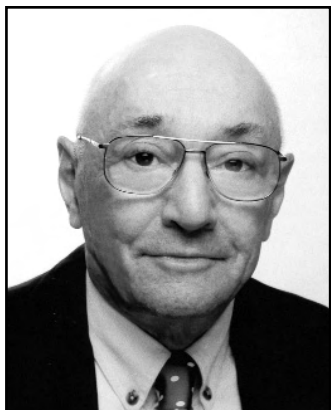# Bulletin of the American Academy of Clinical Psychology

PRESIDENT'S COLUMN

Howard M.Cohen, Ph.D., FAACP

I returned from the AACP Board of Directors meeting of April 5-6, 2003 (see Abbreviated Minutes, this issue) reinvigorated and having a sense that we had not only dealt with Academy housekeeping but focused on our raison d'etre — to provide benefits to and represent our members, and of course to expand our membership through increasing candidacy. All of these aspects of the Academy's mission are interdependent and essential if our Boards are to have impact in the national health picture. As in all meetings housekeeping and procedures are important, but the flush of excitement arises when tangible steps are taken to implement the mission. Among some of the substantive items were: exploring means to facilitate self-study programs for our Fellows, looking into preparatory programs for potential candidates and to urge that the beginning of the specialty examination process be initiated earlier in the potential candidate's training program. A wise man, J.Frank Dobie, once said, "The average Ph.D.thesis is just the moving of bones from one cemetery to another." So, up front I tell you the ideas are not new and just off the drawing

board, but we'll be working on means of implementation and expending effort. We expect to work closely with ABCP on these endeavors. And although, we, as other groups, have always been limited in financial resources, what we do have in fairly abundant supply is the human capital of our members. We have taken steps to implement the policy of placing notices of new Fellows in their local newspapers and that task was placed in the capable hands of Dr. Martin Kenigsberg, Chair, Public Relations Committee. In the near future, that committee will have its work augmented by taking note of significant professional accomplishments of Fellows of the Academy.

An editorial by Jack Ende, M.D., appearing in the May, 2003 Mayo Clinic Proceedings entitled "Rounding Alone: Assessing the Value of Grand Rounds in Contemporary Departments of Medicine" resonated with me, since it had to do with the education of physicians and the proliferation of subspecialties in departments of medicine. What we in the psychology specialty boards view as the success of the precedent setting medical specialty structure, now is experiencing at least some difficulties, which the ABPP BoT might want to take note of when considering additional boards. Ende describes Medical grand rounds as, "...the principle educational conference offered by virtually all departments of medicine." And that over time these

INSIDE

departments "... have been cleaved by increasingly strong forces of subspecialization...." He goes on to say that chairs are empty and "If attendance at grand rounds continues to decline, in a few years will I be rounding alone?" Extrapolate that to some of our miniscule sized boards, not subspecialties mind you, and I think we can see a depletion of what had been a cohesive set of training and experience into what easily may become a set of ever expanding schisms. I am not suggesting that there are not bonafide boards under ABPP, but there is a clear benefit in some boards being subsumed under others. Dr. Ende concludes that there is a "core body of knowledge, both clinical and scientific..." that needs to be shared by the (medical) subspecialties. I believe the Clinical Academy would hold that statement to be even more applicable to many ABPP specialties.

Finally, writing a column such as this allows one to range far and provides an opportunity for serendipity to underscore one's views. This Academy has an important function to concern itself with the delivery of quality psychological services to the public. We have, as mentioned earlier, proven quality capital in our membership, but it is only the quantity of that human capital that for now limits our ability to impact the health delivery system. Nevertheless, it is generally accepted that there is a need to improve the accessibility to health care in the United States. It is a complex matter not easily resolved. Neither the old fee-for-service nor the litany of faults of managed care that appear on psychological and psychiatric list serves are ready answers, but it does behoove us to look at the problems we face. The Organization for Economic Cooperation and Development every year publishes data comparing the health systems of thirty industrialized countries, studying factors such as: pharmaceuticals; health professionals per capita beds; admissions; length of stay; acute care hospital days per capita; and use of sophisticated technologies. The comparison of data for 2000, despite being perhaps simplified with respect to all possible variables, seem to indicate that although we spend considerably more, indeed 44% more than even the next country, Switzerland, "Americans are receiving fewer (health) resources than are people in the median OECD country." (See, "It's the Prices Stupid: Why is the United States Different from Other Countries." Anderson, G.F., Reinhardt, U.E., Hussey, P.S. and Petrosyan, V., Health Affairs, V 22, 1).The importance of health care and ready availability is suggested by Richard Conniff in The Natural History of the Rich: a Field Guide, W.W, Norton & Co.2002, He makes the point that "We all hope to be rich ourselves. We are descended almost by definition from people who liked food and sex. From them we have inherited deeply imbedded biological drives for status, for waterfront real estate, for landscapes of the English country house variety...", etc....features often associated with the rich and famous. Moreover, all our disclaimers to the contrary, we long to be like them. We mimic them as aptly as a viceroy butterfly mimics the coloration of the monarch.

He then goes on to talk about wealth, health and longevity and cites a most imaginative study. I leave it to Conniff to describe. "In one of the stranger pieces of demographic research on record, a team of epidemiologists and psychologists prowled the cemeteries of Glasgow in the mid-1990s armed with chimney sweep rods. They used them to measure the height of more than eight hundred nineteenth century obelisks. People buried under obelisks tend to be affluent, and the researchers assumed that taller obelisks marked the graves of the more affluent people. The study revealed that every extra meter in height of an obelisk translated into almost two years of additional longevity for the people buried beneath." It is interesting that this was based on the article "Some Observations on Health and Socioeconomic Status." Carroll,D., Smith, G.D. and Benett, P., Journal of Health Psychology. That should at least point the way to the need for universal affordable quality health insurance and the desirability of relief from the stress of it not being available. Hopefully, our Academy can expend more of its professional capital on the national mental health delivery system dialogue.

Mourning and Melancholia – Bereavement and Depression
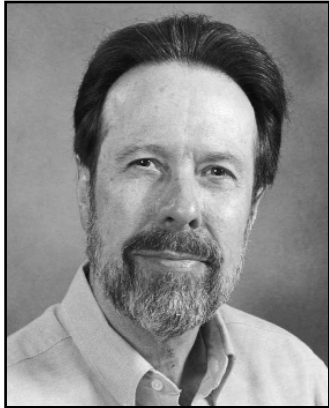
Edward W. L. Smith, Ph.D., FAACP

Sorrow comes as a welcome visitor,
moving my losses to the archives of my life.
But, depression is her monstrous half-sister
wanting to be a murderous wife.

Thus personified, sorrow and depression are revealed as having quite different intentions. Although they are related, as I suggest in my poem, bereavement and depression are two distinct entities. Their separate identities are formally noted in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision) (American Psychiatric Association, 2000) (e.g., pp. 355, 682, 740), but due to their surface resemblance, they are not always distinguished in common parlance or even in the professional literature. Their resemblance is found in their shared symptoms. To wit, they both can manifest by a mood of sadness, diminished interest or pleasure in those things that previously held interest or brought pleasure, weight loss or weight gain, insomnia or hypersomnia, observable psychomotor agitation or retardation, fatigue, and difficulty in concentrating or in making decisions. Like a grammarian might parse a sentence, the authors of the DSM-IV-TR have explicated depression, with nuance of major depressive disorder, dysthymic disorder, depressive disorder, adjustment disorder with depressed mood, bipolar disorder, cyclothymic disorder, mood disorder due to a general medical condition with depressive features, substance-induced mood disorder with depressive features, and so forth.

In the chapter on "Other Conditions That May Be a Focus of Clinical Attention," the authors of the DSM-IV-TR (2000) address bereavement saying, "This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode . . . . The bereaved individual typically regards the depressed mood as 'normal,'…." (p. 740). Although the number, severity, and duration of symptoms are considered in the diagnostic criteria for the differentiation of depression from bereavement (as well as in the differentiation of the various shades of depression), the *differentia specifica* is the sense of worthlessness experienced by the depressed person. It is this sense of worthlessness-cum-low self-esteem, possibly accompanied by corollary guilt and suicidal ideation, that sets depression apart from bereavement. (Nota bene: A grieving person may feel guilt over things done or not done to or for the one who has been lost. Likewise, she or he may feel better off dead than to be without the lost one. These are qualitatively different from the guilt and wish to die that may be manifestations of a sense of worthlessness.)

Just as the Augustinian monk Gregor Mendel, in his discovery of the basic laws of genetics, looked beneath surface appearances in order to understand the genotypes unrevealed through phenotype, Freud looked beneath the surface of symptoms in order to understand the underlying dynamics. The dynamics of what were at that time referred to as "mourning" and "melancholia," had earlier been approached by Abraham, but it was Freud (1963) who offered us the study of "Mourning and Melancholia" in 1917. In both, Freud pointed out, there is the experience of "profoundly painful dejection, abrogation of interest in the outside world, loss of the capacity of love, inhibition of all activity" (p. 165). In addition to this surface manifestation shared by mourning and melancholia, both are brought on by the experience of loss, loss "of a loved person, or the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal, and so

on" (p.164). But, and here is the *differentia speci-fica* that is part of the underlying dynamic, melancholia ensues rather than mourning when there is a "morbid pathological disposition." In the case of melancholia, then, there is "a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment" (p. 165). There it is, loss of self-esteem.

I want to caution most strongly against the blurring of the distinction between bereavement and depression. Bereavement is the natural reaction when loss is sustained. Depression is a pathological process. As Rycroft (1968) succinctly stated, "All schools of psychoanalysis regard mourning as the normal analogue of DEPRESSION" (sic) (p. 94). Therefore, and most importantly, *the grieving process is one to be encouraged, supported, and thus honored*.

In a society that chooses *fast* food, reveres *fast* cars, craves *fast* fax machines, and is in the never-ending pursuit of *faster* computers, the time that mourning labor demands is an inconvenience at best, if not anathema. In such a society the natural process of grieving is often short-circuited, avoided, or pathologized so as to be subjected to efficient treatment. Note the manner in which the bereft person is most often dealt with in film. Calling upon the latest pharmacopeia, the norm is to tranquilize, if not narcotize, thereby arresting the natural process of grieving. Our societal impatience with sorrow may be reflected in the very short time allowed for grieving as stated in the DSM-IV-TR, a mere two months. Grief beyond that is considered cause for a diagnosis of depression. There is also a neglect in recognizing losses other than "a loved one" as warranting a period of grieving. Or, perhaps, we need only extend the definition of "loved one" to include pets, to include a cherished object, a career, or even an idea. My point is that *whenever there is experience of loss of someone or something that was valued, the natural response is one of bereavement. And, the time required to complete the process of grieving varies greatly depending on the depth of attachment now severed. Contemporary main-stream culture typically underestimates, grossly, the time required*. (The loss of a loved spouse may take a year, perhaps two.)

As an aid to recognizing and understanding the individualized grieving process, I have suggested a three-dimensional schema (Smith, 1985). The first dimension is twofold and represents gradual loss and sudden loss. The second dimension is fourfold and represents the type of loss, be it a person, a pet, a personal object, or an abstraction such as a cherished idea, concept or value. The third dimension is one of intensity, a continuum from slight loss to profound loss. The message, here, is that loss comes in myriad forms, and grief naturally follows. Grieving, or to use Freud's term, the "mourning labor," is the person's inherent healing process whereby the loss is acknowledged and the person readies herself or himself to continue with life, unaccompanied by that which was let go. In this process, the person withdraws from the world, to a lessor or a greater degree, and into herself or himself in order to feel keenly the loss and to assess its meaning. As figure, at once natural and powerful, grief can emerge with such clarity and vividness that all else is but vague and shadowy background. The everydayness of life may become an irritant, distracting from the healing at hand. This is a process to be respected. As stated by Freud (1963), "we look upon any interference with it as inadvisable or even harmful" (p. 165).

So it is, then, that sorrow is the welcome visitor insofar as she allows for the processing of loss, allowing the pain to recede naturally, and memories to assume their proper place. Depression, however, wants to bind to those so afflicted, deadening their existence. The therapist's role is to facilitate the natural and individualistic process of grieving, as contrasted with the task of helping the depressed client to eschew this pathological condition.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, D.C.: Author.

Freud, S. (1963). Mourning and melancholia. In P. Rieff (Ed.), *General psychological theory* (pp. 164-179). New York: Collier.

Rycroft, C. (1968). *A critical dictionary of psycho-analysis*. New York: Basic Books.

Smith, E. W. L. (1985). A Gestalt therapist's perspective on grief. In E. M. Stern (Ed.), *Psychotherapy and the grieving patient* (pp. 65-78). New York: Haworth.

Theory, Research and Clinical Practice: two new papers in the series.

In this issue of the *Bulletin* we are pleased to offer two new contributions in our series of reports on developments in psychological theory and research that have relevance for sophisticated clinical practice.   Both authors are board-certified clinicians. Dr. Epstein has combined psychodynamic theory, cognitive research, and a sensitivity to the nuances of psychotherapy to form a creative body of work. It is especially interesting to psychologists who want to remember the fact of the unconscious in their work, while updating their understanding with the latest laboratory findings. Dr. Fischer has focused on the Phenomenological research tradition, and she has developed an approach to clinical theory, training and practice that illustrates how richly useful this approach to scientific psychological work can be.

Cognitive-Experiential Self-Theory, An Integrative, Psychodynamic Theory of Personality
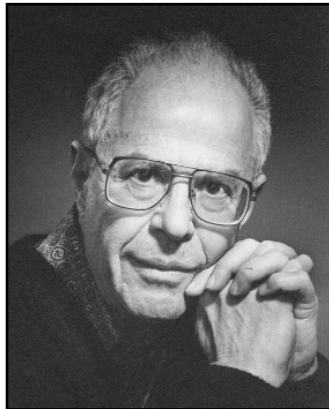
Seymour Epstein
University of Massachusetts at Amherst

It has been over a hundred years since Freud introduced a theory of personality that shook the world. Central to his theory was a view of the unconscious mind that provided an explanation of why human beings, despite their capacity for prodigious intellectual accomplishments, often behave irrationally. Freud considered his book on dream interpretation (Freud, 1900), as his most important contribution because he believed it unlocked the secrets of the operation of the unconscious mind. In the hundred years that followed, nearly every aspect of psychoanalytic theory has undergone modification with the exception of its most fundamental concept, the operation of the unconscious mind. Ironically, that may well be the one aspect of psychoanalysis that was most in need of change.

The problem with Freud's view of the operation of the unconscious mind is that it is indefensible from both an evolutionary viewpoint and from that of modern cognitive science. Freud viewed the unconscious mind as essentially maladaptive, the stuff that dreams are made of. Anyone who acted in real life according to Freud's view of the operation of the unconscious mind, which Freud referred to as the primary process, would be blatantly psychotic. That is why Freud had to add a reality-oriented conscious mind that operated by what he referred to as the secondary process. From an evolutionary perspective, there are two problems with this solution. First, it can not account for the adaptability and survival of non-human animals that have no secondary process. Second, it is unreasonable according to evolutionary principles that the very foundation of the human mind is maladaptive. Why would such a maladaptive mind have developed in the course of evolution? Freud is silent on this issue.

Turning to the views of cognitive scientists, they uniformly agree that most human information processing occurs unconsciously, not

because of repression, as Freud believed, but because it is more efficient (and therefore more adaptive) that way. The viewpoint of cognitive science is consistent with a great deal of experimental evidence, and its proposal of an unconscious system that is adaptive is consistent with evolutionary theory. However, the "kinder, gentler" cognitive unconscious proposed by cognitive scientists has its own serious limitation. The model they propose is better suited for describing robots with computers in their heads than for describing the behavior of real people going about their business of everyday living. The robots can store knowledge and compute, but they are devoid of feelings, self-direction, and original thinking.

Interestingly, although Freudian theory is weak where cognitive science is strong, it is strong where cognitive science is weak. A major strength of Freudian theory is that it provides a compelling picture of full-blooded human beings, of people who not only think, but also feel, who are inspired by passions and torn by conflict, who on the one hand are sublime and on the other depraved.

The complementary weaknesses and strengths of classical psychoanalysis and cognitive science raises the question of whether it is possible to construct a theory that retains the advantages of both with the disadvantages of neither. Cognitive-experiential self-theory (CEST) lays claim to be just such a theory.
Cognitive-experiential Self-theory

CEST solves the problems inherent in the views of the unconscious in Freudian theory and in cognitive science by assuming that the unconscious proposed by cognitive science is emotionally driven. In fact, it is inconceivable how it could be otherwise. Given the ability of the cognitive unconscious to solve problems, why would it not use this ability in the service of obtaining good feelings and avoiding bad ones? This, of course, would make it emotionally driven. Substituting the adaptive unconscious of CEST for the maladaptive unconscious of Freudian theory would not only retain many of the features of the cognitive unconscious but would also include the emotionality of the Freudian unconscious.

This would allow it to explain almost everything that psychoanalytic theory can, including even dreams (Epstein, 1999), and much that it can not, and to do so in a scientifically much more defensible manner (Epstein, 2003). Nothing would be lost in psychoanalysis, and a viable unconscious with new implications for understanding human behavior would be gained.

If there is one attribute that best identifies CEST, it is that it is a highly integrative theory. Not only does it integrate significant aspects of psychoanalytic theory and cognitive science, it also integrates significant aspects of learning theory and phenomenological theory. In fact, the adaptive unconscious proposed by CEST to replace the maladaptive unconscious proposed by Freud is conceived of as an automatic learning system, the very same system with which non-human animals have successfully adapted to their environments over millions of years of evolution. Assuming that nature does not give up its hard-won gains easily, it follows that humans retain this way of adapting to their environments by automatically learning from experience apart from whatever other adaptive systems they have, including solving problems by reasoning with the aid of language.

According to CEST, people process information by two different systems, an automatic learning system, which is referred to in CEST as the "experiential system" and an inferential logical system, which is referred to in CEST as the "rational system." The systems operate in parallel and are interactive. The experiential system operates in a manner that is automatic, preconscious, nonverbal, rapid, relatively effortless, concrete, holistic, intimately associated with affect, and it has a very long evolutionary history. It acquires its schemas, or implicit beliefs, from lived experience. The rational system is a reasoning system that operates in a manner that is conscious, verbal, deliberative, slow, effortful, abstract, analytic, and affect-free (for a more complete list of the attributes of the two systems, see Table 1). It acquires its beliefs by logical inference. To be sure, it also learns from experience, but it does so through inference.

See Table 1

Table 1.
COMPARISON OF THE EXPERIENTIAL AND RATIONAL SYSTEMS

EXPERIENTIAL SYSTEM (An automatic learning system)	RATIONAL SYSTEM (A conscious reasoning system)
1. PRECONSCIOUS	1. CONSCIOUS
2. AUTOMATIC	2. DELIBERATIVE
3. CONCRETE: ENCODES REALITY IN IMAGES, METAPHORS, & NARRATIVES	3. ABSTRACT: ENCODES REALITY IN SYMBOLS, WORDS, & NUMBERS
4. HOLISTIC	4. ANALYTIC
5. ASSOCIATIVE: CONNECTIONS BY SIMILARITY & CONTIGUITY	5. CAUSE-AND-EFFECT RELATIONS
6. INTIMATELY ASSOCIATED WITH AFFECT	6. AFFECT-FREE
7. OPERATES BY PLEASURE PRINCIPLE (WHAT FEELS GOOD)	7. OPERATES BY REALITY PRINCIPLE (WHAT IS LOGICAL AND SUPPORTED BY EVIDENCE)
8. ACQUIRES ITS SCHEMAS BY LEARNING FROM EXPERIENCE	8. ACQUIRES ITS BELIEFS BY LOGICAL INFERENCE
9. MORE OUTCOME ORIENTED	9. MORE PROCESS ORIENTED
10. BEHAVIOR MEDIATED BY "VIBES" FROM PAST EXPERIENCE	10. BEHAVIOR MEDIATED BY CONSCIOUS APPRAISAL OF EVENTS
11. MORE RAPID PROCESSING: ORIENTED TOWARD IMMEDIATE ACTION	11. SLOWER PROCESSING: ORIENTED TOWARD DELAYED ACTION
12. SLOWER TO CHANGE: CHANGES WITH REPETITIVE OR INTENSE EXPERIENCE	12. CHANGES MORE RAPIDLY: CHANGES WITH SPEED OF THOUGHT
13. MORE CRUDELY DIFFERENTIATED: BROAD GENERALIZATION GRADIENT; CATEGORICAL THINKING	13. MORE HIGHLY DIFFERENTIATED; DIMENSIONAL THINKING
14. MORE CRUDELY INTEGRATED: MORE DISSOCIATIVE , MORE SITUATIONALLY SPECIFIC. ORGANIZED IN PART BY COGNITIVE-AFFECTIVE MODULES	14. MORE HIGHLY INTEGRATED: ORGANIZED IN PART BY BROAD CROSS-SITUATIONAL PRINCIPLES
15. EXPERIENCED PASSIVELY AND PRECONSCIOUSLY: WE ARE SEIZED BY OUR EMOTIONS	15. EXPERIENCED ACTIVELY AND - CONSCIOUSLY: WE ARE IN CONTROL OF OUR THOUGHTS
16. SELF-EVIDENTLY VALID: "EXPERIENCING IS BELIEVING"	16. REQUIRES JUSTIFICATION VIA LOGIC & EVIDENCE

A basic assumption in CEST is that all human behavior is simultaneously influenced by both systems, with their relative contribution varying according to the situation and the person. For example, although the rational system is affect-free, a person can be passionate about intellectual matters with the passion provided by the experiential system. In some situations, such as solving mathematics problems, behavior is normally primarily determined by the rational system. However, it is not exclusively determined by the rational system, as no behavior can be performed outside of the context of previous experience. Depending on a person's past experience with mathematics, a mathematics problem may be approached with a sense of confidence or of defeat, which will influence the person's ability to solve the problem. In contrast to intellectual problems, interpersonal problems tend to be primarily in the province of the experiential system (Epstein et al., 1996; Pacini & Epstein, 1999). In addition to the influence of situations, there are important individual differences in the degree to which people tend to process information primarily in one system or the other (Epstein et al., 1996; Pacini & Epstein, 1999).

Implications for Psychotherapy

CEST is not only highly integrative as a theory of personality; it also provides an integrative framework for the different schools of psychotherapy. Its main contribution to psychotherapy is not so much by suggesting new methods of treatment, although it does some of that, but by providing an umbrella for all the major schools of psychotherapy.

In order for psychotherapy to be effective, it is necessary for changes to occur in the experiential system. This does not mean that changes in the rational system are of no consequence, but only that they are therapeutic to the extent that they contribute to changes in the experiential system. If changes are produced only in the rational system, they simply succeed in changing a neurotic without insight into one with insight.

There are three basic ways to produce constructive changes in the experiential system.

These are the use of the rational system to correct the experiential system, the provision of emotionally (i.e., experientially) corrective experiences, and communicating with the experiential system in its own medium. These three approaches provide a unifying framework for a wide variety of approaches in psychotherapy, including insight approaches, cognitive-behavioral approaches, and experiential approaches, such as gestalt therapy and psychosynthesis (Epstein, 1998, 2003).

Using the Rational System to Correct the Experiential System

Each processing system has its advantages and disadvantages with respect to influencing the other system. The experiential system is able to influence the rational system and bypass control from it by operating outside of awareness to bias the interpretation of events. In addition, the experiential system is able to co-opt the rational system into rationalizing, so that the person believes that behavior that was primarily experientially determined was determined consciously and rationally. The rational system has only one major advantage over the experiential system, but it is a critically important one. It can understand the experiential system, whereas the reverse is not true.

What are the practical implications of the ability of the rational system to understand the experiential system? There are a variety of ways such knowledge can be used in therapy. First people must be convinced that they operate by two systems. One way of accomplishing this is by beginning with a discussion of conflicts between the heart and the head or the occurrence of unwanted thoughts, as everyone is aware of these. After convincing people that they operate by two systems, the next step is to teach them about the different rules of operation of the two systems, as summarized in Table 1, and of how the experiential system, operating outside of awareness, routinely influences conscious thought and behavior. They can be taught that, in an attempt to understand their experientially determined behavior, people often rationalize in the sense that they provide a rational but incorrect explanation. People also create situations that provide objective evidence that justi-

fies their conscious beliefs and behavior. Such behavior can produce serious problems in people's relationships. People can also be taught that they can prevent such reactions by becoming aware of the operation of the experiential system in themselves. They can do this by attending to their automatic thoughts, emotions, bodily states, and repetitive behavioral patterns.

One of the advantages of teaching clients that their problems lie primarily in their experiential system is that it reduces resistance and other forms of defensiveness. This is because there is no need for a client to defend his or her rationality once the person understands that it is the operation of the experiential system, not the rational system, that is at issue. All that matters is to understand the influence of the experiential system when it is maladaptive and what can be done do to correct it. In this latter respect, clients should understand that the rational system is not always right and the experiential system wrong. Most often the two systems operate harmoniously, and when they differ, one or the other can provide the better solution. Sometimes behaving according to what has been automatically learned from past experiences is superior to behaving according to reasoning, whereas at other times the reverse is true. However, it is only through awareness that a person has the opportunity to choose between the two sources of information. In the absence of awareness, the person surrenders primary control to the experiential system, which is the default system.

Learning from Corrective Emotional Experiences

The most direct route for changing maladaptive schemas (implicit beliefs) in the experiential system is by providing corrective emotional experiences. One way to accomplish this is through the relationship between client and therapist. This procedure is emphasized in psychoanalysis by the encouragement of transference relationships, which then have to be resolved, but it can be utilized in other ways with fewer complications. Another procedure is to use homework assignments in which clients actively seek out corrective experiences. If too threatening, this can be preceded by equivalent experiences in fantasy. So that they do not subvert potentially corrective experiences, it is helpful

for clients to understand how their characteristic interpretations and self-verifying behavior can interfere with their having constructive experiences. Thus, we come to the importance of "knowing oneself", which from the perspective of CEST means knowing one's experiential self, including its influence on one's conscious thought and behavior. Such knowing is important not only with respect to avoiding self-sabotage of corrective experiences, but in many other aspects of successful adaptation, as well.

Communicating with the Experiential System in its Own Medium

The experiential system encodes information in, and is particularly responsive to imagery, fantasy, metaphor, concrete representations, and narratives. This information can be useful in two ways. One way is by using it to influence the experiential system. For example, people can provide themselves with vicarious corrective emotional experiences by vividly imagining situations. This procedure can be used in a variety of other ways, including rehearsing ways of coping with real-life problems both in anticipation of new situations and in reworking old situations. It can also be used to cope at a symbolic level with deeper levels of unconscious conflict that can not be effectively confronted more directly.

The second way one can benefit from communicating with the experiential system is by learning from it. Through the use of imagery, fantasy, metaphor, associations, and the production of narratives one can obtain information about schemas and conflicts in the experiential system that are not accessible in a person's consciousness. (For a detailed case-history in which fantasy was used in both ways as an integral part of an extremely effective therapy, see A. Epstein, 1989).

Conclusions

CEST is a broadly integrative dual-process theory that has widespread implications for understanding human behavior in general, and more particularly, for treating maladaptive behavior. In this brief article, I could but introduce CEST and some of its implications for psychotherapy. For the interested reader, more

detailed information is readily available in a variety of articles on CEST (e.g., Epstein 1998, 2003), most of which can be obtained as reprints by request.

References
Epstein, A. (1989). <u>Mind, Fantasy, and Healing</u>. New York: Delacorte. (This book is out of print, but copies can be obtained from <amazon.com> or from Balderwood Books, 37 Bay Road, Amherst, MA 01002 by enclosing a check for $18.00, which includes shipping.

Epstein, S. (1998). Cognitive-experiential self-theory: A dual-process personality theory with implications for diagnosis and psychotherapy. In R. F. Bornstein & J. M. Masling (Eds.), <u>Empirical research on the psychoanalytic unconscious</u>, Vol. 7, pp 99-240. Washington, D. C.: American Psychological Association.

Epstein, S. (1999). The interpretation of dreams from the perspective of cognitive-experiential self-theory. In J. A. Singer & P. Salovey (Eds.), <u>At play in the fields of consciousness: Essays in honor of Jerome L. Singer</u>, pp. 59-82. Mahway, NJ: Lawrence Erlbaum Associates, Inc.

Epstein, S. (2003). Cognitive-experiential self-theory of personality. In T. Millon & M. J. Lerner (Eds.), <u>Comprehensive handbook of psychology</u>, Vol. 5, pp. 159-184. Hoboken, NJ: John Wiley & Sons.

Epstein, S., Pacini, R., Denes-Raj, V., & Heier, H. (1996). Individual differences in intuitive-experiential and analytical-rational thinking styles. <u>Journal of Personality and Social Psychology</u>, <u>71</u>, 390-405.

Freud, S. (1900/1953). <u>The interpretation of dreams</u>. In Vols. 4 & 5 of <u>The standard edition</u>. London: Hogarth.

Pacini, R., & Epstein, S. (1999). The relation of rational and experiential information-processing styles to personality, basic beliefs, and the ratio-bias phenomenon. <u>Journal of Personality and Social Psychology</u>, <u>76</u>, 972-987.

Seymour Epstein is Professor Emeritus in the Psychology Department at the University of Massachusetts at Amherst. He is a diplomate in clinical psychology and has published widely in personality psychology. His research has been supported with NIMH research grants for over 40 consecutive years, and he has received two NIMH Research Scientist Awards. He is currently writing a book that he hopes will make a compelling case for why psychologists should adopt his theory of personality.

What is Individualized, Collaborative Assessment?

Constance T. Fischer, Ph.D. ABPP
Duquesne University

Collaborative assessment is a client-focused, versus test-focused, approach to psychological assessment. In this approach, test data, both objective and projective, in conjunction with background information and interview impressions, provide the psychologist with preliminary understandings. That initial comprehension is revised and individualized in discussion with the client. Working collaboratively, psychologist and client explore the contexts in which a particular style of comportment has and has not worked out well for the client. They often develop tailored, concrete suggestions for how in the future the client might recognize previously problematic circumstances, and shift to an already available, more workable style.

Written reports summarize these actual life findings and suggestions; when test data are included for other professionals, they are placed in parentheses and/or in a technical appendix. The client is provided with a copy of the report, and is invited to offer additions, clarifications, corrections, and new insights. These collaborative practices are decidedly different from traditional unilateral feedback, in which the psychologist translates constructs and categories into less technical, but still general terms for the client.

Progressive Openness to Collaborative Practice

Over the past ten years, more and more psychologists have been practicing collaboratively, with or without that label. For example, the American Psychological Association's Division of Humanistic Psychology published a special double-plus issue of its journal, The Humanistic Psychologist (2002, 1-2, pp 3-174; 3, pp 178-236) on Humanistic Approaches to Psychological Assessment, with 22 articles on collaborative practices in a range of settings and with a range of populations, including persons with Altzheimer's Disease, prisoners, and other clients who often are difficult to assess. My textbook on Individualizing Psychological Assessment (1985/1994) is under contract for another edition. Many MMPI books now discuss ways to directly explore test patterns with clients. Phillip Caracena's Rorscan program includes printouts on which clients can specify their agreement or disagreement with statements that seem likely to be descriptive of them. Stephen Finn and his colleagues established The Center for Therapeutic Assessment in Austin, Texas, where clients are referred, and self-refer, to gain therapeutic understandings and insights through collaborative assessment. Steve and I each have presented workshops and lectures in more than half a dozen countries in addition to our work in the United States. The Society for Personality Assessment, the world's major personality assessment organization, encourages collaborative practices through policy statements and convention programming.

I think that as practitioners have been seeing collaborative presentations in books and journals and at conventions, they have been feeling freer to more consistently, thoroughly, and creatively follow their own similar inclinations. In addition, the following events and circumstances encourage life-oriented, personally helpful assessments. (a) The public has been learning to ask for expert opinion to be presented in ordinary English. (b) Many assessors are dispirited when they read or write score-oriented reports which they know will be filed away rather than used for meaningful treatment planning. (c) Third party payers often do not pay for testing, other than neuropsychological, because they've found that it does not assist therapists. And, in contrast, a major mental health clearing house in Texas, after seeing Stephen Finn's videos of Therapeutic Assessment and his reports/suggestions developed for clients, encouraged him to bill his assessment work as therapy; moreover, regarding the Center's work as effective short term therapy, they regularly referred clients to the Center. (d) Our APA code of conduct instructs us to share our findings with clients in ways they can understand. (e) Dissatisfaction with the Diagnostic and Statistical Manual's non-contextual, nonrelational, nonagentic, and exclusively external perspective has been growing apace. And (f) practitioners, if not academicians, are outgrowing the epistemological assumptions underlying most test development, namely logical positivism, reductionism, and determinism. In short, many practitioners are coming to regard our testing instruments and related research as tools for gaining access to persons' lives. Likewise, categories, patterns, and diagnostic labels increasingly are seen as tools rather than as results.

Excerpt from Collaborative Assessment

There are two major life-world assessment approaches, which in practice typically meld. In my own individualized, collaborative approach (e.g., Fischer, 1985/1994, 2000), a third party has made a referral, and the psychologist collaborates with the client to address the referral issues as well as any additional issues that the client may wish to explore. Test by test we evolve our understandings of testings' relationship to the client's life. Concrete, personally viable suggestions for the client and for any helpers are developed as we go. In Stephen Finn's Therapeutic Assessment approach (e.g., 1966; 2002), the client often is self-referred, and even if referred by a third party, works with the assessor to develop a series of questions. Usually following testing, the assessor presents opportunities for the client to personally discover what the assessor has been formulating. The written report reviews the assessor's and client's answers to the presented questions. The examples below could have arisen in either approach.

CF: Mary, I think I'm on to something, about the puzzle of how your project director doesn't think that you're as competent as the other engineers, despite your SATs, and then your university grades and recommendations. And despite your fellow employees coming to you for help.

M: Well, that already reminds me that Jake [director] never sees me helping the rest of the team. Maria [house mate] says I should spell out all those instances to him, but..

CF: Right! That's just where I was going! Even though you've been courageous and determined in pursuing your career in a male domain [M nods], it strikes me that you've often preferred to wait for others to come to you [Rorschach: a:p = 2:5, W:M= 8:3; MMPI-2 scale 0=68]

M: Well, I think a boss should notice good work and reward it. He should help his people get to the top.

CF [smiling]: Like [Rorschach, card VIII] "Somebody's holding on down here, sort of hidden, hoping this hand will reach down and pull them up"?

M: Geez! [quiet reflection, then:] I wonder if I'm that bad at work. But I just can't see myself presenting an argument to Jake on my behalf—-. [after exploration of what Mary imagines would happen, and after she is asked for a story for TAT card 4, which shows a man usually seen as breaking away from a woman:] He misunderstands, and is going to break their engagement [sighs]—-

 CF: but she catches his attention, and insists that he listen to her side. She says—— [M and CF try out style and content until Mary finds a fairly comfortable presentation.]

Another Excerpt

Tyrell: This whole custody evaluation makes me angry. I have to pay for it, and then Charmin will get the kids anyway because they'll believe what she says about my anger.

CF: And after I make you angry with all this testing, then I'll tell the court that Charmin is right?

T: You got it!

CF: Okay, help me understand this: I would guess from your tests that you indeed have engaged in the reported destructive outbursts [MMPI-2 Pd=67, ANG=68, OH=65].

T: Anyone would, when you're disrespected like that!!

CF: But it also seems likely that you know about affection [Rorschach T=3, H=6] and also that you prefer to be a likable, outgoing guy [16 PF A=8, EX=9].

T: That's true!

CF: I'll bet you could think of a time when you were disrespected, but you used these other aspects of yourself instead of getting angry.

T: Do you mean like when my son's coach was threatening to drop him off the team, and I knew that would break Little T's heart, so I ignored his bad ass, nasty attitude and jollied him into giving Little T another chance?

CF: Exactly! Let's see how in other cases too you could be clear about what's at stake, like visitation, and you could use your outgoing ways to avoid getting into angry outbursts.

T: Hey, I did that just this morning with Charmin's lawyer.

Clarifications

Yes, the approach is highly interactive and interpersonal; but because that process yields concrete, contextualized life examples, the results are more rather than less ecologically valid and useful. Most recipients of assessment findings, including judges and juries, are more readily convinced by examples provided by a client than by test scores alone. Yes, as with all psychological undertakings, bright and introspective clients are easiest to work with; but most clients of all levels of motivation and ability are more cooperative in a collaborative approach than otherwise. Generally, one starts with impressions with which the client is likely to readily agree, and then explores with the client the ways in which other findings are and are not true for him or her. Sometimes assessor and client agree to disagree about some matters. Whatever the case, the client's life world is the realm of discussion.

Most theories of personality and development lend themselves to collaborative assessment (see Fischer, Georgievska, & Melczak,

2003). I think that most practitioners have at least at one time or another found themselves individualizing their procedures, reports, and suggestions. With more and more material about collaborative and therapeutic assessment available, I anticipate that we will all be discovering that we can go much further in these directions and thereby render our research and testing expertise all the more useful.

References

Finn, S.E.(1996). Manual for using the MMPI-2 as a therapeutic intervention. Minneapolis: University of Minnesota Press.

Finn, S.E. & Tonsager, M. (2002). How Therapeutic Assessment became humanistic. The Humanistic Psychologist, 30, 10-22.

Fischer, C.T. (1985/1994). Individualizing psychological assessment. Mahwah, N.J.: Erlbaum.

Fischer, C. T. (2000). Individualized, collaborative assessment. Journal of   Personality Assessment, 74, 2-14.

Fischer, C. T., Georgievska, E., & Melczack, M. (In press, 2003) Collaborative exploration with projective techniques: A life-world approach. In M. Hisenroth & D. Segal, M. J. (Eds.), Objective and projective assessment of personality and psychopathology. Volume 2 in M. Hersen (Ed.-in-Chief), Comprehensive handbook of psychological assessment. New York: John Wiley & Sons.

The Humanistic Psychologist, 2002, 30 (1-2) pp 3-174; (3) pp 178-236.

Connie Fischer is Professor of Psychology and Director of the Psychology Clinic at Duquesne University. She also has a part time private practice. Her academic endeavors have focused on human-science foundations and practices for qualitative psychological research and for individualizing psychological assessment.

Two founding members leave Academy Board, and two new representatives have been elected

The Academy Board of Directors has recently lost two members whose term limits expired. Martin (Marty) Kenigsberg and Phillip (Phil) Pierce served the Academy since its inception, and both placed their unique and enduring stamp on the character of the organization.

Marty was responsible for the design and ordering of the Academy Certificates that we all have hanging on our walls. From the beginning he was aggressive in organizing lists of examiners and mentors for candidates. A primary concern for him was that our numbers should grow, and he was a fountain of creative ideas for marketing, recruitment, networking, always reaching out to younger psychologists to inform them about the benefits of board certification to themselves and to the public. He was a refreshing "California presence" on the board, with his youthful manner and sense of broad possibilities.

Phil brought a wealth of organizational experience to his Academy work. As a member of APA Council he has worked for closer working ties between ABPP and APA. In this he has shown the stamina and endurance of the champion marathon runner (which he is). He was cheerful, sometimes quiet, sometimes fiercely pointed and reasoned in his remarks, always intensely ethical in his approach to all professional matters. His wry, Maine smile brought many complicated matters quickly into perspective.

Both men took an unusual degree of ability and devotion to our profession and generously focused it on the needs of our new organization of board-certified clinicians. The membership at large will never know in detail all of their contributions to our common good. However, those of us who were privileged to work personally with them will always treasure that rare opportunity.

The membership recently elected two new Directors. Eugene D'Angelo of Boston will represent the North-East, and Lawrence Majovski of Tacoma, Washington will represent the West.

Minutes (Abbreviated) of the American Academy of Clinical Psychology (AACP)

**Board Meeting   5-6 April 2003
Vancouver, BC**

Respectfully submitted by Joseph G. Poirier, PhD AACP Secretary

The Board meeting was called to order by President Cohen at 8:05 am. A current roster of Board member addresses and other contact information was circulated and changes made. Dr. Cohen will forward the updated information to the AACP CO for final drafting and circulation. Dr. Cohen introduced and welcomed the newest Board members. Dr. Gene D'Angelo, replacing Dr. Pierce from the Northeast region, and Dr. Larry Majorski, replacing Dr. Kenigsberg from the Western region

1. Reading and Approval of Minutes:

• The 12-13 October 2003 Board minutes as prepared by Secretary Poirier were adopted with one correction.

• Dr. Poirier noted that there were a number of items from the October 2002 minutes that remained open issues. The first of these issues was the AACP request for an explanation of the BoT input regarding the decision of the National Register to include vanity boards in its listings. The second issue regarded the AACP request for a response from the BoT regarding a joint effort between the BoT and the Academies addressing the issue of recruitment. The third unresolved issue was the request in the October 2002 minutes regarding"… the lack of timely and meaningful response by the BoT to AACP inquiries, and issues was a persistent, historical problem that was long overdue a corrective action."

2. Treasurer's Report:

• Dr. Zimet presented the current treasurer's report. The AACP financial picture continued in good standing. Dr. Zimet noted the effective efforts of President Cohen to contain Board meeting expenses.

• Dr. Zimet summarized that the Board's assets were currently just under $54,000. The primary means of Board revenues were membership fees and proceeds from AACP Continuing Education offerings. The 2002 membership renewal process resulted in the loss of 40 memberships for a net loss of 7 memberships form the prior year. The losses were offset by the acquisition of 21 new memberships. Ensuing discussion observed that the continued predominance of the membership in older age brackets predicted a significant annual membership loss into the foreseeable future. This reality made recruitment of new (and hopefully younger) members an ongoing and vital priority.

3. AACP Membership Committee:

• Dr. Cohen continued earlier discussion of the idea that psychologists who newly pass their Clinical Boards become automatic members of AACP. He noted that the Neuropsychology Academy had adopted this procedure. Several members expressed that Academy membership should remain optional. It was agreed that the process of inviting newly Board-Certified individuals to join the Academy would be by a congratulatory/invitation letter from the Academy President, which will be drafted by Dr. Cohen. Dr. D'Angelo agreed to become a new Membership Committee member.

Dr. Majorski raised discussion about the Academy Mentoring process. Presently, the Mentoring Committee members were Drs. Poirier and Katz. Dr. Cohen agreed to contact all new Academy members and poll for those interested in serving as mentors in their region. It was also agreed that the Regional Representatives would assume responsibility for contacting individuals who have recently achieved Board Certification and inquire about interest in serving as mentors, since these individuals would have the most enthusiasm, and the most recent knowledge of the Board-Certification process. Dr. Majorski emphasized that the mentoring process should be "personalized".

4. Tax and Corporate Status Summary:

• Dr. Katz explained that the Academy's C-3 tax status was good for three years. He stated that at some point the I.R.S. may ask for a report justifying continued C-3 status, needing documentation that the stated objectives of the

Academy (e.g., CE programming) was not dormant.

• The Academy's corporate status was renewable by a relatively straightforward re-filing process. If, however, the re-filing process deadline were overlooked, the entire filing process would have to be re-done.

• Dr. Katz noted upcoming changes in California legislation regarding psychologists, which has implications for board-certified CA psychologists, as well as setting a national precedent. The first change was for ABPP to be dropped as an automatically approved CE sponsor. Apparently, private CE providers had complained that the automatic approval was preferential consideration. The second and more profound change would impact on CA licensed psychologists who failed to renew their license in a timely manner. The proposal was for these psychologists to be required to re-take the National Licensing Exam to be re-instated. Further, the proposal in CA was for a statutory change whereby the requirement to take the National Exam would be waived for psychologists listed in the National Register, but not provide for such an exemption for ABPP psychologists. Dr. Cohen agreed to contact the BoT President, Dr. Bolles, regarding the issue, and Dr. Poirier agreed to draft a letter for Dr. Cohen's signature to be sent to the CA Board.

5. Archiving Committee:

• Dr. Poirier observed that with the pending rotations of more Board members, it was time to give attention to a mechanism of archiving records held by members as they were rotating off. Dr. Cohen agreed to look into a process, perhaps having the Academy CO collate materials and archive them on electronic media. Dr. Poirier suggested the implementation of an Archiving Committee. The topic will be re-addressed at the next Board meeting.

6. Administrator Officer's Report:

• The Administrator Officer's report was received and approved. Board members unanimously concurred that the AO, Lynn Petersen continued to provide exemplary service. Dr. Cohen noted that Ms. Petersen would receive a modest increase (i.e., $250.00) in her annual compensation.

7. Continuing Education Committee:

• Dr. Poirier summarized that the Academy was completing its first of five years APA approval as a CE provider. Dr. Poirier is to rotate off the Board in October 2003 and a new Chair of the CE Committee needs to be appointment. Also, it was noted that Drs. Katz and Zimet who were members of the CE Committee would likewise be rotating off the Board. Dr. Poirier recommended that a new Chair be appointed quickly so that the necessary paperwork could be studied by the new Chair and that person could also assist in the preparation of the required Annual Report (due September 2003) to APA. Dr. D'Angelo offered to become a co-chair of the CE Committee.

• Drs. Poirier and Cohen initiated discussion about developing a CE course that could be offered through the AACP web site. The proposal was discussed and the general feeling was that this was a viable idea; the next step would be to appoint a Board member to develop a course. Dr. Poirier offered to assist with the development of a website course as a committee member once he rotated of the board.

8. Bulletin and Website Report:

• The *Bulletin* co-editors were Drs. Stamm and Carpenter. Dr Stamm was not in attendance at the meeting and Dr. Carpenter provided the update. Dr. Carpenter summarized that latest issue of the *Bulletin* was well underway, but there was room for additional material. There was discussion of editorial practice with regard to responding to controversial feedback to *Bulletin* articles. Dr. Stamm communicated a decision to retire from his Co-editor position. Dr. Carpenter indicated that he would continue in his position. Dr, Poirier offered to function as a reviewer

• Discussion next re-visited the issue of the Bulletin being made available only over the Web Site as opposed to hard copy being mailed to the general membership. There was consensus that older members would prefer the hard copy because of unfamiliarity with electronic media. A suggestion was made to offer membership the choice of hard copy versus electronic access with the expectation that there will probably be eventual phasing out of hard copies. Dr.Carpenter suggested an effort to solicit more ads for the *Bulletin*

as a means of additional revenue; the suggestion met with consensus support. Still another approved suggestion was to recognize sponsors who underwrote AACP CE offerings in the *Bulletin.*

• Dr. Carpenter discussed numerous problems with the Website Host contractor. Discussion followed about contracting with a new Host service. The current Host ADEPT had been relatively inexpensive, but the service was not satisfactory. There followed discussion about adding a recruitment page to the web site, listing for example, the advantages of achieving board-certification; and developing FTP access to the website so Dr. Carpenter could make changes directly.   Dr. Poirier suggested that there were likely members who had sufficient electronic media savvy to implement the proposed conversion; one suggestion would be to solicit such membership skill through an ad in the *Bulletin*. Dr. Carpenter suggested that compared to other profession web sites, the AACP web site was a bit stodgy and a complete web site re-design was in order. One idea proposed by Dr. Schoenfeld and others was to add useful reciprocal links to other key web sites. It was further suggested that a re-design of the web site could have the objective of establishing the web site as general information resource about the field of Clinical Psychology.   Dr. Schoenfeld offered to become a member of the Web Site Committee, and it was also suggested that retired Board member Dr. Kenigsberg could be asked to become a member of that Committee.

• The foregoing discussion led to a proposal that a web site committee was needed to establish goals, agenda, and overall structure of the website. Dr. Carpenter was asked to cost out a website re-design with transfer of existing content. Dr. Carpenter stated he was already prepared with a preliminary budget; he estimated $800 to transfer the existing web site and approximately four to six thousand dollars for a complete re-design and from there approximately $50 per month for necessary updates and changes.

9. **Bylaws Committee:**

• Dr. Katz led a lengthy review of the revised Bylaws. Copies were provided to each Board member and the Board reviewed the revised by laws line by line. An ultimate vote resulted in a unanimous ratification of the as amended, revised bylaws.

• A motion of commendation applauding Dr. Katz's efforts in revising the by laws was also unanimously approved.

Interjected Discussion:

• Dr. Poirier requested a brief, updated review of existing Committees, and Committee membership that would be summarized in the minutes. That summary is as follows:

Archive Committee, Dr. Cohen.

Bulletin Committee, Drs. Stamm (Chair) and Carpenter.

CE Committee, Drs. Poirier (Chair), and D'Angelo.

Finance Committee, Drs. Zimet (Chair), Cohen, Katz, and Poirier.

Marketing Committee, Dr. Schoenfeld.Mentoring Committee, Drs. Poirier (Chair), Katz, and Majorski.

Nominations Committee, Drs. Zimet (Chair), Katz, Majovski, Schoenfeld, and   Poirier.

Public Relations Committee, Dr. D'Angelo.

Website Committee, Drs Carpenter (Chair), Schoenfeld, D'Angelo and Cohen.

10. **Board Member and Officer Changes:** Dr. Zimet

• Dr. Zimet, Chair of the Nominations Committee summarized the process of filling vacancies of Board members rotating off the Board as per the by laws criteria. As had been the process with the recent nominations of Drs. D'Angelo and Majovski, anticipated vacancies were posted in the Bulletin, and the Nomination Committee selected the top three candidates. Desired candidate criteria were statements of commitment, time-availability, and reasonable awareness of the Board's objectives and purpose.

11. **ABPP BoT Diversity Task Force Memo and Questionnaire**:

• Dr. Katz led rather spirited discussion about the recent task force memo. The consensus opinion was that response to the memo should rest with the BoT, and not with individual academies. That is, it was important for ABPP to be in step with other professional organizations.

12. **Planning for Fall 2003 Meeting**

• Proposals for the meeting side of the fall

2003 the Board meeting included Key West Florida and Savanna Georgia. Dr. Cohen agreed to explore these possibilities and a final determination would be based on projected expenses.

• The dates of the fall meeting would be the first and second of November 2003.

13. Finance Committee Report (general session):

• The Finance Committee reported that the budget would permit an expenditure of up to $6,000 to update the web site. More discussion of the needs for Website redesign followed, with different members suggesting an emphasis on the recruitment function, expanding members' biographical statements, links to member's websites, and using the site to market CE offerings. After discussion of the need for a graduated approach to development, Dr. Carpenter moved that expenditures be authorized in two stages: up to $1,200 could be spent on moving the study site to a stable host and generating four proposals for site designs. A committee made up of Drs. Carpenter, Schoenfeld, D'Angelo, and Cohen will then review the ideas for revision and make further decisions by e-mail, conferring with the whole Board when necessary. The motion was passed unanimously.

• The Finance Committee reported that the Saturday night dinner total cost was $633 Canadian money including guests. Board members would be informed of the US dollar cost later.

• Dr. Cohen suggested that we send out an AACP Appointments Book to all members and the cost would be approximately two dollars apiece. Dr D'Angelo thought that this was an effective marketing tool and also a morale booster for members, and he moved (second by Dr. Zimet) that this be done if ABPP decides not to send out books. The books will be sent out before the dues notice. The motion passed unanimously.

14. New Business:

• Dr. Cohen brought up the issue of making inroads into the structure of state psychological associations. After discussion, there was a consensus that it would be good to contact state associations with lists of our members, requesting that their Certification and Specialty status be given in all of that state's membership lists. It would be important also to communicate what

ABPP is, and to emphasize the importance of not listing vanity boards in a similar manner. This information would be helpful to members, as for example, in qualifying for Workman's Compensation Examiner status. It would also be useful to state associations in many matters such as finding mentors for young psychologists. Dr. Zimet commented that such information would need to include all diplomates and therefore any such request should come from the BoT, and not from individual academies. A consensus decided that Dr. Cohen would write to the BoT president regarding the matter. Discussion also continued from the last meeting regarding the desirability of forming divisions or interest groups in state associations for Board certified psychologists. No action plan was finalized.

• Dr. Carpenter proposed that ABPP might accredit or certify certain postdoctoral training programs such that successful completion of the program by young psychologists would permit them a "fast track" Board Certification examination. This would be similar to the "fast track" process that was offered in the senior program. Considerable discussion followed since this might offer a legitimate means of securing an influx of younger people. Dr. Zimet noted that "accrediting" would not be the appropriate concept, since that is a power jealously held by APA. Rather we might simply identify appropriate programs, and perhaps selected students within programs. Selected students might be given financial aid toward their training expenses (to be raised by grants secured by us) or for the expense of the exam, or both. Criteria for selecting programs were discussed, and members mentioned the following as important: two-year rather than one-year programs, programs directed by Board-Certified clinicians, programs that afforded serious training and not just work opportunities. Dr. D'Angelo noted that the aspect of ABPP mentoring would be a "plus" for programs to cite in competing for funds and students. Dr. D'Angelo agreed to chair a committee to draft a proposal for a demonstration project to present to the BoT, and also agreed to communicate with other Board members on these matters as he develops the idea.

• Former Board member Dr. Philip Pierce by

e-mail proposed discussion of the effort of some parties to form a Clinical Geropsychology specialty in ABPP. There was general consensus that it is inappropriate at the current time to form another tiny specialty group but that this may be an opportunity to form a sub-specialty group under clinical psychology. Hence, persons could be board-certified in clinical, with a subspecialty in Geropsychology. Establishing a precedent for a sub-specialty under Clinical would be desirable, and might result in the inclusion (i.e., "folding in") of other small specialty groups set a later time. Dr. Cohen agreed to call Dr. Michael Nelson to discuss the idea further.

• As per Dr. Carpenter's request, Board members agreed to try and help find advertising for the Bulletin.

• There was discussion about the desirability of printing additional copies of the bulletin to send to psychology departments, internship programs, postdoctoral programs, clinical graduate student groups, etc. Dr. Cohen will determine the cost per thousand of additional printings and report back to the Board.

There being no further business the Board meeting was adjourned at 12:15 p.m.

[1] The participating board members at the Spring meeting were: Dr. Howard Cohen, President, Dr. George Katz, Vice-President, Dr. Carl Zimet, Treasurer, Dr. Joseph G. Poirier, Secretary, Dr. James Carpenter, Dr. Gene D'Angelo, Dr. Larry Majorski, and Dr. Larry Schoenfeld. Absent Board members were: Dr. Ira Stamm.

QUERRY TO MEMBERS

The Academy Board of Directors is considering offering future issues of the Bulletin of the American Academy of Clinical Psychology in an electronic format, through the Academy website (WWW.AACPSY.ORG). The Board wishes to poll the membership about the desirability of this change. Would it meet your personal needs to have the Bulletin available *only* in this electronic form? Would you prefer to stay with the printed and mailed version? Would you prefer both? If you have an opinion in this matter, please write to the Bulletin editors and let us know.

If responding via email, write to jcarp@med.unc.edu. If sending by US post, please write to James Carpenter, Ph.D., 727 Eastowne Drive, Suite 300B, Chapel Hill, NC 27514.

Address for Academy Central Office

Academy of Clinical Psychology
P.O. Box 638
Niwot, CO 80544-0638

Ph: (303) 652-9154
Fax: (303) 652-2723
Email: lpete@indra.com

Have a wonderful summer!

Academy of Clinical Psychology Board Members and Board Affiliate Colleagues (Effective 2003)

President
Howard M. Cohen, Ph.D.
12 Hornbeck Ridge
Poughkeepsie, NY 12603
O: (845) 454-8793
F: (845) 454-8793
H: (854) 454-6004
E: cohenh@matrix.newpaltz.edu

Vice President (NE)
Eugene D'Angelo, Ph.D.
4 Woodholm Circle
Manchester-by-the-Sea, MA 01944
O: (617) 355-7650
F:
H:
E: dangelo@a1.tch.harvard.edu

Vice President (special charge)
West
George G. Katz, J.D., Ph.D.
17337 Tramonto Dr.
Pacific Palisades, CA 90272
O/H: (310) 454-9543
F: (310) 454-6693 (undedicated, call first)
E: bb283@lafn.org   or   Psychlaw1@yahoo.com

Treasurer
Intermountain
Carl Zimet, Ph.D.
4200 E. 9th Ave. C256-47
Denver, CO 80262
O: (303) 315-8611
F. (303) 315-2527
H: (303) 355-9689
E: Carl.Zimet@uchsc.edu

Secretary
Mideast
Joseph G. Poirier, Ph.D.
932 Hungerford Dr., Suite 14-B
Rockville, MD 20850-1711
O: (301) 545-0039
F: (301) 545-0195
H: (301) 929-1534
E: jgpoirier@comcast.net

Bulletin Co-Editors
Ira Stamm, Ph.D. (istamm@aol.com)
James Carpenter, Ph.D. (jcarp@med.unc.edu)

IM
Lawrence S. Schoenfeld, Ph.D.
Department of Psychiatry
Univ. Texas Health Science Center
San Antonio, TX 78229
O: (210) 567-5494
F: (210) 567-6941
H: (210) 494-4545
E: schoenfeldl@uthsca.edu

SE
James Carpenter, Ph.D.
727 Eastowne Dr., #300B
Chapel Hill, NC 27514
O: (919) 493-1102
F: (919) 493-1102
E: jcarp@med.unc.edu

WE
Lawrence V. Majovski, Ph.D.
1902 64th Avenue, W.
Suite 201
H: (253) 851-8422
Tacoma, WA 98466
O: (253) 572-9917
F: (253) 858-4060
E:

MW
Ira Stamm, Ph.D.
College Park Medical Bldg.
11791 W. 112 St., Suite 103
Overland Park, KS 66210
O: (913) 663-1611
F: (913) 469-5266
H: (913) 478-4446
E: istamm@aol.com

ABClinP President
John D. Robinson, Ed.D.
6735 13th Place, NW
Washington, DC 20012-2311
O: (202) 865-4893
F: (202) 865-6212
E: JDRobinson@aol.com

AClinP Administrative Officer
Lynn Peterson
P.O. Box 638
Niwot, CO 80544-0638
O: (303) 652-9154
F: (303) 652-2723
E: acadclinp@attbi.com

AMERICAN PROFESSIONAL AGENCY, INC.
Program Administrator

SPECIAL DISCOUNT FOR YOUR MALPRACTICE INSURANCE

Dear Doctor:

We are very pleased to announce thar ABPP Board Certified Specialists in Clinical Psychology, who are fellows of the American Academy of Clinical Psychology, are now eligible for a 20% discount on their claims-made malpractice insurance.

Due to your additional training and membership in the Academy you have been determined to be a better risk. American Professional Agency, Inc. in cooperation with the Academy has worked to bring this benefit to you.

Please call us at 1-800-421-6694 for rate information and visit our website (www.americanprofessional.com) We are sure you will find that a significant saving from your current policy is now available to you through the American Professional Agency.

Sincerely yours,

Richard C. Imbert, C.I.C.
President

Important!
Valuable information.
Please read immediately.

95 Broadway • Amityville, NY 11701 • (631) 691-6400 • (800) 421-6694
www.americanprofessional.com