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PRESIDENT'S COLUMN

Prescriptive Authority: Moving Toward a New Clinical Psychology?

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No matter what side of the issue you are on, it is recognized that July 1, 2002 marks the beginning of a new era in clinical psychology training, research, and especially practice. This is the date on which New Mexico will begin to allow psychologists to prescribe psychoactive medications. While granting psychologists prescriptive authority remains a controversial topic, there is no doubt that this step by the State of New Mexico, following as it does, a similar one by the territory of Guam, opens the door to a new view of the nature of clinical psychology. Like it or not, as a profession we all are going to have to address some important problems as we move into this new professional definition. Our professional lives will change – in fact, some seem to worry that the changes to clinical psychology will parallel in magnitude the more general life changes to society that were initiated by the terrorist attacks on September 11, 2001. Though unlikely to be this drastic, we will face some interesting professional challenges and opportunities in the next few years as other states follow Guam and New Mexico into this new territory of prescriptive authority for psychologists. Be prepared!

We live in a country that solves many of its disagreements in the courtroom. And, given the stakes, it is quite likely that it will be in the courtroom that many of the questions about prescriptive authority will be resolved–a truly scary thought. In the following pages, I have identified some of the legal questions that are likely to arise at some point along the line. Successful resolution of these questions and the issues that they portend, will determine the future of clinical psychology, and to one extent or another, our personal futures, too.

Legal Challenge #1 – The Limits of Competence

The first lawsuit will probably be one that contends that psychologists are not adequately trained to prescribe medications, safely. Now, make no mistake, the question will not be how effective psychologists are at treating their patients. If the legal system runs true to form, that won't matter much. The legal system typically determines effectiveness on how well the practice complies with certain processes—amount and type of training—not on how effective these processes are in helping anyone. Thus, the question may well resolve to how many hours of training one receives and how similar this training is to that of other professionals who prescribe medications. The model psychology training program used in the Department of Defense program began with a curriculum of 1,418 hours and was reduced to 712 hours between 1991 and 1994 when the program entered its last cohort.

The New Mexico program calls for a mere 450 hours of course work, one third of what

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psychology originally proposed and from 7% to 15% of what is required in other prescribing professions. Physician Assistant programs, as well as training programs in psychiatry, nursing, dentistry, and veterinary medicine, all of which allow their practitioners to prescribe, require at least three times the amount of training planned for psychologists. I think this difference in training requirements will be a critical point of controversy in the legal battle that is about to arise over training criteria.

Legal Challenge #2 –
Practicing Medicine Without a License

At some point, some prescribing psychologist will treat a medically ill patient. The issue of scope of practice could well be raised in a legal challenge. It probably doesn't even matter if the drug in question is appropriate for the patient's medical condition. To the degree that the psychologist is treating the patient independently of a medical specialist, the question of practicing medicine is likely to arise. Dentists circumvent this problem quite easily by having a very restricted formulary. But, the breadth of drugs that induce psychoactive effects, and the many different psychoactive reactions attendant on these drugs, introduce a degree of complexity that is not paralleled in dentistry, where the major objective is analgesia. Thus, the court may well require psychologists to justify not only their training in mental health, but their training in physiology and general medicine as well. Already, certain jurisdictions, the most notable of which is the State of California, are anticipating this challenge and are urging training programs to insert within the predoctoral curriculum, up to one full year of course work in biochemistry, physiology, pharmacology, neuropsychology, and neuroatanomy. If this pattern continues, becoming a prescribing psychologist, a specialty that was intended to be obtained only through postdoctoral training, may begin to leave an indelible footprint on the graduate school curriculum.

"...the challenge to demonstrate that one's practice and science is not permeated with conflicts of interest may be difficult..."

Trainers fear that this change will eventually require that a year or more of traditional course work (developmental psychology, cognitive psychology, social psychology, psychotherapy, human factors, etc.) will be replaced by something akin to premedical training. We will have to decide what body of psychological science is superfluous? If so, the face of clinical psychology will certainly change much more than currently intended.

Legal Challenge #3 – Conflict of Interest

Psychiatry has been criticized for its convoluted relationships with the pharmaceutical industry. Indeed, I've heard proprescribing psychologists argue that this is one reason that the privilege should be extended to psychologists who are (assumedly) less likely to be wooed by the power of the dollar. Whether or not this is true, the challenge to demonstrate that one's practice and science is not permeated with conflicts of interest may be difficult in the face of a pharmaceutical industry that has shown itself to be well prepared to "buy" a large portion of the prescribing community. Pharmaceutical companies have been accused of controlling promotions and appointments in universities, of dictating the prescription patterns of physicians, and even of stopping the release to practitioners, of important scientific information about negative effects of drugs. The problems (and failures) faced by physicians in avoiding this seduction are well documented, as are the forms of the seduction itself. One major example of this influence is seen in the controversial story of how the appointment of a well-known scientist to a prestigious position at a major medical school was reversed under the pressure of a pharmaceutical company who was a financial backer of the university, when the psychiatrist expressed a negative opinion about one of the drug company's favored drugs for treating depression. Lesser examples range downward to the simple reliance on a drug representative, who coincidentally provides the "doctor" with free samples, coffee cups, pens, hotel rooms, trips to exotic places, and other escalating inducements.

Unfortunately, there is no evidence that psychologists are any better prepared than physicians to resist such inducements. The inevitable failure to do so, may well introduce to clinical psychology, many threats to the autonomy and objectivity in which many of our colleagues have invested their identities. Along with that possibility, is the inevitable specter of a legal challenge that requires that one demonstrate that his or her unsuccessful practices were unaffected by such inducements.

A Final Note

Many of our colleagues are troubled by the decisions in New Mexico and Guam. Many have questions that remain unanswered about the threats of prescriptive authority to the integrity of clinical psychology, to the

viability of psychotherapy training, and to the progression of our body of psychological knowledge. These, it seems to me, are important questions. However, it is also clear that the decision in New Mexico tells us that prescriptive authority is a reality, and will not likely go away. We, who have opposed prescriptive authority, may need to concede the battle and direct our efforts to ensuring that the issues raised in the foregoing descriptions of potential legal questions are resolved in a way that protects the body of scientific knowledge and the scholars who are entrusted with it, ensures a well and broadly trained cohort of young psychologists, and maintains the integrity of our scientific community. Though it is unlikely that we will "all just get along", it is imperative that we learn to adapt.

I recently heard it argued that the Oslo Accord, which aimed at developing a shared, mutual respect between Israel and the Palestinians, based on shared interests and commerce, had clearly failed. The speaker, a renowned Senator, argued that a different vision was needed. This vision would emphasize well protected separateness through reinforced borders. That may be what is needed in clinical psychology, as well, well protected and defended boundaries between those who are skeptics and those who are advocates of this new direction in our profession. But, I'm not quite ready yet to give up on the idea of a cooperative and respectful interaction between the perspectives —not yet.□

The Dissemination and Promotion of Pseudoscience in Clinical Psychology: The Challenge to Legitimate Clinical Science

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Bartley (1984) argued that the essential feature of the scientific enterprise is rigorous and informed criticism. Science is not a craving to be correct, but rather a desire or at least a willingness to uncover errors in one's web of beliefs. As the Nobel prize winning physicist Richard Feynman observed (1985), science at its best involves a bending over backward to prove oneself wrong. Indeed, the scientific method can be viewed as an armamentarium of techniques designed to counteract confirmatory bias, the deeply ingrained tendency to seek out findings consistent with one's cherished hypotheses (Lilienfeld, 2002). An adherence to the assumptions and tools of the scientific method lies at the core of the clinical scientist model (McFall, 1991).

Nevertheless, the field of clinical psychology has recently been challenged by a multitude of psychotherapeutic and assessment methods whose proponents have not consistently hewed to a scientific world view. In this article, we examine the dissemination and promotion of claims in clinical psychology that have sometimes been described by their critics as pseudoscientific. To provide a focal point for our discussion, we concentrate on two sets of techniques - the first from the domain of psychotherapy, the second from the domain of assessment - that recently have become flashpoints for scientific and social controversy. These techniques are (1) novel psychological treatments for trauma, particularly eye movement desensitization and reprocessing (EMDR) and critical incident stress debriefing (CISD), and (2) projective assessment techniques, particularly the Rorschach Inkblot Test.

Novel Trauma Techniques and Projective Techniques

Novel Trauma Techniques

Although EMDR and CISD have been controversial virtually since their inception (e.g., Herbert et al., 2000; Lohr, Hooke, Gist, & Tolin, in press), the debate swirling around their use has intensified in the aftermath of the terrorist attacks of September 11, 2001. Both techniques have been administered by mental health workers in New York and Washington, D.C. to victims and witnesses of these attacks (see Bush & Eisman, 2001).

EMDR, which is used increasingly as a treatment for posttraumatic stress disorder and other anxiety disorders, incorporates such nonspecific components as history taking and verbal report of the development of symptoms. More distinctively, the procedure requires clients to construct and maintain an image of the traumatic event and the physical sensations associated with it. While maintaining this image, the therapist induces side-to-side eye movements by asking clients to visually track the therapist's moving finger (Shapiro, 1995).

CISD is a procedure, typically performed in groups, that is administered within 24 to 72 hours of a trauma. Therapists conducting CISD strongly encourage clients to openly share their thoughts and emotional reactions concerning the trauma. In addition, therapists openly discuss the clinical symptoms that clients are likely to experience in the trauma's wake. Clients in CISD programs are strongly discouraged from discontinuing participation (Lohr et al., in press).

Projective Techniques

Most projective techniques present clients with ambiguous stimuli (e.g., inkblots, drawings of social situations, incomplete sentences) that they are then asked to interpret. The most widely used of these techniques is the Rorschach Inkblot Test, which presents respondents with 10 inkblots (5 in black-and-white, 5 containing color). In the most widely used contemporary method of Rorschach administration, scoring, and interpretation, John Exner's (1974) Comprehensive System (CS), respondents are asked to describe what they see in each inkblot. In a subsequent inquiry phase, they are asked to explain the bases for their perceptions (e.g., the shape or shading of the inkblot).

Shared Features

Although novel therapeutic techniques for trauma and the Rorschach Inkblot Test superficially appear to have little in common, they share two important features. First, they have been widely disseminated and promoted to clinical psychologists, and remain widely used. For example, tens of thousands of mental health clinicians have learned EMDR through workshop training since the initial efficacy study published by Shapiro (1989). Surveys of practicing clinicians similarly reveal widespread popularity of the Rorschach. In a survey of 412 practicing clinicians within the American Psychological Association (APA), Watkins, Campbell, Nieberding, and Hallmark (1995) found that 43% reported using the Rorschach always or frequently in their clinical practice and that 82% reported using it at least occasionally. Although there is some indication that the clinical use of the Rorschach has declined over the past five years (Piotrowski, Belter, & Keller, 1998), this instrument remains popular among practicing clinicians.

"...a number of philosophers of science ...have delineated useful indicators or "warning signs" of the presence of pseudoscience."

Second, the claims made by advocates of novel trauma treatments and the Rorschach Inkblot Test have sometimes greatly outstripped the relatively meager scientific support for these methods. For example, although EMDR has been shown in numerous controlled studies to be more efficacious than no treatment, it appears to be no more efficacious, and perhaps less efficacious, than well established behavioral and cognitive-behavioral treatments for trauma, such as exposure and response prevention. Moreover, the eye movements involved in EMDR appear to be irrelevant to the technique's clinical effects (see Cahill, Carrigan, & Frueh, 1999; Lohr, Tolin, & Lilienfeld, 1998, and Davidson & Parker, 2001, for reviews). CISD has been found in several controlled studies to be either ineffective or potentially harmful, perhaps because it may impede natural recovery processes (Gist & Woodall, 1995; Lohr et al., in press; Mayou, Ehlers, & Hobbs, 2000). Finally, with the primary exception of indices relevant to detecting thought disorder, the indices derived from the Rorschach CS have been found to exhibit low or negligible construct validity. For example, although the Rorschach CS possesses some validity for detecting schizophrenia and related conditions, its validity for detecting depression, posttraumatic disorder, psychopathy, and other psychiatric conditions appears to be weak. Nor is there compelling evidence that the CS is helpful for the detection of child sexual abuse, even though it is used frequently for this purpose (Lilienfeld, Wood, & Garb, 2001).

Science and Pseudoscience: Useful Distinguishing Indicators

The distinction between science and pseudoscience is probably not clear-cut (Leahey & Leahey, 1983). Nevertheless, this ambiguity of boundaries does not preclude us from drawing a pragmatically useful line of demarcation between the two; nor does it preclude us from distinguishing prototypical cases of science and pseudoscience. Indeed, a number of philosophers of science (e.g., Bunge, 1984, 1991) have delineated useful indicators or "warning signs" of the presence of pseudoscience (see also Huber, 1991, and Park, 2000, for a discussion of the characteristics of "junk science," a close relative of pseudoscience characterized by the intrusion of unsubstantiated scientific claims into the legal arena). Some of primary features distinguishing pseudoscience from science are as follows (Bunge, 1991; Herbert et al., 2000; Lilienfeld, 1998; Ruscio, 2002):

(1) An overuse of ad hoc immunizing tactics (i.e., loopholes) to shield hypotheses from falsification (Popper, 1965);

(2) An absence of self-correction and an imperviousness to negative findings, resulting in a tendency toward intellectual stagnation;

(3) The use of language that appears scientific but that provides claims with the superficial veneer of legitimacy;

(4) A substantial or exclusive reliance on testimony and anecdote rather than on systematic evidence;

(5) Reversal of the burden of proof, that is, placing the onus of proof on the critics rather than on the proponents of a claim;

(6) Appeals to authority figures (i.e., self-proclaimed "experts") rather than to systematic data.

It is important to note that clinical techniques per se (e.g., the Rorschach Inkblot Test) are not pseudoscientific. Instead, the concept of pseudoscience applies to the ways in which certain proponents of these techniques deal with evidence, particularly evidence that contradicts their hypotheses. In other words, we take issue here not with the validity or efficacy of these techniques per se, but rather with the marked disparity between the scientific evidence for these techniques and the extravagant claims sometimes made on their behalf.

The Dissemination and Promotion of Pseudoscience: Typical Sales Techniques

Pratkanis (1995; Pratkanis & Aronson, 1991) described the sale of pseudoscience as involving a coordinated set of social influence processes. These influence processes help to explain how mental health practitioners can become convinced of the validity of clinical techniques that are lacking in scientific support. They can occur at all levels of training, but may be most pronounced in "weekend workshops" that predominate in continuing education in mental health practice.

Some, although by no means all, proponents of novel trauma treatments and the Rorschach Inkblot Test have used the social influence tactics outlined by Pratkanis to market their favored methods. Although these tactics have facilitated the sale of these techniques to practitioners and the general public, they have sometimes resulted in misleading advertising.

"Some proponents of the Rorschach have maintained that this instrument possesses special, even remarkable, capacities."

According to Pratkanis, a first major social influence process facilitating the purchase of pseudoscience is directed at the creation and use of "phantoms": difficult to achieve goals that are desirable (e.g., complete relief of psychological distress among patients with PTSD). The selling process involves the identification of a means to attain the phantom, and persuasion to convince the consumer that the means are credible (Pratkanis & Farquhar, 1992).

For example, Shapiro (1989), the developer of EMDR, initially claimed that this technique could produce a 100% rate of success in the treatment of traumatic memories in a single session. In a widely marketed popular book, Shapiro and Forrest (2001) referred to EMDR as a "breakthrough" treatment for anxiety and claimed that it is more effective and efficient than existing trauma treatments. In a recently article in the Los Angeles Times, one advocate of EMDR claimed that "With EMDR, you can pinpoint a specific trauma and target that like a laser beam" (see Marsa, 2000). Some proponents of CISD have similarly advanced very strong claims of efficacy (e.g., Mitchell, 1992), particularly in the wake of the September 11th attacks (Fishman, 2002).

Some proponents of the Rorschach have maintained that this instrument possesses special, even remarkable, capacities. For example, when the APA Board of Professional Affairs bestowed its 1998 Award for Distinguished Professional Contributions to Knowledge to John Exner (see Wood & Lilienfeld, 1999), the developer of the CS, it asserted that "Exner has almost single-handedly rescued the Rorschach and brought it back to life. The result is the resurrection of perhaps the single most powerful psychometric instrument ever envisioned" (Board of Professional Affairs, 1998, p. 392).

A second social influence process outlined by Pratkanis is the construction of vivid appeals to persuade potential consumers. For example, vividly presented case studies are typically more convincing than dry scientific data. As a consequence, isolated "hits" (e.g., a single case report of dramatic apparent improvement) frequently receive greater weight than null results obtained in the laboratory. For example, Marquis (1991) reported the results of several uncontrolled case studies to argue that EMDR was efficacious for PTSD, eating disorders, and even learning disabilities. Other uncontrolled case reports have been used to argue for EMDR's efficacy for the distress associated with alcoholism (Shapiro, Vogelmann-Sine, & Sine, 1994) and sexual dysfunction (Wernik, 1993). Some proponents of the Rorschach have similarly advanced striking claims on the basis of isolated case histories. For example, Viglione (1999) related an emotionally powerful story of a woman who committed suicide after her psychiatrist disregarded her elevated score on the CS Suicide Constellation (S-CON) index. Yet the evidence for the validity of the S-CON for predicting suicidal behavior is at best mixed (Wood, Nezworski, & Stejskal, 1996; cf., Fowler, Piers, Hilsenroth, Holdwick, & Padawer, 2001). In a recent article defending the use of assessment techniques, including projective measures, against scientific critics, the President of the Society for Personality Assessment exhorted members of this society to "share case stories, case examples, empirical data, and success experiences of clients whose lives have been transformed by assessment..." (Finn, 2002).

The third sales process is the "rationalization trap." Once consumers commit to purchasing a product, their perspective on the product tends to change. Consumers who may initially have been skeptical are compelled to justify their commitment and alter their beliefs accordingly. In purchasing training in a clinical procedure, the practitioner initially makes a small but psychologically important commitment. This first comes in the payment of fees for training. In addition, trainees are often admonished not to train others in the

technique. Both promotional gambits can lead participants to affirm the conclusion (the logical error) that is at issue, namely the question of the validity or efficacy of the technique. For example, prior to the publication of Shapiro's (1995) book on EMDR, workshop trainees were required to sign a consent form asserting that EMDR is a potent procedure that could be hazardous in the wrong hands. Moreover, this consent form required trainees to vow not to train others in the procedure (see Herbert et al., 2000).

The fourth process is the establishment of what Kurt Vonnegut (1976) called a "granfalloon," a proud but meaningless association of people. Granfalloons are effective means by which to create and establish a sense of social identity among workshop participants. The identification of the individual with the distinctive group is developed through a number of means, including jargon and specialized knowledge. Consequently, an aura of exclusivity often evolves surrounding authorized training. For example, after EMDR trainees signed a vow not to train others in the technique, they observed an EMDR Institute-approved trainer in the company of facilitators, a specially identified group of practitioners with particular responsibilities at training sessions whose special status is officially recognized by the EMDR Institute, Inc. (Herbert et al., 2000). The initial training workshop was followed by Level II training, at which specialized treatment protocols and clinical applications were presented. Participants in these workshops received attractive certificates suitable for framing, one for "Attendance" following the initial training, another for "Completion" following Level II training. This process continued when the trainee was invited to become a member of the EMDR Network, a group that provides such special privileges as a newsletter and summaries of EMDR research.

"...promoters of pseudoscience often attempt to marginalize skeptics through ad hominem criticism rather than through reasoned argumentation."

Group identity is further enhanced when promotional materials appeal to the fact that many professional peers have been trained in the service. However, the number of people trained in a technique is not germane to its validity or efficacy, as logicians familiar with the ad populum fallacy are aware. A similar tactic is known as "misdirection," in which appeals to popularity (e.g., number of satisfied customers) deflect questions concerning the technique's validity. For example, some proponents of the Rorschach have pointed to its longstanding use and popularity as indirect evidence of its scientific merit (Weiner, 2001).

Thus, the granfalloon can function in the avoidance of legitimate scientific skepticism. Once becoming a member of the group, individuals become reluctant to express questions that are inconsistent with the group's purpose. The reluctance may be become even stronger if a fee has been paid to participate in group training (a rationalization trap).

As Pratkanis (1995) observed, pseudoscience tends to flourish when skepticism is devalued. Pratkanis argued that promoters of pseudoscience often attempt to marginalize skeptics through ad hominem criticism rather than through reasoned argumentation. For example, after two of the authors of this article signed a letter published in the APA Monitor on Psychology (Herbert et al., 2001) cautioning well meaning clinicians from using CISD on survivors and witnesses of the September 11th terrorist attacks, a past president of the American Psychological Association (Cantor, 2002) castigated the authors of this letter for suggesting that such clinicians could perpetuate inadvertent harm: "Any implication that we are just well-intentioned do-gooders who create iatrogenic symptoms in those with whom we work is condescending and disrespectful of the profession." (p. 2). After one of us coauthored a critical review of the validity of the Rorschach and certain other projective techniques (Lilienfeld et al. 2001) with two of his colleagues, a well known proponent of the Rorschach referred to the three coauthors on a public listserve as "assassins" and "terrorists."

By attacking one's opponents in this fashion, the debate is quickly moved from the theoretical and empirical issues at hand (e.g., Does a given treatment work? Is an assessment technique valid for its intended purposes?) to the arena of personal motives or ostensible expertise. Proponents of a technique may contend that the critic is clinically unfamiliar with the technique, as would be the case with a skeptical trainee. For example, some proponents of the Rorschach (e.g., Weiner, 2001) have attacked critics of this technique on the grounds that they do not regularly use the Rorschach in their clinical practice or research. One of these proponents also referred to the "limited background" of some Rorschach critics. As we noted in response (Lilienfeld, Wood, & Garb, 2001), the scientific worth of a technique cannot be evaluated solely by its friends. Instead, this technique must withstand the rigorous

scientific scrutiny of all psychologists, including those with no direct personal stake or investment in this technique.

Implications for Clinical Science: Recommendations

The sale of pseudoscientific and questionable claims in clinical psychology poses a grave threat to both the consumers of mental health services and to the integrity of the profession (Lilienfeld, Lynn, & Lohr, in press). Nevertheless, until recently our profession has largely turned a blind eye to the festering problem of pseudoscience (Meehl, 1993). In closing, we delineate five straightforward steps that we believe will help to bridge the scientist-practitioner gap and to combat the growing problems posed by the dissemination and promotion of pseudoscientific claims in clinical psychology. Our five point prescription for narrowing the science-practitioner gap follows:

(1) The APA and other accrediting bodies must insist that clinical psychology graduate students receive adequate training in clinical judgment and prediction (including heuristics and biases that can lead to poor clinical decision making), psychometrics, fundamental issues in the philosophy of science (particularly the distinctions between scientific and pseudoscientific research programs), and the reconstructive nature of memory (see Lilienfeld et al., in press). Moreover, these professional organizations must be willing to withhold accreditation from institutions that provide students with inadequate training in these areas, which are essential to fostering the critical thinking skills necessary for the development of clinical scientists.

"...The sale of pseudoscientific and questionable claims in clinical psychology poses a grave threat..."

(2) The field of clinical psychology must focus not only on developing criteria for, and lists of, empirically supported treatments, but also on identifying treatments that are clearly devoid of empirical support or that are harmful. The development of a formal list of "psychotherapies to avoid" would be an important first step in that direction. Such treatments as rebirthing and reparenting, suggestive techniques for memory recovery, facilitated communication for infantile autism, and CISD should be among the first entries on this list (see Lilienfeld et al., in press).

(3) The APA and other psychological organizations must institute safeguards to ensure that the continuing education (CE) of practitioners be grounded in adequate scientific evidence. For example, the APA must take concrete steps to guarantee that workshops on Imago Relationship Therapy, neurofeedback, calligraphy therapy, and Jungian sandplay therapy (see Lilienfeld, 1998) no longer be permissible venues for CE credit. Such techniques are largely or entirely devoid of scientific support. As a consequence, encouraging practitioners to learn and to apply such techniques is detrimental to the consumers of mental health services.

(4) The APA and other psychological organizations must play a more active role in combating the spread of pseudoscientific and otherwise questionable mental health claims in the popular press and elsewhere (e.g., the Internet). These organizations have been reluctant to adopt the role of media "watchdogs" in the ongoing fight against unvalidated treatment and assessment techniques. This reluctance must change, because unsubstantiated mental health claims place the public at risk. We therefore recommend that the APA, the American Psychological Society, and other psychological organizations develop coordinated networks of media contacts - consisting of experts who can address claims regarding questionable or untested clinical techniques - who can respond to such claims whenever they arise in the media, as well as to media inquiries regarding such claims.

(5) The APA and other professional organizations must be willing to impose stiff sanctions, including expulsion if necessary, on practitioners who routinely use therapeutic and assessment practices that are devoid of scientific support. For example, the APA Ethics Code makes clear in several places (e.g., Rule 1.06) that psychologists must rely on the best available scientific knowledge when making scientific or professional judgments. Yet this feature of the code rarely, if ever, appears to be enforced. Moreover, the APA Ethics Code (Rule 1.14) mandates that psychologists avoid techniques that are potentially harmful to clients, the APA has been reluctant to impose sanctions on its members for administering such techniques. Again, this reluctance must change. *Primum non nocere* must be our first priority as professionals.

We believe that if these five prescriptions are followed, the marketing of pseudoscientific claims in clinical psychology will become much less successful, because such claims will be met by a more skeptical and less receptive audience. It's high time that we get to work. □

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Clinical Psychology in the Courtroom: Part I. Proper and Multiple Roles in Forensic Services

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In addition to a legal duty, professionalism supports that providing expert testimony is consonant with a clinical psychologist's social responsibility. This two-part article asserts that clinical psychologists, and other mental health professionals as well, should be prepared to contribute to the legal system, explains the legal invitation for expert testimony, and offers guidelines for ethics and standards working in a forensic context (with special reference to child custody proceedings). Part I deals with proper and multiple roles in forensic services, and considerations for providing expert testimony in accord with ethics and standards pertaining to psychology. Part II (in the next issue of the Clinical Psychologist) places emphasis on ethics and standards relevant to offering a critique of another mental health professional's testimony.

Clinical Psychology in the Courtroom:
Part I. Proper and Multiple Roles in Forensic Services

Having been court-appointed to conduct a child custody evaluation, I entered the courtroom expecting to present the results of testing, interviews, and home visits, and await the judge's determination. One attorney – and the judge – had other ideas.

One parent had obtained a second evaluation from another psychologist, whom I considered to be both a colleague and friend. After we had both testified, I was recalled to the stand. Rather than simply explaining my opinions further, the attorney opposed to the views expressed by the other psychologist methodically led me through a penetrating critique of my colleague's testimony. It was clear that the attorney had done considerable homework, asking specific questions pertaining to what the other psychologist had said and done.

Having some concern about denigrating collegiality, I objected respectfully. The judge made it clear that the court wanted to hear information from me about the psychometric and other behavioral science issues relevant to possible flaws in the other psychologist's testimony – and there were flaws! Ignoring the tenets of good lawyering, the other attorney clearly had failed to recall the parental admonition to "do your homework," and was not prepared for the impeachment of the other psychologist and made only a feeble attempt at rehabilitation.

This experience or scenario and others led me to the thoughts in this two-part article. In legal proceedings, mental health professionals, including (especially?) clinical psychologists, are increasingly being called upon to serve as expert witnesses. Although it is established that the practitioner will be asked to testify about the diagnostic or treatment services provided to one or both of the parties (or their children) in the legal case, the trend is to use behavioral science to substantiate or evaluate evidence obtained from various sources. Consequently, professionals who have not been clinical service providers to the litigants are sought for expert testimony about how human behavior relates to legal issues.

From providing mental health professionals with legal advice, I am convinced that most clinical practitioners called into the courtroom lack sufficient factual knowledge about the judicial system, such as the rules of procedure and evidence: ". . . courtrooms are foreign territory for psychologists, psychiatrists, and social workers (Melton, Petrila, Poythress, & Slobogin, 1997, p. 4). It is not surprising, therefore, that mental health professionals are reluctant, if not oppositional, to being brought into a legal dispute.

This two-part article addresses both clinically-oriented practitioners and, for want of a better term, academicians (the latter terms is used with an apology, since presumably clinical psychologists predicate their services on academic knowledge). That is, the information aims to instruct all clinical psychologists, not the forensic expert who has a wealth of training and experience in courtroom activities.

Part 1, "Proper and Multiple Roles in Forensic Services," examines the possibility of impropriety occurring when the psychologist fulfills both clinical

and forensic roles. For example, a clinical role occurs in a nurturant context, whereas a forensic role occurs in an adversarial scenario. Part Two, Being a Professional Critic, focuses on: providing testimony that is directed at critiquing the testimony presented by another mental health professional; and maintaining ethics in offering a professional critique.

An Irreconcilable Conflict?

In an analysis of the possible impropriety of a clinical psychologist's engaging in both therapeutic and forensic roles, Greenberg and Shuman (1997) acknowledge the dilemma created by the wish to avoid the courtroom, yet the need to counteract the negative economic factors that currently plague the mental health marketplace: "Although therapists' concerns for their patients and for their own employment is understandable, this practice constitutes engaging in dual-role relationships and often leads to bad results for patients, courts, and clinicians" (p. 50). Further, they note that the dual-role relationships must satisfy explicit ethical precepts: "When the reasons for the ethical precepts are understood, it is clear why no psychologist, psychiatrist, or other mental health professional is immune from the concerns that underlie them" (p. 50).

"...conceptual and practical differences make the dual roles of therapist and forensic expert of high risk for ethical (as well as licensing and other legal) complaints..."

Legalists and mental health professionals have commonalities, such as protected client-practitioner relationships, identification with their clients, a commitment to objectivity, a wish to discover the truth, and so on (Nurcombe & Partlett, 1994). There are also, however, marked differences, especially in the goals for service (Slovenko, 1973). Given the discrepancies between the two fields, conceptual and practical differences make the dual roles of therapist and forensic expert of high risk for ethical (as well as licensing and other legal) complaints (Greenberg & Shuman, 1997).

The Vulnerability of the Expert Witness

The nature of law casts dictates that forensic services by clinical psychologists will occur in an adversarial context. Especially noteworthy is: "in contrast to a clinician, who seeks compromise and adjustment, and compared with a scientist, who strives to disconfirm his hypotheses, a legal advocate presents a polemic that both favors his own side and impugns the other" (Nurcombe & Partlett, 1994, p. 2). The responsibility to impugn the credibility of opposing witnesses can leave the clinical psychologist vulnerable to being pressed into testifying inappropriately, without either a plan or a surefire escape route.

It is fundamental that judges tend to want to hear any testimony that is relevant and material to the matter at issue, regardless of the preferences of the witness. At a recent hearing, the expert witness objected to answering a question. Immediately, the judge sternly admonished the expert, saying (in effect) that, "it is for the attorneys and the court to raise objections, your option is to answer the question, which can include why you can or cannot answer the question more thoroughly." It is wrong to believe that an expert witness can self-determine the questions that will be asked and answered; that is: "The court may interrogate witnesses, whether called by itself or by a party" (Federal Rules of Evidence, Rule 614 [b]). The court has the discretion to order an answer to a question, and the expert witness must respond or face contempt of court. If the expert witness cannot answer the question with a reasonable degree of psychological certainty, the reservations and reasons for them may be expressed. More will be said about this matter later.

Providing fact testimony (as opposed to expert testimony) about diagnostic or treatment information is reasonably free of risk. If the professional witness is simply reporting factual opinion, i.e., no interpretations or opinions, the attorneys are more willing to consider the testimony to be benign, and not to assail the qualities.

The risk emerges when the expert witness voluntarily or involuntarily offers definitions, interpretations, and opinions that do not totally promote the preferences of both parties--which is essentially an impossibility. Of concern herein is the possible contamination of professional ethics that occurs from expert testimony that critiques the testimony provided by another mental health professional. Such a situation elevates the risk of an ethical, regulatory (licensing), or other legal complaint.

Contrary to the idea that there is an irreconcilable conflict between the therapeutic and forensic roles, as posited by Greenberg and Shuman (1997), this article asserts that reconciliation is possible. Cautions and restrictions are, of course, necessary. The views and guidelines expressed here are based on experience

as a clinical-forensic psychologist, an attorney in litigation, and legal consultant to other mental health professionals.

The following discussion relies heavily on documents intended for psychologists per se. In addition to psychology being the primary mental health discipline of the author, it is a fact that the other mental health professions have not addressed forensic services in as much detail as psychology. With reasonable and cautious disciplinary adaptation, the material discussed here, though intended for psychologists, may be useful to all mental health professionals. Certainly the information for psychologists offers guidance for discipline-specific formulations by the other mental health professions.

Professionalism Requires Service to the Court

A substantial number of clinical psychologists, and other mental health professionals as well, believe that they can avoid being called into court. Recently, one psychiatrist told an attorney, "No judge can make me testify about my patients"; to which the attorney patiently countered with photocopies of selected portions of the rules of civil procedure and evidence and explained contempt of court and other penalties that could occur from not responding properly to legal process. Any notion that "I'm above the law because I'm a mental health professional" is blatantly wrong for several reasons, notably there are legal duties to the contrary and a professional responsibility that must be fulfilled.

"...it is a fact that the other mental health professions have not addressed forensic services in as much detail as psychology"

Professionalism involves being a social trustee and contributing to public welfare (Brint, 1994). Therefore, all mental health professionals are expected to contribute in various ways to society. Since the legal system is the backbone of social order, participation by mental health professionals in legal proceedings is fundamental.

Ethical codes open the door for forensic involvement. As stated in the ethics code for psychologists: "They apply and make public their knowledge of psychology in order to contribute to human welfare" (American Psychological Association [APA], 1992, p. 1600).

From the point of view of public policy, mental health professionals have an important role in the legal system because behavioral science expertise benefits the judicial process. For example, psychologists are obligated to "broaden knowledge of behavior, and where appropriate, to apply it pragmatically to improve the condition of both the individual and society" (APA, 1992, p. 1599), and this could include applying and making public "their knowledge of psychology in order to contribute to human welfare" (p. 1600). While being a forensic expert per se requires specialized knowledge and skills (Committee on Ethical Guidelines for Forensic Psychologists, 1991), any mental health professional should be prepared to step forward to bring professional information and expertise into the courtroom.

Crossing the Threshold into the Courtroom

Aside from specialized forensic expertise (e.g., determining competency, mental injury, mens rea, and so on), a clinical psychologist could potentially enter into legal proceedings to provide testimony about academic or scholarly ideas. This entry into the courtroom can be voluntary or involuntary. More specifically, a subpoena or court order can be used to require any mental health professional to appear in a legal proceeding.

The Raison D'être of Expert Testimony

Public policy has recognized a singular reason for allowing experts to participate in legal proceedings, as per the previously-cited Rule 702 of the Federal Rules of Evidence. The role for a mental health expert is limited; for example: "Forensic psychologists are aware that their essential role as expert to the court is to assist the trier of fact to understand the evidence or to determine a fact in issue" (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 11). The same holds true for all mental health professionals who offer expert testimony. The expert witness has no license to be trier of fact (i.e., judge or jury), only a source of information to assist the trier of fact.

It is relatively easy to accept that the clinical psychologist has not been designated to replace the judge or jury. What is more difficult to accept, at least by some mental health professionals, is that professionalism proscribes advocacy of the legal interests for one of the parties. Any advocacy should be directed at mental health interests. It is the attorney who has the duty to advocate legal interests, which can draw from the expressed mental health interests.

The Supreme Court established the requirements for expert testimony in Daubert v. Merrell Dow

Pharmaceuticals, Inc. (1993), which emphasized reliability, relevance, and legal sufficiency for qualifying experts as providers of "scientific" testimony (with the determination resting with the judiciary); at the same time, this ruling was a response "to a period of heightened concern over 'junk science,' premature science, nonscience or 'too soft science'" (Goodman-Delehunty, 1997, p. 131). Incidentally, the whole concept of expert testimony comes under fire in the popular trade book Whores of the Court (Hagen, 1997).

It is important to recognize that Daubert is not antithetical to expert testimony. Rather, it scrutinizes the underlying method used for scientific testimony that is to be admissible evidence. In fact, this decision points to the value of critiquing the testimony of every professional witness: "Because Daubert promotes measures to address the shortcomings of experts in advance of trial, outside the presence of the jury, unconstrained by the rules of evidence, the strengths, rather than the weaknesses, of the adversary system to assess expertise may become more apparent in the future" (Goodman-Delehunty, 1997, p. 136). Thus, the need for professional evaluation of expert testimony is apt to increase.

"In any legal proceeding, the clinical psychologist must have a behavioral science basis for opinions..."

Testifying with a Reasonable Degree of Professional Certainty

In any legal proceeding, the clinical psychologist must have a behavioral science basis for opinions; for example: "Psychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments or when engaging in scholarly or professional endeavors" (APA, 1992, p. 1600). Meeting this standard allows the testimony to be offered with a reasonable degree of professional certainty based on behavioral science and in accord with the previously discussed Daubert decision. In other words, testimony involving definitions, interpretations, opinions, and criticisms must be based on enough research and views held by a substantial portion of the profession (not just the personal experiences or preferences of the particular expert witness); and the rationale must be sufficient to support the statements with a reasonable degree of professional certainty. See Woody (2000) for an elaboration of the rational for a behavioral science basis and reasonable degree of professional certainty for expert testimony.

The determination of the judiciary controls the admission of testimony, but does not absolve the clinical psychologist from meeting the ethical standard. Thus, in the event that, say, the judge orders the expert witness to answer a question that has been posed by an attorney (e.g., an objection from the other attorney was overruled) for which there is an inadequate rationale or cannot be made with a reasonable degree of professional certainty, the clinical psychologist should respectfully express reservations and explain why a more complete response is inappropriate from an ethical point of view.

Misinterpretation by the Court

Being in control of the communications, the attorneys can choose to omit or follow up on certain aspects of the mental health professional's testimony. In other words, the attorneys can "pick and choose" communication bits to give emphasis to the chosen legal tactic. This could create an ethical dilemma because, as psychologists are told, they "do not participate in activities in which it appears likely that their skills or data will be misused by others, unless corrective mechanisms are available" (APA, 1992, p. 1601). This standard should seemingly apply to all mental health professionals, regardless of discipline.

The clinical psychologist must monitor the "pick and choose" tactic, as much as will be allowed by legal procedure. If there is any indication that the testimony has been or is being misconstrued, professional ethics require taking "reasonable steps to correct or minimize the misuse or misrepresentation" (APA, 1992, p. 1601). Even for their own assessment work, psychologists are obligated to "indicate any significant reservations they have about the accuracy or limitations of their interpretations" (p. 1603). For psychologists, there is also a relevant forensic guideline: Forensic psychologists take reasonable steps to correct misuse or misrepresentation of their professional products, evidence and testimony" (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 663). While the term "reasonable steps" will be defined subjectively and on a case-by-case basis, professional standards must be safeguarded. Here again, these ideas merit consideration by all of the mental health professions.

Incidentally, seldom will an expert witness be allowed free reign on the flow of testimony. When such latitude occurs, it is because an attorney is inept (e.g., fails to object) or knows that the particular judge

prefers expert witnesses to be unfettered. For the latter, a skilled attorney (depending upon other considerations of course) might well raise objections, or ask for the judge to restrict the answers to specific questions, knowing that the objection or restriction will be denied--but in the process, the attorney gains a possible basis for appeal later.

Conclusion

Part I of this two-part article has examined proper and multiple roles in forensic services, and provided ideas for keeping expert testimony in accord with ethics and standards pertaining to clinical psychology. Part II will appear in the next issue of The Clinical Psychologist, and will move to more advanced considerations. Again using child custody cases as reference point, Part II will explore the propriety of professional criticism. Although a clinical psychologist has a social responsibility to contribute to and try to improve legal proceedings, there is the risk that the legal scenario will present unique pitfalls. For example, attorneys (and the court itself) may attempt to thrust the clinical psychologist into multiple roles and advocacy that can jeopardize objectivity and maintenance of professional standards. Authoritative sources on professional criticism are minimal, e.g., the APA ethics code provides little or no guidance on being critical of a professional colleague. Therefore, Part II will set forth suggestions for: avoiding inappropriate and potentially conflicting multiple roles; and maintaining safeguards against harm to clients and conflicts in interprofessional relations.□

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Message from the Student Editor

As editor of the Student Forum during the past two years, I have had the privilege of publishing articles written by several talented graduate students. I have received many comments via e-mail and ground mail addressing both the content of these articles and the content of my own columns. One comment, however, has been so consistently offered by so many individuals, that I can no longer ignore it. Specifically, several readers have complained that the work published over the past two years was too focused on research and academia, ignoring issues important to graduate students working toward becoming practitioners. As such, in my last issue as editor, I am pleased to publish an excellent article by Melanie Means dealing with issues that may interest budding clinicians as they begin thinking about the possibility of establishing a private practice.

David Feldman

Student Forum

Building a Private Psychotherapy Practice

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Starting and maintaining a private psychotherapy practice involves all the complexities of running a small business, including hiring employees, accountants, and lawyers, leasing office space, purchasing office equipment, securing bank loans, bookkeeping, insurance, advertising, networking, billing, and taxes. Most clinical psychology graduate students finish their training with an excellent foundation in the clinical skills needed to be a successful therapist, but with very little knowledge of the business skills needed to maintain a successful practice. A lack of business savvy is a clear disadvantage in a competitive marketplace and may lead many therapists to become disillusioned with, and resentful toward private practice (Richards, 1990). However, the therapist with astute business skills will be well equipped to adapt and survive in the ever-changing atmosphere of the American health care system. This article is intended for clinical psychology graduate students who are considering private practice as part of their professional careers. It provides a brief overview of business issues related to private practice, as well as informational resources for interested individuals. For a more in-depth review of this topic, there are a number of excellent books on the market (e.g., Kolt, 1999; Lenson, 1994; Zuckerman, 2002).

Two reasons often cited for entering private practice are autonomy and income (Lenson, 1994; Richards, 1990). Private practice gives therapists the freedom and control in their professional development often not found in other settings. Practitioners can choose their own clients, set their own fees, and pursue their own professional interests. For some, this independence is an enviable alternative to the restrictions and policies that may accompany working for an outside agency (which may be experienced by the practitioner as stifling and oppressive). The freedom of private practice has its costs, however, in that practitioners often have to work long hours to build their practice. Paid holidays, vacations, sick leave, and disability are not automatically guaranteed and thus are important considerations when establishing fees and client loads (Richards, 1990).

In addition to providing practitioners with the

independence of self-employment, private practice can be a lucrative career move. In a successful private practice, income and job security may be greater than that achieved by agency employment. However, higher income is accompanied by increased financial responsibility and risk. Income potential is heavily influenced by the therapist's business and marketing skills. Private practitioners also face a greater risk of financial loss, as their businesses are subject to economic fluctuations. The advantages and disadvantages of private practice are depicted in Figure 1.

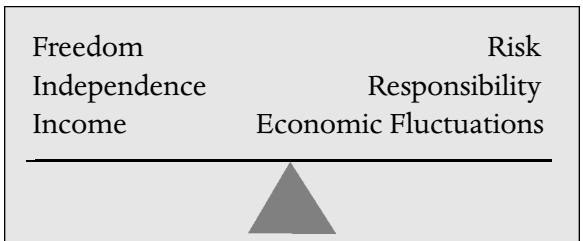

Figure 1: Weighing the Advantages and Disadvantages of Private Practice

Qualities of a Successful Private Practitioner: The Entrepreneurial Spirit

Like any other small business, private practices fail at a high rate; 50% - 60% of new private practices fail within 5 years (Richards, 1990). In order to succeed in private practice, good clinical skills and experience are certainly necessary but not sufficient. A key ingredient in establishing a successful practice is being a successful entrepreneur (Earle & Barnes, 1999; Lenson, 1994; Martin, 1993; Richards, 1990). In addition to having knowledge about running a business, entrepreneurs are willing to take risks in the face of an uncertain future. They are persistent, motivated, responsible, organized, efficient, confident, and flexible. Entrepreneurs are visionaries, self-starters, and leaders. Successful therapist-entrepreneurs need these qualities as well as confidence in their clinical and interpersonal skills. As with all therapists, they need to be physically and mentally healthy in order to best serve their clients. Furthermore, private practitioners need to be able to recognize and cope successfully with stress and ask for help when indicated (Lenson, 1994). Obtaining such support may be difficult when practicing independently in an environment with few or no colleagues. Finally, therapists opening a private practice should be financially secure, as the start-up costs and small number of clients in a new practice create financial strain. Income is often unpredictable, and financial losses may be incurred at the outset (Richards, 1990).

Business Decisions in Starting a Private Practice.

Therapists starting a private practice face a number of business decisions that warrant careful evaluation in reference to the therapist's individual needs and goals. One important decision is whether to practice full-time or part-time. Many therapists open a part-time business in addition to full-time employment elsewhere. In this way, they are able to keep the benefits of being a full-time employee and are ensured a regular paycheck. Some therapists choose to start a part-time practice in order to fulfill alternate role obligations such as parenting. Although less financially risky, a part-time practice is not likely to grow as fast as a full-time practice since the therapist is unable to dedicate as much time and effort to the practice.

Another decision facing therapists is whether to join a group of practitioners or start a solo practice (Beigel & Earle, 1990; Lenson, 1994). Therapists who practice independently have complete control and freedom in deciding how they spend their time, the type of clients they treat, and the type of services they provide. They are not held directly accountable to other professionals, but they must make efforts to network with colleagues and to maintain professional contacts. They also must invest considerable time maintaining the business aspects of their practice. Joining a group practice provides a number of additional advantages over a solo practice. A group of practitioners will offer a wider range of expertise and an available professional support network. The individual practitioner can consult and collaborate with colleagues on a regular basis, benefits not readily available in solo practice. A group practice likely obtains referrals from large health care organizations, supplies the individual therapist with a convenient referral network, and provides cross-coverage for vacations, sick leave, and emergencies. Sharing expenses among group members allows each therapist to save on costs related to administrative and clerical services, overhead, insurance, advertising, and marketing.

Potential drawbacks of joining a group practice include problems inherent to group processes: power struggles, personality conflicts, and gossip. The individual will have less control over decision-making. Because the public will view the group practice as a unit, it is possible that the therapist's reputation may be tarnished by the actions of another group member (an example of "guilt by association"). Additionally, the therapist, as a group member, may be held legally responsible for other group members' transgressions (Lenson, 1994).

Building a Private Psychotherapy Practice

Four Types of Private Practice

After considering the aforementioned business issues, the therapist must decide what type of business structure suits his or her private practice needs. Consulting a business attorney and tax accountant is critical for choosing from among the following four options:

1. Sole proprietorship.

From a business standpoint, a sole proprietorship is the least complicated and least expensive type of practice (Beigel & Earle, 1990; Lenson, 1994; Richards, 1990). The practitioner is considered self-employed and receives all business profits. The therapist has complete responsibility for and control over all legal, financial, and organizational decisions. A sole proprietorship is small-scale, with the therapist usually earning less than $100,000 a year. In addition, obtaining a business license and keeping records in a sole proprietorship are relatively uncomplicated (Richards, 1990). Disadvantages are that the profits may place the therapist in a high tax bracket and that the therapist is subjected to "unlimited personal liability" (Earle & Barnes, 1999, p. 95). As Earle and Barnes (1999) explain, if a legal settlement is brought against the practitioner, all of his/her assets (including personal property such as home and car) may become part of the settlement. Furthermore, liability issues inherent in a sole proprietorship include not only pro-fessional liability (malpractice), but also general liability, such as personal injury occurring on office property.

"A group practice likely obtains referrals from large health care organizations..."

2. Partnership.

A partnership is formed when two or more therapists unite to share ownership, responsibility, and profit of their practices (Beigel & Earle, 1990; Lenson, 1994). This convergence allows each partner lower overhead costs, additional sources of income, and tax advantages. The major disadvantage is that each partner is held responsible and liable for the actions of the other partner(s). A written legal document must be created to address issues such as who controls decision-making and what will happen to the partnership in the event of withdrawal or death of a partner. Choosing a partner with similar business goals and good business skills is critical (Richards, 1990); selecting a partner solely on the basis of friendship and loyalty can strain the friendship and have disastrous financial consequences if the friend lacks business savvy.

3. Expense-sharing association.

Expense-sharing associations are more complex than a sole proprietorship, yet less technical than a partnership (McCue & Ficalora, 1991). In this type of arrangement, a group of sole proprietors may join together and share office space, employees, or billing systems. The advantages of sharing expenses and working among a group of colleagues are maintained along with the financial benefits of a sole proprietorship. In such an arrangement, it is imperative the therapists have a legal agreement documenting the exact nature of the relationship, so that the individual therapist is not liable for malpractice claims made against another practitioner (Richards, 1990).

4. Corporation.

A corporation is the most complex business arrangement and usually is not formed until gross receipts exceed $100,000 a year (Richards, 1990). Once formed, a corporation becomes its own entity with the powers to lend or borrow money and hire or fire employees. A therapist who incorporates becomes an employee of the corporation and purchases stock in it. Tax advantages are a primary reason for forming a corporation (Beigel & Earle, 1990). However, since tax laws are constantly changing, the decision to incorporate requires careful consideration and professional (i.e., legal, tax) consultation.

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Building a Private Psychotherapy Practice

Practical Considerations

A therapist opening a private practice must attend to a number of practical details to ensure success. These include obtaining office space (renting, leasing, or subletting), finding a good location (considering factors such as the neighborhood and available parking), designing the interior office (including layout, furniture, soundproofing, lighting,and restrooms),purchasing and maintaining equipment (including computer, copier, telephone, answering service, and pager), obtaining insurance (including malpractice, general liability, medical, workers' compensation, disability, renter's, and equipment coverage), keeping books and records (such as budget, business expenses, ledgers, bank accounts, fees, billing, collections, and taxes), planning retirement, printing (including stationery, business cards, brochures, and newsletters), advertising (including logo, newspaper and television ads, radio announcements, yellow pages, seminars, billboards, and open houses), managing employees (hiring, firing, and managing personnel records), and obtaining referral sources (from business lunches and networking, for example). Thus, in addition to establishing professional relationships with attorneys and accountants,therapists may need to enlist the services of financial planners, marketing and advertising specialists, and commercial loan officers.A business plan is a key component in building a successful practice (Clay, 2000). A number of sources written by experienced private practitioners offer specific tips and advice on navigating the aforementioned areas (Earle & Barnes,1999; Lenson,1994; Mone, 1983; Richards, 1990).

"Choosing a partner with similar business goals and good business skills is critical."

As entrepreneurs running a small business, private practitioners must actively create a need in the community for their services. Aggressive marketing strategies and knowledge of the competition are essential. In addition to maintaining a professional image and advertising, the practitioner must invest time, effort, and money to develop a marketing plan that will analyze types of clients, referral sources, and competition (Richards, 1990). Therapists also should consider offering specialized services to increase their marketability.

Private practitioners generate income from a variety of sources in addition to fees collected for therapy services (Lenson, 1994; Richards, 1990). They may function as consultants to courts, schools, businesses, psychiatric hospitals, or other organizations. Consultation can be especially viable if the practitioner specializes in a specific area and is regarded as an expert. Practitioners may also supervise beginning therapists. They may develop and market products such as newsletters, books, audiotapes, or therapeutic tools. Some practitioners also may be able to sublet office space to other professionals. In addition to supplementing their income, holding workshops and giving lectures may provide practitioners with community recognition, thereby enhancing their client base. Richards (1990) recommends that practitioners develop a variety of these income sources in order to increase their potential for success.

Surviving in the Era of Managed Health Care

Since the late 1980s, American health care financing has shifted towards managed care, which attempts to control health care costs by emphasizing short-term outpatient care (Beigel & Earle, 1990). As health care delivery systems reorganize, private practitioners increasingly rely on reimbursement from managed care organizations (Poynter, 1994). Thus, it is essential that private practitioners learn how to market themselves within

- Research the needs of each panel and market your skills to fit their needs.
- Create a niche for yourself by developing a specialty area or skill.
- Get to know the staff of the managed care organization personally.
- Don't depend on one provider panel, but apply to as many as possible.
- Have an additional source of income that provides a regular paycheck.
- Be persistent but reasonable and willing to compromise.
- Don't enter private practice directly out of graduate school; instead, spend a few years developing professional stability and building connections within the community.

Tips for Obtaining Membership on Provider Panels

the managed care framework. Four main delivery systems falling under the managed care rubric are: employee assistance programs, health maintenance organizations, preferred provider organizations, and exclusive provider organizations. A brief description of these delivery systems is provided below.

1. Employee assistance programs (EAPs).
EAPs are programs set up within companies to treat their employees. They were developed to increase productivity and reduce absenteeism, and to focus on the treatment of problems affecting job performance, such as depression and substance abuse. Knowledge of corporate culture and experience in a corporate setting are advantages to private practitioners seeking affiliation with an EAP (Beigel & Earle, 1990).

2. Health maintenance organizations (HMOs).
HMOs stress preventative health care and limited interventions. They are independent companies that provide comprehensive services to their members for a fixed fee and hire a staff of providers to supply a variety of services at a lower cost. Thus, as salaried employees of HMOs, private practitioners provide brief therapy at fees determined by the HMOs.

3. Preferred provider organizations (PPOs).
PPOs are brokers between corporations or insurance companies and the providers of health care (Lenson, 1994). They independently contract with providers to establish a panel of providers, who are paid under a fee-for-service agreement. The corporations or insurance companies then offer better coverage if their subscribers use a panel provider and less coverage if they use health care providers outside of the PPO. Usually therapists who contract with PPOs must lower their fees in return for more referrals and greater client volume (Beigel & Earle, 1990; Poynter, 1994).

4. Exclusive provider organizations (EPOs).
EPOs are similar to PPOs except services are paid only if received from an EPO provider; members who see a provider outside of the network are not reimbursed. EPOs are usually formed by large, self-insured companies (Beigel & Earle, 1990).

Exhibit 1 lists suggestions for new practitioners seeking membership on provider panels, based on the experiences of two North Carolina clinical psychologists in private practice (H. Majestic, personal communication, November 20, 1998; P. Trent, personal communication, May 21, 1999). In addition, Poynter (1994) emphasizes the importance of therapists learning how to obtain contracts with managed care organizations in order to survive in the marketplace of managed care. His book provides a detailed guide on how therapists can market themselves, get on preferred provider lists, generate referrals, and remain on panels during provider cuts.

Where Do We Go From Here?
To be competitive as future practitioners within managed care, today's graduate students need to be actively preparing themselves. Although clinical psychology programs may offer lectures or seminars on private practice, students considering careers in private practice would be disadvantaged by assuming that graduate educational programs sufficiently prepare them for a successful career in private practice. Suggestions for graduate students interested in private practice are presented in Exhibit 2.

In addition to a well-rounded graduate education, graduate students must begin to develop their own areas of interest and expertise. Reading professional journals and seeking experiences outside of their psychology program (such as taking business-related seminars or courses) may help prepare students for private practice. Although the issues raised in this article are by no means exhaustive, they provide a brief overview of business issues faced by private practitioners. Most importantly, students must remain current on the evolving status of health care delivery in

- Develop business skills by taking courses at your university or through continuing/adult education courses and community seminars.
- Seek an experienced mentor in your community – perhaps a psychology professor who has a part-time private practice – who can provide sound advice regarding practice issues.
- Develop a marketable specialty area within clinical or counseling psychology.
- Join professional organizations related to private practice, such as APA Division 42 (Psychologists in Independent Practice).
- Attend professional conferences and meetings to network with other professionals.
- Explore the APA's Practitioner's Toolbox Series for information specific to private practice.

Suggestions for Students Interested in Private Practice

the United States. In this way, they can create a niche for their successful private practice in the managed care marketplace.□

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New Editors Appointed for Student Forum

We are pleased to be taking over as the new co-editors of the Graduate Student Forum column, and we are grateful to our predecessor, David Feldman, for setting a high standard for this column and for advising us in our new roles. We are both doctoral students at the University of Kansas. Zoë Peterson is in the General Clinical training track of the program, and Julia Woodward specializes in Clinical Health Psychology. We hope that our different training experiences and interests will contribute to a column that represents a diversity of topics and subject areas within the field of clinical psychology. As editors, we hope to use this column to create a dialogue among Clinical Psychology graduate students. To begin this dialogue, we are currently inviting submissions for the column.

We encourage graduate students to submit summaries of original empirical findings or brief review papers. Also, in keeping with our desire to promote a dialogue, we encourage editorials about controversial issues, and we invite the submission of responses to any of the columns that we publish. Examples of topics from past columns include a review of ethical issues related to incorporating spiritual beliefs in psychotherapy; an interview with Dr. Jack G. Wiggins, an activist and writer in the area of prescription privileges for psychologists; and a discussion of the impact of managed care on clinical psychology training.

We hope that publishing in this column will benefit graduate student authors in several ways. Along with vitae-building, this column offers authors a unique opportunity to highlight issues that are particularly relevant to graduate students and to invite responses to those issues. Additionally, the column can provide an opportunity to publish research findings and receive feedback regarding those findings. Past authors who have published in this column have been contacted by researchers and instructors from around the country who have expressed interest in their articles.

For each article submitted, one of us will serve as primary reviewer based on a match between manuscript content and the co-editor's area of specialization. The second co-editor will serve as a secondary reviewer, and decisions will be made based on consensus between the two. We expect that this selective process will ensure that the articles published in this column are of a consistently high quality.

Manuscripts should be seven to ten double-spaced pages, including references, and should be mailed to the following address:

The Clinical Psychologist
Graduate Student Forum
c/o Julia Woodward or Zoë Peterson
315 Fraser Hall
1415 Jayhawk Blvd.
University of Kansas
Lawrence, KS 66046

We welcome questions or feedback regarding the column. Zoë Peterson can be reached at zoep@ku.edu or at (785) 864-9857. Julia Woodward can be reached at juliawoodward@ku.edu or at (785) 864-4121. We look forward to receiving your submissions!

Book Review

Wagner, E.F., & Waldron, H.B. (Eds.) (2001).
Innovations in Adolescent Substance Use Disorders.
New York, NY: Pergamon.

Reviewed by Oscar G. Bukstein, M.D., M.P.H.
Western Psychiatric Institute and Clinic, Pittsburgh, PA

Information about empirically proven treatments for adolescents with substance use problems and disorders remains limited. Unfortunately, existing knowledge about innovative interventions for youth have had a limited effect on most treatment provided in the community. Interventions in the community are too rarely grounded in research and are based on adult models with little attention to the developmental needs of adolescents. If the quality of this volume translates into influence on clinicians and other researchers in this area, knowledge about effective treatments, prevention efforts, and instruments should increase among those who provide care to youth. Drs. Wagner and Waldron have assembled an impressive array of contributors who are active, important investigators into developmentally-appropriate approaches to the assessment, prevention and treatment of substance use problems among adolescents. The editors arranged the chapters along a continuum beginning with assessment and moving on to prevention, early intervention, treatment, and aftercare. Although I suspect the editors and authors may have aimed this volume to researchers and providers, the coverage of each topic was broad and basic enough to appeal to students and others wanting to obtain a comprehensive overview of what's new and exciting in the field.

The volume begins with Ken Winters and colleagues' coverage of assessment. Similar to previous efforts, this chapter covers definitions and diagnoses, domains of assessment, measurement issues, the validity of adolescent self-reports, and finally a comprehensive listing and review of instruments measures substance use and related domains. While exhaustive in coverage, the chapter could have provided more on a general clinical approach to assessment.

Four prevention chapters describe prevention of the most promising prevention interventions that now have extensive empirical evidence for their effectiveness. Supplementing peer-reviewed publications in journals, these chapters provide additional information about the development, content and ongoing modification and of Life-Skills Training, the Reconnecting Youth Project, and, All-Stars Intervention. Bry and Attaway review community-based prevention interventions and provide brief descriptions of the interventions and evidence supporting their use.

With the exception of Gil and associates' chapter on interventions with Latino adolescents, the remainder of the volume presents almost every major treatment modality having empirical data. These modalities include motivational interviewing, ecological family intervention approaches, school-based interventions, family behavior therapy, multidimensional family therapy, psychopharmacology, twelve-step interventions, cigarette smoking cessation, and Sandra Brown's multiple options approach to facilitating change for adolescents with alcohol problems. Detailed descriptions of the underlying theory, the interventions, and the empirical evidence supporting the interventions use are provided, thus increasing the reader's understanding of each treatment. Fortunately, these chapters cover a diverse array of modalities. Most of these interventions are brief treatments and, hence, practical in terms of the potential acceptability to adolescents, parents, schools, providers and managed care. The interventions also cover diverse settings such as school-based settings and hospital emergency rooms. Although each of the contributors does a good job in outlining their respective treatment modality, several chapters deserve special note. Too often, in our haste to identify effective active treatments, we forget about the potential potency of the self-change process and motivated change in the process of decreasing or eliminating substance use. Sandra Brown describes her work in identifying why adolescents fail and succeed in changing their substance use behavior following treatment. Based on this research, she and her colleagues have developed a set of optional "intervention" formats, which include group discussions, individual sessions and an interactive website. Nancy Barnett and associate's chapter on motivational interviewing (MI) is brief but serves to emphasize the importance of dealing with motivation as an important, if not critical, element of treatment success. Finally, Mark Myer's chapter on treatment for cigarette smoking covers interventions for a psychoactive substance too often overlooked by adolescent treatment professionals and researchers who may be seduced by more exciting illicit drugs.

The coverage of such diverse modalities is a

laudable feature of this book. There are several important treatment research efforts that are omitted such as Scott Henggeler's Multisystemic Therapy (MST) and one of the authors, Holly Waldron's combined family/behavioral model. Also missing are discussions of approaches to treatment planning and selection of modalities, a general orientation to these modalities and a review of the current status of treatment research for adolescent substance use problems. These additions would have served to make an excellent volume close to perfect and would have allowed students and those less acquainted with these innovative interventions to put them in a broader context. I can recommend this volume to a broad audience of readers who, I am certain, will find this book useful and informative. Given the paucity of material on effective treatment interventions, the authors could have given us much less and still advanced knowledge in the area. We are fortunate that they chose to give us more in the form of this quality volume.□

Call for Nominations for Division 12 Awards

Call for Nominations:

Two Awards for Distinguished Contributions in Clinical Psychology

Distinguished Scientific Contribution Award:
Honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology.

Florence Halpern Award for Distinguished Professional Contributions:
Honors psychologists who have made distinguished theoretical or empirical advances in psychology leading to the understanding or amelioration of important practical problems.

To nominate someone for these awards, send nominee's name, recent vita, and a concise (1-2 page) typewritten summary of his/her achievements and contributions to:

Larry E. Beutler, Ph.D., Chair
2003 Awards Committee, c/o Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082

Deadline: October 30, 2002

The award will be presented at the 2003 APA Convention in Toronto, Ontario, Canada

Call for Nominations

2003 David Shakow Award for Early Career Contributions

The "David Shakow Early Career Award" shall be given for contributions to the science and practice of Clinical Psychology. The awardee will be a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to the science and to the practice of Clinical Psychology.
Letters of nomination should include the nominee's vita and a summary of his/her contributions.

Larry E. Beutler, Ph.D., Chair
2003 Awards Committee, c/o Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082

Deadline: October 30, 2002

The award will be presented at the 2003 APA Convention in Toronto, Ontario, Canada

Call for Nominations

2003 Theodore Blau Award

The "Theodore H. Blau Early Career Award for Outstanding Contribution to Professional Clinical Psychology" will be given by the Division of Clinical Psychology to a Clinical Psychologist who has made an outstanding contribution to the profession of Clinical Psychology. Outstanding contributions are broadly conceived as promoting the practice of Clinical Psychology through professional service, innovation in service delivery, novel application of applied research methodologies to professional practice, positive impact on health delivery systems, development of creative educational programs for practice, or other novel or creative activities advancing the profession. Given the difficulty of making such contributions very early in one's career, the award will be given to a person who is within the first 10 years of receiving his or her doctorate. This award is made possible through the sponsorship of Psychological Assessment Resources, Inc.

Larry E. Beutler, Ph.D., Chair
2003 Awards Committee, c/o Division 12 Central Office
P.O. Box 1082, Niwot, CO 80544-1082

Deadline: October 30, 2002

The award will be presented at the 2003 APA Convention in Toronto, Ontario, Canada.

American Psychological Association Convention Division 12 Program Summary

This year's Division 12 program is chock full of cutting-edge clinical research and practice issues. Listed below is a summary of the Division's program. All business and executive meetings are being held in the Division 12 Hospitality Suite (you may find the exact location of the hospitality suite on a board that will be displayed on the main floor of the Hilton Hotel). This is partly because the convention has been concentrated into 4 days and there is the addition of new "cluster" programming. Several Division 12 members are presenting in the new cluster format (see tracks listed separately on p. 29 for highlighted sessions).

Thursday, August 22, 2002

Paper Session: Interpersonal Research
8/22 Thu: 8:00 AM - 8:50 AM
McCormick Place Lakeside Center-Level 2, Meeting Room E270
Brian A. Dahmen, Michael A. Westerman, Gilbert Reyes, Nicholas L. Salsman, Sheri A. McGuffin, Stanley A. Murrell

Paper Session: Trauma, Terror, and Abuse
8/22 Thu: 8:00 AM - 8:50 AM
McCormick Place Lakeside Center-Level 2, Meeting Room E271a
Sheryl Pimlott-Kubiak, Lilia Cortina, Nivla Y. Fitzpatrick, Rosalie M. Orozco, Douglas M. Logsdon, Tamara L. Young, Laura N. Nouguier, Tricia Fong, Heather-Lea Sleeper, David B. Hickel, Michael E. Drebot, Paul W. Robinson, Alan E. Kazdin

Invited Address: Successful Women, Custody Battles, and Unfair Family Courts
8/22 Thu: 9:00 AM - 9:50 AM
McCormick Place North Building-Level 4, Meeting Room N427bc
Adele F. Besner, Lenore E. Walker, Hilda Besner

Invited Address: New Directions in Depression and Heart Disease
8/22 Thu: 9:00 AM - 9:50 AM
McCormick Place South Building-Level 1, Meeting Room S105d
Kenneth E. Freeland

Symposium: Multiculturally Competent Practice With Older Adults
8/22 Thu: 9:00 AM - 9:50 AM
McCormick Place North Building-Level 4, Meeting Room N426a
Hillary H. Deal, B.J. Scott, B. Thomas Longwell

Symposium: Workbook for Overcoming Rejection and Loss of Love
8/22 Thu: 9:00 AM - 9:50 AM
Hyatt Regency McCormick Place Hotel Hotel-Second Floor, Regency Ballroom E
Terrence J. Neary

Symposium: Innovations in Suicide Research and Intervention
8/22 Thu: 9:00 AM - 10:50 AM
McCormick Place Lakeside Center-Level 3, Meeting Room E353c
Mac Turner, Sarah K. Reynolds, Katherine A. Comtois, Marsha Linehan, Evan M. Forman, Aaron T. Beck, Michele S.Berk, Gregg Henriques, Alec L. Miller, Bonnie Altman, Jessica Garno, Eve Goldstein, Katie Mitchell, Marcia Landsman, Elizabeth E. Wagner

Section 8 Executive Committee Meeting
8/22 Thu: 10:00 AM - 12:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Symposium: What About That Intern?
8/22 Thu: 10:00 AM - 10:50 AM
McCormick Place Lakeside Center-Level 4, Meeting Room E451a
Miguel Ybarra, Carole C. Olson, A. Lee Beckstead, Joshua Fogel

Symposium: Anxiety Among African American Children and Adolescents
8/22 Thu: 10:00 AM - 10:50 AM
McCormick Place North Building-Level 2, Meeting Room N226
Golda S. Ginsburg, Rhonda C. Boyd, Sharon F. Lambert

Section 4 Presidential Address: School Violence: Do Clinical Psychologists Matter?
8/22 Thu: 11:00 AM - 11:50 AM
Hyatt Regency McCormick Place Hotel Hotel-Second Floor, Regency Ballroom E
Adele F. Besner

Section 9 Board Meeting
8/22 Thu: 12:00 PM - 2:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Symposium: Presidential Symposium: Board Certification – Aspirational or Essential in Hospitals and Health Science Centers
8/22 Thu: 1:00 PM - 1:50 PM
Hyatt Regency McCormick Place Hotel Hotel-Second Floor, Regency Ballroom B
John D. Robinson, Karen Schmaling, Ronald H. Rozensky

Section 4 Business Meeting
8/22 Thu: 2:00 PM - 4:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Poster Session: Psychotherapy and Clinical Assessment
8/22 Thu: 3:00 PM - 4:50 PM
McCormick Place Lakeside Center-Level 3, Hall D1

Conversation Hour: Supervision
8/22 Thu: 5:00 PM - 5:50 PM
Hyatt Regency McCormick Place Hotel Conference Center-First Floor, Room CC10B
Anne L. Updegrove

Friday, August 23, 2002

Section 6 Presidential Address: Psychology and the Community
8/23 Fri: 9:00 AM - 9:50 AM
McCormick Place North Building-Level 4, Meeting Room N426b
Dorothy Tucker

Section 6 Executive Committee
8/23 Fri: 8:00 AM - 9:30 AM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Paper Session: Facing Challenges in Diagnostic Assessment
8/23 Fri: 9:00 AM - 9:50 AM
McCormick Place Lakeside Center-Level 3, Meeting Room E353a
Anu Sharma, Nicole L. Bentson, John Ruscio, Nancy L. Kocovski, Norman S. Endler, Gordon L. Flett

Symposium: Treating Suicide Risk Factors Among Various Age and Diagnostic Populations
8/23 Fri: 9:00 AM - 10:50 AM
McCormick Place Lakeside Center-Level 3, Meeting Room E350
Neil C. Reynolds, Nico Peruzzi, Drew Canapary, Karin M. Cleary, Lisa M. Brown

Symposium: Social Support in Couples
8/23 Fri: 9:00 AM - 10:50 AM
McCormick Place South Building-Level 1, Meeting Room S105d
Anita DeLongis, Suzanne P. Piening, Daniel Russell, Carolyn E. Cutrona, Todd Abraham, Carolyn E. Cutrona, Sandra L. Jensen

Symposium: New Developments in Treating Women With Abuse Histories---Evidence-Based Psychotherapies
8/23 Fri: 9:00 AM - 10:50 AM
McCormick Place North Building-Level 4, Meeting Room N427bc
Nancy L. Chard,Marylene Cloitre, Caron Zlotnick

Symposium: Using Outcome Measures to Improve Psychotherapy
8/23 Fri: 9:00 AM - 10:50 AM
McCormick Place Lakeside Center-Level 3, Meeting Room E352
Richard Isakson, David A. Vermeersch, Vaughn Worthen, John Okiishi, Jason L. Whipple, Eric J. Hawkins, Michael J. Lambert, Richard Moody, Vaughn Worthen, Barbara Morrell, Eric J. Hawkins, Maureen Rice, M. Kirk Dougher, Stevan Lars Nielsen, Mark Granley

Workshop: Evaluation of Childhood Onset Mood Disorder – A Multidisciplinary Approach
8/23 Fri: 9:00 AM - 10:50 AM
McCormick Place Lakeside Center-Level 3, Meeting Room E353b
Gianni L. Faedda, Nancy B. Austin, Ira Glovinsky

Section 8 Business Meeting
8/23 Fri: 9:30 AM - 11:00 AM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Paper Session: Innovations in Schizophrenia Research

8/23 Fri: 10:00 AM - 10:50 AM
McCormick Place North Building-Level 2,
Meeting Room N226
Martin Harrow, Ellen S. Herbener, Kalman J. Kaplan

Paper Session: Research on the Structure of Personality and Personality Disorders
8/23 Fri: 10:00 AM - 10:50 AM
Robert C. McMahon, Ellen L. Vaughan, Frederick L. Coolidge

Poster Session: Trauma, Anxiety, and Stress
8/23 Fri: 10:00 AM - 11:50 AM
McCormick Place Lakeside Center-Level 3, Hall D1

Section 3 Business / Executive Meeting
8/23 Fri: 11:00 AM – 12:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Invited Address: Lawton Award for Distinguished Contributions to Clinical Geropsychology
8/23 Fri: 11:00 AM - 11:50 AM
McCormick Place Lakeside Center-Level 2,
Meeting Room E258
Victor Molinari, Martha Storandt

Symposium: Women and Aging – Challenges and Rewards
8/23 Fri: 11:00 AM - 11:50 AM
McCormick Place Lakeside Center-Level 3,
Meeting Room E353a
Claire M. Brody, Frances K. Trotman

Symposium: Suicide Prevention in Jail
8/23 Fri: 11:00 AM - 12:50 PM
McCormick Place North Building-Level 4,
Meeting Room N426b
Gary B. Kaniuk, Carl J. Alaimo, Laurie Deckard, Shonda Nixon, Sam Holcombe, Cheryl Scott, Marlo Ellis

Symposium: Children Who Survive Traumatic Events – Treatment and Public Policy Implications
8/23 Fri: 11:00 AM - 12:50 PM
McCormick Place North Building-Level 4,
Meeting Room N427bc
Annette M. La Greca, Robin Gurwitch, Betty Pfefferbaum, Lawrence J. Siegel, Jan Faust, Janine Furdella, Cassandra K. Cochran, Eric M. Vernberg

Section 6, Discussion and Networking
8/23 Fri: 12:00 PM - 2:00PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Paper Session: Advances in the Study and Treatment of Depression
8/23 Fri: 12:00 PM - 12:50 PM
McCormick Place Lakeside Center-Level 3,
Meeting Room E353c
Tony Z. Tang, Robert J. Derubeis, Lester Luborsky, Gregory M. Rogers, Gregg Henriques

Conversation Hour: Incorporating Gay, Lesbian and Bisexual Issues into Mainstream Psychology
8/23 Fri: 12:00 PM - 12:50 PM
McCormick Place South Building-Level 4,
Meeting Room S403b
Marvin R. Goldfried

Section 2 Presidential Address: Family Decisions About Dementia Care
8/23 Fri: 1:00 PM - 1:50 PM
McCormick Place South Building-Level 5,
Meeting Room S504bc
Sara H. Qualls

Paper Session: Ideational Processes in Psychopathology
8/23 Fri: 1:00 PM - 1:50 PM
McCormick Place Lakeside Center-Level 2,
Meeting Room E271a
Kenneth R. Conner, Sean Meldrum, William F. Wieczorek, PhD

Award Address: Distinguished Scientific Contribution Award
8/23 Fri: 1:00 PM - 1:50 PM
McCormick Place Lakeside Center-Level 3, Meeting Room E352
Mark B. Sobell

Symposium: From Helplessness to Depression to Optimism to Positive Psychology – The Research Career of Martin E.P. Seligman
8/23 Fri: 1:00 PM - 2:50 PM
McCormick Place South Building-Level 4, Meeting Room S406a
Raymond D. Fowler, Steven Maier, Lyn Y. Abramson, Christopher Peterson, Edward F. Diener, Martin E.P. Seligman, Barbara L. Fredrickson, Philip G. Zimbardo

Section 2 Task Forces
8/23 Fri: 2:00 PM – 5:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Section 3 Presidential Address: What's Wrong With Clinical Psychology Anyway?
8/23 Fri: 2:00 PM - 2:50 PM
McCormick Place Lakeside Center-Level 4, Meeting Room E450a
Scott O. Lilienfeld

Paper Session: Innovations in Psychotherapy Research and Practice
8/23 Fri: 2:00 PM - 2:50 PM
McCormick Place Lakeside Center-Level 2, Meeting Room E271a
Kerry Murray, Peggy Polompsky, Eric J. Hawkins

Award Address: Florence Halpern Award for Distinguished Professional Contributions in Clinical Psychology
8/23 Fri: 2:00 PM - 2:50 PM
McCormick Place Lakeside Center-Level 3, Meeting Room E352
George Stricker

Section 7 Presidential Address: Evidence-Based Assessment of Risk of Violence to Self and Others
8/23 Fri: 3:00 PM - 3:50 PM
Hyatt Regency McCormick Place Hotel Hotel-Second Floor, Regency Ballroom E
Dale E. McNiel

Section 9 Hospitality Hour
8/23 Fri: 5:00 PM - 6:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Saturday, August 24, 2002

Section 2 Executive Meeting
8/24 Sat: 8:00 AM - 11:00 AM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Poster Session: Psychopathology and Personality
8/24 Sat: 10:00 AM - 11:50 AM
McCormick Place Lakeside Center-Level 3, Hall D1

Meeting for the International Society for Clinical Psychology
8/24 Sat: 11:00 AM - 1:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Invited Address: Empirical Approaches to the Understanding of Suicide
8/24 Sat: 1:00 PM - 1:50 PM
McCormick Place South Building-Level 4, Meeting Room S401bc
David Clark, PhD

Section 2 Business Meeting
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Paper Session: Treatments With Geriatric Populations
8/24 Sat: 1:00 PM - 1:50 PM
McCormick Place South Building-Level 4, Meeting Room S401d
Suzanne Drungle Danhauer, Charles R. Carlson, Michael A. Andrykowski

Presidential Address and Business Meeting (Divisional Presidential Address)
8/24 Sat: 1:00 PM - 1:50 PM
McCormick Place Lakeside Center-Level 3, Meeting Room E353c
Larry E. Beutler

Symposium: Is Psychological Testing Essential for Treatment Planning in Clinical Psychology?
8/24 Sat: 1:00 PM - 2:50 PM
McCormick Place Lakeside Center-Level 3, Meeting Room E352
Theodore Millon, John R. Graham, Norman Abeles, Irving B. Weiner, Roger L. Greene, David Lachar, Alan Raphael

Roundtable Discussion: Will the Real Behavior Therapy Please Stand Up?
8/24 Sat: 1:00 PM - 2:50 PM
McCormick Place South Building-Level 4, Meeting Room S406a
Judith S. Beck, Albert Ellis, Steven C. Hayes, Arnold A. Lazarus, Marsha Linehan,Arthur W. Staats

Symposium: Therapist's Pregnancy – Implications for Clinical Practice
8/24 Sat: 1:00 PM - 2:50 PM
McCormick Place South Building-Level 5, Meeting Room S504a
Julia L. Anable, Margaret J. Byrnes

Invited Address: Explaining Suicidal Terrorism: Theories Versus Empirical Evidence
8/24 Sat: 2:00 PM - 2:50 PM
McCormick Place Lakeside Center-Level 3, Meeting Room E353c
Ariel Merari

Paper Session: Clinical Interventions in Substance Abusing Populations
8/24 Sat: 2:00 PM - 2:50 PM
McCormick Place North Building-Level 4, Meeting Room N426a
Wesley A. Bullock, Melissa Klein, Gayle H. Wuttke

Section 9 Get Acquainted with New Members Meeting
8/24 Sat: 3:00 PM - 4:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Award Ceremony: Society of Clinical Psychology Awards
8/24 Sat: 4:00 PM - 4:50 PM
Hilton Chicago and Towers Third Floor, Williford Room A
Distinguished Scientific Contribution Award
Mark B. Sobell
Florence Halpern Award for Distinguished Professional Contributions in Clinical Psychology
George Stricker
Theodore H. Blau Early Career Award
Michael A. Goldberg
David Shakow Early Career Award
Louis G. Castonguay
Section awards will be awarded at this ceremony as well as the divisional awards listed above.

Social Hour: [Social Hour] Poster Session
8/24 Sat: 5:00 PM - 6:50 PM
Hilton Chicago and Towers Lobby Level, Continental Room A

Symposium: Potential Barriers to the Psychotherapeutic Treatment of Ethnic Minority Males
8/25 Sun: 9:00 AM - 9:50 AM
McCormick Place North Building-Level 4, Meeting Room N426c
Glenn I. Masnda, Tammy H. Ichinotsubo-Ezzi, Kamilah Woodson

Sunday, August 25, 2002

Symposium: Mental Health Service Delivery in Long-Term Care Facilities
8/25 Sun: 9:00 AM - 10:50 AM
McCormick Place North Building-Level 4, Meeting Room N426b
Steven J. Sohnle, Margaret P. Norris, Joseph M. Casciani

Invited Address: Impact of HIPAA on Research and Clinical Practice
8/25 Sun: 10:00 AM - 10:50 AM
McCormick Place Lakeside Center-Level 3, Meeting Room E350
Jennifer Kulynych

Symposium: Parents With Mental Illness---Research on Functioning and Services
8/25 Sun: 10:00 AM - 10:50 AM
McCormick Place Lakeside Center-Level 3, Meeting Room E352
Carol T. Mowbray, Sang K. Kahng, Deb Bybee

Symposium: Disaster Mental Health Responses to Terrorist Attacks of September 11
8/25 Sun: 10:00 AM - 11:50 AM
McCormick Place Lakeside Center-Level 2, Meeting Room E271a
Susan E. Hamilton, Robert L. Dingman, Robert Hayes

Symposium: Empirically Supported Assessment Instruments---An Idea Whose Time Has Come?
8/25 Sun: 10:00 AM - 11:50 AM
McCormick Place North Building-Level 4, Meeting Room N427bc
Martin M. Antony, Gregory J. Meyer, Howard N. Garb, Thomas A. Widiger

Section 7 Business Meeting
8/25 Sun: 10:30 AM - 12:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Symposium: Interpersonal Functioning in Anxiety Disorders
8/25 Sun: 12:00 PM - 1:50 PM
McCormick Place Lakeside Center-Level 2, Meeting Room E271a
Lynn E. Alden, Charles Taylor, Judith M. Laposa, Michael B. Kasoff, Aaron L. Pincus, Louis G. Castonguay, Alexander J. Schut, Leonard M. Horowitz, Charles Hines III, Thane M. Erickson, Michelle G. Newman, Thomas D. Borkovec

Section 9 Business Meeting
8/25 Sun: 12:00 PM - 1:00 PM
Division 12 Hospitality Suite (Check Chicago Hilton for exact Location)

Section 9 Presidential Address: Does Assessment Have a Role in Today's Practice of Psychology?

Cluster Program and Division 12: Debate and Open Intellectual Discussion!

This year is the beginning of a restructuring of the APA convention. The largest change is the introduction of "Cluster" programming, which allows for larger, keynote sessions on specific topics that are likely to be useful to APA members who attend the convention. The name "Cluster" refers to within-divisional "clusters" or groupings of divisions with similar interests. This year there are 10 of these divisional "clusters," which are participating in thematic programming in hopes of guaranteeing high quality, well-attended and relevant sessions.

In 2002, Division 12 has been clustered with 5 other divisions – Hypnosis (30), Psychology-Law (41), Family (43), and Group Psychology and Psychotherapy (49). The cluster that Division 12 is involved with has developed two thematic program tracks that should be of interest to Division 12 membership. One track focuses on trauma and another track focuses on challenges to the treatment authority of the psychologist. The program summary below is from one of the tracks that should be especially interesting to our membership. Please check your convention program for the full cluster schedule.

Friday August 23, 2002

3:00 – 5:00 PM
EMPIRICALLY SUPPORTED TREATMENTS – "MEGA-CLUSTER" DEBATE!

Further Bases of Practice: Debate on Empirically Supported Treatments.
Proposed: Empirically Supported Treatments (ESTs), as defined by the Division 12, Section 3 task force, are optimal (both in regard to good science and practice), to other treatment approaches. Responsible, even ethi - cal, practice should include the use of an EST.

Participants:
David Barlow, Boston University
Larry Beutler, University of California, Santa Barbara
Dianne Chambless, University of North Carolina
Bruce Wampold, University of Wisconsin

Saturday August 24, 2002

What's Happening to the Treatment Authority of the Provider?

This track will explore initiatives for enhancing the treatment authority of the practicing psychologist. A wide variety of external forces – Health Maintenance Organizations, the courts, & even the medicalization of the field – may leave many psychologists wondering if the "cart is before the horse." For example, psychologists may sometimes face the fact that the legal system is directing many of their treatment decisions. The introduction of "Empirically Supported Treatments" and prescription authority for psychologists are two recent proposals for enhancing the psychologist's treatment authority. These issues, many of which have been controversial, are discussed and debated. The goal of this track is to explore these proposed solutions for psychologists, to reduce practice barriers, and to empower psychologists in the role of treatment provider.

Saturday August 24, 2002, 10:00 AM – 12:00 PM
On the Development and Specification of the Empirically Supported Treatment Model
Timothy Anderson, Chair, Ohio University, Athens, OH 45701

Gordon Paul
"The Argument for Evidence-based Treatments in the History of Psychotherapy."
David H. Barlow
"The Introduction of "Empirically Validated/

Supported Treatment Criteria: A Rationale for Enhancing 'Treatment Authority.'"

Peter Nathan

"Specific Examples of How Empirically Supported Treatment Enhance Psychology's Treatment Authority."

Jacqueline B. Persons

"Nuts and Bolts of Evidence-based Psychotherapy"

Larry E. Beutler

"Is it time to identify empirically supported principles rather than treatments?"

Saturday August 24, 2002, 12:00 – 1:00 PM

Role of Alternatives to Evidence Based Treatments

John C. Norcross

"Broadening the Definition of Evidence-Based Treatments: Empirically Supported Relationships."

Bruce Wampold

"Fostering Change Through Psychotherapy: Focusing on the Provider Rather than the Treatment."

Arthur Bohart Jr.

"Evidence Based Psychotherapy Practice? Yes. Evidence-Based Treatments? No."

Saturday August 24, 2002, 9-10 am
PRESCRIPTION AUTHORITY DEBATE!

The Role of Prescription Authority for the Psychologist

Introduction:How Do We Use a Prescription Pad?

John D. Robinson

Debate Participants:

Patrick DeLeon

Elaine M. Heiby

Thank You Reviewers!

Proposals to the Division 12 program of the 2002 APA convention were each evaluated by at least two reviewers who were blind to the author's identity. Reviewers typically received five to eight proposals and returned their evaluations within days. As program chair and long-time procrastinator, I was surprised and truly heartened by the speed and response of the Division 12 reviewers (over 85% responded within the few days that were asked to provide the review). Most of the following reviewers have served the division in this capacity year-after-year and with little formal acknowledgment. Division 12 is deeply indebted to all of the individuals listed below.

Timothy Anderson,
Division 12 Program Chair

8/25 Sun: 1:00 PM - 1:50 PM
McCormick Place Lakeside Center-Level 2, Meeting Room E271b

Dr. Norman Abeles
Dr. Frank Andrasik
Dr. Michael H. Andrykowski
Dr. J. Gayle Beck
Dr. Jeffrey S. Berman
Dr. Larry E. Beutler
Dr. Ronald L. Blount
Dr. Stephen R. Boggs
Dr. Robert F. Bornstein
Dr. Elisa Bronfman
Dr. Tim Brown
Dr. Jonathan Brush
Dr. Bruce Christensen
Dr. Eddie M. Clark
Dr. Gerard Connors
Dr. Raymond Costello
Dr. Florence L. Denmark
Dr. Ronald Drabman
Dr. Barry Edelstein
Dr. Jean C. Elbert
Dr. Sheila M. Eyberg
Dr. Albert Delos Farrell
Dr. John P. Foreyt
Dr. Gary D. Foster
Dr. Sharon Foster
Dr. Cyril M. Franks
Dr. Violet Franks
Dr. William Garrison
Dr. Donna M. Gelfand
Dr. Christine Gidycz
Dr. Stephen P. Hinshaw
Dr. Stefan Hofmann
Dr. Grayson N. Holmbeck
Dr. William G. Iacono
Dr. Joan L. Jackson
Dr. Alan E. Kazdin
Dr. Terence M. Keane
Dr. Peter A. Keller
Dr. Philip C. Kendall
Dr. Candace Konnert
Dr. Gerald P. Koocher
Dr. Mary P. Koss
Dr. Richard I. Lanyon
Dr. Kenneth Earl Leonard
Dr. John C. Linton
Dr. John E. Lochman
Dr. Janet R. Matthews
Dr. Cheryl McNeil
Dr. Andrew Meyers
Dr. Debra A. Murphy
Dr. Peter E. Nathan
Dr. Arthur M. Nezu
Dr. Michael W. O'Hara
Dr. Thomas H. Ollendick
Dr. Sara H. Qualls
Dr. Lynn P. Rehm
Dr. Jeffrey M. Ring
Dr. Paul D. Rokke
Dr. Zindel Segal
Dr. Kenneth J. Sher
Dr. Lawrence J. Siegel
Dr. Anthony Spirito
Dr. Annette Stanton
Dr. George Stricker
Dr. Kenneth J. Tarnowski
Dr. Frank A. Treiber
Dr. Leon D. Vandecreek
Dr. C. Eugene Walker

ABBREVIATED MINUTES: SOCIETY OF CLINICAL PSYCHOLOGY BOARD MEETING
January 4-6, 2002, Coconut Grove, Florida

Program:
Tim Anderson was appointed to serve as Cluster chair and program chair: For this year's APA convention, there are a total of 72 hours,(59 substantive, 13 non-substantive - for awards, mtgs.). There were 170 submissions for the 59 substantive hours. Additionally, there will be 15 Professional Development Institute (PDI) workshops.

Sections:
It was clarified that Society affiliate status members can get discounts for PDIs and can be section members and hold section offices, but they cannot hold division offices, including the position of section representative to the Division Board. It was noted that new section affiliate members have to be division affiliates as well as section affiliates in order to vote on Division issues. Only Division members in sections can vote for representative to the Division Board. Sections will review and report any recommended proposals for housekeeping of their Bylaws corrections.. Laura Toomey will lead this effort.

Fellows:
New fellows voted by the board are :
Paul Craig, Susan Whitmore, Dan Abrahamson, Jay Benedict, and Lynn Pantano.

Awards: 2002:
The Blau Award: Michael Goldberg,
Shakow Award: Louis Castonguay,
Halpern Award: George Stricker,
Science Award: Mark Sobell.

MOTIONS PASSED

1. Develop an active public ad hoc public policy task force that will serve as an information and advocacy mechanism for the diverse interest of the psychologists in the division and within the sections.

2. Create a Young Professional Task Force for recruitment and retention of members, as a subcommittee of the membership committee.

3. Each standing committee, with the exception of the Fellows committee, shall include a new professional who is less than 5 years post degree. These appointments shall initially occur through attrition of current members.

4. Larry Beutler will write a letter to express Division 12's endorsement of the Division 35 paper on competencies.

5. Remove international as the only kind of affiliates so that affiliates can be defined from anywhere. Specific changes to bylaw wording goes to the membership for vote.

6. The finance committee shall consider special requests only with a detailed report of budget, cosponsors, and what money is needed for.

7. That the Society of Clinical Psychology will consider a dedicated slate for ethnic minorities for each election of APA Council Representatives whenever there is more than one position available.

Respectfully Submitted,
Annette M. Brodsky, Ph.D.,
Secretary

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. 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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