



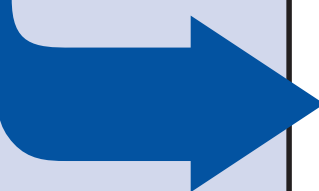
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Violence in society: Where do we go from here?

Violence in America is widespread and affects many aspects of our lives. Stated simply, it is a public health problem of the highest magnitude. In a 1992 editorial for the Journal of the American Medical Association, for example, former Surgeon General of the United States C. Everett Koop and his colleague, George Lundberg, asserted violence had become a public health emergency and that it was time to “bite the bullet back.” Similarly, in a presidential address to the Trauma Society in 1993, C. W. Schwab declared that violence had become America’s “uncivil” war – producing annual rates of morbidity and mortality that exceeded those occurring during the entire “Civil” War. I issued a similar proclamation to the Association for the Advancement of Behavior Therapy in my 1995 presidential address, proclaiming violence in society as our number one target for the remainder of the 20th century. In short, interpersonal violence in America has become widespread and seemingly unrelenting. Despite concerted efforts to curb its advance, it has continued to mount in recent years.

As one illustration, today 1 in every 10,000 people will become the victim of homicide, a rate that has more than doubled in the last 50 years. America’s youth are especially vulnerable. Nearly 3 in every 10,000 young males will be murdered. Among minority males between the ages of 16 and 25 who live in impoverished areas of large cities, the rate is staggering – more than 10 times as high – 1 in every 333. Although rates are not as high for female youths, they are still alarming. In fact, for individuals between 16 and 25 years of age, homicide is the leading cause of death among African-American males and females, the third leading cause of death among Caucasian males, and the sixth leading cause of death in Caucasian females. And, homicide rates only begin to depict the American landscape when it comes to violence. Other forms of violence, including child abuse, spousal abuse, minority abuse, and elder abuse, are also prevalent. A medical illness of similar or greater magnitude would surely be of



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President's Column

In short, interpersonal violence in America has become widespread and seemingly unrelenting. Despite concerted efforts to curb its advance, it has continued to mount in recent years.

alarm and our society would demand immediate and effective solutions. Behavioral cancers associated with toxic environments appear to draw less attention and resources.

Yet, complex problems such as violence in society require complex solutions and “simple” solutions or quick fixes are not readily available. Undoubtedly, violence is a function of many forces including bio-behavioral, socialization, cognitive, and situational factors. In recent years, the American Psychological Association has recognized the complexity and scope of this problem, appointing a Commission on Youth Violence (1993), and, in concert with the American Psychological Society, issued a Human Capital Initiative Report in 1997 entitled “A Behavioral Science Research Plan for Violence.” In the development of these initiatives, the Society of Clinical Psychology was notably absent – it was not at the table and, accordingly, it did not have the opportunity to contribute to the deliberations nor to participate in recommending potential solutions.

In Lewis Carroll's *Alice's Adventures in Wonderland*, Alice asks the Cheshire Cat, “Would you tell me, please, which way I ought to go from here?” The Cat replies, “That depends a good deal on where you want to get to.”

As a Society of Clinical Psychology, where do we go from here? Yogi Berra once quipped, “If you don’t know where you’re going, you will wind up somewhere else.” In Lewis Carroll’s *Alice’s Adventures in Wonderland*, Alice asks the Cheshire Cat, “Would you tell me, please, which way I ought to go from here?” The Cat replies, “That depends a good deal on where you want to get to.” Regarding violence in society, it would seem that we indeed know where we want to go (i.e., toward a less violent society). Yet, we do not seem to know how to get there.

Toward this end, I have appointed an Ad Hoc Task Force on Violence and Youth to begin to explore some of these issues and to provide us a working blueprint of how to get there. Initially, I wanted this task force to address all forms of violence in society including child abuse, spousal abuse, minority abuse, and elder abuse. However, it quickly became evident (to me and others!) my aspirations were too lofty and such a charge would be unrealistic and my goals for the task force would not be reached. Better judgment prevailed. I

determined that we needed to start somewhere and chose violence in youth as the starting point. It is my anticipation and hope that future iterations of task forces will address these other equally compelling and refractory problems in society.

Fortunately for me, Dr. Mark Weist, Director for the Center of School Mental Health Assistance at the University of Maryland Baltimore, accepted my invitation to serve as chair of the task force. Moreover, Mark has recruited a distinguished group of clinical psychologists to serve on the Committee: Drs. Rodney Hammond and Le’Roy Reese from the Center for Disease Control (Division of Violence Prevention), Dr. Michelle Coley-Quille from Johns Hopkins University (School of Hygiene and Public Health), Dr. Phillippe Cunningham from the Medical University of South Carolina (Department of Psychiatry and Behavioral Sciences), Dr. Al Farrell from Virginia Commonwealth University (Department of Psychology), Dr. Olga Acosta from the University of Maryland Baltimore (Center for School Mental Health Assistance), and Kathleen Albus, a graduate student in the clinical psychology training program at the University of Delaware.

The task force has been charged with three specific activities: 1) produce a set of working papers to be presented as part of an invited symposium for the 1999 meeting of APA in Boston; 2) present a postdoctoral institute at the annual meeting on the assessment and treatment of violence in youth; and 3) develop a set of manuscripts to be submitted for a special section of one of our leading clinical journals. It is intended that these products will advance our thinking on the scope of violence in youth and provide us directions on what we need to do, where we need to go to make significant advances against this societal cancer, and how to get there.

I am pleased to share developments associated with this task force and invite you to submit ideas and suggestions to Dr. Weist and his committee members, or directly to me. This is a problem for which the Society of Clinical Psychology has much to offer. It is time we have taken our seat at the violence table.

Finally, in my first presidential column, I want to indicate how honored I am to serve as your president for 1999. I look forward to an exciting, action-packed year and serving you in this regard. Many issues await our collective attention and I invite you to share them through contributions to *The Clinical Psychologist*. I know I speak for Dr. Rokke, Editor, in inviting you to submit letters and other contributions to this publication. The Society of Clinical Psychology can flourish as a society only if its members are involved and we derive companionship or company from one another. Let us hear from you. Happy New Year. ■

Behavior Therapy for Headache

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A number of behavioral therapies for recurrent headache disorders have been described in the literature, but there is strong evidence only for relaxation training, biofeedback, and cognitive-behavioral stress management training. We describe these interventions and summarize the evidence of their efficacy for the treatment of migraine and tension-type headache. We address who benefits from behavioral therapies and how long the improvements last. Clinical references and resources for training are provided.

I. Description of Treatment

Several types of behavioral therapy are utilized for the treatment of recurrent headache disorders including relaxation training, biofeedback, and cognitive-behavioral stress management training, hypnotic analgesia, transcendental meditation, and guided imagery. The research evidence is quite limited, however, on the latter three approaches. Thus, only the first three approaches will be reviewed here.

Relaxation Training

Relaxation training is the most widely used behavioral intervention for the treatment of recurrent headache disorders. Relaxation training is a systematic procedure for teaching individuals to gain awareness of and exert control over physiological responses. The two most frequently used methods are (a) abbreviated progressive muscle relaxation (PMR) – the systematic tensing and relaxing of specific muscle groups throughout the body (Jacobsen, 1938; Bernstein & Borkovec, 1973), and (b) autogenic training – the use of self-statements of feelings of warmth and heaviness to achieve a state of deep relaxation (Schulz & Luthe, 1969). The research literature has not indicated that one method of relaxation training is more effective than the other. A typical relaxation training protocol consists of 10 sessions, with many clinicians using fewer when treating uncomplicated headache problems. PMR typically begins with 16 muscle groups. As the sessions proceed, muscle

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groups are combined to reduce the number to 7 groups, and then 4 groups. Later stages of training are geared towards incorporating relaxation techniques into daily living, thus making them a portable coping skill designed to reduce stress and muscle tension. Relaxation by recall (relaxation of muscles without tensing them first) and cue-controlled relaxation (association of relaxation with a cue word such as ‘relax’) are introduced. Patients are taught to use these skills as preventative rather than abortive techniques. Relaxation training is typically accompanied by instructions to practice 30 minutes daily at home and audiotapes are usually provided to assist the patient in learning relaxation skills.

Biofeedback Training

Biofeedback training uses electronic instruments to provide information about physiological responses typically in an audio or visual display. This information or “feedback” is used by the patient in learning to self-regulate the response being monitored. Two types of biofeedback are frequently employed in the treatment of recurrent headache disorders: (a) electromyographic (EMG) biofeedback – feedback of electrical activity typically from muscles of the forehead, face, or neck – most often used in treating tension-type headache to reduce muscle tension in treating tension-type headache; and (b) thermal or handwarming biofeedback – feedback of skin temperature usually from a finger – typically used in treating migraine. EMG biofeedback training has been combined with relaxation training administered either concurrently or sequentially. A typical biofeedback training protocol consists of 5 to 25 sessions. As with relaxation training, various brief techniques are taught to incorporate biofeedback into every-

This article is part of the continuing series on Empirically Supported Treatments. Treatments selected to be reviewed here are based upon the work of the Division 12 Task Force on Psychological Interventions. Correspondence/suggestions concerning the series can be addressed to the series Editor: William C. Sanderson, PhD, Rutgers University, Department of Clinical Psychology, Piscataway NJ 08854.

day situations to reduce stress, thereby preventing headaches. Biofeedback training is usually accompanied by instructions to practice relaxation at home for about 30 minutes daily.

Cognitive-behavioral stress-management training

The use of cognitive-behavioral stress-management training for the treatment of recurrent headache disorders is based upon the observation that the individual's methods of coping with everyday stressors can precipitate, exacerbate and maintain headache episodes, or increase headache-related disability and distress. Thus, cognitive-behavioral stress-management training focuses on increasing the patient's understanding of the role of cognitions in stress responses, and relationships between stress, coping, and headaches. Before initiating stress-management training, the therapist provides the patient a rationale for this therapy and typically administers relaxation and/or biofeedback interventions. Cognitive restructuring techniques are used to teach patients to identify and challenge dysfunctional thoughts, and subsequently the underlying maladaptive assumptions and beliefs. Pain management strategies such as imagery, attention-diversion, and pain transformation are also often presented. A typical cognitive-behavioral stress-management protocol consists of 3 to 12 sessions.

II. Summary of Studies Supporting Treatment Efficacy

Relaxation training, biofeedback therapies, and cognitive-behavioral stress-management training have been evaluated in over 100 studies. However, these studies have been conducted primarily in headache clinics or in specialized university or medical school settings and have generally been small, averaging 20 patients per treatment group in migraine studies and only about 10 patients per treatment group in tension-type headache studies (Holroyd & Penzien, 1986, 1990). Information about outcomes that can be expected when behavioral therapies are integrated into busy primary care or general neurology settings, or when these therapies are administered conjointly with pharmacological therapies remains limited.

There is considerable evidence from both meta-analytic and narrative reviews that relaxation training, biofeedback therapies, and cognitive-behavioral stress-management training produce clinically significant reductions in headache activity (Blanchard, 1992; Holroyd & Penzien, 1986; McCrory, Penzien, Rains, & Hasselblad, 1996). In general, the improvements reported with relaxation training, biofeedback therapies, and cognitive-behavioral stress management have been at least three times as large as improvements reported with placebo control treatments.

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In the treatment of tension-type headache, relaxation training, EMG biofeedback, combined relaxation training and EMG biofeedback, and cognitive-behavioral stress management have each yielded about a 50% reduction in headache activity. Moreover, the addition of cognitive-behavioral stress-management interventions can enhance the effectiveness of relaxation training for a significant number of patients (for review, Blanchard, 1992). This may occur when psychological or environmental problems, such as chronic daily stress, depression, or other adjustment problems, that are not effectively addressed by relaxation or biofeedback training exacerbate headaches or prevent patients from effectively using self-regulation skills.

In the treatment of migraine, meta-analysis has suggested that combined relaxation/thermal biofeedback training yields about a 50% reduction in migraine activity, with relaxation training and biofeedback therapy alone yielding somewhat smaller improvements. However, the few individual studies that have directly compared the effectiveness of combined relaxation training and thermal biofeedback to either relaxation training alone or biofeedback alone have not consistently supported the superiority of the combined therapy (for review see Blanchard & Andrasik, 1987). Differences in treatment efficacy may have been obscured by the utilization of different treatment protocols and different patient populations across studies. Additionally, some of the studies appear to have included too few patients to possess adequate statistical power, while others have included a significant number of patients unlikely to benefit from behavioral treatment (e.g., patients with chronic substance induced headache). Thus, the hypothesis that combined relaxation/thermal biofeedback training is more effective than either relaxation or biofeedback training alone must be considered tentative.

Cognitive-behavioral stress-management is also effective for the treatment of migraine. In the subset of studies included in the McCrory et al. (1996) meta-analysis, stress-

management training yielded improvements in migraine activity that were very similar in magnitude to improvements reported with relaxation and thermal biofeedback therapies alone. However, studies that have asked if the addition of cognitive-behavioral stress-management interventions enhance the effectiveness of relaxation or thermal biofeedback training for the treatment of migraine have found no evidence of an additive effect (for review see Blanchard, 1992).

Initial reductions in headache activity of 50% or greater achieved by behavioral therapies for headache appear to endure well after treatment is completed. In all but one study that employed daily headache recordings, reductions of 50% or greater were still observed up to 1-3 years post-treatment (Blanchard, 1987, 1992; Holroyd & French, 1995 for reviews).

Information about the effectiveness of behavioral therapy for headaches in children and adolescents is quite limited. Nonetheless, available studies suggest some behavioral treatments are as effective or more effective with children or adolescents than with adults. Thermal biofeedback training alone and combined relaxation training and thermal biofeedback therapy appear particularly effective in controlling migraine in children and adolescents (see for review Hermann, Kim, & Blanchard, 1995). For example, one study of children 8 to 16 years of age reported an 82% reduction in migraine activity with relaxation training combined with thermal biofeedback compared to a 45% reduction with relaxation training alone (Blanchard & Andrasik, 1985). Less is known about the efficacy of behavioral therapy for tension-type in children and adolescents. Nonetheless, the available data is encouraging. In a reanalysis of data from three controlled studies, Larsson and colleagues (1988) report that therapist-administered relaxation training produced larger improvements (63% reduction in what appear to have been episodic tension-type headaches) in adolescents (aged 16 to 18) than group discussion or information only treatments designed to control for therapist contact and other nonspecific aspects of therapy.

Few studies have tested the efficacy of behavioral treatments with older adults. However, studies that have adjusted protocols to include detailed verbal and written explanations of treatment procedures, frequent reviews of the material covered, and additional time to practice elementary skills before more advanced skills are introduced have yielded reductions in headache activity similar to those reported for other adults, particularly with combined relaxation training and cognitive-behavioral stress management (Arena, Hannah, Bruno, & Meedor, 1991; Arena, Hightower, & Chong, 1988; Mosley, Grotheus, & Weeks, 1995).

Behavioral therapies have been found to be effective for the treatment of headache during pregnancy, and equally effective in managing menstrual migraine as they are for nonmenstrual migraine (for review see Holroyd & Lipchik, 1997).

Research suggests that behavioral therapies alone are only minimally effective when headaches are continuous or near daily, or when patients are abusing or over-using medication. The presence of co-morbid psychopathology may also limit the effectiveness of brief interventions though evidence is limited (for review see Holroyd, Lipchik, & Penzien, 1998).

For many patients, behavioral therapies can be administered effectively in limited-contact or group treatment formats. In limited-contact or "home-based" treatment, behavioral therapies are introduced in 3-4 monthly clinic sessions, and written materials and audiotapes are provided to assist patients in acquiring self-regulation skills at home. For both adolescents and adults, limited-contact behavioral therapies have proven as effective as therapist-administered clinic-based treatment and are much more cost-effective (see reviews by Haddock et al., 1997; Hermann et al., 1995; Nash & Holroyd, 1992; Rowan & Andrasik, 1996). Similarly, group treatment appears to be effective (Rains, Penzien, & Holroyd, 1993).

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IV. Resources for Training

Training seminars and workshops are occasionally offered at the annual meetings of the Society of Behavioral Medicine (7611 Elmwood Avenue, Suite 201, Middleton, Wisconsin 53562, phone 608/827-7267) and the Association for the Advancement of Biofeedback and Psychophysiology (10200 W 44th Avenue, Suite 304, Wheat Ridge, Colorado 80033, phone 303/422-8436). ■

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Appreciation to Reviewers

A number of individuals have contributed their time and expertise in reviewing articles for The Clinical Psychologist this past year. We express our gratitude and appreciation to:

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Society News



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Distinguished Professional Contributions Award Named for Florence Halpern, PhD

Gloria B. Gottsegen, PhD
Section Representative, Section IV - 1998

At the suggestion of Section IV, (The Clinical Psychology of Women) the Board of Directors of the Society voted unanimously to name this prestigious award for Florence Halpern, PhD.

Florence Halpern, (1900-1981) was a distinguished former President of Division 12, who also represented the Division on the APA Council of Representatives. She was a recipient of the award in 1973.

She has been described as the "grandmother of psychology" in New York where she trained generations of psychologists at the NYU Clinical Psychology Program, at the NYU Medical School, at Columbia University, and at Bellevue Psychiatric Hospital.

In addition to her leadership in Division 12, her contributions to organized psychology included the Presidency of the New York Society of Clinical Psychology, Presidency of the New York State Psychological Association and membership for 9 years on the first NY State Psychology Board. She was instrumental in formulating the state's first licensing law.

A Diplomate of the American Board of Psychology, she maintained an active practice testing children which led to one of her books, *A Clinical Approach to Children's Rorschach* in 1953. An earlier book (with Ruth Bockner) was entitled *Clinical Application of the Rorschach Test*.

A little known but important aspect of her life was her activity in the civil rights movement. At the age of 68, she moved to Mound Bayou, Mississippi where she served as staff psychologist for the Tufts University School of Medicine Delta Health Center for three years! This experience led to another book, *Survival: Black/White* in 1973.

A small measure of the esteem in which she was held by her professional colleagues was the publication of a full-page obituary in the *American Psychologist* by Ruth Ochroch and Bernard Kalinkowitz in December 1982.

The Society is making plans for a celebratory reception at the APA annual meeting in Boston to honor her memory. Family, former graduate students and Mississippi co-workers will be invited to share their memories of this wonderful woman at the initial presentation of the award in her name.

Division 12 Net

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Clinical Psychology Brochure

The popular brochure "What Is Clinical Psychology" is available from the Society 12 Central Office. It contains general information about Clinical Psychology, and is suitable for both the general public and high school/college students. The cost is \$15 per 50 brochures. Orders must be pre-paid. For more information, contact: Society 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082. (303) 652-3126. Fax (303) 652-2723, Email: <lpete@indra.com>

Research Training Institute in Psychology of Aging: Cohort 2

Nationally recognized experts in research methodology related to the psychology of aging will lead a training institute specifically designed for psychology faculty from 4-year colleges who received their doctoral degree at least 5 years ago. The institute, sponsored by APA's Division 20, and funded by the National Institute on Aging, aims to strengthen participants' knowledge and skills essential for developing an active agenda and integrating research in aging with teaching. The institute will be held in Duluth, MN, overlooking beautiful Lake Superior, from July 25 to August 6, 1999, with on-call consultation available during 1999-2000. The participants will also have the opportunity to interact with the members of the first cohort and to review their proposals. In addition, participants will attend a one-week follow-up institute in summer 2000. Food, lodging, and travel support will be provided for the 15 applicants selected to participate in the program.

For details and application materials, please contact Chandra M. Mehrotra, Director, Research Training Institute, The College of St. Scholastica, 1200 Kenwood Ave., Duluth, MN 55811; cmehrotr@css.edu. Please see the web page (www.css.edu/depts/grad/nia) for additional information about the institute.

Thank you for any assistance you can give us.

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2000 APA Scientific Awards Program Call for Nominations

The American Psychological Association (APA) invites nominations for its 2000 awards program. The Distinguished Scientific Contribution Award honors psychologists who have made distinguished theoretical or empirical contributions to basic research in psychology. The Distinguished Scientific Award for the Applications of Psychology honors psychologists who have made distinguished theoretical or empirical advances in psychology leading to the understanding or amelioration of important practical problems. To submit a nomination for the Distinguished Scientific Contribution Award and the Distinguished Scientific Award for the Applications of Psychology, you should provide a nomination form, nominee's current vita with list of publications, letter of nomination, up to five representative reprints, and the names and addresses of several scientists who are familiar with the nominee's work.

The Distinguished Scientific Award for Early Career Contribution to Psychology recognizes excellent young psychologists. For the 2000 program, nominations of persons who received doctoral degrees during and since 1990 are being sought in the areas of animal learning and behavior, comparative; developmental; health; cognition/human learning; and psychopathology. To submit a nomination for the Distinguished Scientific Award for Early Career Contribution to Psychology, you should provide a letter of nomination, nominee's current vita with list of publications, and up to five representative reprints.

To obtain nomination forms and more information, please contact Suzanne Wandersman, Science Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242; by phone, (202) 336-6000; by fax, (202) 336-5953; or by e-mail, swandersman@apa.org. The deadline for all award nominations is June 1, 1999.

Announcement of the 1999 Award Competitions of the Society

The Society for General Psychology (formerly APA's Division of General Psychology) announces its 1999 awards program to recognize outstanding achievements in General Psychology. In addition to its prestigious William James Book Award, the Society sponsors two other awards—the Ernest R. Hilgard Award recognizing lifetime contributions to General psychology and the George A. Miller Award given for an outstanding recent article in General Psychology. In each case the awards include a plaque or certificate and a cash prize—\$500 for the Hilgard and Miller awards and \$1,000 for the William James Book Award.

For all of these awards, the focus is on the quality of the contribution and the linkages made between the diverse fields of psychological theory and research. The Society for General Psychology encourages the integration of knowledge across the subfields of psychology and the inclusion of contributions from other disciplines. The Society is looking for creative synthesis, the building of novel conceptual approaches, and a reach for new integrated wholes. A match between the goals of the Society and the nominated work or person will be an important evaluation criterion.

Self-nominations are encouraged for these awards as well as nominations by others. For the Hilgard Award, nominators are asked to submit the candidate's name and vitae along with a detailed statement indicating why the nominee is a worthy candidate for the award and supporting letters from others who endorse the nomination.

For the Miller Award, nominations should include: vitae of the author(s), four copies of the article being considered (which must have a post-1993 publication date), and a statement detailing the strength of the candidate article as an outstanding contribution to General Psychology.

Nominations for the William James Award should include four copies of the book (dated post-1993 and available in print); the vitae of the author(s) and a one-page statement that explains the strengths of the submission as an integrative work and how it meets criteria established by the Society. Textbooks, analytic reviews, biographies, and examples of applications are discouraged.

Winners will be announced at the fall convention of the American Psychological Association the year of submission. Winners will be expected to give an invited address at the subsequent APA convention and also to provide a copy of the award address for inclusion in the newsletter of the Society.

All nominations and supporting materials for each award must be received on or before May 1, 1998. Nominations and materials for all awards and requests for further information should be directed to General Psychology Awards, c/o c. Alan Boneau, Department of Psychology, George Mason University, Fairfax, VA 22030. Phone: 703-993-4118; Fax: 301-320-2845; Email: aboneau@gmu.edu.

APA Science Directorate Accepting Proposals for OHP Curriculum Development

The APA Science Directorate is now accepting applications from universities interested in developing courses or curricula in the area of occupational health psychology (OHP). In the broadest terms, OHP refers to the application of psychology to protecting and promoting safety, health, and well being of workers, and to improving the quality of worklife. Awards are expected to range between \$18,000 - \$22,000. Currently funded sites may submit new proposals for a possible second-year continuation of their program (depending on quality and feasibility of the pro-

posal). Completed applications must be received by March 1, 1999. Administration of the grants will be staffed through the APA Science Directorate. Individuals and departments interested in obtaining application materials should contact Adonia Calhoun or Heather R. Fox, PhD at APA, 750 First Street, NE, Washington, DC 20002-4242 (E-mail: acalhoun@apa.org; hrfox@apa.org) Applications can also be found on the APA web site after October 15 at <http://www.apa.org/science/ohp.html>.

*Minutes of the Division 12 Board of Directors Meeting**

January 8, 1999

The Division 12 Board of Directors met on Friday, January 8, in Savannah, GA. The meeting was called to order by President, Dr. Thomas Ollendick. The agenda was quite full and there were many discussions about various topics. Among these were:

I. The announcement of the Division's award winners:

Florence Halpern Professional Award: Jerome Resnick

Distinguish Scientific Award: Gordon Paul

David Shakow Early Career Award: Patricia Arean

Theodore Blau Early Career Award: Juan Gonzales

II. The need to increase membership. Sections I and V will be dissolved when they move to division status. Though section leaders have tried to reassure the board that this change should not impact membership because many intend to maintain their membership, the board remains optimistically cautious. The division needs to actively recruit new PhDs as well as the many clinical psychologists who are members of APA but not of Division 12. A motion was passed to have the President sent a letter to the Chair of the Medical School Professors group to seriously consider being organized as a new section of the Society.

III. The progress of the Convention Program with submissions of 31 symposia and 276 posters and the Postdoctoral Institutes with 16 presentations. A motion was brought forth by President-elect that the chair of the PDI, a subcommittee of the Program Committee, will be appointed for a 2-year period, beginning with the 2002-2003 appointment. (This person will serve as the Associate Chair in 2001.) Responsibilities of this Chair include serving as an Associate Chair for a year prior and a year subsequent to serving as Chair. These appointments continue each year based on the approval of the Board upon recommendation of the President. Funds shall be paid from the PDI expense budget line to provide for 3 nights lodging during the annual APA Convention for both the Chair and the Associate Chair. This motion was passed unanimously. Relating to the APA Convention, another motion was also passed that the Hospitality Suite have a separate program manager, and that this be established as a subcommittee of the Program Committee. Provisions will be made for three nights lodging.

IV. The status of the 1999 and 2000 Budget led to a motion to set the assessment in the year 2000 for members at \$50 and for students at \$25. The current assessment has been maintained for seven years. The cost of the journal is expected to increase and the Clinical Psychologist will need to maintain its 1998 budget of \$25,000. A motion was passed to increase the 1999 budget by \$4,000 for this purpose.

V. A strategic task force will be put together by the President to implement a motion passed at the October meeting that all sections, committees, and task forces of Division 12 strive to include persons who represent the ethnic and gender diversity of the Society of Clinical Psychology. This task force will also address the recommendation made by the Nominations and Elections Committee to draft a By-laws amendment to establish one slate for the Council of Representatives for ethnic minority nominees.

VI. All sections provided reports. Section VI requested that the Board endorse a "Multicultural Resolution" to be brought forth at the Multicultural Summit on January 28-30 at Newport Beach, CA. The resolution recommended that expertise in multicultural competence is needed in delivery of services systems. Section VII, Emergencies and Crises, was welcomed to the Society.

Respectfully submitted,

Elsie Go Lu, PhD

*A complete set of minutes of this meeting will be available from the Division 12 office once they have been approved at the May 1999 Board meeting.

1998 SSCP Internship Directory

The 1998 SSCP Internship Directory is now available. This 5th edition of the Directory has been fully revised with updated information on all internships listed. Edited by Jack J. Blanchard, the 298 page Directory provides detailed information on 149 internship programs including:

- A. Research activity of internship faculty
- B. Recruitment of interns
- C. Facilities and resources such as computers, travel funds, time for research
- D. Expectations for research by interns
- E. Research productivity of prior interns
- F. Job placements of prior interns
- G. Availability of training in 72 empirically supported psychological interventions (updated list from Chambless et al., 1998)

New to this edition is information on what Internship Directors look for in their review of intern applicants. Directors were asked to rate (1=not at all, to 5=very important)

the importance of an applicant's training in 1) research, 2) objective personality assessment, 3) projective assessment, and 4) behavioral assessment and the use of structured interviews.

The cost of the 1998 Directory is \$15 (that includes postage and handling). Proceeds are used to support the activities of SSCP including student dissertation awards, student poster sessions, and future editions of the Directory.

To order, please use the printable form located on the SSCP web page:

<http://www.sscp.psych.ndsu.nodak.edu/> and send to:

Paul D. Rokke, PhD
SSCP Book Order
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North Dakota State University
Fargo, ND 58105-5075

Position Openings

UNIVERSITY OF MIAMI invites applications for a tenure track Assistant Professor position in child, adult or health psychology to begin August, 1999. The strength of the person's academic record is more important than the particular interest area. The successful candidate will have a PhD in Psychology and show promise as an excellent classroom instructor and researcher. The department is especially interested in candidates who can work effectively in its minority-focused community-based research programs. Duties include teaching at the graduate and undergraduate levels, establishing an independent research program, mentoring graduate students, and maintaining involvement in community affairs. The University of Miami is a private, independent research university with over 13,000 undergraduate and graduate students. The Department of Psychology has 40 full-time faculty members and has graduate programs in: applied developmental, behavioral medicine, behavioral neuroscience, adult clinical, child clinical, pediatric-health, and health clinical psychology. The department is located on the University's suburban Coral Gables campus, with additional facilities located on the Medical School campus. Opportunities are available for research with varied ethnic, adult, child, pediatric and elderly populations. Applicants should send a

vita, statement of research interests, available reprints, and three letters of recommendation to the Search Committee, Department of Psychology, P. O. Box 248185, Coral Gables, Florida 33124. Applications will be reviewed as received and the review process will continue until the position is filled. Minorities and women are strongly encouraged to apply. The University of Miami is an equal opportunity affirmative action employer.

POSTDOCTORAL FELLOWSHIPS IN PTSD. Two one-year fellowships available through the multidisciplinary PTSD Training Program at the National Center for PTSD, Pacific Islands Division of Honolulu Veterans Affairs Medical and Regional Office Center. Training includes working with veterans in outpatient and inpatient settings, weekly didactics in PTSD, and opportunities to be involved with PTSD research. Qualifications include: U.S. citizenship, earned doctorate from an APA-approved program by start date and completed APA-approved internship. Appointment begins September 1, 1999. Stipend for the current year (40 hours per week for the full year) is \$36,000 before taxes, including ten paid federal holidays, 13 days of annual leave, and 13 days of sick leave if needed. Request application packet from: Education Program Coor-

dinator, Department of Veterans Affairs, NC-PTSD, Pacific Islands Division, 1132 Bishop Street, Suite 307, Honolulu, HI 96813, Fax (808) 566-1885. Applications available on website: <http://www.dartmouth.edu/dms/ptsd/>. Complete applications must be received by February 26, 1999. VA is an Equal Opportunity Employer.

Want ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of *The Clinical Psychologist*. Ads will be charged at \$2 per line (approximately 40 characters). Submission deadlines are February 15, May 15, September 15, and November 15. Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, and advertisement to Wanda Kapaun, Assistant to the Editor of TCP, wkapaun@plains.nodak.edu, North Dakota State University, Department of Psychology, Minard Hall 115, Fargo, ND 58105-5075.

Join a Division 12 Section

Division 12 has six sections that reflect the wide range of interests in the Division. There are separate memberships, and dues vary. If interested, contact the Section Membership Chairs listed below or the Division 12 Central Office.

Clinical Child Psychology (Section 1)

John Piacentini, PhD, UCLA Neuropsychiatric Institute, 760 Westwood Plaza, Room 68-251A, Los Angeles, CA 90024

Clinical Geropsychology (Section 2)

Peter Litchenberg, PhD, Rehabilitation Institute of Michigan, 261 Mack Boulevard, Detroit, MI 48201

Society for a Science of Clinical Psychology (Section 3)

Michael E. Addis, PhD, Dept. of Psychology, Clark University, 950 Main Street, Worcester, MA 01610

Clinical Psychology of Women (Section 4)

Sue Schmidt, PhD, 525 Almar Avenue, Pacific Palisades, CA 90272

Society of Pediatric Psychology (Section 5)

Kathleen Lemanek, PhD, Depts. Of Psychology, Human Development and Family Life, University of Kansas, Lawrence, KS 66045

Clinical Psychology of Ethnic Minorities (Section 6)

Michelle Cooley-Quille, PhD, Department of Mental Hygiene, Hampton House, Johns Hopkins University, 624 North Broadway, 8th Floor, Baltimore, MD

The Clinical Psychologist

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