurricane Katrina and We Who Treat Them

8/12 Saturday: 8AM – 9:50AM

Morial Convention Center, Meeting Room 252

Margaret Dempsey, Christopher Dehon,

Mark A. Sands



DIVISION 12 APA PROGRAM (cont.)

Symposium: Partner Abuse and Suicidal Behavior in Low-Income African American Woman

8/12 Saturday: 9AM – 9:50AM

Morial Convention Center, Meeting Room 284

Natalie Arnette, Carli H. Jacobs, Sarah E. Dunn,

Kafi Bethea

Workshop: Core Competencies in the Assessment and Management of Suicide Risk

8/12 Saturday: 9AM – 10:50AM

Morial Convention Center, Meeting Room 254

David Rudd

Conversation Hour: Aaron T. Beck in Conversation with Frank Farley

8/12 Saturday: 9AM – 10:50AM

Morial Convention Center, Meeting Rooms 343 & 344

Aaron T. Beck

Poster Session: Assessment, Personality, and Professional Issues

8/12 Saturday: 10AM – 10:50AM

Morial Convention Center, Halls E & F

Symposium: Tribute to Ivan Mensh – The Man and His Work

8/12 Saturday: 10AM – 10:50AM

Morial Convention Center, Meeting Room 265

Paul D. Nelson, Annette M. Brodsky, John Carr

Invited Address: Distinguished Achievement Awards in Teaching and Research

8/12 Saturday: 11AM – 11:50AM

Morial Convention Center, Meeting Room 283

Nadine J. Kaslow, Peter P. Vitaliano

Symposium: Suicide Terrorism in the 21st Century

8/12 Saturday: 11AM – 12:50PM

Morial Convention Center, Meeting Rooms

343 & 344

Philip G. Zimbardo, Bruce Bongar, Larry Beutler,

Ariel Merari

Section IV (Clinical Psychology of Women)

Presidential Address: Ethical Use of E-Mail and Listservs in Clinical Psychology

8/12 Saturday: 12PM – 12:50PM

Morial Convention Center, Meeting Room 269

Lynn H. Collins

Applying for Fellow Status in Division 12

Fellows Applicants:

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

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

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

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



Symposium: Relationship of Education and Intellectual Scores Across Cultures

8/12 Saturday: 12PM – 1:50PM

Morial Convention Center, Meeting Room 273

James P. Choca, Lawrence G. Weiss, Elaine Fletcher-Janzen, Sara Corral Gregorio, Kristin Krueger

Division 12 Presidential Address: Can We Disagree Without Being Disagreeable? Thoughts About Some Current Issues in Clinical Psychology

8/12 Saturday: 1PM – 1:50PM

Morial Convention Center, Meeting Room 272

Gerald C. Davison

Section III (Society for a Science of Clinical Psychology) Presidential Address: Implementing Large-Scale Transformation to Support Provision of Evidence-Based Mental Health Sciences

8/12 Saturday: 1PM – 1:50PM

Morial Convention Center, Meeting Room 278

Antoinette M. Zeiss

Section VI (Clinical Psychology of Ethnic Minorities) Presidential Awards Presentation

8/12 Saturday: 1PM – 1:50PM

Morial Convention Center, Meeting Room 280

Steven James

Sunday, August 13, 2006

Discussion: Graduate Students and Early Career Psychologists

8/13 Sunday: 8AM – 8:50AM

Morial Convention Center, Meeting Room 269

George Slavish, Chad Hartman

Section VII (Emergencies and Crises) Presidential Address: Treatments for Suicidal Adolescents

8/13 Sunday: 9AM – 9:50AM

Morial Convention Center, Meeting Room 345

Alec L. Miller

Discussion: Invited Panel – Multiple Minority Issues in Clinical Psychology

8/13 Sunday: 9AM – 9:50AM

Morial Convention Center, Meeting Room 355

Eduardo Morales, Reggie Nettles

Symposium: Disaster Relief in Katrina's Wake – Perspectives From Responders and Researchers

8/13 Sunday: 9AM – 10:50AM

Morial Convention Center, Meeting Room 342

Richard M. Gist, Patrick O. Smith, James R. Rundell, Richard J. Seime, Dean G. Kilpatrick

Symposium: Understanding Documentation – Medical Necessity, New Codes, and Voluntary Compliance

8/13 Sunday: 10AM – 11:50AM

Morial Convention Center, Meeting Room 265

James M. Georgoulakis, Antonio E. Puente, Donna Rasin-Waters

Section III (Society for a Science of Clinical Psychology) Award Ceremony

8/13 Sunday: 11AM – 11:50AM

Morial Convention Center, Meeting Room 241

Symposium: Evaluating Cognitive Behavioral Case Formulation Hypotheses Using Repeated Measurement

8/13 Sunday: 11AM – 12:50PM

Morial Convention Center, Meeting Room 338

William H. O'Brien, Gregory H. Mumma, Scott R. Mooney, Sean A. Lauderdale, Phillip N. Smith

Symposium: Common Risk Factors for Different Forms of Violence

8/13 Sunday: 12PM – 12:50PM

Morial Convention Center, Meeting Room 346

Dean G. Kilpatrick, Alan L. Berman

Symposium: Translating Research into Treatment for Depression – Implementing Science in Clinical Practice

8/13 Sunday: 1PM – 1:50PM

Morial Convention Center, Meeting Room 260

Daniel A. Klein

ABBREVIATED MINUTES

Society of Clinical Psychology
Board of Directors Minutes
San Antonio, Texas
February 3-5, 2006

Minutes – October 27, 2005

MOTION: To approve the minutes

ACTION: Passed unanimously

There have been three votes of the Board of Directors by email since the October 27, 2006 conference call. They are as follows:

MOTION: To appoint Dr. Gerald Davison to be the Division 12 liaison to the APA Board of Educational Affairs.

ACTION: Passed unanimously

MOTION: To approve the slate of nominees for the upcoming election as put forth by the Nominations Committee.

ACTION: Passed unanimously

MOTION: To enlarge the Science and Practice Committee by one person for 2006-2008 by the appointment of Dr. Howard Garb.

ACTION: Passed unanimously

2006 Meeting Year Update

The next meeting will be held in Santa Monica, CA from June 9-11, 2006. The meeting will be held at the Doubletree Guest Suites.

Publication Committee meeting:

Friday, June 9, 8:00 a.m. to 3:00 p.m.

Finance Committee meeting:

Friday, June 9, 4:00 p.m. to 6:00 p.m.

Board of Directors meeting:

Saturday, June 10 through noon on Sunday, June 11, 2006

Blackwell will be meeting with the Publications Committee on Friday, June 9, 2006.

The Board discussed whether to meet in June for the second meeting of the year in 2007 or to meet at another time, such as in the fall. Having a third yearly meeting was also discussed. There is a lot of Division business to be done in the fall. A suggestion was made to have meetings in the fall and in the spring with a conference call in the summer. The two meetings would be six months apart.

MOTION: The Board will meet in the fall (September/October/November) and in the spring (February/March).

ACTION: Passed unanimously

Appointments

2007 Program Chair: Dr. Alec Miller

Apportionment

Division 12 will continue to have four representatives to the APA Council of Representatives. The Division President sends an apportionment vote reminder each year with the message "Vote 10 for 12". This is sent to new members and fellows.

Finance

Division 18 requested money (no specific amount) for Psychology Shield to help defend California psychologists against a lawsuit.

MOTION: To give \$500 to Division 18 for Psychology Shield

ACTION: Passed unanimously

Requests for Funds

Financial requests will be considered at each Board meeting. Requests must be made one month before the meeting (although exceptions can be made if the need is urgent). There is \$2,000 in the 2006 budget for external requests for funds. There is a \$500 limit per request. The Multicultural Summit, which is a biannual event is a separate line item.

Mentoring Award

This would be the eighth award given by the Division. Sections also give awards, and some Sections give Mentoring Awards. However, a Mentoring Award can be helpful to a person applying for tenure. The Board wanted to recognize efforts not recognized elsewhere.

MOTION: To have an Outstanding Clinical Educator Award

ACTION: Passed unanimously.

APA Policy Issues

There has not been a report of this committee for several years.

MOTION: Remove the APA Policy Issues Committee from the Bylaws.

ACTION: Passed unanimously

Committee on Diversity

MOTION: Division 12 affirms the APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists; Guidelines for Psychotherapy with



ABBREVIATED MINUTES (cont.)

Lesbian, Gay, and Bisexual Clients; and Guidelines for Psychological Practice with Older Adults.

ACTION: Passed unanimously

MOTION: To commend the Committee on Diversity for an outstanding and thoughtful job of analyzing and making recommendations to Division 12.

ACTION: Passed unanimously

Public Policy Workgroups

In her role as the Division 12 Federal Advocacy Coordinator, Dr. Raisin-Waters asked the Board for financial support to attend future Division 12 Board meetings.

MOTION: The Division will pay \$500 for the Federal Advocacy Coordinator to attend one Board meeting per year.

ACTION: Passed unanimously

Dr. Raisin-Waters also would like to develop a Division 12 advocacy list serve so that advocacy issues can be posted to a larger membership in the Division. The Board agreed by consensus.

Division 29 Proposal

Drs. John Norcross and James Bray

Division 29 has become increasingly concerned over the past few years about the use in APA publications of generic terms to describe health care activities of psychologists. In accreditation documents, psychotherapy does not appear, only intervention. In some states, the term psychological is legally protected. Generic terms come about to build bridges with other professions. However, we need to be more discerning. If we are referring to something generic, then we should refer to it generically. If it is about psychology, use the term psychological.

Division 29 approved a policy statement to address the above concerns. Division 12 was asked to support this policy statement.

Two amendments were recommended by the Division 12 Board

1. This policy is recommended and encouraged but not mandated.
2. This policy is for professional communications.

MOTION: To adopt the Division 29 policy statement

as amended.

ACTION: Passed unanimously

Section Reports

A discussion was held about increasing APA program hours for Sections from three to five. This will be communicated to the 2007 program chair. All Sections had their hours cut proportionally and all Sections would like more hours.

MOTION: For the 2007 APA Annual Convention, all Sections will have four program hours assuming the total number of program hours for Division 12 remain essentially comparable. This will be for one year only.

ACTION: Passed unanimously

2007 Meeting Year

February meeting: Discussion of meeting with the Multicultural Summit in Seattle. The Multicultural Summit will be held January 24, 25, and 26 at the Sheraton in Seattle. The Board would meet January 27 & 28, 2007.

MOTION: To have the 2007 Winter Board meeting in conjunction with the Multicultural Summit.

ACTION: Passed unanimously.

September meeting: The proposed dates are September 15 & 16, 2007. The only conflict may be the APA Educational Leadership Conference. Cities for the September 2007 meeting will be determined by the economic analysis done for the June 2006 meeting.

Request for Funds

Add \$1,000 for the 2007 Multicultural Conference
Add \$1,000 to Line 52 for Liaison to BEA—Dr. Davison

Add \$800 for CoS and \$100 for APA Caucus memberships to line 56 (The total for this line is \$900)

Move \$500 from Line 58 to Psychology Shield

Move \$500 from Line 58 to Federal Advocacy (for the Federal Advocacy Coordinator to attend one Board meeting next year).

MOTION: Accept the 2006 budget as modified.

ACTION: Passed unanimously

**Respectfully submitted,
Linda Knauss, Secretary**



NEWS FROM DIVISION 12

Division 12 Award Winners—2006 Congratulations

Philip C. Kendall, Ph.D., ABPP for distinguished scientific contributions to Clinical Psychology

Florence Halpern Award presented to Beverly Greene, Ph.D., ABPP for distinguished professional contributions to Clinical Psychology

David Shakow Early Career Award Julie Loebach Wetherell, Ph.D. for outstanding early career contributions to the science and practice of Clinical Psychology

Theodore H. Blau Early Career Award presented to W. Dean Klinkenberg, Ph.D. for outstanding early career contributions to the profession of Clinical Psychology

Stanley Sue Award for Distinguished Contributions to Diversity presented to Gordon C. Nagayama Hall, Ph.D. for outstanding contributions to diversity in the profession of Clinical Psychology

Past issues of TCP are available at
[http://www.apa.org/divisions/
div12/clinpj.html](http://www.apa.org/divisions/div12/clinpj.html)

Please note that the following book is a result of a Division 12 Task Force

Castonguay, L. G. & Beutler, L. E. (Eds)(2006)
Principles of Therapeutic Change that Work
New York: Oxford University Press.

This book represents the work of a Task Force jointly sponsored by the Society for Clinical Psychology (Division 12 of APA), and the North American Society for Psychotherapy Research (NASPR). The Task Force was charged with the tasks both of translating and integrating the major contributors to treatment outcome that have been identified as important to change in prior work by Division 12's task force on ESTs, as well as other similar efforts. Participant, relationship, and treatment factors that contribute to change were first identified for four major patient groups: Depression, Anxiety, Personality Disorders, and Substance Use Disorders. From this literature, consistent findings were translated into workable principles. These principles were subsequently identified as either common to work with multiple disorders or unique to one set of disorders through a process of iteration and consensus. The 46 renowned scholars who contributed to chapters to this task force report identified over 60 principles that are supported by research evidence and that can be used by clinicians to guide their practice.

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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.

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