

# THE CLINICAL PSYCHOLOGIST



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

## CONTENTS

- 01 President's Column
- 07 Internet Update:  
Developing a Website
- 08 Early Career:  
Conventional Wisdom
- 10 History: The Division of  
Clinical Psychology,  
1955-1965
- 12 Student Column: Essays  
on Internship
- 14 Diversity: Cape Verdean  
American Women
- 17 Psychopharm: The Texan  
Medication Algorithm  
Project
- 19 Book Recommendations
- 20 Section Updates
- 21 Board Meeting Minutes
- 22 News from Division 12

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**Gerald C. Davison, PhD**  
University of Southern  
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## PRESIDENT'S COLUMN

### Politics, Ethics, and Goal-Setting in Psychological Interventions: Limitations in the Evidence-Based Practices in Psychology Report.

Gerald C. Davison, PhD

 API (Apocryphal Press International). The governor recently signed into law a bill prohibiting discrimination in housing and job opportunities on the basis of membership in a Protestant Church. This new law is the result of efforts by militant Protestants, who have lobbied extensively during the past ten years for relief from institutionalized discrimination. In an unusual statement accompanying the signing of the bill, the governor expressed the hope that this legislation would contribute to greater social acceptance of Protestantism as a legitimate, albeit unconventional, religion.

At the same time, the governor authorized funding in the amount of twenty million dollars for the upcoming fiscal year to be used to set up within existing mental health centers special units devoted to research into the causes of people's adherence to Protestantism as their religion and into the most humane and effective procedures for helping Protestants convert to Catholicism or Judaism. The governor was quick to point out, however, that these efforts, and the therapy services that will derive from and accompany them, are not to be imposed on Protestants, rather are only to be made available to those who express the voluntary wish to change. "We are not in the business of forcing anything on these people. We only want to help," he said.

In my first column (Davison, 2006a), I discussed two issues that strike me as important in the APA's Evidence-Based Practices in Psychology (EBPP) report (APA Presidential Task Force on Evidence-Based Practice, 2006), namely the nature of research and evidence, and the sometimes unacknowledged role of theories and paradigms in clinical practice and research. In my second column (Davison, 2006b), I offered for your consideration the implications that I believe the EBPP document has for education and training in clinical psychology. In this my third and final TCP column I would like to discuss the issue of patient preferences and how goals are set in psychological intervention. It can be a subtle and sometimes very contentious issue, as I hope to demonstrate.

### The EBPP Report and other APA Policies on Setting Therapy Goals

The EBPP report pays thoughtful and laudable attention to questions of values and therapeutic goals. Like nearly all accounts of these important issues, the report asserts that the patient's values and preferences are of overriding importance, to wit:

"...patient characteristics ... essential to consider in ... implementing specific interventions ... include... personal preferences, values, and preferences related to treatment (e.g., goals, beliefs, worldviews, treatment expectations" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 279).

**Look inside  
for nomination  
ballot!**

(continued on page 2)

## President's Column (cont.)

“Cultural values and beliefs and social factors (e.g., implicit racial biases) also influence patterns of seeking, using, and receiving help... and desired outcomes... Psychologists also understand and reflect on the ways their own characteristics, values, and context interact with those of the patient” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 279).

“The patient’s social and environmental context, including recent and chronic stressors, is also important in case formulation and treatment planning... Patient values and preferences (e.g., goals, beliefs, preferred modes of

treatment) are a central component of EBPP. Patients can have strong preferences for types of treatment and desired outcomes, and these preferences are influenced by both their cultural context and individual factors... EBPP seeks to maximize patient choice among effective alternative interventions. Effective practice requires balancing patient preferences and the psychologist’s judgment — based on available evidence and clinical expertise — to determine the most appropriate treatment” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 280).

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I believe that the report stops short of confronting fully some political and ethical issues that set the parameters for deciding upon therapy goals and that are too seldom dealt with.

Some of you may be familiar with a position against sexual reorientation that I took in 1974 in my presidential address to the annual meeting of the Association for Advancement of Behavior Therapy (AABT, recently renamed the Association for Behavioral and Cognitive Therapies). I have elaborated upon and extended this position in several subsequent publications (Davison, 1976, 1978, 1991, 2001). Many years after my initial statement, the APA adopted guidelines that are similar to my earlier position but that do not, I believe, go far enough. Passed by the Council of Representatives on August 14, 1997 and elaborated upon in an informative and useful article in the *American Psychologist* (American Psychological Association, 2000), the 1997 Council resolution was as follows:

*“Therefore be it further resolved that the American Psychological Association opposes portrayals of lesbian, gay, and bisexual youth and adults as mentally ill due to their sexual orientation and supports the dissemination of accurate information about sexual orientation, and mental health, and appropriate interventions in order to counteract bias that is based in ignorance or unfounded beliefs about sexual orientation.”*

Note that the resolution asserts the importance of basing treatment decisions on scientific evidence and that decisions about intervention should be aimed at reducing prejudice about homosexuality. Who can argue with relying of scientific evidence and with reducing unfounded negative biases? I’m afraid I can. I believe that the APA position, enlightened as it is, stops short of analyzing the forces impinging on gays and lesbians to want to change their sexual orientation. The gist of my argument against sexual conversion therapies is that societal prejudice and, in the extreme, hate crimes committed against people with same-sex attraction make it imprudent or impossible to regard patients’ wishes for sexual reorientation as voluntary and that agreeing to attempt such change in therapy confirms and strengthens these prejudices. My view is based on political and ethical, not empirical grounds. Whether sexual reorientation is possible is not relevant.<sup>2</sup> There is a context for this argument that I would like to review here. I believe the issue is much broader than the EBPP report or the APA resolution address.

### **The Myth of Therapeutic Neutrality**

I do not believe that therapists make ethically or politi-

cally neutral decisions, and I believe that there is a danger in suggesting that they do. “Any type of psychiatric [psychological] intervention, even when treating a voluntary patient, will have an impact upon the distribution of power within the various social systems in which the patient moves. The radical therapists are absolutely right when they insist that psychiatric neutrality is a myth” (Halleck, 1971).

This is the thesis of Seymour Halleck’s important — and too little read — book, *The politics of therapy*, and it plays a major role in my argument against sexual conversion therapy even when clients request it. Most of the time the very naturalness of and familiarity with our therapeutic practices (do fish know they are in water?) blind us to the nonempirical biases that affect how we construe the patient’s problems and the goals we regard as acceptable to work towards. Better to be aware of and own up to our biases than to pretend that we have none.

### **No Cure Without a Disease**

I believe that clinicians devote effort to developing and analyzing therapeutic procedures only if they are concerned about a problem. Until around the late 1970s, for example, behavior therapists spent a good deal of time and effort trying to reduce homosexual attraction and increase heterosexual attraction in homosexuals (and for the most part, the target population was men only). Little if any time — and none at all when I first made my remarks — was spent by mainstream therapists encouraging health professionals to change their biases against homosexuality and foster gay-affirmative attitudes and behavior in society and in patients who happened to be homosexual. The question for me was and still is the following: How can therapists honestly speak of nonprejudice when they participate in or tacitly support therapy regimens that by their very existence and regardless of their effectiveness condone the societal prejudice and perhaps also impede social change? As Begelman pointed out many years ago (1975):

*“[sexual reorientation therapies] .... by their very existence constitute a significant causal element in reinforcing the social doctrine that homosexuality is bad. Indeed, the point of the activist protest is that behavior therapists [and other therapists] contribute significantly to preventing the exercise of any real option in decision making about sexual identity by further strengthening the prejudice that homosexuality is a ‘problem behavior’ since treatment may be offered for it.... homosexuals tend to seek treatment for being homosexuals.... contrary to the disclaimer that behavioral therapy is ‘not a system of ethics’ (Bandura, 1969, p. 87), the very act of providing*



therapeutic services for homosexual 'problems' indicates otherwise (p. 180, emphasis in original)."

Another way to understand this argument is to consider the availability of operations to alter the facial appearance of Asian women by making their eyes rounder and by narrowing the bridge of the nose — changes designed to approximate Caucasian standards of appearance and beauty. What do the availability of and the desire for this kind of elective cosmetic surgery say about the way Asian facial features are appraised (Kaw, 1993)?

I would add that the availability of a technique encourages its use. For example, Wolpe's (1958) systematic desensitization ushered in a period in which behavior therapists looked vigorously for antecedent cues that could be arranged on an anxiety hierarchy and be paired in imagery with deep muscle relaxation. Thus, a problem like social isolation might be viewed at least in part as a consequence of unnecessary anxiety that could be translated into an anxiety hierarchy and then desensitized. The therapist's assessment and problem-solving efforts are channeled in ways conducive to the

**"...the availability of a technique encourages its use."**

application of therapeutic techniques that are believed to be effective. This is not a bad thing! But, as with all assessment and therapeutic efforts, it does skew what the therapist sees and finds out about a patient, a topic we turn to next.

### Clinical Problems as Clinicians' Constructions

As I have argued elsewhere (e.g., Davison, 1991), clients seldom come to mental health clinicians with problems as clearly delineated and independently verifiable as what patients often bring to a physician. A client usually goes to a psychologist or psychiatrist in an unhappy state. Life is going badly; nothing is meaningful; sadness and despair are out of proportion to life circumstances; the mind wanders and unwanted thoughts intrude, etc. The clinician *transforms* these often vague and complex complaints into a diagnosis or functional analysis, a set of ideas of what is wrong, what the controlling variables are, and what might be done to alleviate the suffering and maladaptation. My argument, then, is that psychological problems are for the most part *constructions* of the clinician. Clients come to us in pain, and they leave with a more clearly defined problem or set of problems that we *assign* to them.

Some would argue that diagnostic practices within the framework of the DSM are not constructive in nature. I do not agree with this but a fulsome discussion goes beyond the scope of this paper.

In the case of homosexuality, I argue that when

a person with such attractions/behavior goes to a therapist, whatever psychological woes they have are generally construed as caused entirely or primarily by their sexual orientation. This happens because (a) their sexual orientation is usually the most salient part of their personhood, to the clinician and usually to the clients themselves because of the negative salience homosexuality has been accorded by society; and (b) their homosexuality (or bisexuality) is regarded as abnormal, regardless of the liberal stance the clinician may take overtly. Even with the changes in the DSM over the past 30-plus years, but especially when I first articulated this position, the clinician's perceptions and problem-solving are skewed in a direction that implicates homosexuality — no matter what the actual presenting problems are (cf. Davison & Friedman, 1981) — and, most importantly, imply the desirability of a change in sexual orientation.

None of this is to gainsay that being homosexual in our society is difficult psychologically and that it can occasion people considerable distress — particularly a generation ago but even now, given the disproportionate exposure to hate crimes and simple everyday prejudice that homosexuals are subject to (discussed in next section). The political and ethical I point I tried to make in 1974 and, despite incredulosity on the part of some of my friends and colleagues, I still hold to, is that mental health professionals have a responsibility not to be co-opted by the societal pressures that, sometimes subtly, channel our clinical problem-solving and decision-making into narrowly defined domains that result in a maintenance of a status quo that, in official pronouncements, we say we do not support.

### Discrimination, Stress, and the Voluntariness of Seeking Change

Research supports the view that gays and lesbians are discriminated against in all kinds of ways and that this discrimination takes a particularly heavy toll on their emotional well-being. Hate crimes highlight this problem. A hate crime (sometimes referred to as a bias crime) is an assault that is based primarily or solely on a person's (perceived) membership in a group against which the perpetrator is prejudiced. The ultimate modern-day hate crime was, of course, the Holocaust in Germany and other parts of western Europe prior to and during World War II. The Nazis sought out for imprisonment and execution millions of Jews and hundreds of thousands of gypsies, Communists, and homosexuals. The more recent "ethnic cleansing" in Bosnia and Kosovo and the 9/11 attacks in New York and Washington, D.C. and in many other parts of the



world show us that humankind has not learned much from the Holocaust experience. But hate crimes as well as hurtful discrimination are carried out every day in less organized and less dramatic fashion.

Anti-gay attitudes are strong, sometimes virulent, with many people believing that homosexuals are sick and their behavior disgusting (Herek, 1994). These negative attitudes can take the form of open heterosexism — as when people directly insult a gay person with epithets like *faggot* or *dyke* — or a more subtle, indirect kind of anti-homosexual stance — as when people tell jokes that deride homosexuality without knowing (or caring) if a gay person is present. This prejudice creates what has been termed “minority stress”, a source of pressure and tension that is a special burden of those in despised or feared minorities (Meyer, 1995) and no doubt is the major factor in gay and lesbian people suffering particularly high levels of depression (Herek et al., 1996).

**“...questions can been raised about how voluntary is the desire of some gays to change their sexual orientation.”**

In light of all this, is it surprising that gays may seek out sexual reorientation treatment? Being subjected to verbal and physical assault for being gay is not likely to enhance one’s sense of comfort with and acceptance of one’s sexual orientation. Little wonder, then, that questions can be raised about how voluntary is the desire of some gays to change their sexual orientation.

### **A Proposal Regarding Sexual Reorientation Therapy**

These several considerations led me to make a proposal that surprised no one more than myself, an idea that was present for several years in the some of the gay activist literature (see especially Silverstein, 1972, 1977): *Therapists should stop engaging in change-of-orientation programs, whether the client makes the request or if someone else does.* The social pressures, discrimination, and in some cases violent hatred directed to people with homosexual inclinations make it highly doubtful that client-requests for conversion therapy approach what we regard as voluntary. In a sense, by attending to the reasons for a “voluntary” request for change, we are, I believe, doing nothing less than remaining true to our deterministic stance. And without entering the free will-determinism morass, we can, I believe, consider more carefully than we have the societal pressures that would seem to underlie “voluntary” requests for conversion therapy.

As noted earlier, the EBPP report states that

“Patients can have strong preferences for types of treatment and desired outcomes, and these preferences are influenced by both their cultural context and individual factors.... Effective practice requires balancing patient preferences and the psychologist’s judgment — based on available evidence and clinical expertise — to determine the most appropriate treatment” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 280). The report, however, does not examine the pressures placed on clients — and not just gays — to request certain changes. The complexities of “balancing patient preferences and the psychologist’s judgment” are not discussed.

### **Psychotherapy, Politics, and Morality**

And this takes us to the final aspect of my argument. I had not considered myself a community psychologist until the formulation of my brief against conversion therapy, but I think the connection is apt. In Rappaport’s (1977) terms, I am working at an institutional level, which is traditionally the domain of community psychology. In contrast, most therapists function at the individual level, which is where I believe the EBPP report is operating by and large. An institutional analysis of human problems examines those values and ideologies that guide the decision-making of a society. Individual therapy work, in contrast, assumes that society is basically benign and that psychological suffering can best be alleviated by helping the patient adjust to prevailing values and conditions. My underlying assumption is that issues surrounding therapy for homosexuality should be addressed at an institutional level, and that greater societal acceptance of homosexuality as a normal variation of human sexuality rather than as a problem that needs to be fixed will, in fact, redound to the benefit of the individual by reducing the discrimination and oppression described earlier. This oppression, I firmly believe, accounts for the distress that can be associated with homosexuality and ultimately the desire of some homosexual individuals to seek sexual reorientation.

Do therapists have some kind of abstract responsibility to satisfy a patient’s expressed desires and wishes, as asserted by some (e.g., Sturgis & Adams, 1978)? No. Therapists constrain themselves in many ways when patients ask for assistance, and under some circumstances, therapists are even legally required to break the confidentiality that is inherent in the relationship. In any event, requests alone have never been a sufficient justification for providing a particular service to a patient.

### **Concluding Comment**

I am keenly aware that my arguments place a great deal



of responsibility on therapists, that one's immediate reaction is to insist that the patient determines goals. I used to believe this but I was wrong. I believe we are, to use Perry London's term, "secular priests" (London, 1964). The EBBP report does not deal with these nonempirical issues, perhaps because the focus is on *evidence-based* practices. That focus is laudable and the task force did a great job on it. But any study of psychosocial assessment and intervention is incomplete without placing the issues in a broad societal context that considers questions of a qualitatively different nature from what we define as empirical evidence. Whatever one's stance on sexual reorientation or most other biopsychosocial human phenomena, the political and ethical issues need to be faced squarely. □

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**Bill Sanderson has agreed to publish as many responses 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 per question to William. C.Sanderson@Hofstra.edu. Early replies will be given preference and the deadline is 12/1/06.**

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.
2. There is a sense in which efficacy relates to ethical issues. If an ineffective reorientation therapy is undertaken, the patient is going to be disappointed and likely therefore to feel even worse about his predicament – he has not only failed to achieve the reorientation goal but comes away continuing to believe that his homosexuality is bad and sick and perhaps feeling even worse about being gay. Thus, not only do ineffective treatments not bring about desired change (by definition); they may also have a negative impact on the patient's self-esteem and even worse.

## Developing a Website

Simon A. Rego, PsyD



In my inaugural column I stated that readers with comments could contact me via my email ([dr.rego@gmail.com](mailto:dr.rego@gmail.com)) or my website ([www.simonrego.com](http://www.simonrego.com)). In my second column, I used my email address as an excuse to discuss Google, and highlight some of the syntax commands and features that have made it one of the most visited websites on the Internet. For this issue, I thought it would be appropriate to discuss how one goes about developing a presence on the web.

While the idea of building a website may seem daunting to some of you, I am here to say that it is easier than it appears - much easier! I should add that I am no expert when it comes to web design or code. In fact, I have never taken a single class in design, programming, or HTML (HyperText Markup Language). And the good news is that as the technology has advanced, it has become increasingly easy to develop and maintain a website with little-to-no knowledge of web programming. In brief, all it takes is a little time, planning, and familiarity with the basics. So, without further delay, here are what I consider to be the three essential steps you need to get started.

**Step 1:** get a domain name. While this may seem obvious, there are several things to consider when deciding on a domain name. First and foremost, you should think of a name that is easy to remember - and spell! The general consensus amongst experts appears to be the shorter the name the better, with the target being one or two, common, 1-2 syllable words. In addition, most experts on website development suggest that you avoid using names with hyphens, as they are more likely to be misspelled. Second, your name should include key words related to your services and/or products. For example, while I have registered my name, I have also registered additional domains, such as [www.cbtclinic.com](http://www.cbtclinic.com) and [www.worry.biz](http://www.worry.biz) for future use. Before finalizing your choice: (a) ask a few colleagues and friends for feedback, and (2) check to see if it is available! There are many ways to check on availability (most tap into "WHOIS" - a directory of domain name information), such as [www.networksolutions.com/whois/index.jsp](http://www.networksolutions.com/whois/index.jsp) or <http://www.internic.net/whois.html>. If available, you might also consider purchasing variations on the domain exten-

sion (e.g., if you buy [therapy.com](http://therapy.com), you may also want to buy [therapy.net](http://therapy.net) and [therapy.org](http://therapy.org)) and perhaps even domains with common misspelled variations of your name (e.g., [therepy.com](http://therepy.com)). Domain registration typically costs \$10 to \$35 per year, with many places allowing discounts on multiple registrations. Popular sites include: [www.networksolutions.com](http://www.networksolutions.com), [www.godaddy.com](http://www.godaddy.com), and [www.register.com](http://www.register.com).

**Step 2:** get a host. Once you have registered your name, you will need to arrange to have your site hosted. A host is basically a service that stores your content and allows you to upload it to the web. There are many different services for hosting out there, which can range in cost from free to hundreds of dollars per month. Generally speaking, for a simple website, the cost should be minimal. Things to consider in addition to the cost include: how much bandwidth you are allowed, whether the host supports applications you want to use, whether it includes email addresses, and whether it has tools that aid in site creation. Tip: many sites that register domain names also offer hosting. Tip 2: you may want to start with a site such as [www.upperhost.com](http://www.upperhost.com), which is an independent web host review website.

**Step 3:** build a site. I would suggest you begin this step by looking at some of your favorite (and least favorite) sites. You may also want to do a search using keywords similar to the services or products that you plan on offering and see what other people have done. Write a summary of what you want to offer - or at least the major categories you want to have on your site. Then, you must decide on whether you want to do the design yourself or hire a website designer. If you plan on hiring a designer, your work is nearly done - but it will cost you! If you plan on building it yourself, there are online website builders (many of which are free), as well as offline website builder programs (e.g. Microsoft FrontPage or Dreamweaver) that are becoming increasingly user friendly. I recommend, however, that you familiarize yourself with at least a little HTML - as it is one of the foundations of the World Wide Web! While there are other things to consider, such as site promotion (search engines, pay per click, etc.) and site maintenance (new/dynamic content, etc.), you should now have enough to get started. If you want more tips, feel free to contact me via my email: [dr.rego@gmail.com](mailto:dr.rego@gmail.com) or my website: [www.simonrego.com](http://www.simonrego.com). □



## “Conventional” Wisdom: An Insider’s Guide

Katherine L. Muller, Psy.D.

 Greetings, early career psychologists! I am writing this column as I sit in the airport after attending one of the rituals of our breed- the professional conference. Whether you are a clinician or a researcher, you’ve probably been to at least one. In fact, according to my informal survey of a group of psychologist colleagues, most of us attend at least one per year. So, how do you decide which conference to attend? How do you make the most of a conference as an early career psychologist? Is there a difference between networking and stalking? Herein, some conference “dos” and “don’ts”.

### Selecting a Conference/Convention

First, let’s establish the vocabulary. The consensus seems to be that the terms “conference” and “convention” are interchangeable. That is unless you are speaking to the chair or organizer of the event- I’ve found that they may be sensitive to this!

Now, which conference to attend? The best approach is to “sample” different conference offerings over the course of a few years. You may find that one conference favors research and academic topics. Another conference may be very broad in its professional reach and include all types of clinicians. Still others may include professionals and consumers (I’d recommend trying at least one of these- it’s an eye-opening experience). Keep your goals in mind when selecting a conference. Are you looking for continuing education credits? What about training in a certain specialty area? Trying to connect with others who have similar professional interests? Look for conferences that meet these needs.

### Making the Most of the Conference

Grab a pen and browse the conference brochure. Go ahead, circle things. Mark it up like you did the Holiday Wishbook catalog when you were a kid! This is your “wish list”. You may find that your desired talks overlap or conflict. That’s okay, you can pare down later. Previewing the offerings can help you avoid “presentation paralysis”. This is the phenomenon that occurs when you stop dead between “Grand Salon A” and “Grand Salon B”, torn between two equally interesting presentations, convinced you will miss out on earth-shattering information if you make the wrong choice. It happened to me once and I eventually decided to skip them both and go to Starbucks. I don’t recommend this.

Another mistake I made early on was consulting with colleagues or friends and “meeting up” for certain talks. A presentation is like a movie- you are supposed to be watching and listening. It’s not a social event. Attend what you want to see so you won’t be thinking about how much you’d like to be at the research symposium on brain imaging while you sit through the play therapy workshop that your friend really wanted to go to (no offense to the play therapists out

there). Going to different talks also means you and your colleagues will have more to talk about when you meet up later for drinks or dinner.

### Business and Pleasure?

Conferences provide an opportunity to advance your knowledge of the field and keep up to date on the newest trends in research and clinical work. They also tend to be held in some pretty great destinations that offer the opportunity for sightseeing and pleasure excursions. Imagine attending a conference in San Diego and not going to the zoo. Or, going to Philadelphia and not sneaking off for a cheese steak! Plan some pleasurable activities while at the conference. This can help you prevent “conference overload” and keep you interested when you are attending the presentations.

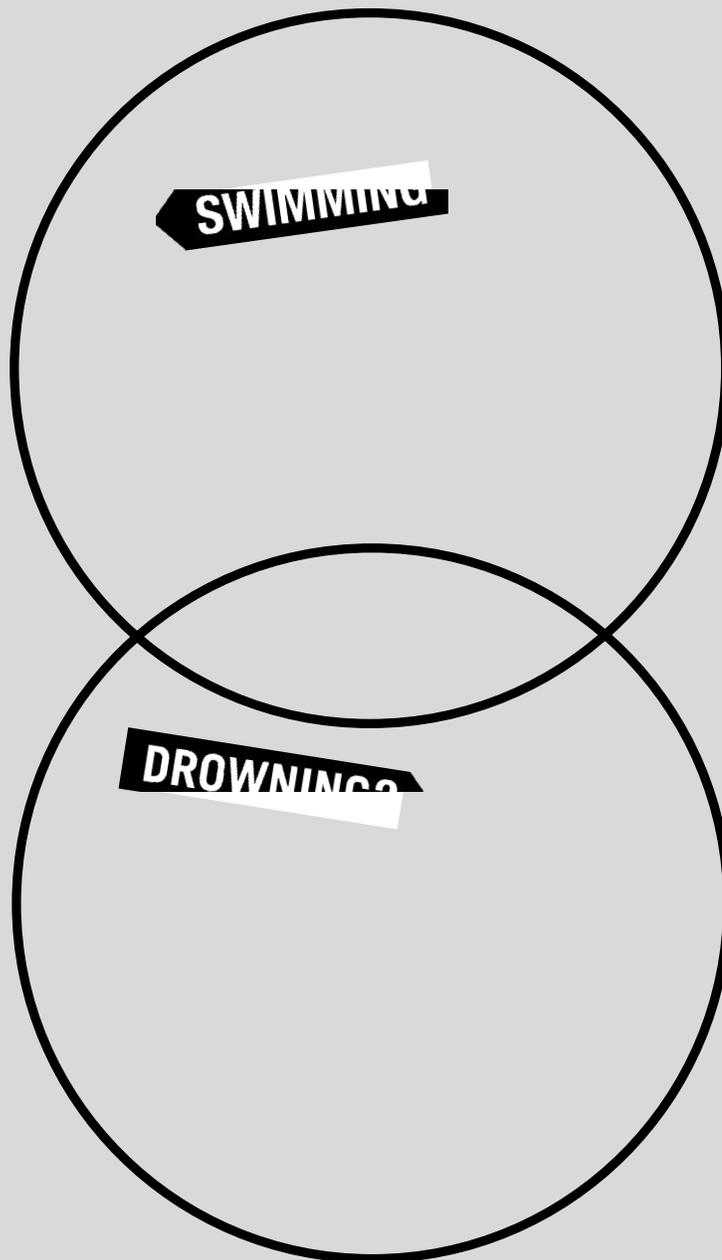
Conferences took on a new meaning for me when I moved from my first post-doctoral position to my current position. They became reunions. I now look forward to catching up with former supervisors and colleagues from near and far. As an internship director, I also get to see my former interns and find out what they are doing now. As you sample conferences and find your favorites, you may decide to attend them annually. Many other professionals do the same and you can develop a “conference cohort” that may serve as an additional professional and social network in the future.

### Networking vs. Stalking

On the last day of the conference I just attended, a colleague and I returned to the hotel after having lunch. As we approached the hotel entrance, we observed the exodus of conference attendees waiting for cabs and airport shuttles, luggage in hand. One of these folks happened to be a well-known researcher who had presented at multiple talks during the conference. He was dressed casually, the ubiquitous conference name-tag now absent, looking a little flustered as he spoke to the valet parking attendant. My colleague whispered, “There’s Dr. So-and-So, should I go up and introduce myself?” I stared at him in disbelief.

This is not networking- this is an example of prestige-induced loss of etiquette. These people are the Paris Hiltons and Brad Pitts of our field and it’s understandable that we may get a little star-struck. But, there’s a right time and a wrong time to introduce yourself and express your fascination with their work. This is an example of the wrong time. Immediately after their talk, as they are scrambling to shut down their LCD projector so the next presenter can set up, is also the wrong time. When is the right time? At one of the evening mixers or socials, or during one of the quintessential continental breakfast spreads the conference hotel sets up. You might also consider a post-conference (as in a few days to a week later) e-mail to compliment them on their talk and ask for slides or reprints of articles.

I hope this column helps you to answer your own “conference call”. Feel free to drop me a line to share your conference experiences (and exploits!): [kmuller@montefiore.org](mailto:kmuller@montefiore.org). □



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## The Division of Clinical Psychology, 1955-65

Donald K. Routh, PhD

 In my first two columns, I described how the forerunner of APA Division 12 began in 1917 and how the organization developed over the years, under four different names. In 1955, its name was simplified from The Division of Abnormal and Clinical Psychology to The Division of Clinical Psychology. Developmental theorist Heinz Werner says that as an organism grows, there is a process of differentiation and hierarchical integration. The same can

***“The Division already had over 2000 members by 1960.”***

be true of organizations. Accordingly, during the decade under discussion, Division 12 became both larger and more complex. Its growth, like that of the field of clinical psychology,

was fueled by training funds from the NIMH and the VA and by new job openings in universities as well as in the VA and other clinical settings.

The president of Division 12 in 1955-56 was Jean W. Macfarlane of the University of California at Berkeley. She began what she called the Berkeley Guidance Study but could never seem to refrain from providing guidance to youngsters in her control group as well as to those in her treatment group. Thus, the population she studied simply became part of the

famous California studies of human development over the lifespan. Child psychoanalyst Erik Erikson was one of her consultants, and over time the research project evolved its own rigorous ways of tracking changes in all domains of development.

In 1956-57, the Division president was George A. Kelly. A scientist of considerable originality, he developed his own version of psychotherapy, which might be considered a very early version of cognitive behavior therapy. In order to track what was going on in therapy, he developed a unique assessment procedure as well, known as the Repertory Grid. Both of these are described in his best known book, *The Psychology of Personal Constructs*, published in 1955. Although Kelly died in midcareer, his work continues to be influential. For example, a *Journal of Personal Construct Psychology* was founded in the U.K. in 1988.

In 1957-58, the president of Division 12 was Anne Roe. In private life, she was married to the evolutionary biologist, George Gaylord Simpson, and in her research she studied among other topics the development of eminent scientists. During her time as president, the Division made the decision to begin to recognize some of its own eminent contributors, and began to give awards for Distinguished Contributions to the Science and Profession of Clinical Psychology. The first two awards of this kind, given in 1958, were to John C. Darley and F. L. Wells. Darley (a counseling psychologist) was recognized for his role in founding the American Board of Examiners in Professional Psychology (recognizing advanced competence). F. L.

### ***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.  
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Wells had been an expert psychological examiner who worked at McLean Hospital, the Boston Psychopathic Hospital, and the Harvard University Department of Hygiene. He had chaired the APA Clinical Section (the forerunner of Division 12) back in 1921. Division 12 has continued to give such awards every year, later adding several others.

As stated at the outset of this column, the continued growth of Division 12 led it to become a more differentiated organization. The Division already had over 2000 members by 1960. Nicholas Hobbs, who served as its president in 1960-61, became dissatisfied with how difficult it was becoming for young clinical

***“...the idea for a Section on Clinical Child Psychology originated in an informal meeting in a 7th Avenue Deli in New York ...”***

psychologists to come into contact with the leadership of the Division. Hobbs' attempted solution to this problem was to form what was called the Corresponding Committee of Fifty (CCF). APA-approved doctoral programs were asked to nomi-

nate their most outstanding graduates of the previous five years to be members of this group of “young turks.” The original chair of the CCF, in 1961, was Roger Bibace, a graduate of Clark University. One meaningful role of the CCF was helping to plan a major training conference in clinical psychology, in Chicago during the 1960s.

In 1962, Division 12 began to permit the organization of special interest groups among its members called Sections. The president of the Division in 1962-63 was Victor C. Raimy, a professor at the University of Colorado, Boulder, and the organizer of the famous 1949 Boulder Conference on clinical training, which included participants representing very diverse constituencies. Section 1 of the Division, was called the Section on Clinical Child Psychology, and was founded by Alan Ross in 1962. At the time Ross was the chief psychologist at the Pittsburgh Child Guidance Center and in 1959 had published a widely read book, *The Practice of Clinical Child Psychology*. In those days, many clinical psychologists, especially those who worked with children, belonged to an interdisciplinary group called the

American Orthopsychiatric Association (“Ortho”). As Ross told the story, the idea for a Section on Clinical Child Psychology originated in an informal meeting in a 7th Avenue Deli in New York at the time of the 1961 Ortho meeting.

Section 2 of Division 12 originated in a group called Psychologists Interested in the Advancement of Psychotherapy (PIAP) which had been meeting informally at APA since the late 1940s. Its members were among those who fostered the APA conferences on research in psychotherapy, the first of which was held in Washington, D.C. and led to the book edited by Rubenstein and Parloff in 1959. Section 2 was officially approved by Division 12 in 1963, when Starke R. Hathaway was president of the Division. The first president of Section 2 was Eugene T. Gendlin.

Section 3 of Division 12 had a rather unwieldy name to begin with: The Section for the Development of Clinical Psychology as an Experimental-Behavioral Science. (Its name was subsequently simplified to Society for a Science of Clinical Psychology.) Section 3's Organizing Committee, which met in 1965, included Albert Bandura, Cyril M. Franks, Arnold Goldstein, Frederick H. Kanfer, Leonard Krasner, Peter Lang, Robert Rosenthal, Kurt Salzinger, and Irwin Sarason. This Section was approved that same year, when the president of the Division was Sol L. Garfield. An influential conference on behavior modification held in Charlottesville, Virginia, in 1962, provided important background for this group. The first of the behavior therapy journals, *Behaviour Research and Therapy*, began publication in 1963. The immediate impetus for Section 3 was provided by a book of case studies in behavior modification edited by Leonard Ullman and Leonard Krasner in 1965.

In conclusion, Division 12 was successful in becoming considerably larger even by 1965, the last date covered here. As a result, it began to try to develop mechanisms such as the Corresponding Committee of Fifty to facilitate communication between its younger members and the leadership. Finally, it began to allow the formation of Sections for those of its members with particular interests, such as work with children, psychotherapy, or behavior therapy. □.

## “Essays on Internship”

George M. Slavich, PhD

 The internship application process is multifaceted, making it a topic about which much can be said. For this installment of the student column, I asked three individuals who recently endured the process to share their thoughts with us. Each selected a part of the process (applications/essays, interviews/site visits, ranking/transitioning), and here is what they had to say!

### “Writing Essays That Fit”

David P. Lichtenstein  
Health Sciences Center,  
University of New Mexico

The internship application is long, and filled with detail. And everyone has a unique process for applications. So, rather than dispense advice, I decided to briefly describe my essay-writing process and distill a few key elements that may — or may not — be helpful to current applicants.

When I first downloaded the application I quickly scanned through the essay topics and noted the major areas covered. Then I put the application down for a few days, during which I talked to colleagues about important things to include in our essays.

*“I am of the opinion that being honest and genuine is the recipe for success.”*

Eventually, I made a list of key activities, accomplishments, and values that I wanted to include in my essays, which I saw as effectively five opportunities to create a dynamic picture of myself. Then one night when I felt that the ideas had stewed in my head long enough, I sat down, poured myself a glass of wine, and sketched out all four of the main essays. I did it by hand and wrote quickly, trying to pour out my main ideas and creative framework to hang ideas on. For each essay, especially the personal statement, I tried to show as well as tell — that is, I wrote in a style (humor, metaphor, connecting activities to the big picture) that I thought would convey who I was almost as much as the achievements I listed. Later, I went through a fairly extensive review/editing process, reworking the words, making sure each item from my original list was integrated somewhere in the essays, soliciting

feedback from peers I respected.

For me, I think the key to putting together a strong application was finding my own comfortable way not only to complete it, but to represent myself in my writing. Finding this self-tailored style was critical for the application as well as the interview process...

### “Interviews, Site Visits, and Suits, Oh My!”

Joyce P. Chu, Ph.D.  
University of California,  
San Francisco

Then comes the happy day when you get called for an interview. Your application worked, moment of joy! Unfortunately, that moment passes pretty quickly and your joy meets a friend: anxious anticipation. It's time for site visits.

In many ways, the interviews are a balancing act. You're trying to get them to like you, but simultaneously assessing if you like them. I am of the opinion that being honest and genuine is the recipe for success. Your interviewers are a bunch of psychologists, after all. Most likely, you won't be able to pull a fast one on them, or convince them you believe/want something you don't! So, try to relax and be yourself. Portray genuine excitement, and take the stance of figuring out if that site really fits your needs. If you do that, the right site for you will like you.

Now, the nitty gritty. Beyond a general approach of being honest and genuine, there are a few things you should do. First, get to know the site and why you would want to go there. Do your research and write a crib sheet about the program details, what you're excited about, and possible questions. Second, practice talking about a couple of cases, eloquently. Many sites ask you questions like “Tell me about a personally challenging case.” Third, every moment of the site visit counts. Whether you're hanging out in between meetings or with program support staff — be on, the whole day. Fourth, practice makes perfect. So, go to one or two “less important” sites first. Fifth, follow-up. Not necessarily the quintessential thank you card, but it's a good idea to maintain some sort of contact after the interview — a thank you, a question, an expression of interest. They'll be more likely to remember you, and hopefully rank you.

**“Coping Skills for the Match Process”**

Rebecca Silver, Ph.D.  
Health Sciences Center,  
University of New Mexico

Although ranking sites and waiting for match results can be anxiety provoking, it can also be empowering. You’ve spent the past several months putting your best foot forward, now you get to decide the best fit for you.

There are myriad factors to consider when ranking sites: location, post-doc positions, training

***“Although ranking sites and waiting for match results can be anxiety provoking, it can also be empowering.”***

experiences, research opportunities, current interns’ happiness, benefits and salary, intangible feelings of fit, etc. I found it helpful to talk to my peers, advisors, supervisors, and family, but ultimately it is your priori-

ties and your decision. I applied as part of a couple, so that was my priority. Although we still joke about whether we made the right decision (even now that we are happily together at internship), we also realize that there were many sites that would have fit our needs. Indeed, the places that we knew we

wouldn’t be happy, we decided not to rank at all.

The rest was a waiting game. To pass the time, I planned a celebration/ commiseration event for Match Day. Knowing that we would soon be spreading out to different parts of the country, it felt important to mark the transition with my friends who had also applied to internship.

Match Day came with positive results, but also marked the beginning of a significant transition for which I wasn’t entirely prepared. In the midst of defending my dissertation, moving, and saying good-bye to friends and colleagues, I didn’t make time to think about what lay ahead. I’m not sure I could have formally prepared myself (brushing up on the DSM wouldn’t have helped), but it has been reassuring to remind myself that transitions are naturally unsettling. So for the moment, I’m trying to focus on the excitement of my new experience instead of on my dysfunctional pager or on all the new paperwork.

In conclusion, I think it is important to emphasize just how much one’s mindset can affect the internship application experience. Viewing the process as an opportunity to explore your professional goals and different parts of the country might just make the year fun! □

**ANNOUNCING NEW DIVISION 12 AWARD:  
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This award will be conferred annually beginning in 2007 to a psychologist displaying excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty. It will recognize those individuals who have been outstanding in supporting, encouraging and promoting education and training, professional and personal development, and career guidance to junior colleagues. Qualities that can contribute to good mentoring are advisor/guide in research related to clinical psychology, advisor/guide in clinical practice related to clinical psychology, advisor/guide in education and teaching related to clinical psychology, advisor/guide in public policy related to clinical psychology, acting as a successful role model, fostering the development of talents, acting as an advocate and guide, “friend” with concern for students and junior colleagues as people and support of their personal development, supportive on both a personal and professional level and long-term commitment to mentoring. This award seeks to recognize those individuals who truly go out of their way to mentor more junior colleagues, honoring them for efforts which often go unnoticed—but not unappreciated.



## Cape Verdean American Women: Acculturation and its Relationship to Gender Role Attitudes

Maria Coutinho, MA  
Boston College

 Researchers assert that the character of gender relations varies across racial and ethnic groups and this impacts gender role attitudes; however, research on racial/ethnic differences in gender role attitudes is scarce (Kane, 2000; Phinney & Flores, 2002; Sigal & Nally, 2004). Immigration and the resulting acculturation process influence how men and women perceive their roles within the family (Amaro & Russo, 1987; Baca Zinn, 1975; Dion & Dion, 2000). This paper provides a preliminary examination of acculturation and its relationship to gender role attitudes in a sample of Cape Verdean American women.

### Cape Verdeans and Acculturation

The complexity of Cape Verdean's racial identification is an important aspect of the Cape Verdean experience

*“Gender is an important component of the immigration experience that is often overlooked...”*

in the United States that directly affects the acculturation process (Nunes, 1982). As Cape Verdeans settled in the U.S. both they and the Americans had to deal with the issue of racial identification. Early Cape Verdeans identified themselves as Portuguese;

however, the White Portuguese rejected them. In addition, the Cape Verdean community is characterized by tightly knit enclaves, which have been described as a strategy to insulate itself from the discrimination and prejudice experienced in the mainstream society (Halter, 1993). With Cape Verdeans largely choosing to remain closely connected to their culture of origin (Halter, 1993), it is important to examine how the acculturation experience of this population manifests itself in the realm of gender role attitudes.

### Gender Role and Cape Verdeans

Gender roles refer to “people’s beliefs about the appropriate roles and obligations of women and men” (Frieze, Ferligoj, Kogousek, Renner, Hiorvat & Sarlija,

2003, p. 256, as cited in Sigal & Nally, 2004). When discussing gender role attitudes the debate usually encompasses the dichotomous concepts of traditional vs. egalitarian attitudes (Brooks & Bolzendahl, 2004; DeSouza, Baldwin, Koller & Narvaz, 2004; Sigal & Nally, 2004). Traditional gender role attitudes conceptualize men as possessing greater status, power and control over women, while, egalitarian gender role attitudes refer to men and women equally sharing power and responsibility (Sigal & Nally, 2004). Cape Verdean society is characterized by a patriarchal power structure in which men have greater status than women and expectations are defined within the traditional gender role conceptualization (Nunes, 1982).

Twenty-six Cape Verdean women from the New England area completed the Acculturation Rating Scale for Mexican Americans - II (Cuellar et al., 1995) and the Attitudes Towards Women Survey (Spence et al., 1973). The sample consisted of first and second generation Cape Verdean American women. Participants ranged in age from eighteen to fifty-six years of age, with 65% of the sample under twenty-nine years of age and 35% over 30 years old. Twenty one percent of the women were born in the U.S. (n=5) while the remainder of the sample ranged from 1 year to more than 20 years living the United States. Pearson Product Moment correlations and ANOVAs were computed to assess the relationships between levels of acculturation, gender role attitudes, level of education, years in the U.S. and age.

Results indicate that younger women exhibited more egalitarian views of gender roles as well as greater acceptance of American values, than their older counterparts. In addition, women with higher levels of education held more egalitarian gender role attitudes and were more open to American values. No relationship was found between acculturation and gender role attitudes, and the number of years in the United States was not related to any of the variables of interest. The absence of a relationship between acculturation and gender role attitudes may have been a function of a number of limitations of the study. The small sample size limits the generalizability of these findings. In addition, this sample was limited to women, so that it is unclear how Cape Verdean men perceive gender roles. Gender is an important component of the immigration experience that is often overlooked (Suárez-Orozco & Qin, 2006). However, studies indicate differences in the immigration and socialization experiences of immigrants as a result of gender (Dion & Dion,

## Diversity Column (cont.)

2000; Suárez-Orozco & Qin, 2006). Understanding the intersection of gender and cultural context in the experience of immigrants will allow clinicians and service providers to provide more effective services for these communities, particularly as differences in gender role norms between the original culture and the receiving culture have been found to put women at higher risk for acculturative stress (Suárez-Orozco & Qin, 2006). □

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## 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  
Niwt, CO 80544-1082

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## The Texas Medication Algorithm Project: A Lesson in Dissemination via Demonstration?

Timothy J. Bruce, PhD

 President George W. Bush's New Freedom Initiative was established to promote access to educational, employment, and community resources for those with disabilities. As part of that initiative, The President's New Freedom Commission on Mental Health was formed. It was charged to assess problems in the public mental health system and make specific

***“The authors concluded that algorithmic care for schizophrenia was more cost-effective than usual care ...”***

recommendations for improvement. Among the six goals and 19 recommendations made by the commission was a call to increase consumer access to evidence-based treatments, pharmacotherapeutic and psychosocial, through dis-

semination and demonstration projects. Cited as a model project was the Texas Medication Algorithm Project (TMAP).

Initiated in 1995, TMAP was a public-academic collaboration between the Texas Department of Mental Health and Mental Retardation and the University of Texas Southwestern Medical Center in Dallas, its College of Pharmacy in Austin, and its Health Sciences Center in San Antonio. TMAP investigators developed and studied the use of empirically informed medication algorithms within disease management programs for major depression, bipolar disorder, and schizophrenia. A primary aim of the project was to compare health care costs and clinical outcomes between algorithm-guided medication management and medication management as it occurred naturally (i.e., treatment as usual) across 19 public mental health treatment centers. Details of TMAP, including the development of the algorithms, the disease management models, and methodological features of its studies can be found in the references listed at the end of this article.

Recently, the TMAP group published results of its first costs studies (Kashner, Rush, Crismon, et al., 2006), allowing them to comparing these data with

those of previously published TMAP outcome studies (Miller et al., 2003, Suppes et al., 2003, Trivedi et al., 2004) and judge cost-effectiveness of algorithmic versus non-algorithmic medication management. The outcome studies used primary diagnosis symptom change as their main outcome variable. Multiple costs measures were used including overall costs as well as costs to the treating agencies.

In general terms, results showed that participants treated with the schizophrenia algorithm achieved symptom reduction faster than their usual-care counterparts. Over time, the magnitude of symptom reduction in the usual-care group caught up with that achieved by algorithm participants. Overall costs and costs to the treating agencies were approximately equal and not significantly different between groups. The authors concluded that algorithmic care for schizophrenia was more cost-effective than usual care by virtue of producing sustained symptom reduction more rapidly than usual care.

Similar results were reported with the bipolar algorithm. Participants treated with this algorithm showed a stronger magnitude of initial symptom reduction than their counterparts in usual care, a significant difference that sustained over the one-year course of the trial. Although overall costs of the two treatments did not differ significantly, costs specific to the treating agencies were 22% lower for algorithm-driven care. Higher inpatient treatment costs for usual care seemed to have accounted for much of that difference. The authors' conclusion was that algorithmic medication management of bipolar disorder was more cost-effective than usual care.

In the study of major depression, clinical outcome was similar to that of the other algorithms in that participants in algorithmic care reported faster and stronger initial symptom reduction that remained significantly different from the relatively poor response to usual care throughout the one-year trial. Agency and overall costs were significantly higher for algorithmic treatment however, something the authors termed mixed cost-effectiveness.

As effectiveness studies, the design of the TMAP studies emphasized generalizability to real world treatment settings over design features that would help identify how the results occurred (i.e., external over internal validity). Consequently, we don't know how the algorithmic treatments produced stronger initial responses than usual care. For example, did

they produce this effect because of relatively superior medication efficacy? Most first-line indications on the algorithms are there because they reduce side-effect risks. Or, perhaps the result was due to the aggressiveness with which algorithmic treatments target symptom remission and prompt prescribers to frequently assess and take clinical actions toward achieving this goal. The interpretive differences between efficacy and effectiveness studies are well-known in the literature. Perhaps results from these initial studies may inform decisions on how to optimize the balance between internal and external validity in the design of demonstration studies to improve interpretation of their results.

In the meantime, it seems that TMAP has been effective in terms of dissemination. With increased financial support from their state

***“The interpretive differences between efficacy and effectiveness studies are well-known in the literature.”***

legislature, Texas is now well into TIMA: the Texas Implementation of Medication Algorithms initiative. Several other states are now doing algorithm implementation projects based on the Texas model, and

with increased state and/or federal support. Although the lack of good controls precludes certainty, it seems that results from TMAP show that demonstration facilitates dissemination. □

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## BOOK RECOMMENDATIONS

Lata K. McGinn, PhD — Section Editor

### Science and Pseudoscience in Clinical Psychology

Scott O. Lilienfeld, Steven Jay Lynn,  
& Jeffrey M. Lohr (Eds.)

New York: Guilford (2003)

Reviewer: James D. Herbert, Ph.D.  
Drexel University

 The past three decades have witnessed tremendous growth in the science of clinical psychology and related fields. These developments contributed to the growth of increasingly sophisticated research methodologies for evaluating the effectiveness of

***“It is useful to recall that CBT was initially dismissed by its critics as hopelessly simplistic and naïve.”***

psychotherapy. An emerging scientific basis allowed us to declare that some treatments actually worked relative to meaningful control conditions.

At the same time, an astonishing variety of assessment and intervention techniques were being developed that claimed to offer unprecedented cures for notoriously treatment refractory conditions in as little as a single session. The result has been a growing “culture war” in psychology, pitting scientist-practitioners against those whose epistemologic leanings favor authority and “clinical experience.” Against this backdrop, Lilienfeld, Lynn and Lohr (2003) present an edited volume that critically discusses the most common of these questionable assessment and intervention approaches. The volume begins with a gem of an essay by Carol Tavris, who wryly notes

that the so-called “scientist-practitioner gap” in psychology has grown to the point that today it is “like saying there is an Israeli-Arab ‘gap’ in the Middle East.” Subsequent chapters span a wide range of topics, including projective tests, politically inspired clinical syndromes, multiple personality disorder, recovered memory therapy, various “new age” therapies, reparenting and coercive restraint therapies, “power” and “energy” therapies for PTSD, among others. In each case, the claims about the phenomena are reviewed and the evidence (or lack thereof) is critically examined.

The book is highly accessible, and could be useful for many audiences, ranging from practicing professionals to policy wonks to graduate or even undergraduate students. If the book has one flaw, it is that it might reinforce a sense of exaggerated self-righteous indignation bordering on cynicism in some readers. Psychologists must walk a fine line between healthy skepticism and open-mindedness. Although we should have little tolerance for many of the more egregious topics covered in the volume, we must not become reflexively dismissive of all novel developments. It is useful to recall that CBT was initially dismissed by its critics as hopelessly simplistic and naïve. CBT won its current standing by demonstrating its effectiveness scientifically, not by making outrageous claims that far outstripped the data. If we are to make progress toward bridging the scientist-practitioner gap in mental health, we must remain open to—and indeed encouraging of—innovation, while simultaneously insisting that claims be evaluated against and tempered by data. □

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



### **Section II: Geropsychology Deborah A. King, Ph.D.**

So much happening and so little space to tell you about it! The National Training Conference on Professional Geropsychology was held in June and attained its goal of outlining aspirational educational models for all levels of training from doctoral to post-licensure psychologists. Conference proceedings and outcomes will be published in 2007.

The Public Policy Committee, co-chaired by Donna Rasin-Waters, Ph.D. and Peter Kanaris, Ph.D., continues to make impressive progress. The public media campaign is ongoing, providing wonderful opportunities for psychologists to represent their areas of specialty to the media. Media training workshops continue at the annual convention and the Section continues to post geropsychology profiles on the media platform Profnet to expand public knowledge of our profession. Also, as the D12 Federal Advocacy Coordinator (FAC), Dr. Rasin-Waters is working with state FACs on a voter registration drive. Anyone interested in participating in these or other advocacy efforts should contact Dr. Rasin-Waters at [DrRasinWaters@aol.com](mailto:DrRasinWaters@aol.com).

Finally, major kudos to Paula Hartman-Stein, Ph.D. for receiving the Alfred M. Wellner Senior Career Psychologist Award for Excellence in a Health Service Provider in Psychology. Paula has worked tirelessly to promote excellence in our field and to further both public and professional understanding of geropsychology. She is a terrific role model and an impressive advocate for psychology. Hats off to you, Paula!

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

### **Section III: Society for a Science of Clinical Psychology E. David Klonsky, Ph.D.**

The Society for a Science of Clinical Psychology (SSCP) is currently exploring ways to focus media attention on the importance of evidence-based treatments. We are in contact with Division 12 officers who are planning a similar initiative. In addition, SSCP and D12 are discussing how SSCP can interface with D12 and the D12 Committee on Science and Practice to promote science in clinical psychology. The development and promulgation of the empirically-supported treatments list was very successful in many regards, and the question now is how to formulate and implement next steps. A formal committee structure to lead this initiative is being developed. We are also investigating ways to work with the APA continuing

education committee to ensure that CE offerings are based in good science. Finally, Mike Miller will be taking over as manager of the SSCPnet listserv. We welcome Dr. Miller, and express our gratitude to Michael Bailey for his many years as listserv manager. Additional information about SSCP can be found at our website, [SSCPWeb.org](http://SSCPWeb.org).

### **Section VIII: Association of Psychologists in Academic Health Centers Danny Wedding, Ph.D.**

The Association of Psychologists in Academic Health Centers (APAHC) recently conducted elections for three positions. The election was conducted online, and the results were announced at the APA convention in New Orleans. The new officers are as follows: Member at Large, John Robinson; Secretary, Elena Reyes; and Division 12 Representative, Ron Brown.

Leadership for the Journal of Clinical Psychology in Medical Settings has now passed from founding editor Ron Rozensky to the new editor, Barbara Cubic. Dr. Cubic works in the Departments of Psychiatry and Family Medicine at Eastern Virginia College of Medicine.

APAHC has selected the 2006 recipients for its two major awards. The APAHC Award for Distinguished Achievement in Research was awarded to Dr. David Antonuccio, Professor of Psychiatry and Behavioral Sciences at the University of Nevada School of Medicine. The Ivan Mensh Award for Distinguished Achievement in Teaching was awarded to Dr. Danny Wedding, Professor of Psychiatry and Director of the Missouri Institute of Mental Health at the University of Missouri-Columbia School of Medicine. Both awards were presented at the APA Convention in New Orleans.

Last year's award winners (Nadine Kaslow for Teaching and Peter Vitaliano for Research) presented papers describing their work at the APA convention. In addition, Paul Nelson, Annette Brodsky and Jack Carr presented a symposium titled "Tribute to Ivan Mensh—The Man and His Work."

The Association is continuing to plan for a national conference to be held in Minneapolis May 3 – 5, 2007. As conference details become available, they will be posted on the APAHC home page ([www.http://www.apa.org/divisions/div12/sections/section8/](http://www.apa.org/divisions/div12/sections/section8/)). Information about joining APAHC is available at this same site.

The members of APAHC mourn the recent death of Dr. John Conger. Dr. Conger was a past president of APA and a champion of medical school psychologists; in addition, he formerly served as Dean and Vice President for Medical Affairs at the University of Colorado School of Medicine.

# ABBREVIATED MINUTES

Society of Clinical Psychology  
Board of Directors Minutes  
Santa Monica, CA  
June 9-11, 2006

Minutes – February 2006

MOTION: To approve the minutes as corrected.

ACTION: Passed unanimously

**2007 Meeting Year:** There was a discussion about changing the meeting year dates to March and October to coincide with the budget planning process. It was decided that the meeting dates will remain as scheduled for 2007. Changing the dates will be reconsidered in the future. The 2007 meeting dates are as follows: January 27-28, 2007 in Seattle, WA and September 14-16, 2007 in Tucson, AZ.

**Appointments:** Dr. Edward Craighead will remain as the Publications Committee Chair in 2007.

**BEA Activities:** BEA task force is working on guidelines for undergraduate education in psychology. There is helpful information including very good resources for high school teachers as well as undergraduate faculty on the website. However, there is concern that these guidelines may become requirements. It is important for universities to maintain control over their curriculum.

MOTION: We are concerned that APA not be viewed as encroaching upon the undergraduate curriculum in psychology in its well-intentioned efforts to provide resource materials and other assistance to educational units. The integrity and independence of the academic enterprise has to be respected.

ACTION: Passed

Dr. Kenneth Sher sent a letter to Dr. Cindy Carlson, the chair of BEA expressing concern about the ASPPB/NR policy on prescription privileges. The issue is whether prescription privilege training can be done through continuing education (CE) or should be university based. One problem is that CE training can not provide oversight for practicum experience. Prescription privileges fits a specialty model, not a proficiency model.

MOTION: We endorse the position taken by the CE Committee of APA with regard to education and training of prescriptive authority. That is that education and training in prescription privileges be based in regionally accredited universities and professional schools.

ACTION: Passed unanimously

**Finance:** The contract for the Division 12 Administrative Officer ends in December 2007.

MOTION: Pursue re-negotiation of the contract for five years. The President and Treasurer are authorized to negotiate the specifics of the contract.

ACTION: Passed unanimously

**Stipend for Editor of CP:SP:** The contract with Blackwell called for a stipend of \$14,000 per year. Miscommunication and budget concerns led to payments of \$10,000 in year one and \$12,000 in year two.

MOTION: Pay a lump sum of \$6,000 to the CP:SP editor to compensate for underpayment (\$4,000 in year one; \$2,000 in year two) and increase the stipend to \$14,000 effective in 2007.

ACTION: Passed unanimously

**Committee on Diversity:**

MOTION: To commend Dr. Gail Wyatt and the Diversity Committee for their hard work and fine report.

ACTION: Passed unanimously

MOTION: Division 12 leadership will submit the report of the Diversity Committee as a symposium at the Multicultural Conference in Seattle in January, 2007.

ACTION: Passed unanimously

All Division 12 committee chairs were charged with reviewing the recommendations and preparing a plan for implementing the recommendations that are relevant to their committee. It was suggested that the committee's recommendations could be published in *The Clinical Psychologist*.

MOTION: Endorse the draft recommendations that have been presented by the Diversity Committee.

ACTION: Passed unanimously

MOTION: The final copy of the Diversity Committee's report will be sent to all committee chairs. Each committee will develop a strategy for implementation and action. At the next meeting of the Board, all committee reports will include their implementation and action plan.

ACTION: Passed unanimously

**Publications:**

*Clinical Psychology Science Practice*

The transition from Oxford to Blackwell went very smoothly. Dr. Davison will send a letter to Elizabeth Kidder and Margaret Zusky's boss commending them. The first issue of the journal was early.

Dr. Philip Kendall is doing a great job as editor and has an excellent working relationship with Elizabeth Kidder and the Production Department at Blackwell. The turn around time from submission to editorial decision is 44 days. From the time of the editorial decision to publication is the next issue. The Executive Committee members who met with the representatives from Blackwell were very impressed. Thus far Blackwell has kept their commitment.

MOTION: The content of CP:SP is review papers and commentaries. To support the editor in his attempt to embellish the content of the journal by accepting empirical papers with or without commentaries.

ACTION: Passed unanimously

**Section Reports:**

Section IV

MOTION: The Society of Clinical Psychology would like to commend the APA Public Affairs Office for their support of the message on National Public Radio that emphasizes the contributions of APA to the science and practice of psychology.

ACTION: Passed unanimously

Section X

There is a great deal of energy around this new Section for students and new professionals. There will be a meeting of interested students at APA in New Orleans.

MOTION: To approve the revised Bylaws

ACTION: Passed unanimously

**Request from Division 18:** A request was made to publicize Division 12's support of Psychology Shield to encourage other divisions to give financial support as well. Dr. Davison read a letter that will be posted on the list serve for division leaders encouraging support.

MOTION: To post Dr. Davison's letter on the list serve for division leaders.

ACTION: Passed unanimously

**Budget:** Division 45 – Society for the Psychological Study of Ethnic Minority Issues is partnering with New Orleans public libraries by requesting donations to restore books lost due to the hurricanes and aftermath of the floods.

MOTION: Division 12 will donate \$250 for books for New Orleans public libraries.

ACTION: Passed unanimously

MOTION: Add \$500 to the budget for the Interdivisional Task Force on Child and Adolescent Mental Health

ACTION: Passed unanimously

**Respectfully submitted,**

**Linda Knauss, Secretary**



### **Division 12 Creates a New Section: Graduate Students and Early Career Psychologists**

Last year the Board created a mechanism for encouraging and sustaining graduate students' and early career psychologists' membership in the Division. To do this a new section the Board voted to establish a new section. The proposed bylaws amendment establishing this new section, Section 10: Graduate Students and Early Career Psychologists, was approved by the membership last year and at its June 2006 meeting the Board approved the section's bylaws.

Section 10 as with all sections will have elected members and as such will have a sustained body of individuals committed to the goals of the section. Each section elects a Representative to the Society's Board of Directors who attends the Board meetings as a voting member

Already a group of interested individuals are ready to get this new section off to a good beginning. Elections for officers (i.e., President, Secretary, Treasurer, Representative) will take place before the end of this year. If you have questions or are interested in joining the section and/or running for one of the elected offices please email the Division's Administrative Officer, Lynn Peterson, at [div12apa@comcast.net](mailto:div12apa@comcast.net).

Linda C. Sobell, Ph.D., ABPP  
Past-President

### **Congratulations!**

Dr. Asuncion Miteria Austria was recently awarded the Committee on Women in Psychology (CWP) Distinguished Leadership Award. The award was presented at the annual American Psychological Association Convention in New Orleans, by CWP chair Dr. Louise Silverstein.

The citation read:

In recognition of her outstanding contributions to education and training and to the delivery of psychological services to women through her teaching, writing, administrative leadership, mentoring, and guidance for their professional careers. She has been a mentor and a role model for students and professionals in many capacities. Her dedication and compassion reflect the best and deepest values not only of psychology but of humankind. Within APA governance she has championed the voice and worked to raise the visibility and participation of women and ethnic minority psychologists. Dr. Austria is a gracious bridge builder who listens to and is respectful of alternative views. She is an advocate of quality mental health care for all. Dr. Austria is truly a distinguished leader for women in psychology.

### **A Tribute to Charles D. Dr. Spielberger, Ph.D., ABPP**

The Society of Clinical Psychology is distinctly pleased to honor Charlie Dr. Spielberger, Ph.D., ABPP for his long, dedicated, and extraordinary service to the division. Born in Atlanta, Georgia, Dr. Spielberg received his BS degree in Chemistry from Georgia Tech after a stint in the U.S. Navy. He then completed the requirements for his BA in Psychology at the University of Iowa. As a graduate student at the University of Iowa, he worked as a research assistant with Judson Brown, Ph.D., I.E. Farber, Ph.D., and Grant Dahlstrom, Ph.D., and was greatly influenced by Hullian Learning Theory and the exceptional teaching of Kenneth Spence, Ph.D. and Gustav Bergman, Ph.D.. He did his internship training at Worcester State Hospital and there was guided by Lesley Phillips, Oscar Parsons, and psychiatrists associated with the Boston Psychoanalytic Institute.

He began his academic career at Duke University with a joint appointment in Psychology and Psychiatry. He served as Chief Psychologist of the Psychiatric Outpatient Clinic and developed the Duke Check List, which provided the foundation for the State-Trait Anxiety Inventory (STAI). While in the Duke Psychology Department, he secured funding from the National Institute of Mental Health (NIMH) to support his experimental research on verbal conditioning as well as his work on a preventive intervention to alleviate the adverse effects of anxiety on academic performance. He also developed a community mental health program in Wilmington, NC where he consulted with ministers, public health nurses, welfare caseworkers, and high school teachers.

In 1962, he moved to Vanderbilt University as Professor of Psychology and continued his research on verbal conditioning and anxiety. His first book, *Anxiety and Behavior*, was based on a national conference he convened. While on leave from Vanderbilt at NIMH, he conducted site visits and participated in the evaluation of psychology training programs at more than 100 academic institutions. His next position was as Professor and Director of Clinical Training at Florida State University, where he completed his work on the development and validation of the STAI. The STAI has been translated and adapted in 66 languages and dialects, and used in more than 15,000 archival studies during the past thirty years.

Dr. Dr. Spielberg's active involvement in international psychology was stimulated by spending six months in London at the Florida State University Study Center. In collaboration with Irwin Sarason, Ph.D., Dr. Spielberg obtained a NATO Grant to support an Advanced Study Institute and worked with

## News from Division 12 (cont.)



*Charlie Spielberger was warmly bid farewell at his last Div 12 meeting in Santa Monica, CA.*

Sarason and Hans Eysenck, Ph.D. in organizing a conference on "Stress and Anxiety in Modern Life", convened in Germany. Three additional conferences supported by NATO grants were held in Norway, Italy, and England. Dr. Spielberger spent a sabbatical year as a Research Fellow at The Netherlands Institute for Advanced Studies (NIAS). While devoting most of his time to research, he organized two major conferences on "Stress and Anxiety". Returning to NIAS as a Research Fellow in 1985-86, he organized international conferences on "Health Psychology" and "Stress and Emotion" that were convened at the University of Tilburg and in Budapest/Visegrad.

In 1972, Dr. Spielberger found a permanent home at the University of South Florida. As Professor and Director of Clinical Training, he provided leadership in obtaining APA accreditation for the USF Doctoral Program in Clinical Psychology. His research contributions were recognized by USF in 1973 as the first recipient of its Distinguished Scholar Award, and by the 1977 Florida Psychological Association's award for Distinguished Contributions to Psychology Theory and Research, the 1985 USF Sigma Xi Award for Outstanding Faculty Researcher, and his appointment as Distinguished Research Professor of Psychology in 1985. He developed the USF Center for Research in Behavioral Medicine and Health Psychology in 1977, served as its Director for the past 25 years, and retired in 2003 as Professor Emeritus.

Although Dr. Spielberger's career has focused primarily on research, he has also given a high priority to training and professional practice. He is board certified through the American Board of Professional Psychology in Clinical Psychology, and recognized as a Distinguished Practitioner of Psychology by the National Academies of Practice. A fellow of 14 APA Divisions (1, 3, 5, 8, 12, 13, 17, 26, 27, 38, 42, 46, 47, 52), he served as President of Divisions 12, 27 and 52, and received awards from these Divisions for Distinguished Contributions to Clinical, Community, and International Psychology; and Distinguished Contributions to Education in Psychology and to Knowledge and Professional Practice; and Distinguished Lifetime Contributions Awards from Psi Chi, the Society for Personality Assessment, and the Society for Stress and Anxiety Research (STAR). Additional leadership responsibilities have included serving as APA President and Treasurer, and as Chair of the National Council of Scientific Society Presidents and the US National Committee for International Psychology.

We are particularly grateful to him for his invaluable 14 years of service to our division. In addition to serving as President, he has represented us with distinction on the APA Council of Representatives for many years. He has done an admirable job as our Treasurer and Finance Chair, helping to ensure that we are fiscally sound. In addition, we appreciate that he has contributed an honorary board member to our Division, Carol, who loyally attends all of our meetings.

For his impressive contributions to psychology both nationally and internationally and for his dedication to our Division, we say THANK YOU.

Nadine J. Kaslow, Ph.D., ABPP  
Former President of the Society of Clinical Psychology and Council Representative

## INSTRUCTIONS FOR ADVERTISING

Want ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of *The Clinical Psychologist*. Ads will be charged at \$2 per line (approximately 40 characters).

Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, phone number, and advertisement to the editor. E-mail is preferred.

*For display advertising rates and more details regarding the advertising policy, please contact the editor.*

*Please note that the editor and the Publication Committee of Division 12 reserve the right to refuse to publish any advertisement, as per the advertising policy for this publication.*

### **Submission deadlines for advertising and announcements:**

February 1<sup>st</sup> (Winter/Spring Issue – mails in early April)  
May 1<sup>st</sup> (Summer Issue – mails in early July)  
September 1<sup>st</sup> (Fall Issue – mails in early November);

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## Instructions to Authors

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

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

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

## THE CLINICAL PSYCHOLOGIST

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