



Division 12

CLINICAL SCIENCE

Society for the Science of Clinical Psychology
Section III of the Division of Clinical Psychology of
the American Psychological Association

developing clinical psychology as an experimental-behavioral science



Newsletter

Winter 2006 Issue

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INSTRUCTIONS FOR AUTHORS

Clinical Science is published as a service to the members of Section III of the Division of Clinical Psychology of the American Psychological Association. The purpose is to disseminate current information relevant to the goals of our organization.

Feature Articles may be submitted to the editor via e-mail. They should be approximately 16 double-spaced pages and should include an abstract of 75- to 100- words.

Brief Articles may also be submitted, and should also include a 75- to 100-word abstract.

All articles should be submitted as an attachment to an e-mail and formatted according to the *Publication Manual of the American Psychological Association, 5th edition*.

Editor: William Horan, horan@ucla.edu

Articles published in *Clinical Science* represent the views of the authors and not necessarily those of the Society for a Science of Clinical Psychology, the Society of Clinical Psychology, or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

President's Column:

Antonette M. Zeiss, Ph.D.
 V.A. Central Office, Washington, D.C.
 Email: Antonette.Zeiss@va.gov

I am delighted to be writing the first of the columns I will offer as President in 2006 of the Society for a Science of Clinical Psychology (SSCP). Let me begin with some introduction. I know many of you who are members of SSCP, and I have been a member since I joined APA as a full member in 1977, but many of you may not know me. After a brief sojourn in academia, I have spent most of my career in the Veterans Affairs health system, combining roles as clinician, administrator, researcher, and training director/supervisor. For 23 years, from 1982 to 2005, I worked at the VA Palo Alto Health Care System, an institution I have experienced as standing for excellence in research, education, and provision of evidence-based clinical care.

Over those years, I developed increasing ties to VA Central Office in Washington, DC, particularly through roles with the Office of Academic Affiliations, which funds training for all professions in VA, and the Office of Mental Health Services, which guides national policy in mental and behavioral health care and has oversight to ensure that high quality care is delivered nationally. Recently, at the end of September, 2005, I moved cross-country with my beloved and supportive husband (also a career-long member of SSCP) to begin a new position as the Deputy Chief Consultant in the Office of Mental Health Services, based in Washington, DC. It is now my job to guide those policy and service delivery efforts for VA nationally in mental and behavioral health care. As I go through the next year, both newly in this job and newly in the role of SSCP President, I want these roles to inform each other. My efforts as SSCP President need to be informed by this new work role, and my efforts as Deputy Chief Consultant need to be informed by the principles that define SSCP.

SSCP stands for principles that have been central to my career and what I believe professional psychology should embrace. Our web site presents this clearly: "**The common bond of the membership is a commitment to empirical research and the ideal that scientific principles should play a role in training, practice, and establishing public policy for health and mental health concerns.**" That is my theme for the year. SSCP exemplifies the idea that we need a science of clinical psychology, and that science should guide our training

efforts and clinical practice. But there is more - i.e., the idea that clinical research should be used in setting and implementing public policy; we need to make sure that science is used *as a matter of policy*, not just in our personal training and clinical efforts. How to go about doing that is enormously challenging, but this organization can be one locus for such efforts.

I also have the exciting and daunting opportunity to guide such efforts for an enormous health care system that is also the only national health care system in the United States. In this first column, I plan to lay out a sequence that has been followed in the VA system to create policy related to mental and behavioral health care, not just for Psychology but for the full interdisciplinary effort that such care requires. This sequence is one that could be used by any organization, including graduate training programs, other health care delivery systems, research programs, etc. I offer this not to laud VA, but to provide a road map that I believe can help SSCP members explore the role of influencing public policy, both within APA and in any setting where health care is planned, offered, or evaluated.

The process for VA began with the development of the President's New Freedom Commission on Mental Health Report in 2003. This Commission grappled with the current state of mental health care in the US, and their report begins with the sobering, but candid, words, "The system is fragmented and in disarray." They go on to say, "To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America." Their recommendations for creating that transformation of mental health care in the US are built around six goals:

- Goal 1. Americans understand that mental health is essential to overall health
- Goal 2. Mental health care is consumer and family driven
- Goal 3. Disparities in mental health services are eliminated
- Goal 4. Early mental health screening, assessment, and referral to services are common practice
- Goal 5. Excellent mental health care is delivered

and research is accelerated

- Goal 6. Technology is used to access mental health care and information

All of these are goals that SSCP members could embrace, and the research done by many SSCP members has helped to develop approaches captured in the details of the full report. For now, I want to emphasize Goal 5, "Excellent mental health care is delivered and research is accelerated," because it has even more relevance to SSCP than is captured in that brief label. The philosophy guiding this goal is that "excellent mental health care" is evidence-based mental health care. Further, the goal is to accelerate dramatically the translation of research findings into care actually provided for mental health problems. Specifically, the report calls for some radical changes that echo the radical messages I believe SSCP has been sending since its inception:

- Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses
- Overcome the 15- to 20-year lag between discovering effective treatments and incorporating them into routine practice, i.e., move from science to service and from the field back to science
- Advance evidence-based practices (EBPs) using dissemination and demonstration projects and create a public-private partnership to guide their implementation
- Change reimbursement policies to more fully support EBPs
- Improve and expand the workforce providing evidence-based mental health services and supports
- Train more mental health professionals in evidence-based and emerging best practices

In summary, this commission report calls for transforming mental health care in this country in many ways, including exactly the items I cited above from the SSCP website, defined there as our "common bond": "commitment to empirical research and the ideal that scientific principles should play a role in training, practice, and establishing public policy for health and mental health concerns."

So the President's New Freedom Commission on Mental Health Report (PNFCMHR) is the starting place – Step 1 – on the road map I offer for those who are interested in expanding SSCP's role (or their own personal role) in public policy. The next step is to adapt the general goals in that report to the specific needs of your organization. VA did that soon after release of the report. In the fall of 2003, a work group was established to create an action agenda for VA to implement the PNFCMHR throughout the VA system. That work group's report, "Action Agenda: Achieving The Promise, Transforming Mental Health Care In VA," was released in December, 2003. It presented specific recommendations for action, built around the six

overarching goals of the PNFCMHR, as adapted to be relevant for VA. I worked on a component of that VA report, which focused on care for older veterans, with particular emphasis on improved integration of mental health and physical health care. The report had a wide array of other recommendations, with special emphasis on implementing a psychosocial rehabilitation model of care for veterans with serious mental illness, in contrast to a traditional model of symptom control focused care. The action agenda also incorporated many suggestions related to Goal 5 of the PNFCMHR, concerning evidence-based mental health service delivery. For example two of the suggestions were:

- Develop a knowledge management system to disseminate almost real-time, program specific education that will keep staff continuously apprised of new information on best practices and research.
- Implement an improved Clinical Practice Guideline (CPG) process to reduce the time between initiation of development and release of a CPG and ensure timely, periodic updates.

Such adaptation to the context of a particular organization or program is Step 2 on the road map. For some systems, especially less complex ones, that may lead directly to a third step, involving active implantation of a well-crafted series of action steps. In VA, a definitely complex system, it became clear that another step was needed first, i.e., the development of a more thorough, comprehensive Mental Health Strategic Plan. This plan was developed in 2005 and approved in November of that year. The plan drew on the PNFCMHR, on other data generated within VA concerning gaps in behavioral health services, on reports related to the growing importance of the Psychosocial Rehabilitation model for treatment of individuals with SMI, on information about likely care needs of returning troops from Iraq and Afghanistan, on interdisciplinary models for integrating primary care and mental health care, and on the evidence-base for best practices in mental health services. This plan has over 250 action steps, including all of the items from the Action Agenda (step 2 of the road map), expanded to provide a truly comprehensive plan for transforming VA mental and behavioral health care over the ensuing five year period. Thus Step 3 on VA's road map has been the development of a very specific and expansive strategic plan, since policy changes need to be complex and comprehensive and involve implementation across diverse circumstances over a large area.

My engagement as a member of the strategic plan development work group triggered my desire, seen as irrational by many, to leave a beautiful part of the country that had been my life-long home, working in a stellar institution, with family living close by, to come to VA Central Office and take part in creating that transformation. In future columns I want to talk more about that process of actually implementing a well-developed public policy. That task is

daunting and exhilarating and will absorb my efforts over the next few years. My commitment to SSCP's values has helped guide my work thus far on this change in VA mental health care policies and practice. In prior chapters of my career, I have focused on the first three elements of the SSCP "creed"; I have organized my career around a commitment to empirical research and the ideal that scientific principles should play a role in training and practice. Now I have the opportunity to take on the more difficult challenge embodied in the last part of that "creed": to work toward establishing public policy for health and mental health concerns, based on the implementation of scientific principles and empirical research.

As I face that task, I also want to come back to my opening words concerning wanting to use SSCP membership as a resource for this process. In his excellent recent Presidential Column for Division 12, Jerry Davison ends by asking members to think about important questions that have been on his mind, in a spirit of "Auseinandersetzen" (a word that is pretty daunting itself) – roughly translated as engaging in a thoroughgoing analysis and passionate discussion, and studying a complex issue from all possible angles. I will ask different questions, but in the same spirit. Over the year of my Presidency, I want to know what members think about the questions I pose, what experiences they have had that could help inform my

path, and what actions they think SSCP can promote to meet its goal of "establishing public policy." For now, I invite members to think about the following three questions, and to send messages in response to SSCPNET or to me personally (Antonette.Zeiss@va.gov).

1. Which of the principles in SSCP's "common bond" guided you to join this organization, and how do you pursue these principles in the work you do?
 - Commitment to empirical research
 - Ideal that scientific principles should play a role in training
 - Ideal that scientific principles should play a role in practice
 - Ideal that scientific principles should play a role in establishing public policy for health and mental health concerns.
2. Which of these principles have you *not* included in your professional roles, and why not?
3. Are you interested in expanding in any way to embrace more of SSCP's "common bond" as part of your professional life?

I look forward to hearing from you about these questions or other issues you think SSCP should be addressing. I also look forward to sharing more about the task of implementing policy change in the next SSCP Newsletter.

2006 SSCP Election Results

Congratulations to:

Daniel Klein
President-Elect

E. David Klonsky
Division 12 Representative

Student Representative's Column:

Careers in Clinical Psychology

Eva M. Epstein

Temple University

Most graduate students in clinical psychology begin graduate school with a specific career path in mind. However, some students find themselves rethinking their career goals during the course of their graduate education as a result of exposure to various clinical and research training opportunities. In order to make progress towards selecting a career path many students feel that they must declare themselves either solely research or practice oriented and that these early career choices are mutually exclusive. Although having a sense of the type of work one would like to pursue and obtaining the relevant experiences during one's graduate education is ideal, a doctorate degree in clinical psychology is appealing, in large part, because of the career flexibility this degree affords. Indeed, it is not feasible to write a newsletter article that outlines the various career choices that are available for clinical psychologists. However, the purpose of this article is to highlight some of the career choices that are available, which include some that many students may not have considered.

Traditional careers for clinical psychologists, such as working as a practitioner within a mental health clinic, private practice, or medical center, or working within an academic environment remain viable career choices. However, as the field continues to grow so do the career choices. Clinical psychologists now play a pivotal role in primary care settings, primary school systems, the military, and the corporate environment.

Universities

If a graduate student believes she might want to pursue a career as a faculty member it would be wise to gain some teaching experience. This type of experience will help prepare one for a faculty position but, more importantly, such experience will also be critical in determining whether one is suited for a career in teaching. That said, faculty positions in universities and colleges widely vary. Some positions place an emphasis on research productivity, whereas other positions place the greatest emphasis on teaching with an emphasis on research being small to nonexistent. Most often, the emphasis on teaching will be reflected by the type of institution (e.g., liberal arts college) as well as the number of courses one is expected to

teach each semester. Faculty positions that place an emphasis on research do not typically require that a faculty member teach more than two courses per semester and may encourage course buy-outs when a faculty member has the means to do so.

Mentoring is important for almost all faculty positions, but the population that one is mentoring also varies according to the type of institution. University settings that have a graduate program in clinical psychology will place an emphasis on mentoring of graduate students, whereas liberal arts colleges will expect faculty to spend considerable time mentoring undergraduate students. Although teaching is an important component of a faculty members' responsibilities at a research-oriented university setting, most often the type of people that pursue these types of academic positions are largely interested in a research career.

Students tend to forget about the academic positions that emphasize teaching, though these types of positions are excellent career options for clinical psychologists. For both types of academic positions, faculty members are typically hired on tenure-track lines. This means that faculty will be considered for tenure after several years (typically in the 6th year). Again, criteria for tenure evaluation will depend on the type of setting (e.g., research productivity and scholarship, quality of teaching), but the standards required for tenure are made clear to faculty early on in the process. Of course, the appeal of acquiring tenure is that it affords job security that is not typically found in other professional positions.

For some clinical psychologists, pursuing a research career within a university medical center makes the most sense because of their research interests (e.g., pediatric psychology, schizophrenia, oncology). As with university-based psychology department positions, the types of positions a clinical psychologist can obtain within a university medical center can widely vary, with some positions placing a high emphasis on research, other positions focusing solely on practice, and still other positions emphasizing the importance of both research and practice. Although a clinical psychologist can obtain a position

on a psychiatric unit within a medical center, there are also a variety of positions in which a psychologist can work more broadly within the medical center. For instance, clinical psychologists are frequently called upon for consultations on medical units to assist with various issues such as dealing with "difficult" patients, counseling patients with terminal illnesses, facilitating treatment adherence, assessing a patient's ability to make medical decisions, and teaching patients relaxation skills (e.g., chronic pain patients). These various roles highlight the ways in which medical staff and clinical psychologists can collaborate to better serve the needs of patients.

Medical centers and other medical settings

For clinical psychologists who specialize in health psychology, pursuing a career in a medical center environment often makes the most sense. Individuals with such specialization might work within a multi-disciplinary team on a transplant unit, cardiovascular unit, pediatric unit, chronic pain center, sleep disorders center, oncology clinic, or rehabilitation clinic to name but a few.

Emergency rooms are another place within the medical center setting in which clinical psychologists can play a critical role in patient care. That is, a clinical psychologist can provide crucial consultation services to the medical team in the emergency room through performing diagnostic assessments and recommending further psychological evaluation or treatment for patients in extreme psychological distress. Clinical psychologists in emergency rooms are also often the first source of assessment and treatment for individuals who have experienced traumatic events such as natural disasters, accidents and sexual/physical assaults.

Whereas psychosocial therapy services on medical units are typically time limited and just one aspect of the type of services clinical psychologists provide, within psychiatric units clinical psychologists spend a considerable portion of their time providing psychosocial therapy (both individual therapy and group therapy). In addition, most medical centers have outpatient treatment facilities in which psychologists can provide long-term psychosocial therapy to a variety of patients.

In addition to the roles within the medical center, clinical psychologists are playing an increasingly large role in medical practices, ranging from pediatrician's offices and cancer treatment facilities to the offices of doctors performing cosmetic surgery. For example, the significant psychological factors associated with individuals seeking plastic surgery has increased awareness of the crucial role a clinical psychologist can play within cosmetic surgery practice. For instance, a preoperative psychological evaluation can identify patients who may suffer psychologically from a cosmetic operation and protect them from their own misconceptions about what cosmetic surgery will

do for them in terms of their self-esteem and body image. Another example of an emerging role for clinical psychologists can be found in dental practices. Within such practices clinical psychologists can treat patients with extreme dental anxiety so that these individuals are able to obtain dental procedures that they need.

Physicians are also finding it useful to have clinical psychologists conducting a practice within the medical setting. With such an arrangement physicians can more easily refer patients who (repeatedly) present with concerns that are more psychological in nature and would consequently be best served through psychological treatment. As individuals with depression and anxiety are more likely to present to medical providers than to mental health care professionals, working within a medical group practice may be the best way to reach a large majority of patients who can benefit from psychological services.

In all of these medical settings a clinical psychologist can, and should, integrate science and practice by either actively conducting clinical research within their work or by functioning as a true scientist practitioner when providing assessment and treatment services to medical patients. In addition, the responsibilities of clinical psychologists can, and often do, include teaching. This may include supervising interns and doctoral graduate students as well as teaching seminars and classes to medical students and residents.

Community mental health centers

Some clinical psychologists opt to work within a community mental health center. Such centers typically provide access to outpatient mental health care for underserved populations. Working within a community mental health center a clinical psychologist would provide outpatient assessment and treatment to individuals with chronic mental health difficulties. Provision of services may be more flexible to adapt to patients' changing needs and may include assessment of functioning, crisis intervention, and social organizational skills training such as helping a patient find a job. In addition to providing these types of services, clinical psychologists also play a vital role as supervisors of other mental health care staff (e.g., masters level psychologists), as well as performing a variety of administrative responsibilities that could include serving as director of a community mental health center.

Private practice

Another option for clinical psychologists who are primarily interested in pursuing a career as a practitioner is to work in a private practice setting. Establishing a new private practice may be an overwhelming task for beginning psychologists. Therefore, many individuals begin private practice work by either joining an established private practice or starting a practice while they are working in at least one other setting until their practice is grown. Private

practice clinicians may also conduct psychological assessments ranging from structured interviews to projective tests. If one is interested in opening a new private practice it is advisable to gain some knowledge in business (e.g., marketing, accounting) in order to develop and sustain a thriving practice. Most private practitioners have a diverse case load in terms of both assessment and therapy cases. Indeed, for many private practitioners it is important to be flexible (and competent) in the types of client cases one accepts.

Businesses

Another career option for clinical psychologists is to work as consultants to businesses. Within this role the clinical psychologist may have the task of improving employee productivity or morale, and/or providing therapy services to employees of the business. One might also obtain a position with a consulting firm. Such firms routinely conduct evaluations of potential employees. These firms also provide services such as holding workshops within businesses that are geared towards helping employees dis-

cover their personal strengths and weaknesses, increasing communication skills, and helping employees develop better conflict resolution skills.

Summary

This article was intended to highlight just a few of the career opportunities that are possible for clinical psychologists. As indicated above, some of these positions truly merge research and clinical skills, whereas other positions emphasize one skill set over the other. Although graduate students do not have to select their specific career path immediately upon entering graduate school, it does behoove students to consider a variety of possible career options during the course of their graduate training so that they can obtain training that will allow them to pursue careers that are of most interest to them. Exposure to a wide variety of clinical and research opportunities will not only provide students with an idea of what working in that field would be like, but also offer the opportunity to make contacts in the field who may be able to help with achieving career goals after graduation.

Secretary & Treasurer's Update:

Denise Sloan

Temple University

As with last year, SSCP members continue show a preference for renewing their membership on-line. However, a number of our members have not renewed for 2006. If you have not yet renewed your membership please do so by going to the following website: <http://pantheon.yale.edu/~tat22/membership.htm>

We received many outstanding applications for the 2006 SSCP dissertation grant award. This year we gave out five awards to students, which are listed below. We continue to be impressed by the quality of the applications we receive. The excellent quality of dissertation projects makes us feel very encouraged about the quality of clinical scientist entering our field.

Over the past several years we have seen a decline in the number of submissions to the SSCP student poster session held at the APA convention. As a result of this

decline we have decided to not hold the student poster session at APA this year, though we will be holding a SSCP student poster session at the 2006 APS annual meeting. We hope to offer the SSCP student poster session at the 2007 APA convention and we are currently exploring ideas to encourage students to submit their work to be presented at this session. If members have suggestions regarding how to make the SSCP student poster session more attractive to our student members please let me know.

This past fall we were very fortunate to have outstanding candidates running for both SSCP president-elect and Division 12 representative. We will be putting out a call for nominations for president-elect and secretary/treasurer positions later this summer. We hope our members will consider nominating individuals for these two positions on the SSCP board.

Awards and Recognition:
2006 SSCP Dissertation Grant Winners

Lea R. Dougherty

Temperamental Low Positive Emotionality and HPA Reactivity in
Preschoolers
Stony Brook University

Eva M. Epstein

Emotional Reactivity in Eating Pathology
Temple University

Coreen A. Farris

Feature Integrality Between Diagnostic and Non-Diagnostic Cues of
Women's Sexual Interest: Influence of Alcohol Intoxication and
Sexual Coercion History
Indiana University - Bloomington

Kelly O'Brien

A Preliminary Examination of Coaching in Parent-Child
Interaction Therapy (PCIT) and Parenting Skill Acquisition
University of Florida

Brian Wymbs

Does Disruptive Child Behavior Cause Interparental Discord?
An Experimental Manipulation
University at Buffalo, SUNY

Federal Advocacy News:

Donna Rasin-Waters, PhD

Division 12 FAC

Chair, Division 12 Advocacy Workgroup

Co-chair, Division 12, Section II Public Policy Committee

As the Federal Advocacy Coordinator for Division 12, I am frequently asking for your assistance on issues important to the practice of psychology. Having worked closely with the APA Practice Organization for several years, I can tell you that there is often a lot more going on "behind the scenes" that you may not hear about. So, I want to take this opportunity to let you know about the work that was done to secure new testing codes along with all of the advocacy efforts following Hurricane Katrina. I look forward to providing similar updates for you in the future.

Testing Codes

Psychologists providing testing services now have a more accurate way to bill as seven new Current Procedural Terminology (CPT®) codes became effective on January 1. Implementation of the codes reflects a change in thinking by the Centers for Medicare and Medicaid Services (CMS), which by awarding work values to the codes is finally acknowledging that psychologists are engaged in professional work when providing psychological and neuropsychological testing services.

These changes are the result of continued advocacy by APA over the past several years. Due to concerns about the level of professional work involved in furnishing testing services, previously CMS only reimbursed psychologists for the estimated costs of practice expense, essentially overhead, and a small amount for malpractice insurance. The psychologist's time and effort in providing the service went unrecognized.

Previous attempts in 2002 and 2003 to obtain professional work values for the testing codes failed to gain approval from the American Medical Association's reimbursement committee. APA continued its efforts by engaging staff from the AMA's coding and reimbursement committees in a strategy to revise the testing codes. APA developed a proposal that more closely identified the psychologist's involvement in the testing service, thus making the codes more suitable for the assignment of professional work values.

APA gained the approval of the coding committee to revise the codes in 2004 and then used survey data from psychologists across the country to persuade the reimbursement committee to recommend professional work values for the codes in 2005. Later that year, CMS adopted the reimbursement committee's recommenda-

tions and assigned professional work values for the revised codes.

The professional work values assigned to the new codes will significantly improve the amount paid by Medicare for these services. The previous psychological and neuropsychological testing codes (96100, 96115 and 96117) were all reimbursed at an average hourly rate of \$74. Under the 2006 Medicare fee schedule, average payments for outpatient testing services under the new codes will increase from 26% to 69%. For a complete list of the revised codes and their new values go to: <http://www.apapractice.org/apo/payments.html#>

Hurricane Relief Efforts

In the weeks and months following Hurricane Katrina, Congress focused its attention on a wide range of proposals to provide relief to hurricane evacuees, including relief for evacuees' health care needs. In late December 2005, the Senate approved a measure to provide a 100% federal match of existing Medicaid plans for those states with evacuees. Significantly, this measure will allow states the option of expanding their Medicaid mental health services while receiving the 100% federal match for up to nine months. This program will enhance opportunities for psychologists in the affected states of Louisiana, Mississippi, and Texas, as well as in other states where evacuees currently reside that do not normally cover outpatient psychologist services in their Medicaid programs.

This critical provision was included in the Budget Reconciliation legislation that passed both the House of Representatives and the Senate in December in the final hours of the Congressional session. Due to amendments made in the Senate, however, the Budget Reconciliation legislation must come before the House for one more vote before final passage; as of this writing a vote is predicted for early February 2006. The Practice Organization is pleased that, in the interim, state-by-state Medicaid waivers are allowing funds to be spent on mental health services not previously covered by the hurricane affected states.

Among the dozens of earlier proposals considered by Congress, one sponsored by Senate Finance Committee Chairman Charles Grassley (R-IA) and Ranking Member Senator Max Baucus (D-MT) initially appeared quite promising. Known as the Emergency Health Care Relief

Act (S. 1716), the bill also sought to create a Disaster Relief Medicaid program to provide evacuees below the poverty line 100% federal payment of their health care for up to ten months. Importantly, and at our urging, S.1716 would have required coverage for a wide range of mental health services as part of the proposed relief, including for example screening, assessment and diagnostic services, psychotherapy, rehabilitation and other therapies, medications prescribed by "health professionals," inpatient care and other mental health services, as well as alcohol and substance abuse treatment resulting from circumstances related to Katrina, and family counseling for Katrina survivors and for first responders. The Practice Organization particularly appreciated the sponsors' express recognition of mental health services as an important part of Disaster Relief Medicaid. This bill stalled in the Senate due to budgetary concerns, however.

The debate in Congress over the need to offer some form of health care relief to the Hurricane victims certainly presented the Practice Organization with a unique opportunity to inform members of Congress about the significant mental health repercussions of major natural disasters and the extensive volunteer relief services that psychologists have been providing "on the ground" to hurricane victims

through the Disaster Response Network. In September, APA's Chief Executive Officer, Norman Anderson, Ph.D., sent a letter to the Senate, prepared by the Practice Organization, endorsing S.1716. The Practice Organization also developed and distributed widely an informational fact sheet concerning the substantial mental health needs of disaster survivors, highlighting the fact that when natural disasters cause extensive community-wide destruction and disruption – as with Hurricanes Katrina and Rita — 25 to 30% of the survivors are likely to develop anxiety disorders, including post traumatic stress disorder (PTSD), depression and other clinically significant problems. The fact sheet is available at: <http://www.apapractice.org/apo/pracorg/legislative/HurricaneImpact.html#> The Substance Abuse and Mental Health Services Administration (SAMHSA) recently confirmed these statistics, and is now projecting that up to 500,000 people may be in need of professional assistance as a result of the hurricanes. The SAMHSA news release is available at: http://www.samhsa.gov/news/newsreleases/051207_hurricane.htm. This information has been very favorably received by Senator Trent Lott (R-MS), who suffered the personal loss of his home, and other key Members of Congress, and continues to be requested by other offices on Capitol Hill.

Highlights of Upcoming Association for Psychological Science (APS) Convention: New York, NY, May 25 - 28, 2006

Jack Blanchard

University of Maryland, College Park

SSCP members will be interested in attending the outstanding APS convention planned for NYC this May. Details concerning the convention can be found at the APS web site: <http://www.psychologicalscience.org/convention/>

This year's APS convention includes an array of exciting programming including the keynote address by Sir Michael Rutter ("Why the different forms of gene-environment interplay matter") and special themed programs on "Memory and Consciousness," "Plasticity and Change: A Lifelong Perspective," and "The Psychology of Terrorism". In addition, there are a number of invited speakers addressing topics within clinical science:

Award Address:

Timothy B. Baker

University of Wisconsin – Madison

Effective Clinical Science: Progress in Understanding and Treating Tobacco Dependence

When I began to study addictive disorders in the early 1970's the treatment of addictive disorders was informed by hunch, clinical lore, and tradition. Tobacco users receiving clinical services were probably no better off than those who stayed home. There were no effective clinical interventions for tobacco use, and, in fact, it was generally not recognized as an addictive disorder. Thirty years of clinical research have produced remarkable achievements. Today multiple psychosocial and pharmacologic interventions significantly boost cessation rates and prevent relapse. Research has

revealed vital information on the design and delivery of such interventions, their cost-effectiveness, and their mechanisms of action. In addition, transdisciplinary research has produced dissemination and system-change strategies that make effective interventions available on a population-wide basis. While difficult research questions remain, progress in the treatment of tobacco use serves as a remarkable testament to the precept that clinical disorders are highly amenable to scientific inquiry.

Thomas Borkovec

Pennsylvania State University

Generalized Anxiety Disorder with Integrations of Interpersonal and Experiential Therapies.

This presentation reviews findings on CBT effectiveness for clinical outcome, comorbidity, vagal tone, EEG, and startle reactions. The talk will end with preliminary process and outcome data from a recent trial based on empirical data indicating the potential importance of interpersonal factors and contrasting CBT with and without interpersonal therapy.

Kelley D. Brownell

Yale University

Changing The American Diet: Real Change Requires Real Change.

Overnutrition has surpassed undernutrition as the chief food problem in many parts of the world. Human biology intersects with changing environments to create record levels of diseases such as obesity and diabetes. Real change to the environment requires bold, aggressive, and dramatic action that can affect individuals, institutions, and governments.

Barbara S. McCrady

Rutgers University

To have but one true friend: The role of the social environment in the resolution of alcohol use disorders.

Social networks exert complex influences on the recognition and resolution of drinking problems. This presentation will present data on the structure and functioning of problem drinkers' social networks and treatment models involving the social network. Data from a clinical trial of conjoint treatment for alcohol dependent women will be presented.

Adrian Raine

University of Southern California

Antisocial Behavior: Brain Mechanisms, Prevention, and Moral Responsibility.

There is increasing evidence for a significant neurobiological basis to antisocial behavior. This presentation will discuss recent brain imaging research, the importance of biosocial interaction effects, biosocial prevention programs, and the implications of a clinical neuroscience perspective on violence for moral responsibility, blame, and punishment.