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Contents

President's Column

Behavioral Principles and Public Policy: Dissemination in Action

Raymond DiGiuseppe, *St. John's University*

The name of our organization includes the word "therapies." This implies that our members treat people who have developed psychosocial problems. Recently, I have been thinking that our organization could focus more on long-term and large-scale primary prevention. Many children and families who are referred for mental health services have problems that result from the poverty that surrounds them. Although behavioral and cognitive principles can lend themselves to the prevention of behavioral problems, many primary prevention programs reach only a small number of people. Perhaps behavioral principles could be applied on a larger, societal scale. Perhaps we could use science to develop effective social policies that help eliminate many of the problems that lead to psychological difficulties, educate children, promote healthy behaviors, and teach skills linked to independent functioning.

Recently I heard a story on my local public radio station, WNYC (Lehrer, 2007), that inspired me to believe that we can have such a large-scale impact. The mayor of New York City, Michael Bloomberg, announced that the city would start a conditional cash transfer program. Instead of receiving monetary benefits noncontingently, as in most social service programs, families in the Opportunities NYC program would receive money contingent upon completing certain behaviors that have been linked to good outcomes. The target behaviors identified by the program include increasing children's school attendance, attending parent-teacher meetings,

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The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
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- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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improved scores on children's standardized educational tests, participation in prenatal care, well-baby care, preventive checkups, and keeping medical appointments.

Was I dreaming? Was the city of New York going to use incentives to reinforce families for "good behavior"? Yes! Under the Opportunities NYC program, impoverished families could earn up to $5,000 per year for positive behaviors linked to better health, education, and job skills. Behavioral scientists have long promoted the use of incentive-based programs to increase desirable, socially appropriate, adaptive behaviors. Behavioral psychologists have been criticized by other psychotherapists for designing such programs and not getting to the "deeper" causes of behavior problems. Could government policy planners finally have accepted the idea of contingency management?

The idea of contingent cash transfers is not new. New York City will model its program after PROGRESA/Oportunidades, developed in 1997 by a Mexican government economist, Dr. Santiago Levy. This program started by serving 300,000 families a year throughout Mexico with a budget of $58 million. Presently, 5 million families are involved in the Mexican program, with an annual cost of more than $3.2 billion. Extensive research on this contingent cash transfer program has appeared mostly in political economy and economic development journals. Dr. Levy (2006), presently with the Brookings Institute, recently published a book reporting extensive research on the program's effectiveness. Children in families that participated in the program had reduced illness rates and fewer cases of anemia, a major medical problem in Mexico. The results have failed to indicate that the children remained in school longer. Researchers speculate that this occurs because the increased income to families for participation in the program may not be large enough to offset the wages a child receives from employment after leaving school (Scientific Evaluation for Global Action, 2007).

The New York City program will not spend taxpayers' dollars. Several foundations, including the Starr Foundation, the Robin Hood Foundation, the Open Society Institute, and the American International Group, will fund the project. The Rockefeller Foundation, however, is the lead organization. The president of the Rockefeller Foundation, Dr. Judith Rodin, a well-respected research psychologist, is familiar to many of our members. Judith gave an invited address at our 1979 annual convention and was a member until 1984. She went on to become the president of the University of Pennsylvania before moving to the Rockefeller Foundation. Amazingly, the protocol for this project will be peer-reviewed by academic experts. The design also includes a control group. Clearly, good science makes good government.

I have followed the development of this news story. Surprisingly, very little criticism has emerged and almost none of the criticism usually leveled at reinforcement-based programs has appeared. Mayor Bloomberg, however, seemed to anticipate the criticism leveled at most contingency-management programs. He was asked why the government should pay people to do what society believes they ought to do. How many of us get similar versions of this question whenever we ask teachers or parents to reinforce children for completing homework? Mayor Bloomberg focused on the reality that people are not doing these things, and if a program works, we should employ it. Mayor Bloomberg seems to believe in empirically supported treatments. Is he one of our members?

Many questions remain unanswered about noncontingent cash transfer programs. Can behavior therapists help public policy planners to develop individualized programs based on what we have learned over the course of decades of research and practice in contingency-management programs? Once the efficacy of such programs is established, ethical concerns will emerge. Some people may express concern that our government reinforces certain behaviors with fiscal incentives. However, governments are already in the behavior-change business. This occurs through government tax policy. For example, the high tax on tobacco products is designed to reduce tobacco usage. The mortgage deduction on private homes supports purchasing homes over renting. A debate may follow on what target behaviors should be reinforced. Also, governments will have to face the task of drawing the line where target behaviors are related to independent self-sufficiency versus a needless intrusion into privacy that is not related to goals of the program. This program may mark the introduction of behavioral psychology into welfare policy and reform. Are we, as a science, ready to enter the public debate on what behavioral science says about how welfare policy should be crafted? Skinner (1976) suggested in *Walden Two* that contingent rewards could help design a society that promoted human happiness. I hope we will continue that tradition. I believe our profession has much to offer and that we can do the most good for the most people by developing humane and effective social policy. I would encourage all of us to follow the Opportunities NYC program and watch for the research and real-life results. We can encourage academic debate through our conventions and journals on how social policy can be constructed to reinforce adaptive behavior. Perhaps we could even have a Behavioral Social Policy Special Interest Group.

Designing social policy presumes that one knows which behaviors to increase and which behaviors to decrease. This will require extensive thought and research to ensure that such programs reinforce target behaviors that truly are related to healthy and adaptive behaviors and not behaviors that are valued by the policymakers with no value to the participants.

Several good things are reflected in this news story. Social programs can be designed on sound behavioral principles. Governments can learn the value of empirically testing the efficacy of their interventions. I hope that behavioral scientists and therapists will engage in the discussion about the Opportunity NYC program. Perhaps we can all learn from this story to think big and consider how our work can lead to a better society.

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News and Notes

Anne Marie Albano Appears on *Today*

Jill Panuzio and David DiLillo,
University of Nebraska–Lincoln

Anne Marie Albano, Ph.D., Columbia University associate professor of clinical psychology and ABCT member, appeared on the September 20, 2006, edition of NBC's *Today* show to discuss school-related separation anxiety among preschool- and kindergarten-bound children. Noting that separation anxiety occurs for a number of reasons, both genetic (e.g., familial predisposition to anxiety) and social (e.g., little experience with previous separation), Dr. Albano highlighted several ways that parents can ease their children's transition to school. Suggested strategies for reducing separation anxiety prior to the first day of school included: scheduling playtime with classmates, establishing routines (e.g., bedtimes), taking children to visit their school and teachers, and including children in the school preparation process.

Dr. Albano stressed that while parents are not at fault for their children's separation anxiety, children often detect and mirror their parents' emotions. For this reason, parents' attempts to manage their own emotions, positive and negative, are important for keeping children's expectations positive and realistic and essential to successful separation. When saying their goodbyes in the classroom or at the school bus, Dr. Albano suggested that parents keep it "short and simple" and to walk away, even if the child cries. Finally, Dr. Albano stressed that positive reinforcement throughout the school year is necessary to keep school attendance a positive experience and that activities such as maintaining a scrapbook of their school experiences can assist with this goal. Dr. Albano's suggestions are likely to help families with young children cope with school-related separation anxiety.

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Pharmacotherapy

The Effectiveness of Antidepressant Medications: Results From a Major New Study

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Some years ago, the National Institute on Mental Health funded a major research project on the effectiveness of antidepressant medications in treating depression. The study, funded with $35 million, was the largest trial of antidepressant medications ever conducted. Over a 7-year period, over 4,000 outpatients were enrolled in a project entitled Sequenced Treatment Alternatives to Relieve Depression—STAR*D. As implied by the title, the main goal was to determine the effectiveness of several follow-up treatments for depressed patients who had not responded well to a first course of antidepressant treatment. In early 2006, the initial results were published. Although antidepressants are widely believed to be exceptionally effective, the data from the STAR*D study tell a much more ambiguous story. How effective are antidepressant medications and what percentage of people benefit? Three publications from the study (Rush, Trivedi, et al., 2006; Trivedi, Fava, et al., 2006; Trivedi, Rush, et al., 2006) attempted to answer these questions and more.

The authors maintain that there is only limited scientific evidence on how to treat the category of depressed patients who fail to get relief after their first trial of antidepressants. Although it is not well known to the public, a majority of patients fall into this category. The authors wanted to investigate next-step treatments for these patients. Furthermore, they wanted to study real patients in real clinics so that the results could generalize to clinical practice in the real world. Past research trials of antidepressants, frequently designed and sponsored by the pharmaceutical companies that sell them, often failed to simulate real-world conditions in several ways. The trials were usually short (4 to 8 weeks), used selected volunteer subjects recruited by advertisements whose depression was uncomplicated by other psychiatric, medical, or substance abuse problems, used "improvement" rather than "remission" in evaluating outcome, and rarely reported a follow-up treatment after the initial medication trial was over. Critics maintain that this sort of research simply does not correspond to the real world of clinical practice where patients often have multiple problems in combination with depression and where continued and varied treatment is the rule. Critics also point out that improvement (a better score on the test assessing depression) is not a useful endpoint. Improvement that leaves the patient with symptoms of depression is too often followed by relapse, continued disabling symptoms, poor work productivity, impaired psychosocial functioning, and a risk of substance abuse. The STAR*D project was designed to address these criticisms and to study next-step interventions in the many people who failed to benefit from their first treatment with an antidepressant. Unfortunately, the trial did not include a placebo control group.

The entire study, as planned, was set up with four complicated sequential levels (steps) of treatment. The first two levels have been completed and are described in the three 2006 publications referred to above (Rush, Trivedi, et al., 2006; Trivedi, Fava, et al., 2006; Trivedi, Rush, et al., 2006), so we will focus on these two levels, which are complicated enough. I will describe the goals of the study, the participants, the treatments, the results, and, finally, a summary and commentary on the study.

The Goals

The preliminary goal, addressed in the Level 1 trial, was to treat a large sample of real-world outpatients with citalopram (trade name: Celexa), a selective serotonin reuptake inhibitor (SSRI), to determine how many patients would achieve remission from depressive symptoms. The second goal, addressed in the Level 2 trial, was to study two follow-up treatments for the many patients who emerged from Level 1 with either unacceptable side effects or continued symptoms of depression. One fol-

low-up strategy was to switch to a different antidepressant, and the other was to augment (add to) the Celexa dose with another medication. A third and final goal was to determine the characteristics of people with depression that will predict who will or will not do well on antidepressant medications.

The Participants

A large number of outpatients, 4,790, were screened for possible inclusion in the study. These were real outpatients voluntarily seeking treatment in either primary medical sites ($n = 17$) or in specialized psychiatric sites ($n = 23$), both public and private, throughout the United States. The patients were informed of the treatments to be studied and had to give their consent to participate at each step. From the original 4,790 people screened, 1,914 (40%) were lost to the study for a variety of reasons. The primary reasons included refusal to participate, failure to return, certain psychiatric diagnoses (bipolar, psychosis, obsessive-compulsive, eating disorders, or substance abuse requiring detoxification), and a history of nonresponse to the four antidepressants used in the study. The loss of 40% is a matter of concern because of the potential bias in who participated in the trial. Certainly, those who would not agree to initial treatment by antidepressant medication were excluded.

Ultimately, 2,876 persons diagnosed with major depressive disorder entered the Level 1 study and were treated with Celexa. From among many antidepressant drugs, Celexa was selected as a prototypical SSRI, with the advantages of fewer discontinuation (withdrawal) problems and less interaction with other medications. The patients were advised to consult the treating physicians at Weeks 2, 4, 6, 9, and 12. At these visits the physicians, following an extensive protocol, inquired about depression and drug side effects and adjusted the dosage of Celexa. They also treated general medical conditions and, in addition, any anxiety, agitation, sexual dysfunction, or sleep problems—all symptoms of depression. Notably, this degree of care is rarely found in the real world of clinical treatment.

Results of the Level 1 Treatment With Celexa

In advance of the study, the researchers decided that the primary outcome of interest would be "symptom remission" as defined by a score of 7 or less on a well-known measure, the 17-item Hamilton Rating Scale for Depression (HRSD-17). In comparison to the average pretreatment score of 21.8, a score of 7 represents a very substantial reduction in depressive symptoms. Independent assessors, uninformed of a patient's treatment, administered the Hamilton scale by telephone in an effort to ensure that investigator bias would not influence the results.

Of the 2,876 outpatients treated with Celexa for up to 14 weeks, 790, or 27.5%, reached remission. This means that 2,086 patients—72.5%—did not. Patients who dropped out of the study, sometimes because of intolerable side effects, were included in the number who did not achieve remission. This low level of treatment success occurred even though the patients received an exceptional level of medical and psychiatric care.

The results, stated in terms of remission (7 or less on the HRSD-17), can be hard to comprehend unless you are familiar with the test items comprising the scale. For example, the item labeled "Delayed Insomnia (after 4:00 A.M.)" lists a score of 1 for *mild (wakes earlier than usual but goes back to sleep)*. A 1 on this item indeed sounds mild and seems consistent with a reasonable definition of remission. On the other hand, the test item labeled "Suicide" scores a 1 for *feels life is empty, not worth living*. A score of 1 on this item doesn't sound so mild. The item on "Work and Interest" scores a 1 for *mild (feels incapable, listless, less efficient)*. For the "Guilt" item, *mild self-reproach (feels he/she has let people down)* is scored a 1. If at the end of treatment an individual scored a 1 on each of the four items mentioned above, the Hamilton score would total 4 and that individual would be classified as "in remission," despite the potential significance of these symptom reports. This example is designed to illustrate that "remission" as defined in the STAR*D study does not necessarily indicate that the patient is symptom free.

Another goal of the Level 1 study was to determine the characteristics of depressed people who will probably do well on antidepressant therapy and those who probably will not. Questionnaires and interviews revealed the usual suspects. Worse outcomes were found among people who were unemployed, less educated, non-Caucasian, male, unmarried, and living alone. Other factors associated with a poorer response were lower income, more medical disorders, more severe depression, more psychiatric problems, greater co-occurring anxiety, more substance abuse, less satisfaction with life, and, incidentally, less private health insurance. In depressed people who have such problems as low education, low income, unemployment, and low social support, perhaps it is unreasonable to expect medication to help. How are we to incorporate these psychosocial factors into neurochemical theories of depression? Are we to believe that depressed people who are unmarried, have lower income, less education, and less health insurance also have brain chemistry that is more resistant to medication?

Results of Level 2 Treatment

The researchers had expected that a large number of patients would not benefit from a single course of Celexa. Therefore, they planned the research protocol to offer a second level of treatment. Consistent with the goal of having the research simulate real-world psychiatric treatment, the unsuccessful patients from Level 1 were offered two types of continuing treatment: (a) a switch to one of three other antidepressants, or (b) an augmentation (addition) of a second drug to the Celexa they had taken previously. Actually, a third treatment, cognitive therapy, was offered, but only 10.2% chose this option. The data on cognitive therapy await future evaluation. The published results (so far) describe the two medication treatments only.

In the "switch" treatment, 727 patients consented to be randomized into three groups receiving either Zoloft (sertraline), Effexor (venlafaxin), or Wellbutrin (bupropion). The researchers offered Zoloft, another frequently prescribed SSRI, on the grounds that a different SSRI might work, even though Celexa did not. They offered Effexor, a "dual-action" drug believed to inhibit the reuptake of both serotonin and norepinephrine, on the grounds that a depressed person's brain might benefit from more serotonin and more norepinephrine. And finally they offered Wellbutrin, an "out-of-class" antidepressant whose neurochemical mechanism of action is unknown (although it is not an SSRI), on the grounds that depressed patients might benefit from something entirely different. The hypothesis: If the patients who failed to respond to Celexa did so because Celexa did not produce the right neurochemical change, then switching to a new drug with a different neurochemical action might be particularly therapeutic.

In the "switch" wing of the study, the results were quite similar for the three drugs in spite of the different mechanisms of action. The remission rates measured by the HRSD-17 were 17.6% for Zoloft, 24.8% for Effexor, and 21.3% for Wellbutrin. Statistically, there was no significant differ-

ence among the three medications. Of the 727 patients who were switched to these three medications, a total of 155 achieved remission. Thus, the overall remission rate from switching medications was 21.3%. Stated differently, 78.7% were not relieved of depression. This result was at variance with the neurochemical hypothesis in that drugs with different neurochemical actions were essentially equivalent.

In the "augmentation" wing of the study, 565 patients consented to having another medication added to the Celexa they had taken previously. They were randomly assigned to have either Wellbutrin or Buspar (buspirone) added. Wellbutrin is another antidepressant, but Buspar is not. It is used clinically to treat anxiety and has some mild sedative effects. As measured by HRSD-17 scores, remission rates differed very little between the group given Celexa plus Wellbutrin (29.7%, or 83 out of 279 patients) and the group given Celexa plus Buspar (30.1%, or 86 of 286 patients). If we total the remissions from both augmentations, we find that 169 of 565 patients, or 29.9%, reached a remission. The numbers might be interpreted to say that it is somewhat better to augment Celexa with Wellbutrin or Buspar with a 30% remission rate than to switch to other antidepressants with remissions rates ranging from 18% to 25%. However, due to the way the research was conducted (with different sets of patients consenting or not consenting to be assigned to certain treatments), the switch and augmentation treatments cannot be directly compared.

Summary and Commentary

We often see TV ads, newspaper articles, and even scientific journals promoting the notion that antidepressant medications work because they modify brain serotonin levels (or perhaps norepinephrine, dopamine, gamma amino butyric acid, and others). However, the "switch" study revealed that medications with various neurochemical actions were all essentially equivalent. Can we infer anything about the presumed neurochemical action of antidepressants? At this point, we need to understand that the widely reported mechanisms of action of antidepressants are presumptive and are not scientifically established as causal. If we look up the various antidepressants in the *Physicians' Desk Reference* (2007), where information must be FDA approved, we note a preponderance of cautionary phrases such as, "is presumed to be" and "is believed to be." For example, the lead sentence describing the pharmacology of Zoloft reads as follows: "The mechanism of action of sertraline is presumed to be linked to its inhibition of CNS neuronal uptake of serotonin." In the pharmacology section on Effexor, we read, "The mechanism of the antidepressant action of venlafaxine in humans is believed to be associated with its potentiation of neurotransmitter activity in the CNS." The basis of the presumption often comes from animal studies where a laboratory investigator can extract samples from an animal's brain after exposure to large doses of the antidepressant drug. In the animal studies, it can be shown that an SSRI increases brain serotonin—among other neurochemical changes. However, even if the drug has the same neurochemical action in humans and helps to alleviate depression, it is a logical leap to assume that a particular neurochemical action was responsible. A basic finding in pharmacology is that all drugs have multiple actions in various sites in the human body. If we observe changes in a neurochemical event (more serotonin) and simultaneously observe changes in another event (less depression), we have observed a correlation. We have not established that the first event caused the second. One or more of the many other actions of the drug, or combinations thereof, could be responsible. The cock's crow in early morning accompanies the sunrise (a correlation), but it would be a leap of logic to think the cock's crowing caused the sunrise. Suffice it to say, with respect to brain chemistry and depression, exactly what causes what is far from clearly established.

For sufferers from depression, are the results of the STAR*D study good news or bad news? Suppose, for the moment, we look on the bright side and take the results at face value. A depressed person, even if he or she has complications from other medical and psychiatric disorders, has about a 28% chance of getting relief after a single 3-month course of an antidepressant drug (Celexa). People who did not get relief can persist with a second 3-month course of medication, either by switching to another drug or by augmenting the original drug with a second one, and have a 21% chance of relief with one strategy and a 30% chance with the other. Although a statistician might tell us we are playing a little fast and loose with the numbers, we can estimate that the people who plan to persist through both levels of treatment have about a 43% chance of gaining remission in the worst case and a 50% chance in the best case. An even larger percentage of patients, of course, had some improvement even though they did not reach the remission criterion. This outcome could be considered good news to a depression sufferer because depression is an exceedingly unpleasant disorder, and 6 months of treatment, even if the drugs are expensive and the side effects are disagreeable, might well be worth it.

Now for the bad news. By taking the results of the STAR*D study at face value, we are assuming that the antidepressant medication was responsible for the remissions. There are at least three other factors that probably contributed to the observed remissions. One is spontaneous recovery. A number of studies have shown that many depressed people recover on their own, perhaps with the help of family, friends, exercise, a book on depression, a deliberate return to their life's normal activities, etc. A second factor is the large amount of individualized psychiatric and medical care that patients received at Weeks 2, 4, 6, 9, and 12. Following the standard study protocol, treating physicians talked to the patient, evaluated depressive symptoms and side effects at each visit, adjusted the dose of medication, and provided medical management. The medical management included medications for symptoms commonly associated with depression, such as sleep disturbances, anxiety, agitation, and sexual dysfunction. It would not be far-fetched to describe the STAR*D study as a trial of antidepressants plus other medications. While no doubt beneficial to the patients, this level of care is quite unusual in the real world of psychiatric and medical care. How much difference could this exceptional care make? A *Washington Post* article (Vedantam, 2006), based on interviews of lead researchers of the study, stated the following: "If patients in this study had received the kind of care that patients receive on average, the researchers said, the remission rate probably would have been significantly lower—perhaps even in the single digits."

The third factor that probably contributed to the observed remissions is the placebo effect. A substantial number of depressed people will get better if they think they are getting an effective medication, even though the pill is a placebo. The pool of participants in Level 1 had all consented to treatment with Celexa, and the pool in Level 2 consented to continued drug treatment. It is not unreasonable to believe that most people who gave informed consent to participate in the study must have expected to benefit from medication. A placebo control group, had it been included in the study, would have benefited from the

placebo effect plus the medical/psychiatric care plus a 6-month opportunity for spontaneous recovery. How much remission can be expected in this sort of placebo control group? Kirsch, Moore, Scobabria, and Nicholls (2002) reanalyzed 47 placebo-controlled trials of six widely prescribed antidepressants. These trials, supported by the pharmaceutical manufacturers of the drugs, were reported to the FDA to gain approval of their medications. Kirsch's analysis showed that, although a positive response to antidepressants occurred, the response to inert placebos was almost as great. The average difference, though statistically significant, was only 2 points on the HRSD-17. Kirsch concluded that 82% of the drug response was accounted for by placebo effects. More than half of the 47 trials failed to find any significant differences between placebo and drug.

The bad news, then, is that it is very hard to tell how much, if any, of the reported positive outcomes in the STAR*D studies were specifically due to the medications. An individual seeking relief from depression might find it hard to justify the high expense of antidepressants and the disagreeable side effects when a positive outcome is so uncertain and might well be due to factors other than the medication.

Pharmaceutical industry advertising may bias the public's view of the effectiveness of antidepressive medications. TV ads showing smiling models and saying "Ask your doctor about Drug X" do not state that less than 30% can expect remission from a course of treatment. In addition, the pharmaceutical industry, perhaps with assistance from biological psychiatry, may be promoting a misguided faith in the evidence supporting a biological basis for depression. A recent book, *The Myth of Depression as Disease*, by Leventhal and Martell (2006), addresses this issue with a broad array of evidence. The authors find reason to view depression not as a brain disease but rather as a mood and behavioral disorder resulting from adverse life situations ("It's Not Your Brain; It's Your Life" is the title of one of their chapters). When a person encounters extremely adverse life situations and becomes locked in depression, his or her brain chemistry may change as a result. However, the authors could not find scientific evidence for the widespread belief, fostered by pharmaceutical companies and biological psychiatrists, that defective brain chemistry is the cause of depression.

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Pharmacotherapy

Do Antidepressant Medications Really Increase Suicide Risk for Adolescents? Reflections on the FDA's Black Box Warning

Lauren Mikula, Amanda Bronson, and David Reitman, *Nova Southeastern University*

Increased utilization of psychotropic medication for the treatment of depression in children and adolescents has received widespread attention in the past decade. This attention is reflected in media coverage of research (Dulcan, 1997), in updated clinical practice standards (American Academy of Pediatrics, 2000), in the Surgeon General's national action agenda for children's mental health (U.S. Department of Health and Human Services, 1999), and in consumer-sponsored (Lewis, 2001) and government-sponsored (National Institute of Health Consensus Development Conference Statement, 2000) consensus statements.

Recent evidence that antidepressant drugs may increase the risk of suicide attempts and suicidal thinking in children and adolescents has rendered the practice of writing prescriptions for antidepressant medications controversial (Lock, Walker, Rickert, & Katzman, 2005). In response to rising concerns, the United States Food and Drug Administration (FDA) has required manufacturers to include a "black box warning" label on antidepressant medication that alerts health care providers and consumers of an increased risk of suicidal behavior in children and adolescents being treated with these medications (Lock et al., 2005). The purpose of the present paper is to examine the broader empirical support for the FDA's warning to determine if these actions appear reasonable in light of the available scientific data: Do antidepressant medications increase the risk of suicide when prescribed to adolescents?

What Is a Black Box Warning?

A black box warning is a label placed by the FDA on a medication to alert prescribing doctors and patients that special care should be exercised for certain uses of that medication (Sharav, 2004). It is the most serious warning placed on the labeling of a prescription medication, and in the case of antidepressant medications, the warning label refers to an increased risk of suicidal

thoughts and behavior in children and adolescents (Sharav, 2004). This label has been applied to all antidepressants, not just selective serotonin reuptake inhibitors (SSRIs), because many of the FDA review panel experts were concerned that limiting the warning to only SSRIs would lead to an increased use of the tricyclic antidepressant medications (TCAs), which potentially have more side effects, narrower margins of safety, and an association with higher rates of completed suicide (Birmaher, Brent, & Benson, 1998; Valuck, Libby, Sills, Giese, & Allen, 2004). Though the new warning language does not prohibit the use of antidepressants in children and adolescents, it does emphasize that children and adolescents treated with SSRIs be closely monitored for increased depression and any unusual changes in behavior, such as sleeplessness, agitation, or withdrawal from normal social situations (National Institute of Mental Health, 2005). The warning label also encourages prescribers to balance this risk with clinical need (Rappaport, Prince, & Bostic, 2005).

What Prompted the FDA Warning?

In June of 2003, the Medicines and Healthcare Products Regulatory Agency (MHRA), the FDA counterpart in the United Kingdom, warned physicians about the potential increased risk of suicidal thoughts or attempts in children and adolescents taking the SSRI paroxetine (Paxil in the U.S. and Seroxat in Britain) (Olfson, Shaffer, Marcus, & Greenberg, 2003). After further examination of data on all of the SSRIs, the MHRA found that, with the exception of fluoxetine (Prozac), SSRIs have not been proven effective for youth with depression and may actually increase the risk of suicidal thinking or attempts (Olfson, Shaffer, et al., 2003). However, as the MHRA pointed out, it is important to note that "lack of proven effectiveness" is not the same as "proven ineffective."

Before making their own recommendation, the FDA attempted to determine the risk of suicidality for antidepressant medications in a combined analysis of short-term (up to 4 months) placebo-controlled trials of nine antidepressant drugs, including the SSRIs, in children and adolescents with major depressive disorder (MDD), obsessive-compulsive disorder (OCD), and several other psychiatric disorders (FDA Public Health Advisory, 2004). A total of 24 trials involving over 4,400 patients were included in the analysis. Through their investigation, the FDA concluded that there was indeed a greater risk and a "consistent link" between the use of the medications and suicidal tendencies in children and adolescents (FDA Public Health Advisory, 2004). In fact, the FDA concluded that the risk of suicidality during the first few months of treatment in those receiving antidepressant medications was twice the risk (4%) of those receiving the placebo (2%) (FDA Public Health Advisory, 2004). The FDA further reported that no completed suicides occurred during these trials. However, despite the fact that no completed suicides were recorded, the increased risk that was observed was deemed noteworthy by the FDA. As a result, the FDA issued a Public Health Advisory that required the manufacturers of antidepressant medications to attach a "black box warning" label recommending close observation of adults and children treated with these medications for worsening depression and/or the emergence of suicidality (Olfson, Shaffer, et al., 2003).

Limitations of the FDA's Study and Implications of the Black Box Warning

The FDA's decision to place a black box warning on antidepressant medications was met with considerable controversy and criticism. For example, Rappaport et al. (2005) noted that the FDA investigation identified a relatively small number of suicide-related events. Specifically, suicide-related events were identified in only 95 of the 4,400 research participants. Rappaport et al. also pointed out that considerable differences existed among the studies included in the FDA analysis in terms of recruitment, assessment, and classification of suicidal intent or related events, all of which may limit cross-study comparisons. Additionally, suicidal thoughts and/or related events may have been influenced by medication noncompliance, which was inadequately monitored throughout the studies (Rappaport et al.). Lastly, according to Brent and Birmaher (2004), many patients seen in "typical" clinical practices, including patients with severe psychopathology, comorbid conditions, and/or significant suicidal risk, were excluded from the 24 clinical trials. The consensus of these critical reviews of the FDA's action appears to have been that methodological limitations should have been more carefully considered before drawing conclusions about the safety of antidepressant medication use in adolescents.

Rappaport et al. (2005) also questioned the FDA action on the grounds that widespread antidepressant use may have been responsible for recent reductions in suicide. For example, data gathered by the World Health Organization (WHO) indicate that suicide rates across all age groups in the United States increased 5.08% from 1980 to 1990 (WHO, 2005). Interestingly, a 16.13% decrease from 1990 to 2000 coincided with a period of rapidly increasing antidepressant use (specifically, SSRIs). Rappaport et al. argue that the link between rising antidepressant use and decreased suicide may well be causal. In light of these data, Rappaport et al. caution readers that the FDA black box warning could dissuade physicians from prescribing a class of medications that may have played an important role in reversing the escalating prevalence of suicide noted from 1980 to 1990.

What Is Known About Adolescent Suicide?

Suicide ranks as the third leading cause of death among adolescents in the United States and Canada (Vitiello & Swedo, 2004). While the general adolescent suicide rate has declined by over 25% since the early 1990s, the rate for those between the ages of 15 and 24 has tripled (Gibbons, Hur, Bhuamik, & Mann, 2005). In 2001, 3,971 suicides were reported in this age group (Anderson & Smith, 2003). Suicide risk factors vary with age, gender, cultural influences, and social influences and may change over time. Epidemiological studies report that the risk of suicide increases with an increase in the number of risk factors present (Cohen et al., 1980; Gould, King, & Greenwald, 1998; Pfeffer, 1986). Several risk factors that are known to be associated with adolescent suicidal behavior include socioeconomic status, evidence of psychiatric disorders among the adolescents themselves (e.g., depression, anxiety disorders, conduct disorder, alcohol and drug abuse), and a history of psychiatric disturbance in the family as a whole (Cohen et al.). Additionally, other risk factors that increase suicide risk include a family history of completed suicide, previous suicide attempts, irritability, agitation, and recent stressful life events (Cohen et al.; Gould et al., 1998; Pfeffer, 1986).

Antidepressant Medications

A variety of antidepressant compounds, including TCAs, SSRIs, monoamine oxidase inhibitors (MAOIs), and a number of other novel compounds, are currently available for the treatment of child and adolescent depression (Walsh, 1998). SSRIs (the focus of the present paper) were first intro-

duced in the late 1980s and have received the most attention in psychopharmacologic studies of child and adolescent depression (Walsh, 1998). SSRIs represent an improvement over older antidepressants, as their side effects are better tolerated and they pose less of a risk in the event of an overdose (Walsh, 1998). The use of SSRIs in juvenile populations has increased substantially over the years, with children as young as 8 being treated with fluoxetine for depression (Vitiello & Swedo, 2004). Other SSRIs currently available in the United States include sertraline (Zoloft), paroxetine (Paxil), and fluvoxamine (Luvox) (Walsh, 1998).

How Are Antidepressants Thought to Increase Suicidal Ideation in Adolescents?

Several hypotheses have been advanced to explain how antidepressant medications may increase suicidal ideation in adolescents. Akathesia, the feeling that one cannot keep still physically or mentally, manic episodes precipitated by antidepressant medications, and, paradoxically, enhanced well-being (i.e., increased vitality, better sleep) in advance of the medication's antidepressant action, have all been cited as possible explanations for increased risk (Watkins, 2004). Similarly, Cuffe (2004) contends that as depression improves, individuals become more energetic, less apathetic, and more inclined to take action. For patients that remain suicidal, however, the risk of suicide is thought to increase. Cuffe (2004) suggests that less common side effects of antidepressants, including activation, agitation, impulsivity, and disinhibition, may also increase the risk of suicidal thoughts and attempts in adolescents, but he notes that there is no evidence that exists to support this hypothesis.

Does Research Support the Hypothesis That Antidepressant Medications Increase the Risk of Suicide in Adolescents?

Despite the ominous message conveyed by the black box warning, the empirical evidence concerning the likelihood that antidepressants increase suicide risk is decidedly mixed. As noted above, among adolescents 10 to 19 years of age, a 25% decrease in the suicide rate from 1992 to 2001 was accompanied by sharp increases in the prescription of antidepressants to this population (Anderson & Smith, 2003; Olfson, Gameroff, Marcus, & Waslick, 2003). It is also noteworthy that a 1% increase in the use of SSRIs among adolescents in this age group was "associated with a decrease of 0.23 suicides per 100,000 adolescents per year" (Olfson, Gameroff, et al., 2003). In other words, as suggested by Rapport et al. (2005), the decline in youth suicide rates may be explained by the increased rates of SSRI prescriptions to young people during this time period. Conversely, Olfson, Gameroff, et al.'s observation may represent only epidemiological coincidence. Vitiello and Swedo (2004) contend that it is extremely difficult to demonstrate a causal link (either positive or negative) between antidepressant treatment and suicide because suicide is such a rare event in the first place. The authors also suggest that controlled clinical trials with thousands of subjects would be needed to detect a treatment effect for SSRIs (Vitiello & Swedo, 2004). To further examine the claims that antidepressant medications pose a risk to adolescents in treatment, we examined two recent large-scale studies of adolescent treatment for depression that addressed the risks associated with antidepressant medication.

The first study reviewed was conducted at the University of Colorado Health Sciences Center (UCHSC), where researchers identified 24,119 adolescents diagnosed with depression and/or receiving antidepressant medications using claims data from both commercial insurers (92%) and Medicaid (8%) (Valuck et al., 2004). The adolescents either received the diagnosis of MDD and/or an antidepressant medication between January 1998 and March 2003, as indicated by insurance claims data. Exclusion criteria for this study included having had any of the following recorded on paid claims within 12 months prior to a diagnosis of MDD: another mood disorder, a filled prescription for antidepression medication, a paid claim to a health care provider coded as psychotherapy, or a claim that was coded as a suicide attempt. Follow-up data were gathered, with the average length of follow-up being 1.36 years following the onset of treatment for MDD.

The UCHSC research team concluded that treatment with an antidepressant medication (either an SSRI or a non-SSRI) did not result in a statistically significant increased risk of suicidal attempts (Valuck et al., 2004). Closer inspection of the data, taking into account severity of depression and other factors thought to influence suicidal behavior, revealed that the drugs did not increase suicide attempts among adolescents (Valuck et al.). In fact, according to the researchers, adolescents who took antidepressants for 6 months or more were less likely to attempt suicide (Valuck et al.). However, an increased risk of suicide attempts was observed among adolescents with more severe depression, among those who were younger at the time of diagnosis, among females, and, lastly, among those living in the Midwest or Western part of the United States (Valuck et al.). Taken together, the results of Valuck et al. suggest that factors such as severity of depression and gender may complicate estimations of suicide risk for antidepressants.

The multisite randomized clinical trial sponsored by the National Institute of Mental Health (NIMH), Treatment for Adolescents With Depression Study (TADS), was designed to evaluate the short- and long-term effectiveness of four treatments for adolescents with MDD: fluoxetine, cognitive-behavioral therapy (CBT), their combination, and a placebo. Participants were 439 adolescents, aged 12 to 17 years, with a primary *DSM-IV* diagnosis of current MDD (TADS, 2004). Patients were recruited without regard to sex, race, or ethnicity from (a) clinics; (b) paid and public service advertisements in newspapers and on the radio and TV; (c) primary care physicians; (d) other mental health clinicians; and (e) schools and juvenile justice facilities at 13 academic and community clinics (TADS, 2004). All of the patients and at least one of their parents provided written informed consent. Inclusion criteria for the study were the ability to receive care as an outpatient; a *DSM-IV* diagnosis of MDD at consent and again at baseline; a Children's Depression Rating Scale–Revised (CDRS-R) total score of 45 or higher at baseline; a full-scale IQ of 80 or higher; and absence of antidepressant(s) treatment prior to consent (TADS, 2004). Additionally, a depressive mood had to have been present in at least 2 of 3 contexts (home, school, among peers) for at least 6 weeks prior to consent. Concurrent stimulant treatment for attention-deficit/hyperactivity disorder (ADHD) was permitted (TADS, 2004).

The exclusion criteria for the TADS study included "a current or past diagnosis of bipolar disorder, severe conduct disorder, current substance abuse or dependence, pervasive developmental disorder(s), or a thought disorder" (TADS, 2004, p. 808). In addition, participants could not be undergoing simultaneous treatment with psychotropic medication or psychotherapy, as it is regarded as unethical to enroll a subject into a treatment study when he or she has another disorder that requires a different treatment than that already being offered in the current study. Children or adolescents

that had "previously experienced two failed SSRI trials, a poor response to clinical treatment containing CBT for depression, intolerance to fluoxetine, a confounding medical condition, had a non-English speaking patient or parent, or were pregnant or refused to use birth control were also excluded" (TADS, 2004, p. 808). Finally, "patients were excluded if they had been hospitalized for dangerousness to self or others within three months of consent, or if they were deemed to be a high risk because of a suicide attempt requiring medical attention within six months, had clear intent or an active plan to commit suicide, or verbalized suicidal ideation with a disorganized family unable to guarantee adequate safety and monitoring" (TADS, 2004, p. 808). While the aforementioned exclusions are reasonable and necessary for research participation, the exclusions also limit the generalizations that can be made from the TADS study. Specifically, the study may not be able to address concerns about risks for adolescents with more severe depression or disorganized family environments. Caution seems warranted as the UCHSC study suggested potentially increased risk for adolescents with more severe depression (Valuck et al., 2004).

To ensure patient safety and evaluate the tolerability of treatment, specific procedures were used in order to monitor for adverse events. In this study, an adverse event was defined as "any unfavorable medical change occurring post-randomization that was accompanied by functional or clinical impairment" (TADS, 2004, p. 809). An adverse event may or may not be related to or caused by the study drug or CBT treatment. A harm-related adverse event was defined as "involving harm to self, which can include a non-suicidal event, such as cutting for relief of dysphoric affects, worsening of suicidal ideation without self-harm, or a suicide attempt of any lethality; or harm to others, which includes aggressive or violent ideation or action against another person or property" (TADS, pp. 809-810). Finally, a suicide-related adverse event requires that the "patient exhibit either worsening suicidal ideation or make a suicide attempt, or both" (TADS, p. 810). It is important to note that harmful behaviors without suicidal ideation or intent, such as some instances of cutting, are not included in the definition of a suicide-related adverse event.

With the above-noted caveats, the TADS research team recommended combined treatment with fluoxetine and CBT. The team's recommendation was for combined treatment, despite finding that CBT alone was less effective than fluoxetine and that CBT was not superior to placebo pill (TADS, 2004). Importantly, while fluoxetine alone did not appear to increase suicidal ideation, harm-related adverse events were reported to occur more frequently in fluoxetine-treated adolescents. The addition of CBT to treatment with fluoxetine appeared to reduce the likelihood of harm-related events.

TADS researchers were concerned about the clinical response rate for CBT alone, which was lower than in other studies, and speculated that the lower response rate may have been due to greater severity, chronicity, and comorbidity in the TADS trial participants compared with previous trials (TADS, 2004). With regard to suicide, a general decrease (with a few exceptions) in suicidal thinking was found in adolescents taking fluoxetine (Bernard, 2004). However, 15 of the 216 youths on fluoxetine (6.94%) had a suicide-related event, such as making a suicidal attempt or threat, as compared to 9 of the 223 on the inert placebo pill (4.04%) (Bernard, 2004). The FDA, in their review of clinical trials, also found that the rate of suicidal thinking or behavior, including actual suicidal attempts, among nearly 2,200 children treated with SSRI medications, was 4%, or twice the rate of those receiving inert placebo pills (2%) (NIMH, 2005). Despite the increase in suicidal thinking and/or behavior, the data revealed no completed suicides among the children in either the FDA clinical trials or the TADS study.

In summary, despite considerable research on antidepressant use among adolescents, there remain significant questions about the cost and benefits of their widespread use. Currently, there is no sure way of establishing, in advance, who may be sensitive to the potentially adverse effects of an SSRI. Put simply, an individual's response to medication cannot be predicted with confidence from the studies that have been conducted so far. It is also extremely difficult to determine whether or not SSRIs increase the risk of completed suicide, not only because depression itself increases the risk for suicide, but also because completed suicides are so rare. Some evidence suggests that antidepressants may increase, and perhaps double, the rate of suicide attempts or threats, yet other studies suggest no increase in ideation. Further limiting any definitive conclusions is the fact that controlled trials typically include only hundreds of patients, not the thousands that would likely be necessary to detect effects for rare events (see Vitiello & Swedo, 2004). Lastly, controlled trials have typically excluded patients considered at highest risk for suicide, thus the potential adverse or positive impact of antidepressants in this population remains understudied (and may remain so). Prospective, longitudinal studies would be valuable but prohibitively expensive. Until the risks can be evaluated more fully, it is likely wise to use SSRIs in children and adolescents with caution, and to pay special attention to suicide risk assessment when treating children and adolescents, especially early in treatment. Viewed in light of the available empirical data, the FDA's requirement of a black box warning appears to be a judicious use of governmental oversight. Moreover, mental health professionals can play an important role in ensuring the safety of children receiving antidepressant medications by providing feedback to primary care physicians and psychiatrists concerning the efficacy of pharmacological interventions.

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Election Results

PRESIDENT-ELECT (2007-08):

Robert Leahy

REPRESENTATIVE-AT-LARGE (2007-10):

Stefan Hofmann

ABCT

Student Forum

The Academic Job Search: Time Line, Tips, and Tactics

Cynthia L. Huang-Pollock, *Pennsylvania State University*, and Amori Yee Mikami, *University of Virginia*

The process of finding a first academic job is almost a full-time job. Each of us, within the last 2 years, completed nationwide job searches representing a range of research universities and teaching-oriented colleges. The purpose of this article is to pass on tips and tactics to students and postdocs who are gearing up for a first job search. We are both clinical psychologists but believe that the majority of the principles discussed will be applicable to individuals in all areas of psychology.

Put Your Whole Self In

If you're going to do a job search, do a job search. Don't tell yourself that you'll "just see"—this process takes far too much effort to only put half of yourself out there. Because the majority of applications will require the same six basic components (research statement, teaching statement, curriculum vitae, recommendation letters, article reprints, and sometimes teaching evaluations; we discuss each of these in more detail below), there is not much difference in applying to a handful of jobs versus 30. This is not to say that one need apply to every posting. Rather, the applications you do submit should represent your best work, and you should be mentally geared up to begin an academic job—because this attitude will come out in the interview.

How to Choose Which Jobs to Apply For

The best source for job information is probably the APA *Monitor* online classified ads (which are updated daily; http://psyccareers.apa.org). You can supplement this with listings in the APS *Observer*, *Chronicle of Higher Education, the Behavior Therapist*, listserves, and word of mouth. Always apply for any job that you want, even if you think you are not a great fit with the advertisement. If the search committee can't find the exact job candidate they want, they will sometimes consider well-qualified applicants who don't quite match. If you already know you would not accept a particular job, then you should not apply because you will be wasting everyone's time. However, try to keep an open mind, because your impressions might change after the interview.

Time Line for Applications

Most deadlines range from October 1 to February 1. We have known individuals who began their search process much later than we did, and were successful, but the following is the time line that worked the best for both of us. We deny that neuroticism played any part in this.

- **June–July:** Draft your research statement and update your curriculum vitae. Decide who you will be asking to write letters of recommendation and notify these people of your intent. If you are seeing clients, discuss with your supervisor how you will handle last minute or extended absences throughout the winter for job interviews.
- **August:** Edit your research statement and then send it and your vita to your letter writers. Draft your teaching statement and collect your teaching evaluations. Draft a template cover letter. Order a few graduate transcripts. Make sure that reprints of your articles are available.
- **September–January:** Mail job applications. One time-saving strategy is to create hanging folders in a file cabinet for "research statement," "teaching statement," "reprint #1," etc., and fill them with multiple copies of the material. Then, as you see the advertisement posted, you can quickly collate an application by pulling the relevant materials from your files.
- **September:** Draft your research talk. Schedule as many opportunities as possible to present your talk in front of other people and get feedback. Ask to present in your lab group from graduate school or postdoc. One of us invited over student friends and fed them takeout to cajole them into listening to the job talk. The other one simply forced her significant other to sit through it with no type of food enticement. Each of us presented her full job talk three times before actually giving it.
- **November–February:** Attend job interviews. Some places will conduct a first round by phone and then decide whether to invite you to an in-person interview.
- **December–March:** Job offers are made. Negotiate your contract, go back for a second visit, and decide on a job. Then celebrate and prepare to move!

Cover Letter, Research Statement, and Teaching Statement

The purpose of a cover letter is to make your vita idiot-proof. It should be about one to two pages, single-spaced, including letterhead and contact information. In a cover letter, you want to briefly describe your research, your clinical/teaching experiences, and highlight your honors/awards/grants. If you have a specific set of skills that makes you a good candidate for the advertised position, you should emphasize that clearly in your cover letter, as well as organize and tailor your CV to underscore those aspects of your training or expertise.

In contrast to a cover letter, think of a research statement as a review article of your program of research. This should be about four pages, single-spaced. You want to discuss findings from posters, presentations, MA data, etc., and you want to link your projects conceptually. "I did study X, and found that . . . so, I got interested in question Z . . . which led me to conduct this other study, in which I found . . ." Cite yourself liberally.

Your teaching statement should showcase your teaching philosophy, using specific examples from previous experiences. Consider discussing your role as a clinical supervisor and mentor. Finally, if you are applying to teaching-oriented schools, your statement should convey your enthusiasm and exuberance for undergraduate education.

Letters of Recommendation

Most places will ask for three, or "at least three," letters of recommendation. If you have more than three strong letters, it is a good idea to send more (up to five), unless the school specifically asks for "no more than three." You may want to enclose a different set of letters for research versus teaching or clinical positions. Make it easy for

your letter writers and provide them with pre-addressed mailing labels to where you are applying, as well as an electronic file that includes the names of the chair of the search committee, addresses, and deadlines. Letters of recommendation are usually sent directly by the letter writer to the university and are not included in the package that you prepare.

Tips for Phone Interviews

Our experience was that about one-third of jobs will do some kind of phone interview process, formal or informal, before they invite you to an in-person interview. The majority of places will email you to arrange a time for a phone call, or if they call, they will ask to arrange a future time. However, you should be prepared to be cold called. Never put your home number on your vita if you don't want calls at home.

If a search committee member calls you in your office and you are not ready to talk to them (e.g., left your notes at home and have no idea who is on the phone with you because you applied to 34 positions), you can make a polite excuse—you have a client coming in soon—and ask to arrange another time to talk. But, to the extent possible, try to accommodate them—they are clearly calling at a time that is most convenient for them. Relatedly, if you need a quick moment to take a deep breath, you can say, after expressing appropriate greetings, "Please hold on a second and let me close my door." That your student office may quite literally be the size of a small closet, and doesn't require (or allow) you to do more than swivel around in your chair to reach the door, is beside the point.

To prepare yourself for a phone interview, you should be ready with a 1-sentence, 3-minute, and 5-minute explanation of your program of research and future directions. You should also be ready to talk about classes you want to teach and people with whom you'd like to collaborate. They will always ask you what questions you have for them, so think about something to say in advance that shows you have done research on their school, and that you are interested in them. To close the conversation you can say, "I am sure that if I am invited to interview, I will have a lot more questions and that we'll have a lot to talk about. My only remaining question at this time is what is the process/time line from here? [*they answer*] Okay, that sounds terrific! I want to reiterate that I am very interested in your program, am excited about your interest in me, and hope to have an opportunity to visit to see if it is a good fit."

Invitations for in-Person Interviews

If you are invited to an in-person interview, try to accommodate the search committee in their choice of dates. Do not say, "I need to check with my supervisor," because to them, this should be your biggest priority, and waffling suggests that you are not serious about the position. You should discuss ahead of time with your supervisor/mentor your plan to go on the job market and work out how to handle absences. You may ask to change the interview date if you have (a) another offer that has a decision deadline before your scheduled interview, (b) conflicts with previously scheduled interviews, or (c) a previously scheduled interview in the same geographical location that would make it convenient for you to visit back to back.

Declining in-Person Interviews

Although it is true that you cannot turn down an offer that you don't have, you may find that you need to prioritize which interviews to accept. You may wish to decline an interview if you physically have too many to attend, if you already have an offer, or if you are no longer interested in the position given your other choices. It's worth attending several interviews, though, to increase your chances of receiving multiple offers and thus increasing your leverage during negotiations. You also want sufficient "shopping experience" so you can make informed program evaluations. You can't do that as effectively if you've only seen one university because you will have nothing with which to compare it (e.g., Are they weird, or was I just nervous? Is this a normal department structure or an outlier?).

You can also accept an interview, and then decline later. If you back out 2 weeks or more prior to the interview, they will simply go to their next candidate on the list. In declining interviews, you can say something like: "I've been surprised by the number of interviews I've been offered and it won't be physically possible for me to do them all. As a result, I've decided to withdraw my application at this time. I appreciate very much your consideration and I regret any inconvenience this may cause you." Most search committees will in fact appreciate that you have declined because you have saved them time and money.

Preparing for Travel to the in-Person Interview

Increase your line of credit a few weeks in advance. The majority of schools will want you to buy your own plane ticket and then reimburse you later, although schools generally reserve and pay for your hotel room themselves. The cost adds up quickly, especially since many schools will ask you to arrange your flight at the last minute. If you attend 10 to 12 interviews, prepare to support a balance of at least $4,000 at any given time. One of us flew from San Francisco to New York City and paid $1,000 because it was less than 1 week in advance. It can take more than a month after your actual visit to be reimbursed, so also be prepared if you don't want to pay high credit card interest fees. To expedite the reimbursement process, bring all of your receipts to the interview and hand them in to the administrative assistant at that time rather than waiting until after the interview.

Try to line up interviews so you don't have to go home in between each one (which is especially a killer if you're living on the West Coast—we distinctly remember having breakfast with graduate students on the East Coast at what was 4:00 A.M. Pacific time). Many schools will divide the total cost of a multi-stop circle-trip by the number of places at which you interviewed.

You will need two suits and comfortable shoes because interviews typically last 2 days and include a walking tour of campus. Some arrange dinner with faculty the night you arrive and/or meet you at the airport. So, you may also need a third outfit that is less formal but still nice to wear for that occasion. It is most efficient if you simply pack an extra blouse/shirt/tie that will go with the pants/skirt part of one of your suits for those situations.

Bring your own laptop. Some versions of PowerPoint are not compatible, and can mess up your bullets and formatting. We know someone whose PowerPoint "bullets," while giving a talk on suicide, converted to little happy faces on the university's laptop. Plus, you will likely need to be up to date on your correspondences, especially if you're on the road for a week or more at a stretch. During our travels, we addressed negotiation issues with other universities, scheduled new interviews, and sent panicked emails to our advisors asking what to do given a particular situation. Also, bring a backup copy of your talk on a CD in case

your laptop doesn't work and you need to upload it to their computer.

You ideally want to travel lightly so you won't have to check any luggage. If the airline loses your baggage and you have to interview in your jeans, faculty will be sympathetic, but you've ruined your chance to make a great first impression. Senior candidates can get away with this because the search committee has other data by which to judge them. However, a junior faculty candidate interviewing for his first job is an unknown entity.

The Job Talk

All places will ask you to give a research talk for roughly 50 to 60 minutes, with 20 to 30 minutes of questions afterward. Your research talk is an expanded version of your research statement. Start by reviewing the literature for 10 minutes. Then, spend the bulk of your talk discussing your personal program of research. End by discussing specific plans for conducting future studies at their university. A common mistake first-time job applicants make is spending too much time reviewing other people's work in the literature. You need to do some of this to show your knowledge of the field, but you must prove that you can be an independent researcher, not just someone who can reiterate your dissertation advisor's work.

Again, like in the research statement, you want to describe a coherent program of research that tells a story. You want to engage the audience by getting them excited about the mystery of what you study, and then telling them piece by piece how you have conducted various studies to attack this mystery and understand it better. You want them to leave thinking, "Wow, I never knew that X was true . . . This candidate is really on to something that X happens because of Y. I can't wait to find out the results of her future planned studies." Another good piece of advice is, "Think of the three key things you want people to walk away knowing, and keep repeating those things."

We cannot overstate the importance of practicing your talk in front of multiple groups of people so you can (a) be sure it is intelligible to different audiences, and (b) be exceedingly comfortable with delivering the material. One of us found it useful to tape record her talks to listen to on the plane. You want to make sure that you have your talks memorized so that no surprises can derail you from your planned delivery.

Some clinical psychology programs (about 20%) will ask you to give a second, 45- to 50-minute clinical talk. One of us presented a therapy case study she had seen that covered a difficult diagnostic picture and creative treatment. The other one of us presented an algorithm for handling treatment failure that she had previously written as a clinical paper in graduate school. Whatever you choose to present should be representative of your skills as a clinical supervisor, and should demonstrate how well you are able to teach clinical information.

Teaching-oriented colleges may ask you to give a guest lecture in a class on a topic of your choice during which the search committee will observe you. They are looking for you to engage with the students and show that you can relate to them, not just lecture at a podium from afar. At selective small liberal arts schools, students usually participate in class and interrupt the professor to ask challenging questions more often than students do in large research universities. If your teaching experience is in the research-oriented university from where you received your Ph.D., be prepared for a different type of student.

The more neurotic one of us found that it was helpful during the talk to place both hands on either corner of the podium, or slightly apart on the table, as if she were just resting them there, so people couldn't see her hands shaking. Hand shaking is magnified if you happen to be holding a sheaf of notes, which will quiver like leaves in the wind, so if anxiety is a problem for you, consider placing your notes flat on the table or podium so you can easily flip the pages but don't have to hold them. If you can do your talk without notes by just using the PowerPoint slides as cues, however, this is probably better because it is less distracting for the audience. No matter what your talk strategy, though, you will probably find that you'll feel better as soon as you get started and that the anticipation was the worst part.

After your job talk, there will be a short question-and-answer period. A common anxiety when applying for your first job is, *What if some senior faculty asks a difficult question in a hostile way, and I can't answer it?* If this happens, you should keep your cool and respond the best that you can. If it goes on excessively, the search committee chair will probably rescue you. However, if the person has asked, you have answered, and the person won't let it go, it is fair to respectfully tell the person that you value his or her opinion and ask if, in the interest of time, the two of you could continue your discussion at a later meeting. Ultimately, if the person is being rude, he or she definitely already has a reputation within the department for rudeness, so if you stay calm and handle yourself with dignity, other people's respect for you will actually increase.

The Rest of the in-Person Interview

Other than giving your talk(s), you will meet with faculty, students, and the dean. Research universities typically have you meet with graduate students (and not undergraduates), while teaching colleges have you meet with undergraduates. You can plan on having all your meals with faculty or students. The days are long, and you will be with people from 8 A.M. to 9 P.M. The school should send you a copy of your schedule a day or so beforehand. Print out the home pages and abstracts of the most recent articles of people you'll be meeting with. Read these on the plane and jot down quick notes to yourself so you can refresh yourself later on as to what this person does. Try to think of anything that intersects with your research interests to discuss during those awkward silences or if they ask if you have any questions. Don't worry about doing this for your meeting with the chair, or the dean (you might want to just be familiar with what they do, in case it comes up), because mostly you'll just talk business with them.

Your goals for these meetings are to (a) show them you will contribute to the department, (b) assess whether the department has the resources to support your work, and (c) discover whether you like the social/emotional climate. Faculty will assess your potential for contribution by asking you follow-up questions about your research and interpretations. To determine if you have thought through a feasible research plan for when you arrive, they will probably ask with whom you wish to collaborate. Another question that often comes up is, "Would you really move to our geographic area?" One possible answer is, "I am very serious about this position, otherwise I would not have applied. What is most important to me is whether or not I will be able to conduct my research at a particular university than where I am geographically living." Finally, they will probably ask you what you are interested in teaching.

However, another way in which faculty evaluate your potential contribution is by noticing the type of questions you ask them. If you ask questions that assess whether the department has the resources to support your work, this has the dual benefit of (a) showing them you have a specific plan for the future, and (b) helping you learn

whether the department will be beneficial for you. If you stick to chit chat and the more general questions (e.g., collegiality, quality of students, and percentage of people who get tenure), your interviewer may walk away thinking you were a pleasant sort of a person, but feel vague about whether you actually had the ability to carry on your work independently.

Instead, ask specific questions: How many participants are you able to recruit in a year? How much do you have to pay participants? How many participant pool hours are available per faculty member? How much lab space is available and which space is designated to new hires? Is parking available for your participants? Or, for teaching, does the university provide funds to purchase materials for classes? What are the major requirements? How many students would you supervise? Is the structure of supervision individual or group? What courses would you be required to teach?

We also recommend asking them something like, "What are you hoping this new hire will bring your department?" to determine what they really want in their job candidate (which may not be what they said they wanted in their advertisement). If you find that they want someone who will further this part of the area, or teach this class, then you can use that information to tailor what you emphasize about yourself in later interviews.

The assessment of department climate and personality will come out naturally. You want to notice if they stick to their interview schedule, handle your hotel reservations, pick you up from the airport when they said they would, and offer you water and bathroom breaks. They will be on their best behavior when you visit (it's like a first date), so if they can't even be at the right place at the right time, remember your name, or buy you a bottle of water, this is a bad sign for the future once you actually accept the job.

A final thing to remember is that even if you think you completely blew it, reframe your thinking: You made connections with people you otherwise would not have met and your program of research will probably improve from their suggestions about your work. Send a joint thank-you email to members of the search committee and to the chair. It will not affect their hiring decision, but it is polite and it leaves you on good terms for future collaborations.

Tips for Those With Partners

Both of us relocated with significant others, and we recommend being as open as you can if you will be considering your partner's needs in your job decision. Coordinating dual careers is a legitimate concern. Do not feel embarrassed or act apologetically.

Technically, schools are not allowed to ask you about your relationship status, but we found that the vast majority of schools assessed this in some way, consciously or not. They are also not supposed to ask you about whether you have children or your plans to start a family, but this may also come up occasionally. So if you are not comfortable discussing these issues, it is really important to think beforehand of what you're going to say to questions like, "So, will you be relocating with a partner?" "What does your partner do?" "What does your partner think of this area?" "Would your partner be willing to relocate?" If your situation is complicated (e.g., not sure if partner will be coming), you might consider saying, "I do have a partner, and whether my partner will be able to relocate may come into the discussion at some point. For now, I think it's most important for me to focus on my fit with the department." For individuals in same-sex relationships, it is even more important to plan how you will respond to these questions.

If you're going to be open about your partner and your partner's needs, we recommend briefly mentioning dual-career issues to the "big" people involved: the chair of the search committee, the department chairperson, and/or the dean. When you're deciding where to apply, don't necessarily rule out rural areas because you think it won't work for your partner. Rural universities may in fact work harder for you because they know they have to in order to recruit the candidates they want. You can assess how helpful a university will be based on their response after you broach the topic. If the conversation doesn't really go very far (e.g., if they say, "The university typically doesn't assist in that area," or the more frequent and subtle, "Oh, your partner won't have a problem at all finding a job in this area" or "You could probably try calling such-and-such company, I know a person there, remind me to get you the number"), we recommend suspending the discussion until you have an offer in hand.

If they've made you an offer, you may ask for a second (expense paid) visit with your partner (but don't be surprised if such a request is denied owing to limited departmental funds). Whether your next contact is via phone or face-to-face, use this time to discuss any concerns you had about your position, as well as career options for your partner. For example, it is possible to negotiate a potential joint hire into a faculty or other full/half-time staff position, office space while partner is completing dissertation, adjunct teaching position, clinical position, postdoc, or admittance to a graduate program. If your partner is offered a position at the university, don't be afraid of negotiating a higher salary for him or her, if appropriate or necessary. If your partner is considering companies in the area, ask that the university arrange informational, if not real, interviews with them. Never agree to discuss career arrangements concerning your partner after you've accepted the position. If you do this, you've given up all the leverage you had to negotiate for him or her, or even to decline if your partner isn't ultimately satisfied with the options.

Finally, we found that coordinating dual career needs during this job search to be among the most stressful, as well as most relationship-enriching, processes. Although neither of us was in a new relationship, this was the first time we needed to consider ourselves a single "unit" in terms of our separate careers. It was ultimately helpful to think of particular situations/offers as a liquid. Our goal was to maximize the entire amount of that liquid; it mattered less how the proportions were doled out between two containers. This is not easy, because most of us have spent our lives aiming for our professional best—we wouldn't be here otherwise. So this could mean the place you ultimately accept isn't the best position for you or your partner, but it may be the only place where the two of you together can have a reasonable chance to pursue each of your own career aspirations. The only time proportions matter is if one container is mostly empty. Remember that regardless of how great an offer you are getting, if your partner is unhappy, ultimately, you will be, too.

Once You Get the Offer

Most likely the chair of the search committee will call you and say something like, "I have fabulous news. We would like to offer you the position." After exchanging pleasantries, the chair will probably ask you for a spreadsheet detailing your startup needs (some may have already done this earlier in the process). In general, this first phone conversation is only to relay the good news. The school will review your requests

and present you with the monetary details of your offer at a later point. If you've got a dedicated advisor, we'd recommend being in close contact with that person throughout this negotiation process.

The job offer itself has three components: salary, startup budget (the amount of money they will give you to get started on your research), and other perks. Other perks are things like reduced teaching load in your first year (always ask for that), moving expenses, paying for conference travel, career options for your partner, a guaranteed space at the child care facility for your child, a space in university-subsidized housing, etc. All of these things are generally negotiable. The school may be less flexible in salary and more flexible in startup and perks.

Salary itself is usually given as a 9-month figure. Our experience was that research universities on average provided $10K more than teaching colleges, although there is variability. You should also ask for summer salary (an additional two-ninths of your base salary) for at least the first 2 years. Most research universities will give you that if you request it. Teaching-oriented universities may not be able to do this, or may only agree to do this for 1 year.

Your startup budget should be a spreadsheet that includes the item and the cost, for a grand total. Ask your advisor, colleague, or chair of the department at your home university to review a draft for completeness. Also consider asking assistant professors at the university offering you the job what was useful for them to include, or what they would include now but didn't know any better at the time. The more detailed you are in what you ask for your startup, the more likely it is you'll get what you need. Your spreadsheet should have specific items grouped into categories (e.g., lab space, research assistant support, computers/software, assessment batteries/questionnaires, participant recruitment, etc.) with the number requested and price for each.

If you have a degree in clinical psychology and it is in your (and the department's) interests that you get licensed, ask them to pay for your licensing examination fees. Make sure they either already have a plan for giving clinical faculty continuing education credits and malpractice insurance, or else have them agree to pay for it.

Negotiating

Most individuals applying for their first academic job have little experience negotiating. You likely managed the cognitive dissonance resulting from your infinitesimal graduate stipend by thinking, "I don't care about money because if I did I would have gone into another field." You may be so excited you are actually being offered a salary that puts you above the poverty line (with dental insurance!) that you are willing to accept anything. This may be true, but remember that future salary raises will be based on your original salary. You may be incredibly angry when you learn that the person down the hall started his job with $4,000/year (about the average increase we found, in our experience negotiating) more than you did just because he asked and you didn't. Assuming a 3% annual pay increase, by the time the two of you reach tenure 7 years later, he will have been paid $31,300 more than you.

Remember that department chairs and deans have to negotiate all the time with job candidates. As long as you ask respectfully, they will not be insulted, and they cannot rescind the offer based on your request for increased funds. Don't worry about asking for too much; one of us got the advice that "if they haven't said no to something, then you haven't asked for enough." Negotiation usually doesn't last more than four go-rounds (you, them, you, them), so think through every response before you give one.

Negotiation is a game and the game works on leverage. The best leverage is another, better offer from a competing school. But, sometimes even having another offer doesn't help because a school just can't provide more. If they have done the best they can, it is time to pause the negotiations: "I continue to have some reservations, but I recognize that it is a generous offer overall and I appreciate that you have done what you can." That is, be honest, but remain positive without committing to accept the conditions so that you can weigh the whole package before making a final decision. However, even if you do not have another, better offer, you still have leverage in your ability to decline their offer. We know of more than one job candidate who had no other offers, yet still successfully negotiated for an increased salary by creatively justifying and strongly advocating their position. Thus, we encourage all applicants to negotiate respectfully, regardless of how many other offers they might have. Accepting an offer "as is," without seriously considering whether or not those conditions provide the necessary support to successfully carry out your professional goals, may jeopardize your early career trajectory.

The search committee will usually give you a deadline by which to decide, typically around 2 weeks to a month, but nothing is certain. If you are truly interested in an offer, but feel you honestly cannot make a decision by that time, ask for a short extension.

Declining and Accepting Offers

After you decline an offer, have an email ready to send to the committee as soon as you get off the phone with the chair, because the chair will immediately email the department. In explaining why you are declining an offer, it may be easier to give a reason that does not criticize the department (e.g., I'd like to be geographically closer to my family, I'd like to be in a more rural/cosmopolitan area, dual career issues with partner, etc.). Because you will see the faculty at other professional venues, you want your relationship with them to remain positive. Keep in mind that no single offer is likely to meet all of your professional and personal needs (e.g., ideal type of job, salary, job for your partner, and geographic location), so it will help if you can prioritize those needs to the extent that you can.

After It Is All Over

As you go through the adrenaline withdrawal, you may find that you are not able to sustain concentration on anything for about 4 to 6 weeks, so just (try to) accept it. Send thank-you notes or small gifts to your letter writers and update them on the status of your search, if you haven't already been doing so (and we recommend that you do!). Finally, plan a huge vacation and celebrate often!

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The Culturally Relevant Psychologist's Struggle With Science and Personal Values

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Multicultural counseling/therapy (MCT) has been referred to as the fourth paradigmatic force in psychology (Pedersen, 1991). Undoubtedly, recent years have witnessed a greater emphasis than ever before on the importance of being a culturally relevant psychologist. This increased focus on multicultural issues is long overdue in psychology and should lead to the development of more effective practices in our field. However, the emerging literature on MCT also challenges some firmly rooted convictions about the nature of psychological science.

In his popular introductory textbook, David Myers (2004) defines psychology as "the science of behavior and mental processes." For clinical psychologists, we are particularly concerned with how this science applies to human beings and how we can employ science to understand and alter humans' maladaptive behaviors, thoughts, and feelings. Psychologists are concerned not merely with the study of human behavior but with the science of it. In other words, psychologists are committed to certain scientific principles when studying human behavior, including the testing of ideas and a reliance on empirical evidence. Given this, two questions regarding the scientific merits of MCT should be considered.

Can the Field of MCT Ever Become a Full-Fledged Science?

To consider this question, it is essential to understand how psychologists approach science. The empirically supported treatments movement in clinical psychology has resulted in a dramatic decrease in single-case studies and a dramatic increase in applied research (Ollendick, Heimberg, Agras, Wilson, & Marlatt, 2006). As a result, scientific psychology has become a science largely based on generalities. Rare is the psychological law stating that people will always behave in such-and-such a manner under such-and-such conditions. Instead, clinical psychologists take empirically derived generalities and apply them to the individuals presenting for treatment. Because we lack psychological laws, we can never really know if even the most empirically supported treatment with the largest effect size will work for any given client. Rather, we operate from "best-guesses" based on empirically derived probabilities.

One of the fundamental complaints voiced by MCT researchers is that current therapies may not work well for culturally diverse populations because the research population comprising most efficacy studies consists largely of Caucasians or middle- and upper-income households (i.e., our scientifically determined probabilities may not apply to non-White individuals). To the extent that this is true, it could represent an enormous problem in our increasingly diversified society. However, lack of evidence does not constitute an invitation for therapists to abandon science and rely solely on their own subjective hunches (Dawes, Faust, & Meehl, 1989). Rather, it stands as an invitation to more closely examine the influence of cultural factors on therapy outcome and, more importantly, to test them. In the interim, we must rely on the available, if limited, empirical evidence to inform our practice. So, one barrier for MCT in achieving scientific legitimacy is that there is a lack of good scientific evidence. This is not so much a barrier as a deficit, and the problem can be rectified by simply conducting the necessary research.

A subtler and potentially more problematic barrier is the notion that individuals are so diverse that it is senseless to use group-level data to make decisions about any single person. This notion is in direct conflict with science as it is currently practiced in clinical psychology. Empirically supported treatments generally rely on groups of persons for scientific legitimacy. Inferring from generalities is how scientifically oriented psychologists are taught to practice. However, it is true that generalities will always represent, in Alexis de Tocqueville's words, "the tyranny of the majority." There will always be a subgroup within every group. People can be divided according to nationality. Nations can be divided according to ethnicity. There are virtually infinite ways to categorize people, and none of them is entirely valid or reliable. Insofar as MCT insists that generalizing from groups is inappropriate because it denies individual differences (a point with good merit), the field will stand in contradiction to current scientific practices in psychology. Of course, MCT can still approach individual therapy using idiographic scientific methods – formulating theories about the development and maintenance of client problems and testing these theories with interventions – but many scientific psychologists would view this as only a partial embrace of the scientific method.

To answer the question posed above, it would appear that further research could help MCT become more scientific, but strong sentiments supporting individualism may prevent the field from developing into a fully scientific enterprise.

How Do Values and Science Interact in MCT Research?

Admittedly, any researcher's moral and ethical principles will intersect with how that individual practices science. It seems, though, that the values held by MCT researchers are much more strongly embraced and have a much greater impact on research endeavors than the values held by physicists. To the general public, science is often conceived as an entirely objective pursuit of truth. Even some researchers view it this way. Yet, for better or worse, it is immediately apparent when reading MCT literature that these researchers come down strongly on one end of the social and political spectrum. One can formulate a similar impression less often in other psychological literatures, and very rarely could a physicist's voting tendencies be ascertained from her writings. This of course has much to do with the subject matter being studied. It means, though, that MCT researchers are much more apt to report and interpret findings in such a way that will further their social and political agendas.

It would appear that values drive research agendas in MCT to a greater degree than science drives values. This is not meant as a derogatory assertion; in fact, this arrangement may be quite appropriate. In order to accomplish something one believes is right, some authors may selectively attend to the empirical evidence. For example, to encourage integration, scientific evidence that supports public education and the benefits of co-educating ethnic minorities with ethnic majorities may be emphasized and contrary evidence may be

disregarded. Many in our society believe that such integration is the morally right course of action regardless of what science might find. It is important to remember that simply because something *is* does not mean that it *ought to be*. Science reflects what is. Values reflect what ought to be. At the moment, values have been given precedence over science in the MCT literature.

Many authors have depicted what could happen if science were used to dictate what ought to be: Aldous Huxley in *Brave New World*, George Orwell in *1984*, B. F. Skinner in *Walden Two*. However, society currently appears reluctant to use science in this prescriptive manner. Our values structure society more than our science. MCT researchers appear to understand this, but an overt acknowledgment is necessary. Masquerading values as science will only backfire on researchers when this charade is discovered. Rather, values and science must be thought of as distinct if MCT is to retain its integrity as the "new force" in psychology.

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Clinical Forum: On Culture

From Talk to Action: Ethnic Diversity Issues in Clinical Assessment and Treatment

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The United States is becoming increasingly more diverse. The overall population is estimated to be 81% White, 13% Black or African American, 13% Hispanic or Latino,[1] 4% Asian, 1% American Indian or Alaskan Native, and .1% Native Hawaiian or Pacific Islander (U.S. Census Bureau, 2004). By the year 2050, it is estimated that approximately one third of the U.S. population will be people of color (Hall, 2001; Iijima Hall, 1997). Unfortunately, the field of psychology has not kept pace with the nation in terms of diversifying research. Historically, the theories and tenets upon which we base our methods of research, assessment, and treatment are largely a result of studies with Western, European American, middle-class populations (Bernal & Scharron-Del-Rio, 2001; Hall, 2001; Hall & Barongan, 2002; Kazdin, 2003; Rogler, 1999), often college students (Kazdin, 2003; Sue, 1999). Though great strides have been made to increase research on and treatment of ethnically diverse groups, such as strengthened policies and updated guidelines (American Psychological Association 2001; National Institutes of Health, 2001), the progress to date leaves much to be desired.

According to the U.S. Department of Mental Health and Human Services (2001), ethnic minorities are disproportionately in need of mental health services. Unfortunately, less than 50% of ethnic minority adults with diagnosable mental disorders actually seek and/or receive these services, and only one third of ethnic minority children are treated (Centers for Disease Control, 1999). This limited access to and/or fears about the relevance of contemporary mental health care may be warranted. Burlew (2003) cites a wealth of research suggesting only a minimal number of empirical articles concerned with African Americans, Latinos, and Asian Americans, and noting a marked decline in articles on African Americans between the early seventies and late eighties. In behavioral psychology, the top three journals devoted little attention to ethnic minorities, publishing three or less "culturally diverse" articles each year between 1970 and 1993 (Iwamasa & Smith, 1996). In spite of the virtual exclusion of diverse populations from the majority of research studies, many of findings are inappropriately generalized to all ethnic groups, leading to misdiagnosis and mistreatment (Iijima Hall, 1997; Rogler, 1999). For example, African Americans are more frequently diagnosed with schizophrenia and less frequently diagnosed with affective disorders. Only 27% of African Americans (in comparison to 44% of Whites) receive antidepressant medication, and those that do receive medication are often given higher dosages. Newer SSRI medications with fewer side effects are prescribed less often to African Americans than to European Americans (U.S. Department of Mental Health and Human Services, 2001). Similarly, only 24% of Hispanics/Latinos with depression and anxiety receive appropriate care. Moreover, Hispanics/Latinos with bipolar disorder are more likely to be misdiagnosed with schizophrenia than their non-Hispanic European American counterparts, and it has been found that evaluations of bilingual patients differ depending on the language used for assessment (U.S. Department of Mental Health and Human Services, 2001).

To meet the needs of an increasingly diverse population, the field of psychology must improve research, assessment, and treatments for people of color who suffer with mental health disorders. Ongoing limitations in the field do a disservice to psychology as a whole, promoting mistrust among ethnically diverse persons and disbelief in the ability of the mental health care system to provide necessary services. The purposes of this article are to explore re-

[1] The U.S. Census Bureau separates Hispanic or Latino from race/ethnic group; it is instead considered an origin. Therefore, there is overlap in the percentages, as individuals report that they belong to one of the other races/ethnic groups listed and are of Hispanic or Latino origin.

search on the empirically supported assessment and treatment of ethnically diverse persons, and specifically, (a) to discuss its historical background, (b) efforts to increase the quantity, quality and applicability of this research, and (c) to discuss future steps that can be taken to ensure adequate inclusion of all ethnic groups in this growing area of research.

Historical Perspective

In a review on the history of ethnic minorities in psychology, Holliday and Holmes (2003) state that "the content, timing, and significance of many events in the history of ethnic minority psychology are in response to a major nemesis: psychology's involvement in scientific racism and resulting implications for the development of ethnic minority communities and peoples" (pp. 15–16). Whites have been the dominant group in psychology (Hall & Barongan, 2002), and in the past have even claimed superiority. The common belief that individuals who were not White or Anglo-Saxon were innately inferior was supported by the writings of the founders of U.S. psychology, Francis Galton and G. Stanley Hall; as a result, the input of ethnic minority group members was devalued on many levels, and scientific racism would serve to support the oppression of people of color (Holliday & Holmes, 2003). Nevertheless, ethnic minority group members became actively involved in research and theory development, and provided data that disconfirmed major theories of scientific racism.

Since the 1950s, changes in U.S. law and government led to major changes in the inclusion of ethnic minority groups in the public sector of society. The field of psychology also took part as a result of increasing numbers of ethnically diverse psychologists. A number of ethnic minority psychological associations were created, including the Puerto Rican Psychological Association in 1954 and the Association of Black Psychologists in 1968 (Holliday & Holmes, 2003). Official, organized support advocating for the importance and necessity of ethnic minority research took many years to develop. Twenty-two years after the National Institute of Mental Health (NIMH) was created, it established the Center for Minority Group Mental Health Programs. This center was created to fund studies devoted to the mental health concerns of ethnic minorities, to establish and administer research on the mental health needs of specific racial/cultural groups, to oversee the initiation of the Minority Fellowship Program to provide minority fellowships for research and clinical training (Holliday & Holmes, 2003). Throughout the 1970s, the American Psychological Association (APA) also created offices, boards, and societies devoted to ethnic minority inclusion; however, it was not until 1986, nearly 100 years after its inception, that the APA established the Society for the Psychological Study of Ethnic Minority Issues–Division 45 (Holliday & Holmes, 2003) to advance psychology as a science, promote public welfare through research, and apply research findings to ethnic minority issues.

Research on both assessment and empirically supported treatments has been criticized for its lack of attention to diversity issues, and with good reason. Individuals who seek psychotherapy are often White, educated, and from the middle and upper class; as a result, few efficacy studies or randomized clinical trials have been conducted with ethnic minorities (Bernal & Scharron-Del-Rio, 2001). Cognitive-behavioral therapy (CBT) has the most research to support its effectiveness, and its integration of assessment procedures throughout the therapeutic process is considered a strength. However, there has been little evaluation of the appropriateness of the assessment methods used in terms of treating ethnic minorities (Vera, Vila, & Alegria, 2003). Hays (1995) highlights some limitations with the multicultural application of CBT, citing concerns about its representation as a "value-neutral" approach, failure to consider the implications of racism and other forms of oppression for CBT, lack of attention to client history, and its emphasis on rational thinking and the scientific method, which, according to Hays, tends to be biased against diverse styles, views, and behaviors. In a review on CBT and ethnic minorities, Vera and colleagues (2003) summarize major studies that included minority groups since 1981. Eleven studies are cited, treating problems such as drug use, depression, panic disorder, and bulimia nervosa. They note that for many of these 11 studies, the sample of ethnic minority groups was so limited that findings specific to ethnic minority groups were not reported. Thus, CBT and other treatments are potentially limited in terms of their applicability and generalizability to ethnic minority populations. In an update on empirically supported treatments, the Division 12 Task Force revealed that most researchers did not specify the ethnicity of their participants or only included data from White participants, and others did not include ethnicity as a variable of interest (Bernal & Scharron-Del-Rio, 2001).

The question of measurement equivalence in assessment has been a problem in terms of translation equivalence, conceptual equivalence, and metric equivalence (for definition of terms, see Brislin, 1993; Okazaki & Sue, 1998). One response to promoting the development of culturally competent assessment measures has been to translate. However, translation alone is insufficient due to the fact that many instruments are phrased in colloquial English and direct translation affects conceptual meaning (Rogler, 1999). Okazaki and Sue (1998) add that translation equivalence should not be assumed for functionally English-speaking minorities. There are also questions about the conceptual equivalence of psychological constructs (i.e., depression, anxiety, and intelligence) across diverse ethnic groups. Caution must be used when dealing with participants and clients from different ethnic groups, as responses may differ due to variability in contextual factors and levels of acculturation (Hall & Barongan, 2002; Okazaki & Sue, 1998). Metric equivalence becomes an issue when researchers assume that the same metric measures the same concept in more than one culture. Okazaki and Sue (1998) cite research that found major differences between the English and Spanish versions of the Wechsler Adult Intelligence Scale in terms of conversion of raw and scale scores, administration, and content, and hence concluded that psychologists should not expect the scores to be comparable. Translation is not the only issue when considering metric equivalence, as cultural and inter-ethnic factors may violate certain assumptions upon which statistical analyses are based, resulting in different scoring patterns across ethnic groups.

While past inattention to ethnic diversity issues is thought to have been a reflection of the times, which were wrought with racism and prejudice, theories concerning continued exclusion have been more heterogeneous and numerous. One concern relates to the lack of diversity among researchers (Gil & Bob, 1999). The vast majority of individuals who have doctoral degrees in psychology are White, tend not to think of themselves in terms of their ethnic group, and have been taught that ignoring color is politically correct (Hall, 2001). In addition, limited access to diverse populations has often been a complaint of researchers, partly due to small overall population size (Okazaki & Sue, 1998). Sue

(1999) suggests that research has often emphasized internal validity over external validity, and with respect to empirically supported treatments, some psychotherapy researchers fail to realize the need to consider the possibility that their treatment may not achieve similar results with other ethnic groups (Bolling, 2002; Clay, Mordhorst, & Lehn, 2002; Hall, 2001). Bolling (2002) mentions that "it is difficult for people in the U.S. cultural mainstream, including researchers, to believe that there are any assumptions other than their own about how the world works, what a "person" is, how we function, how time works, what feelings are, how to use language, what the goal of life is, how people interrelate, how and where it is appropriate to show feelings or to seek help . . ." (p. 22). Many assessment instruments and treatments are emic in nature, meaning that they have been developed specifically for one population; however, it is assumed that these measures and treatments are etic, meaning that they are culture-general or universal (Gil & Bob, 1999; Hall, 2001). This assumption of universality (Burlew, 2003), which assumes that the presentation of disorders and interventions for these disorders are universal, continues to be a problem in the field and limits the ability to provide appropriate services to diverse populations.

Major Strides

The key to increasing ethnic diversity research that would properly inform assessment and treatment is to focus on ethnic minority leadership development and opportunities (NIMH, 2001). To move toward achieving this goal, the APA Board of Directors, APA Board of Social and Ethical Responsibility, and the NIMH sponsored the 1978 Dulles Conference, entitled "Expanding the Roles of Culturally Diverse Peoples in the Profession of Psychology," which acted as a precursor to the APA Board of Ethnic Minority Affairs in 1980 and the Society for the Psychological Study of Ethnic Minority Issues (APA Division 45) in 1986. The efforts of the APA and other psychological associations and societies resulted in a substantial increase in ethnic minority participation in organized psychology (Holland & Holmes, 2003).

Increases in the numbers of ethnic minority psychologists has contributed to the development of ethnocentric theories and interventions that emphasize ethnic/racial identity development, acculturation in ethnic minority identity and behavior, and cultural-specific conceptions of mental illness (Holland & Holmes, 2003; Lopez & Guarnaccia, 2000). Unique ethnic-specific symptomatologies have been discovered, including *ataque de nervios* ("attack of nerves") seen in Hispanic/Latino populations, brought on by a stressful life event related to family members or significant others (Lopez & Guarnaccia, 2000), and *kaumaha* syndrome, a form of depression seen in Native Hawaiians brought on by collective sadness and moral outrage concerning the colonial experience (Holland & Holmes, 2003).

Such advances have led to increased diversity in diagnosis and assessment, as evidenced by the addition of syndromes specific to ethnic cultural groups in the *DSM-IV* (1994). The appendix of the *DSM-IV-TR* (American Psychiatric Association, 2000) defines culture-bound syndromes as "localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations" (p. 898). Twenty-five syndromes are listed in the glossary of this revision; a promising increase over the 12 listed in the 1994 version. *DSM-IV-TR* also contains guidelines for a "cultural formulation" for supplemental use with the multiaxial system (Cormier & Nurius, 2003).

Research to assess the equivalence and applicability of assessment tools and empirically supported interventions is currently under way. In a study on the validity and reliability of the Brief Symptom Inventory in Latina American mothers, Prelow, Weaver, Swenson, and Bowman (2005) found that, in contrast to its supposed multidimensional structure, the BSI-18 measured a single dimension of general psychological distress. In low-income Latin American populations, the BSI-18 proved a reliable measure of distress, but further research is necessary to assess clinical cutoff scores for the Latin American population (Prelow et al., 2005). Wong, Kim, Zane, Kim, and Huang (2003) examined the credibility of treatment rationales for cognitive therapy and time-limited dynamic psychotherapy, analyzing how cultural identity, value orientations, and culturally bound self-construals affected credibility perceptions in an Asian American population. Findings indicated that cultural identity and self-construals moderated credibility ratings across cognitive therapy and time-limited dynamic psychotherapy interventions for depression, and highlight the necessity for in-depth examination of culturally based variables rather than pure ethnic group analyses (Wong et al., 2003).

Efforts to increase knowledge of ethnic minority issues in mental health and improve mental health care for ethnic minority groups continue, and such efforts are supported financially by programs like the American Psychological Association Minority Fellowship Program and the National Institute of Mental Health Mental Health Dissertation Research Grants to Increase Diversity in the Mental Health Research Arena (APA, 2004; NIH, 2004). As leading psychological organizations attempt to increase the numbers of individuals interested in engaging in research on ethnic minority populations, they also create policies and initiatives to reduce disparities in mental health research and care. The NIMH National Advisory Mental Health Council Workgroup on Racial/Ethnic Diversity in Research Training and Health Disparities Research (2001) note that "central to the challenge of health disparities are the related problems of insufficient scientific information about racial/ethnic minority groups and a low number of racial/ethnic minorities who obtain advanced academic degrees. Sustained attention and a commitment to resolving these issues are imperative to the economic soundness and scientific leadership of the nation and to the health of its people" (p. 15). Plans to produce a diverse group of independent researchers with an interest in producing multiculturally sound research have been put into action, and will hopefully result in more research on the assessment and treatment of diverse populations.

Looking Ahead

To increase interest in ethnic diversity issues in psychology, the logical first step is education. Sue, Bingham, Porche-Burke, and Vasquez (1999) note the inadequacy of coverage of racial/ethnic minorities, women, sexual minorities, and the disabled in psychology curricula. University psychology curricula must be culturally inclusive, and failure to diversify curricula should be punishable by loss of APA accreditation (Iijima Hall, 1997). Thorough coverage of ethnic diversity issues in all psychology courses, undergraduate and graduate, would serve to decrease biases and assumptions of universality that hinder the progress of culturally competent research. Improvements must be made in the recruitment and retention of diverse faculty and students, which will undoubtedly prove advantageous to research, as members of the

groups being studied will play a central part in the research process (Gil & Bob, 1999).

The need for more research has always been great. Sue (1999) cites guidelines proposed by the NIMH to increase the quality and quantity of research on ethnic minority populations: "Women and members of minorities and their sub-populations must be included in all human participant research; cost is not an acceptable reason for excluding these groups; programs and support for outreach efforts should be initiated to recruit these groups into clinical studies" (p. 1075). Iijima Hall (1997) asserts that publication guidelines should aid authors with acceptable ethnically diverse research and publications, research must be relevant and conducted in a multiculturally appropriate manner, the diversity of authors must be increased, and the diversity of journal editors and reviewers should be also be improved.

Mandatory inclusion of minority groups in general research and clinical trials has been suggested; however, Sue (1999) notes that inclusion, by itself, does not establish external validity. Existing concepts of ethnicity and culture, and how these concepts guide research, must be critically analyzed. Okazaki and Sue (1998) outline guidelines for considering ethnicity and related values, including that "assumptions underlying the use of ethnicity should be made explicit; individual studies should consider using multiple measures and multiple methods of assessment; [and] findings from assessment tools pertinent to ethnic and cultural variables should generate hypotheses for further testing rather than routine assumptions that the findings are valid" (p. 37). In response to the difficulty of recruiting substantial samples of ethnic minority populations, Okazaki and Sue (1998) acknowledge the challenge; however, rather than aggregate data from various ethnic groups, researchers must report the demographics of the sample, as well as the sampling methods used to obtain the group under study, and discuss the generalizability of findings according to these sampling methods. It is important to realize that research should not simply concentrate on the generalizability of existing approaches, but must examine general processes and culture-specific processes for differences and similarities. Ethnicity and culture cannot be treated as independent variables or factors to be controlled for; rather, ethnicity and culture must be examined in terms of social and cultural processes and the manner in which these influence mental health (Lopez & Guarnaccia, 2000).

While research and assessment must address key issues in terms of diversifying literature and assessment instruments, practitioners must continue to treat clients. According to Iijima Hall (1997), to improve the effectiveness of practice, competence in ethnic diversity issues must be required of all practicing psychologists, through undergraduate, graduate, and postgraduate education and training. All practitioners must remain abreast of current research on diverse populations. The psychologist who is unable to competently provide services to culturally diverse clients must refer or be at risk for charges of unethical conduct (Iijima Hall, 1997).

Conclusions

Amidst the dialogue and controversy concerning ethnic diversity in the field, psychologists must remain engaged in research, assessment, and treatment of all people. Suggestions have and will continue to be made; action has been and must continue to be taken. In spite of the challenges described above, it is likely that the nation will become increasingly more diverse. As a result, the number of ethnic minorities seeking mental health will increase. As scientists and practitioners, it would be unethical to be apathetic concerning the current state of research, assessment, and treatment with diverse ethnic populations. The price has been misdiagnosis and mistreatment, and a less than positive public view of psychology as a whole. Clinicians and scientists must become more aware of existing assumptions, and accept that some of these assumptions may not apply to ethnic minority groups (Bolling, 2002; Holliday & Holmes, 2003). Researchers and practitioners must also be willing to consult with individuals who may be more equipped to deal with diversity. Mainstream psychotherapy researchers might also seek to collaborate with developers of nontraditional therapies to broaden the base of available empirically supported treatments (Bolling, 2002; Gil & Bob, 1999; Hall, 2001). Rather than wait for further pressure from the managed care system, or for malpractice suits and legal problems, we must take on the responsibility of good science and practice. Finally, ethnic diversity issues must be seriously considered whenever researchers seek to expand the range of empirically supported assessment and intervention methods. It is high time that talk becomes action.

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