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Division12

CLINICAL SCIENCE

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

Developing clinical psychology as an experimental-behavioral science

NEWSLETTER

WINTER 2013: VOLUME 16, ISSUE 1

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Presidential Column

The Science of Intervention: From Translation to Implementation

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University of California Los Angeles

I am honored to assume the role of President of SSCP for the 2013 term. Thank you to Rick Heimberg, our Past-President, for his leadership during 2012. In this column, I outline the latest research developments across the full spectrum of intervention science, from translation to implementation, and conclude with my goals for my term as President of SSCP.

Across the developmental trajectory of behavioral therapy, then cognitive behavioral therapy, and now acceptance-based approaches, the majority of clinical psychology research has focused on clinical efficacy trials, in which we evaluate treatment outcomes in highly controlled research settings. Most recently, clinical efficacy trials have expanded to include sophisticated mediational modeling to isolate the biological, behavioral and cognitive mechanisms that are accountable for therapeutic change. Predictor models are another burgeoning research area, aimed at identifying for whom treatment is more or less effective. Even more valuable are moderator models to identify which of a set of treatments is more or less effective for a given individual. Clinical efficacy research has served an enormously important role in establishing the evidence-base for psychological treatments. Indeed, this evidence-base is now being reviewed by independent panels as part of the APA effort (from the Board of Professional Affairs, Board of Scientific Affairs, and the Committee on the Advancement of Professional Practice) to develop Clinical Practice Guidelines, in accord with standards established by the Institute of Medicine. The mission of the guidelines is to translate the best available research evidence into clear statements regarding interventions for the treatment of people with various health conditions. Despite past hesitation about such guidelines, the evidence-base is now sufficiently strong to justify this major undertaking by APA. However, clinical efficacy research is only one part of the spectrum of intervention science.

Lisa Onken, from the National Institute on Drug Abuse, has outlined six stages for the development of behavioral therapies (basic research, intervention generation/refinement, efficacy-research clinics, efficacy-community clinics, effectiveness, and implementation and dissemination) that represent the full continuum of intervention science. More broadly speaking, the spectrum of intervention science extends from translational models that use basic science to inform treatment development, to testing of clinical outcomes in controlled settings (labeled clinical efficacy trials in the preceding section), to implementation in the real world. Some of the most exciting developments within our field are occurring at either end of that spectrum.

Translational models enhance our understanding of behavioral, cognitive and biological dysregulation that underlies psychopathology and the mechanisms by which such dysregulation can be modified or treated. Translational intervention science offers the potential to identify novel mechanisms and treatments and to optimize existing treatments. An example is the way in which the basic science of Pavlovian conditioning has optimized exposure therapy for anxiety disorders and substance use disorders. For example, recognition of

the context specificity of extinction learning has led to investigation of retrieval cues that bridge the gap between therapy contexts and the contexts in which substances are encountered once therapy is completed, in order reduce cravings. Also, recognition that pathological anxiety often is characterized by deficits in extinction learning, which in turn may be linked to deficits in inhibition of fear responding, has opened new pathways for modifying exposure therapy for anxiety disorders. These include d-cycloserine augmentation of exposure therapy to enhance the consolidation of extinction learning, and behavioral methods that aim to increase the encoding and retrieval of inhibitory learning (e.g., stimulus variability). Another example of translational intervention science is cognitive bias modification training for anxiety and depression. Particularly exciting is the use of neuroscience to inform intervention. The most direct example is neurofeedback, but indirect examples exist as well. For example, 'affect labeling' as a means for augmenting exposure therapy (Kircanski et al., 2012) was derived from evidence for the neurobiological effects of linguistic processing of emotional material.

Neuroscience, behavioral science and cognitive science are also serving to identify core dimensions of psychopathology that cut across traditional diagnostic categories and which may eventually guide treatment development. For example, whereas amygdala hyperactivity to threat stimuli is characteristic of anxiety and depression (e.g., Craske, Rauch et al., 2009), deficits in striatal activation to reward stimuli appear to be more relevant to depression than to anxiety (e.g., Hardin et al., 2007). Conceivably, dysregulation of threat processing underlies excessive negative affect (which is shared between anxiety and depression) whereas dysregulation of reward processing underlies deficits in positive affect (that is more unique to depression). Positive valence and negative valence systems are two of the five concepts which are highlighted in the NIMH Research Domain Criteria approach to classifying psychopathology. Corresponding therapeutic strategies could eventually be tied directly to enhancing reward processing when there are deficits in positive affect and to reducing threat processing when there are excesses in negative affect.

Furthermore, basic neural, cognitive and behavioral science is alerting us to differences at the individual level that should also inform treatment. For example, even though attentional bias to threat is stronger on average in anxious groups relative to healthy controls, large individual differences exist within anxious groups in terms of attentional bias toward or away from threat (Schechner et al., 2012). This would suggest that attentional bias modification training is best suited to that subset of anxious individuals who show a selective attention towards threat. Similarly, whereas anxious individuals on average display deficits in extinction relative to healthy controls, not all anxious individuals show such deficits. This would suggest that methods for augmenting extinction learning (e.g., d-cycloserine) may be optimal for only a subset of anxious individuals as they progress through exposure therapy. In other words, translational research may lead to improvement in clinical outcomes by personalizing treatment to the areas of cognitive, behavioral, emotional, or other functioning that are most dysregulated for a given patient, akin to the biomarkers and biosignature approach recommended by NIMH.

At the level of implementation, recent advances involve technologies to enhance the fidelity of evidence-based treatments when implemented in real world settings. As Varda Shoham noted in her SSCP Presidential Column in 2011, with current changes in the health care system, we can expect an increase in the delivery of mental health, and therefore run the risk of greater provision of services with lesser assurance of fidelity. We are faced with enormous challenges in informing mental health providers about evidence-based treatment approaches in general, let alone assuring that once evidence-based approaches are introduced into a system of care, they are implemented with fidelity and continuously so over time. Technological developments offer solutions to this challenge in terms of a) training mental health providers in evidence-based approaches b) delivery of evidence-based treatments, and c) assurance of fidelity of evidence-based treatment.

A report from Weissman and colleagues in 2006 indicated unacceptably low rates of training in evidence-based practices for mental health providers, including psychiatry, psychology and social work, across the

United States. Only one third of PsyD and MSW programs provided didactic training plus clinical supervision in at least one evidence-based psychosocial treatment. The corresponding percentage was higher but still unacceptable for PhD programs (i.e., 57%), whereas such training was almost universal for MD programs due to residency requirements. The limited training in evidence-based approaches, especially among social workers who provide by far the majority of mental health services, is very troubling. One barrier to such training was lack of experienced faculty. Technology offers a solution through internet-based CBT training programs for clinicians. Such programs are available and growing in number. They not only offer training in areas where training facilities/personnel do not otherwise exist, but have the additional advantage of built-in checks on training to adequate levels of adherence and competency. Internet based CBT training has the potential to fill the large gap in evidence-based training.

Technology is also being used for the delivery of evidence-based treatments in real world settings. My colleagues and I have been testing implementation of cognitive behavioral therapy for anxiety and depression in primary care in the hands of novice clinicians for some time (Roy-Byrne et al., 2005; Craske et al., 2005; Roy-Byrne et al., 2010; Craske et al., 2011). We began by training and supervising novice clinicians in cognitive behavioral therapy for a single disorder (i.e., panic disorder). We then expanded the focus to the full array of anxiety and depression in primary care, and developed a computer-assisted program to guide the clinician in the delivery of cognitive behavioral therapy for multiple disorders. This is an interactive program that clinicians use as they interact with their patients, with the intent being to maintain the integrity of cognitive behavioral therapy. Another approach is self-directed evidence-based treatment through computer and internet programs which completely by pass the clinician; such programs are exploding in the areas of anxiety, depression and particularly substance abuse. Computer/internet evidence-based treatment, whether clinician or self directed, inherently provides assurance of fidelity in treatment delivery, as well as a number of other advantages (e.g., greater precision in dismantling the components of an intervention and when analyzing mediational mechanisms). Furthermore, technology is likely to offer solutions for how to monitor fidelity over time after evidence-based practices have been introduced into a system of care.

I have outlined my perspective on some of the most exciting developments in translational models, clinical efficacy models, and implementation models of intervention science. Ideally, the various stages of intervention research inform each other, although some barriers exist between translational and clinical efficacy models on the one hand and implementation on the other hand, simply due to the realistic constraints upon provision of mental health services in naturalistic settings. As clinical scientists, it behooves us to become more familiar with the scientific methods and constraints at each stage of intervention research, in order to further our mutual goal of developing new treatments, improving treatment efficacy, and enhancing implementation in settings where they are most needed.

The Delaware Project on Clinical Science Training was initiated by members of the University of Delaware clinical faculty and further supported by a Past SSCP President, Varda Shoham, while on sabbatical at NIMH. The Delaware Project aims to improve training in clinical science across the spectrum from translational research, to intervention generation and refinement, to dissemination and implementation. The project began with a conference that brought together a group of prominent psychological clinical scientists representing each of these aspects of treatment development and evaluation. This conference, held at the University of Delaware, was sponsored by APCS, the University of Delaware's Department of Psychology and College of Arts and Sciences, NIMH, NIDA, OBSSR, and SAGE. A web-based training resource will shortly be launched that will provide syllabi, reading and other materials that exemplify cutting edge training techniques and experiences. The web site will also be used to promote cross-program collaborative projects aimed at the continuity of training across the spectrum of intervention science. My primary initiative for my presidential term is for SSCP to facilitate the further development of the Delaware Project.

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The Society for a Science of Clinical Psychology (SSCP) wishes to announce the third annual "Clinical Scientist Training Initiative" grant program.

Applications are invited for small (up to $1500), non-renewable grants for training programs at the predoctoral, internship, or postdoctoral levels to launch new projects or support ongoing initiatives that are designed to more effectively integrate science and practice into their training program.

Applications are due by March 31, 2013, and funds will be distributed during the summer of 2013. Application instructions are available at:

https://sites.google.com/site/sscpwebsite/awards.

The application is
short and easy, so please consider applying!

Also, for more information on the grant and coverage of prior winners,
see the APS Observer:
http://www.psychologicalscience.org/index.php/publications/observer/2012/january-11-2012-observer-publications/training-grants-encourage-integration-of-clinical-science-and-practice.html

Bethany Teachman, Matthew Lerner
(SSCP Clinical Scientist Training Grant committee)

Presidential Reflections

Richard G. Heimberg, Ph.D.
Temple University

This is my final column and my opportunity to thank the numerous people who contributed to the experience and to the good of SSCP. I also want to welcome some new faces to the SSCP leadership and to look back briefly at the last year as well.

Three colleagues transitioned off the SSCP Board of Directors at the close of 2012. Bunmi Olatunji completed his term as member-at-large and as the Chair of SSCP's External Nominations Committee. Bunmi of Vanderbilt University was a steady voice in the chaos that sometimes surrounds the work that we do, and I have little doubt we will hear from him further in the future. My colleague at Temple University, Lauren Alloy, replaces him as member-at-large. As I know her in so many ways for our work together over the years, she will be a tireless worker for the organization and for the good of clinical science.

Sara Stasik, doctoral student at University of Notre Dame, finished her stint as one of our two student representatives. Sara worked closely with Kristy Benoit of Virginia Tech this past year and Rebecca Brock the year before that to form a very effective team. Best of luck to you, Sara, as you go on to complete your degree and beyond. Sara will be replaced by Victoria Smith of the University of Maryland, and we we welcome her into the fold.

Most importantly, Varda Shoham, now of the National Institute of Mental Health, completes her year as Immediate Past President, and steps off the Board. I cannot begin to express my gratitude to Varda, for helping me learn my way, for supporting me at times, confronting me at others, and generally working very hard for the good of the field. As many of you may know Varda was instrumental in the Delaware Project on Clinical Science Training, described in previous columns in Clinical Science by Varda, which brought together clinical scientists from doctoral, internship, and postdoctoral training programs, treatment researchers, training experts, methodologists from medical schools and re¬search institutes, and representatives from vari¬ous NIH agencies for a meeting in October 2011 with the lofty goal of redefining clinical science training. The goal, of course, is one that is never reached because we change even as we make changes, but this sensational effort by Varda and many others will have a huge impact on clinical science for years to come. Varda's presence on the SSCP Board helped to keep the focus on this important agenda to the good of us all. Varda, you will be most deeply missed, although I know that you will continue to influence the field in most positive ways.

Dave Smith of the University of Notre Dame completed his elected term as secretary-treasurer at the end of the year. However, he remains in the post for a few more months, as Stewart Schenkman of the University of Illinois at Chicago, who will ultimately replace him, is on sabbatical leave. Thanks to Dave for his willingness to make this transition a smooth one. Thanks to him as well for his frequent advice and counsel during my time as President. It was often sought and always invaluable. Happily, we will not lose Dave from the ranks of those actively serving the organization, as he has recently taken the role as Chair of the Membership Committee and will be with us in that capacity for a while yet.

Further thanks are due to other folks as well. Sheryl Goodman of Emory University continues her good work as member-at-large, and Doug Mennin of Hunter College continues his strong efforts as SSCP's

representative to the Society for Clinical Psychology (Division 12 of APA). Frank Farach of the University of Washington continues as webmaster. Denise Sloan of the National Center for PTSD and Boston University worked very hard in a very compressed time frame to put together our program at the APA convention this past year. Howard Garb, Past President of SSCP, put together our program at the APS convention and coordinated the SSCP Student Poster Session Competition held at that meeting. Howard has done this work for several years and done much to solidify SSCP's connection to APS, all to the good of our students and members. Lea Dougherty of the University of Maryland came on board as the Editor of Clinical Science and has worked hard to keep it a vibrant outlet for our organization. Finally, Peter Norton of the University of Houston chaired the Student Dissertation Awards Committee this year. He and his committee members worked very hard to evaluate the many applications we received and to select the winners. Thanks so much for that.

As I become Past President, I hand the reigns over to our new President, Michelle Craske of UCLA. After knowing her as a colleague and friend for many, many years, and working with her quite a lot these last couple of years, both on the SSCP Board and in our roles related to the DSM-V, I can say with great confidence that she will do an outstanding job. Also, welcome back to the Board to Bethany Teachman of the University of Virginia, former member-at-large, who is now our President-Elect. Bethany has continued to be active in SSCP initiatives in her year off the Board (the Clinical Scientist Training Initiative Grants Program and the collaborative APS/SSCP Job Mentorship Program), so it seems like she never left, and that seems completely right.

Because I have taken so much space to recognize people and to thank them for their contributions to the organization, I will be brief in my remaining comments. Many things happened during my presidential year, but I want to note just a couple of them. First, the APA issued its Resolution on the Recognition of Psychotherapy Effectiveness, and it did not reflect in some central ways values that members of SSCP hold dear. A heated debate about the implications of this took place on the SSCPnet. I posted about this in October 2012 and stated that the SSCP Board was considering how and whether we could have a more proactive role and a greater influence on APA from within, who would do it, how we would measure the success of such efforts, and what we would do if the measurement suggested a poor outcome. This deliberation continues within the Board under President Craske.

The major content of my Presidential Columns and my Presidential Address was the proper mentoring of doctoral students, both for their own development and for the greater good of the field of clinical science. One important outcome of that effort was the establishment of the Lawrence H. Cohen Outstanding Mentor Award, which will be awarded for the first time in at the 2013 meeting of APS. The award is dedicated to the memory of Larry Cohen, late SSCP member, professor at the University of Delaware, widely known and respected as a mentor of students, and my good friend since we were classmates in graduate school at Florida State University in the 1970s. Nominations for this important award are still open and will be open until March 1, 2013. More information is available on the SSCP website at https://sites.google.com/site/sscpwebsite/announcements/newsscpawardlawrence-hcohenoutstandingmentoraward.

Finally, the field of clinical science very recently lost one of its leading lights. Susan Nolen-Hoeksema passed away on January 2, 2013. She will be sorely missed.

SSCP Treasurer's Report

David A. Smith, Ph.D.
University of Notre Dame

BALANCE as of 12/31/2012:
$29,036.75

FINANCIAL HIGHLIGHTS:

Expenses:
SurveyMonkey for fall elections (-$48.00)

Income:
Membership dues renewals (+$3,162.00, +$40.00, + $130.00), Interest income (+$1.67).

Pending Expenses:
Dues renewals (+$3,026.00, +$237.50), APS poster award (-$100), Credit Card Server Fee (-$434.71, -$220.95). .

NOTES:
The taxes have been completed and submitted.

MEMBERSHIP COMMITTEE REPORT:
2012 non-renewers are now being purged from SSCPnet (the ListServ). These are people who were members in 2011 but did not renew for 2012, which means they had a year's grace period. This may produce some renewals.

Div12 recently notified us that we lose the credit card server at the end of the month. This affects the Division and all the Sections. Options are being explored among the affected groups. We have also asked Alan Kraut about piggybacking with APS the way we have with Div12 in the past. An integrated payment/record-keeping system is also worth exploring (e.g., http://www.123signup.com/association-manager/individual-membership-management.aspx). If a decision is not reached by the end of the month, there will be a gap in ability to pay with credit cards. Decisions ought to be made before the next scheduled Board call, so a process for decision-making outside the conference call should be discussed by the Board.

There are now 224 Members and 258 Student Members. At approximately this time a year ago, there were 172 Members and 195 Student Members. Membership peaked in 2012 after the APS conference, with 242 Members and 352 Student Members. The final renewal drive will be this week. New recruitment will begin as soon as the credit card server issue is resolved. We are ahead of last year's pace but have a fair amount of work left to reach last year's peak, especially in the recruitment of new student members.

As this is my last report as SSCP Secretary-Treasurer, I would like to include a few general remarks about SSCP's financial status before giving our current financial snapshot. From the perspective of tracking our budget and resources the past three years, it is clear that SSCP is quite healthy financially. Our cash reserve has ranged from $23,600 up to $36,200 over the past three years. We tend to be quite flush with cash at the end of the year, when dues payments have been coming in and we have very few expenses. Then our funds decline through the spring and summer as we pay out for the many awards the Society confers, including the Distinguished Scientist Award,

Dissertation Awards, conference Poster Awards, training awards, and the Mentor Award. Owing to the effectiveness of our outstanding Membership Committee (Doug Mennin, Chair, Elizabeth Hayden, and Ashley (Pietrefesa) Hart), as well as loyal members (that's you!), and enthusiastic new members (that may be you, as well!), dues income increased from $12,245 to $13,985 from 2010 to 2011. We also nearly doubled the amount of awards we confer over that time, from $5,500 to $10,500. Dues collected in 2012 are still coming in, but we have also continued the trend into 2012 of increasing the number of awards we give, so much so that the low ebb in funds typically observed at the end of summer and through the renewal season is lower than it has been in the past two years, by about $3,500. In short, for 2012 I expect that our awards largess will finally overtake our member recruitment and retention effectiveness, though to a degree that is sustainable for 7-8 years, assuming no changes in income or expenses. So, again, the Society continues to be in good financial condition, and I want to thank you for your continued loyalty and extremely helpful recruitment efforts. Each renewal and new member helps support and expand SSCP's efforts to encourage a science of clinical psychology.

-Dave A. Smith, Ph.D.
University of Notre Dame

SSCP would like to congratulate its newly elected board members:

President:
Michelle Craske, Ph.D.
University of California, Los Angeles

Secretary/Treasurer:
Stewart Shankman, Ph.D.
University of Illinois-Chicago

President-Elect:
Bethany Teachman,Ph.D.
University of Virgina

The Role of Internships in Clinical Science Training Time for a Reappraisal

Marc S. Atkins, Ph.D.

Director of Psychology Training in Psychiatry & Professor of Psychiatry & Psychology

As I write this, APPIC has published an update through December 2012 on the registration numbers for this year's impending match. An expected additional 223 internship slots over last year's numbers is little solace for the estimated 23% of applicants who will go without placements. The discussion of this as a supply and demand problem is misleading if not pernicious. The only relevant market forces at work are the profits to be made by schools with very large class sizes. Based on the APPIC survey of 2,731 applicants in last year's match (65% of applicants), only 42% were in classes of 10 or fewer students, the typical size of a graduate class in a Ph.D. Clinical Psychology program. About the same number (41%) were in classes of 20 students or greater, with 390 (14.4%) reporting class sizes of 50 students or greater and an astonishing 97 applicants (4%) reporting class sizes of 91 or greater! Is there a reasonable educator who could argue that class sizes this high are associated with quality education?

Solutions appear either impractical or inadequate. From the "supply" side of the equation, Larkin (2012) used ten years of APPIC data to project the impact of several proposed changes on the supply and demand imbalance. He showed that the best solution was to require programs to reduce the number of applicants by 10% and to limit match availability to students from accredited programs. However effective this might be, there is little chance of it occurring and in any case it begs the question of why either APA CoA or APPIC allow a relatively few programs to glut the market with inordinately high class sizes?

On the "demand" side of the equation, the American Psychological Association last year allocated $3 million to provide administrative support for nonaccredited internship programs to complete the CoA accreditation process. Although improving standards for internship training is a laudable goal, it appears that that many if not most of these programs were already in the APPIC match, and therefore it was unclear how this would substantially increase the number of internship positions. But perhaps more concerning is why there are so many unaccredited internship programs in the APPIC match. With a full appreciation for the law of unintended consequences, does our current system of clinical training promote the training of highly skilled graduate students in non-paid (i.e., clinical practica) or low-paid (i.e., internships and post-docs) positions to keep ever-struggling social service agencies afloat?

In my two terms on the board of the Academy of Psychological Clinical Science (APCS), I have been involved in many discussions about how APCS programs can respond to this apparently intractable problem. At last year's meeting, several graduate programs, apparently tired of the nonsense, reported that they were developing in-house internship programs, while others reported eliminating the internship requirement for those students with clear academic career goals. The first solution appears highly reasonable if the full year internship remains a graduation requirement, as Kihlstrom (2012) has sug

gested for several years, although this requires resources that many graduate programs do not have and therefore it is not clear that it is a viable solution nationally.

The second solution, eliminating the internship requirement for academically oriented graduate students, is also reasonable given the lack of quality internship positions especially for academically oriented graduate students. However, if this promotes the view that only clinically oriented graduate students – or more specifically graduate students interested in becoming licensed psychologists -- benefit from internship then this would be an unfortunate missed opportunity for clinical science. From its inception, APCS included internships that advocated clinical science values as member programs but the predominance of the full year internship was not challenged, due largely to the requirement imposed by the APA CoA and by state licensing boards. However, with the recent advent of the Psychological Clinical Science Accreditation System (PCSAS; http://www.pcsas.org), and its status as an accrediting program by the Council for Higher Education Accreditation (CHEA), there is an unique opportunity to consider alternative models for internship training that more closely align with the values and goals of clinical science graduate training.

At last year's Association of Psychological Science meeting, Varda Shohan organized a symposium to discuss innovative training models in clinical science emanating from discussions and presentations at the APCS-NIMH sponsored Delaware Project at the University of Delaware in October 2011 (http://128.175.41.92/wordpress/1011-conference/). Tim Strauman led the discussion of new models for internship training, with help from Greg Kolden, Jill Cyrnanowski and myself (http://128.175.41.92/wordpress/wp-content/uploads/2012/10/Cat-3.2-ppt-6.-Strauman-redefining-Internship.pdf). As we were developing these ideas I became curious about the history of the clinical internship year – how we got to the current model -- and how this might inform new models going forward.

The Origins of the Full Year Internship

The earliest report on internship training was in 1945 by an APA committee headed by David Shakow (Subcommittee on Graduate Internship Training to the Committees on Graduate and Professional Training of the APA and the AAAP, 1945; see also, Shakow, 1938), which informed a broader report in 1947 on recommendations for clinical psychology graduate training by an APA committee headed by Ernest Hilgard (Hilgard, Kelly, Luckey, Sanford, Shaffer, & Shakow, 1947). The Shakow subcommittee report promoted a full year clinical internship following the third year of graduate training to provide extensive and intensive clinical experiences with normative and patient populations. Following the internship, students returned to graduate school to complete their dissertations, allowing for an incorporation of the internship experience into their broader graduate school experiences. Interestingly, the Hilgard et al. (1947) report suggested several variations on the full year internship including partial year and multi-site training. However, the report indicated a strong preference for "block training" (i.e., a full year in one setting), modeled after medical training (Flexner, 1925), which has been the unquestioned standard going forward.

Over the years, clinical psychology graduate training evolved to include more clinical experiences during graduate school, predominantly reflecting the growing market for practitioners, and the dominance of the scientist-practitioner model established at the Boulder Conference in 1949, which promoted clinical psychologists who were both investigators and practitioners. Over time, the placement of the clinical internship moved to the last year of training, which is its current status where advancement to dissertation is required for application to internship. This shift in timing of the internship reflected the

difficulty of interrupting scholarly activities in graduate school to complete the internship, and the subsequent difficulty of returning to complete the dissertation. An unintended consequence of this change was the further detachment of internship training from graduate training and a growing gap between graduate education and internship training, mirroring, and perhaps accelerating, the research-to-practice gap that spawned the evidence-based practice movement.

The 1987 Conference on Internship Training in Gainesville, FL headed by Cynthia Belar further emphasized that internship training should occur after the dissertation was completed, although the report backed off from this as a formal requirement (Belar, Bieliauskas, Larsen, Mensh, Poey, & Roelke, 1989). The impetus for this guideline was the need to reduce the prevalence of ABD students. This report also stated that the one-year internship was obsolete and recommended two years of full year clinical training for licensure. The impetus for this change was enhanced clinical specialization and the apparent need for increased clinical proficiency for graduates who aspired to become practitioners; an ever increasing number given the proliferation of professional schools and Psy.D. programs in the past three decades (Donn, Routh, & Lunt, 2000; Norcross, Hanych, & Terranova, 1996).

However, the increasing importance of the clinical internship and the subsequent postdoctoral year occurred without any substantive input from graduate programs resulting in a tail wagging the dog phenomenon. As research mentors looked on in growing frustration and concern, graduate students responded to the intense competition for internship positions with an accumulation of clinical experiences in order to make themselves more competitive on internship applications. The recent ascendance of the for-profit professional schools many with very large class sizes accelerated this process further leading to the present crisis of a "supply-demand" imbalance.

New Goals for Clinical Science Training: Closing the Research to Practice Gap

In the 66 years since the Boulder Conference, much has changed in clinical psychology. Whereas in 1947, clinical psychologists were promoted as an urgently needed resource for mental health services, especially for the large numbers of returning WWII veterans (Baker & Benjamin, 2000), in today's health care arena the mental health care of our nation is increasingly less reliant on doctoral level psychologists (Schoenwald, Hoagwood, Atkins, Evans, & Ringeisen, 2010; Wang, Lane, Olfson, Pincus, Wells, & Kellser, 2005). In part, this reflects the availability of master's level clinicians in social work and counseling who can provide mental health services at lower costs, compounded by the lack of doctoral level psychologists in many locales, especially rural areas, and the resulting increased provision of mental health care in primary care (American Academy of Child and Adolescent Psychiatry, 2009; Regier, Goldberg, & Taube, 1978).

From the perspective of clinical science training, the diminishing presence of clinical psychologists in clinical service presents new opportunities. Specifically, if clinical psychology is becoming an ever-reduced workforce for clinical service, its role in reducing the research to practice gap in mental health is no less urgent. To accomplish this, however, training must shift from a primary focus on delivering evidence-based practices towards advancing research on the dissemination and implementation of evidence-based practices as delivered by allied disciplines such as social work, counseling, and primary care. Internship programs can play a critical role in promoting an integration of science and practice but they will likely need to look very different from current programs in setting, timing, and structure to better align with new areas of specialization within mental health care.

Flexible Models for Clinical Science Internships

To reflect contemporary trends in mental health care will require many adjustments for clinical science training programs. As health care reform takes shape with the implementation of the Affordable Care Act, the landscape for mental health care will need reform as well to better reflect changes in funding and health care priorities (Koh & Sebelius, 2010). For internships, one obvious change is that dedicated mental health care facilities, which currently house the vast majority of internship programs, will likely go the way of the psychiatric hospital and represent an ever-smaller proportion of the mental health care delivery system (Hoagwood, Olin, & Cleek, 2013). Reliance on mental health facilities, principally at VA hospitals, mirrored medical training to the neglect of public health approaches (Albee, 2000). Going forward, alternative settings and services are likely to become more prominent venues for mental health care to overcome barriers to care and to enhance population outcomes (Atkins & Frazier, 2011; Stiffman, Stelk, Evans, & Atkins, 2010).

As health care reform moves swiftly to embed mental health care in specialized settings, clinical training programs will need to adapt to align clinical training goals with advances in health care. On internship, specialized (i.e., individualized) programs can take several forms based on the training needs and career goals of graduate students. From the perspective of clinical science training, this is long overdue as standardization of the full-year internship is in conflict with the norms of clinical research that promotes specialized skills. Specialized curricula have the advantage of involving students in the shaping of their training experiences, which can promote enhanced learning (e.g., Dolmans & Schmidt, 1994, King, 1992). This may be especially the case with advanced training in clinical and clinical research skills in which learning is often inductive as much as deductive and knowledge-seeking is an important goal to promote life-long learning.

For these reasons, the full-year internship should not be the only option for clinical science graduate training. Exposure and experience with selected clinical populations could be accomplished successfully by more numerous but shorter intensive experiences throughout graduate school, as originally described in the Hilgard et al. (1947) report. This would not negate the need to delineate and provide general skills in the application of scientific principles in the assessment and treatment of mental health disorders, which would remain a primary goal for clinical science training (McFall, 1991). Rather, to the extent that closing the research to practice gap will become a core goal for clinical science, individualized goals for internship would emerge from the set of additional skills and experiences necessary for the student's planned career trajectory.

To be sure, intensive training and exposure to clinical practice sites throughout graduate training would not necessarily preclude a full year internship. For some students, a full year internship may be necessary to address complex clinical problems or to participate in extended clinical trials. However, many students may find that shorter duration full-time internships, for example over summer months or during a semester, and in a variety of sites, would provide training experiences best suited to their career goals. For example, screening for depression in primary care can vary by specialty (e.g., family medicine, gynecology, pediatrics, internal medicine), region (e.g., urban, suburban, rural), and community (e.g., income level, education). Thus, training in new models of depression screening and treatment would presumably benefit from exposure to a variety of settings. Whereas some of these goals could be accomplished by part-time practica, either full year or partial year full-time internships offer several advantages over the part-time practicum, such as embedded training, opportunities for intensive

mentoring, and continuity of care.

Summary

Internship training in clinical science is due for reappraisal. The persistent lack of available internship positions offers a compelling rationale, and the recent recognition of PCSAS by the Council for Higher Education Accreditation a unique opportunity, for new models to emerge. Further, the changing landscape for mental health services requires flexible models of training to avoid promoting outdated practices and procedures and to train a new cadre of clinical scientists to help bridge the research to practice gap. With a new accreditation system in place, it is no longer acceptable for clinical science training programs to be weighted down by cumbersome accreditation criteria that reflect the priorities of outdated practices and models. A flexible training model that allows for well-specified specialized training goals and structures is best aligned with clinical science training. After 66 years is it not time to try something new?

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The Predoctoral Internship Crisis

Results from the Revised Internship Survey

Internship Committee Members: Sara Stasik, Rebecca Brock, Frank Farach, Kristy Benoit, Kelly Wilson

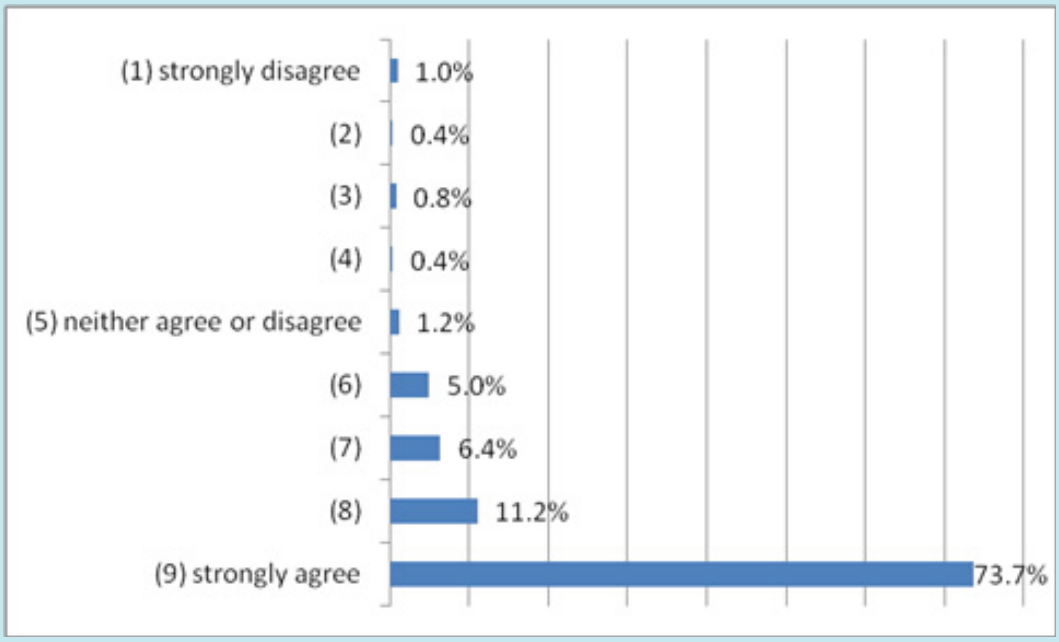
In response to the poor match rate of the psychology predoctoral internship (77-79% of students matched in the 2010, 2011, and 2012 application cycles), an Ad Hoc Internship Committee (Rebecca Brock, Frank Farach, and Kelly Wilson) was developed by SSCP to take a closer look at the current state of the internship process. The committee developed a survey that was launched in November 2010 to assess the extent to which the current internship process is perceived as problematic and to begin to identify possible solutions for addressing the low match rate. Results of this survey were published in Clinical Science and reported at the annual SSCP membership meeting in 2011.

Between October 2011 and April 2012, we circulated a revised version of the internship survey to SSCP members through the SSCP listserv and Clinical Science newsletter. The revised survey (which can be accessed at http://uofmississippi.qualtrics.com/SE/?SID=SV_7OhtZfzhIgmDWOE), included updated items asking about experiences with the Phase II Match, as well as perceptions of the effectiveness and feasibility of several suggested solutions to the internship crisis, incorporating solutions that had been suggested by previous respondents. Below are selected preliminary results from this survey, reflecting responses from 501 individuals.

The majority of respondents to the revised internship survey were graduate students (46%); however, responses were also received from current interns (12.5%), internship directors (2.8%), internship supervisors (6.7%), postdoctoral fellows (12.7%), directors of clinical training in doctoral programs (2.6%), and faculty members in doctoral programs (16.8%).

Does the psychology community believe that we are facing a crisis?

The worsening match rate suggests that the current predoctoral internship program is facing a crisis that should be addressed by the psychology community.



A Closer Look at the Nature of this Problem

19% of post-doc fellows and 20% of current interns completing the survey reported that they did not match to an internship site the first time they applied. This is very close to the non-matching rate nationwide, indicating that our sample of current/former applicants is fairly representative.

The majority of graduate students who completed the survey (61.5%) indicated that, when interviewing at their current graduate programs, no one explained to them that a predoctoral internship is not guaranteed and there is a possibility they may not match to an internship. The majority of current interns (83.6%) also reported they were not informed of this possibility. In contrast, 100% of directors of clinical training and 70% of current faculty members of doctoral programs reported that applicants are routinely informed of the possibility that they may not match to an internship program.

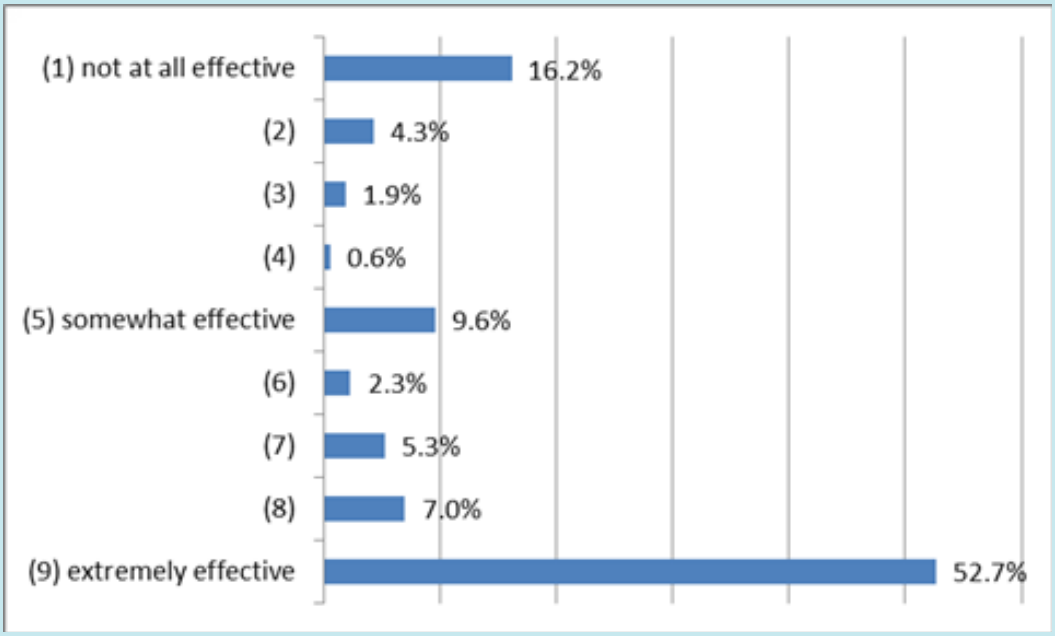
Identifying Solutions

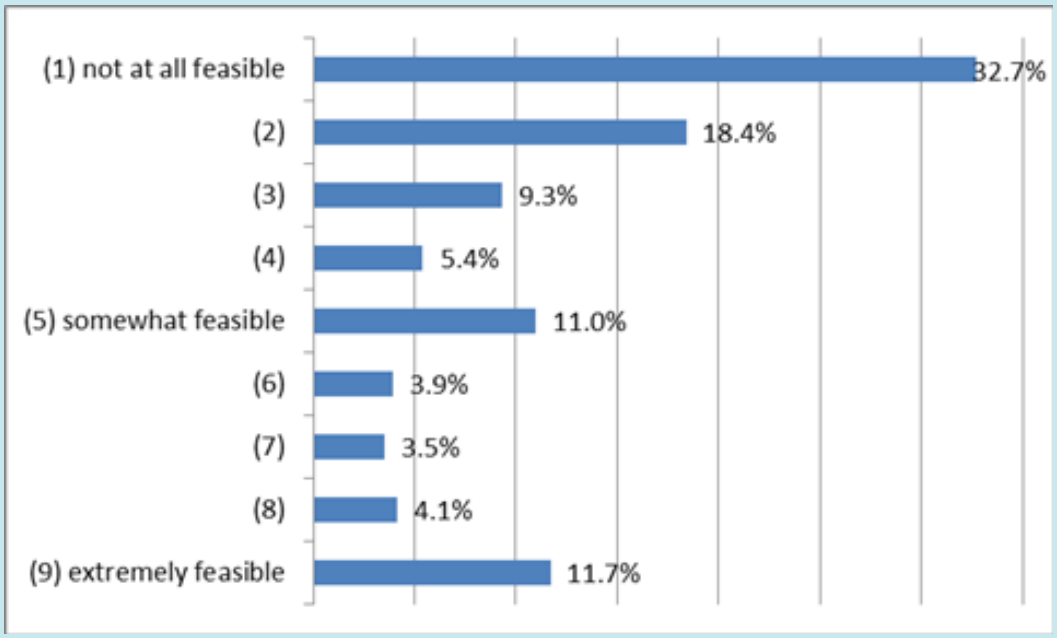
The following potential solutions for addressing the worsening match rate were presented and respondents were asked to rate the degree to which they believed each solution would be both effective and feasible:

- Clearer guidelines provided by internship sites explicitly stating what constitutes a competitive candidate (e.g., clarifying the criteria that are most strongly considered when reviewing applications) so that students can make more educated decisions about whether to apply to certain sites.

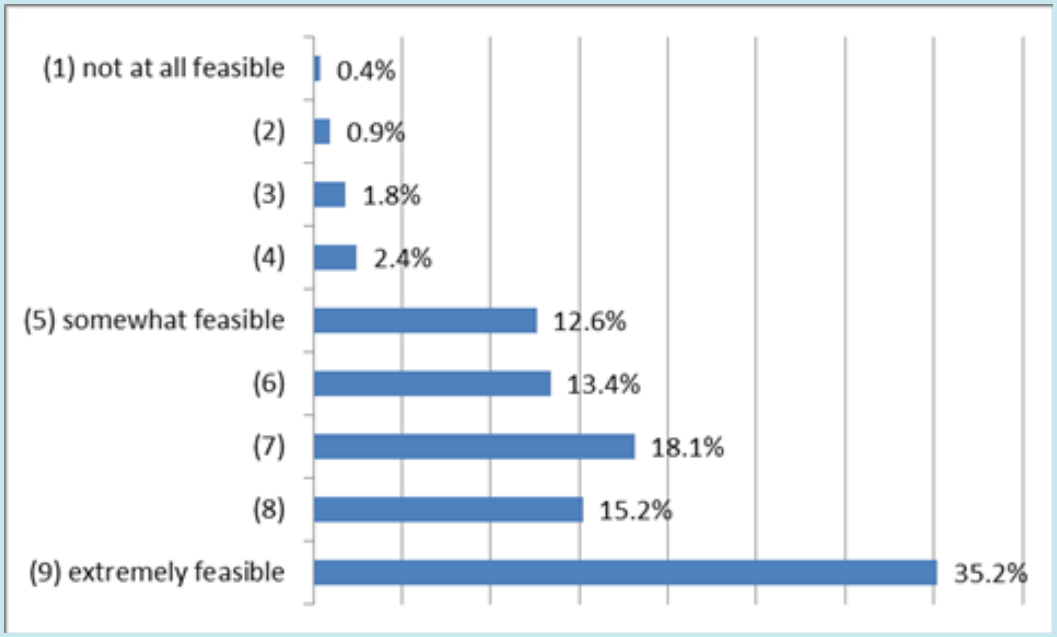
- More guidance and supervision at the departmental level for students who are preparing to apply for a predoctoral internship (e.g., a weekly or monthly seminar helping students navigate the internship application process, stricter guidelines with regard to determining whether a student is "ready" to apply).
- Increased funding to create additional internship positions (e.g., from the Graduate Psychology Education program).
- Development of "in-house" internships created by psychology departments.
- Elimination of the predoctoral internship requirement altogether.
- Making the predoctoral internship requirement a post-doctoral internship, as in medicine.
- Adding fewer students to graduate programs.
- Making the accreditation process less expensive and cumbersome for internship sites.
- Replacing the internship requirement with a requisite number of clinical hours to be completed at some point during graduate training.
- Having a Phase II to the match for students who do not match during the initial phase.

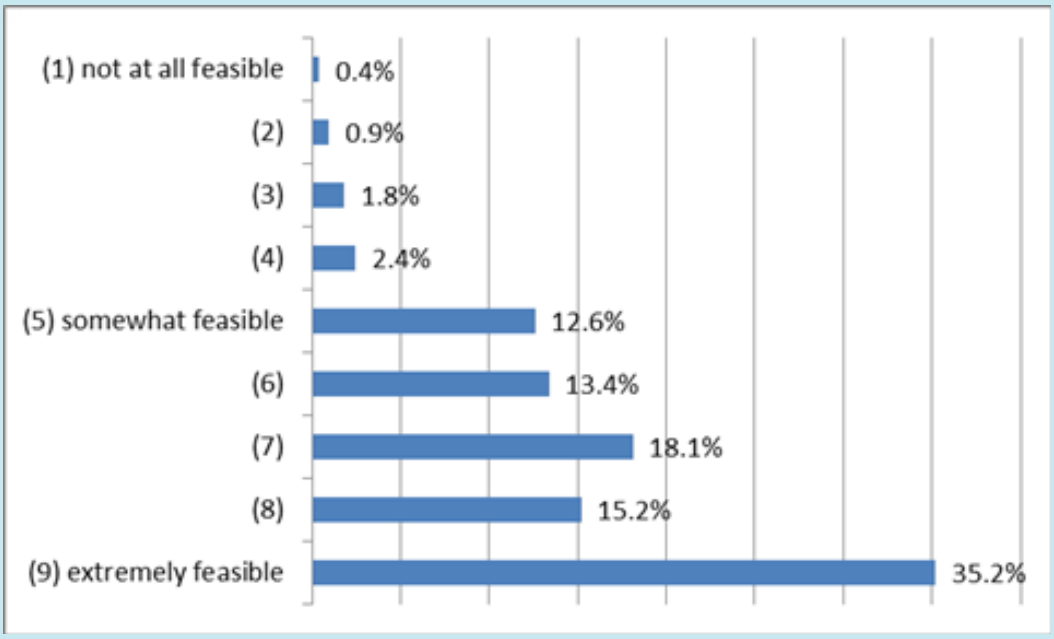
Similar to our previous report, results of the revised survey suggest the majority of psychology professionals view the most effective solution to be ***eliminating the predoctoral internship requirement altogether***; however, this was also viewed as the least feasible solution.

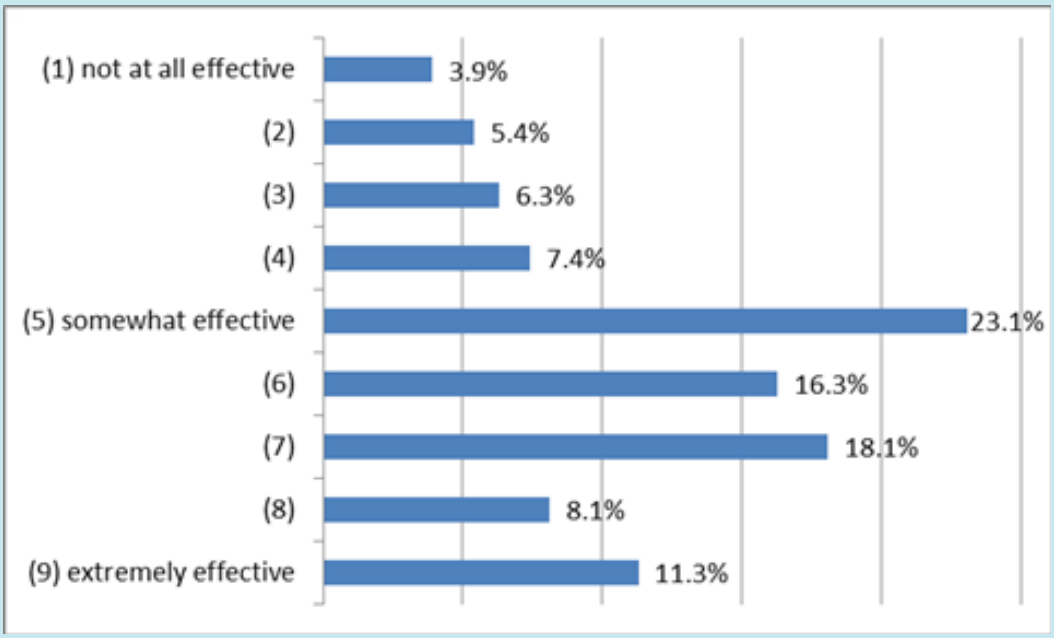




The most feasible solution that was identified was ***having a Phase II to the match for students who do not match during the initial phase;*** however this option was viewed as being only somewhat effective. It is not surprising that this would be identified as the most feasible solution given that it had been implemented in the time since the first version of the survey was circulated.







Ninety-four respondents also shared their own ideas for addressing the worsening match rate. Some of the most common responses included: (a) establishing different internship sites and match procedures for different types of programs (e.g., PhD., PsyD., etc.); (b) restrict the number of applicants that can apply for internship from each graduate program; (c) penalize or eliminate graduate programs that do not meet a specified student match rate.

How did students experience Phase II of the Match?

Of those respondents who applied for internship in 2012, 36.4% reported that knowing that there was going to be a second round to the match made them feel less anxious, whereas 7.3% reported it made them feel more anxious.

Of the respondents to our survey, 7.3% reported that they participated in Phase II of the Match. Students were asked to complete an open-ended question asking about their experience with Phase II. The most common responses indicated that the Phase II process was difficult to navigate because (a) parameters were less strictly defined than in Phase 1; (b) there was not a standardized process for the Phase II applications; and (c) it was difficult to get guidance from graduate programs due to a lack of understanding of the new process.

Conclusion

In summary, results of the revised SSCP internship survey suggest the following preliminary conclusions. First, the poor match rate is indeed viewed as a crisis by the psychology community and there is agreement that something should be done to address this crisis. Second, elimination of the predoctoral internship requirement is viewed as the most effective solution but also the least feasible. Third, having a Phase II to the match for students who do not match during the initial phase was viewed as the most feasible solution; however, this option was viewed as being only somewhat effective for addressing the match crisis. APPIC match statistics from the first two years of having a Phase II of the match confirm this opinion. In 2011, the match rate increased from 76% in Phase I to 79% in Phase II. In 2012, it increased from 74% to 78% across the two phases on the match. SSCP and the Internship Committee will continue to explore the feasibility/effectiveness of these and other proposed solutions.

Update from the Student Representatives

Victoria C. Smith, University of Maryland College Park

Kristy Benoit, *Virginia Tech*

With the beginning of the new year, we would like to update our fellow members on a few recent changes in student leadership.

Student Representative
Sara Stasik has just wrapped up her term as Student Representative and we thank her very much for her hard work and dedication to SSCP over these past two years. We are pleased to welcome our new Student Representative, Victoria Smith!

Listserv Facilitator
Evan Kleimen is stepping down from the position of Listserv Facilitator and we thank him very much for his great work on maintaining the student listserv over the past year. Evan will be staying on as our Listserv Manager. We would like to welcome our new Listserv Facilitator, Rosanna Breaux.

Communications Managers
We are also excited to tell you about our recently developed Communications Manager positions that were created to increase our presence on social media (Facebook and Twitter) and improve the student section of our website. We would like to welcome our inaugural Communications Managers, Carol Chu and Christina Emeh!

We have provided statements from our new leadership members below so that our student members can begin to get to know them. We very much look forward to their future contributions to the SSCP community.

Victoria Smith, University of Maryland College Park
Student Representative

I am a third-year graduate student in the Clinical Psychology program at the University of Maryland. My research interests broadly relate to developmental psychopathology, with a particular interest in mood disorders in young children. I initially became involved with SSCP through my work on the 2009 Internship Directory. As part of this effort, I contacted over 140 internship sites and helped compile survey responses into a unified database. The final product was a comprehensive resource providing information on research and training opportunities to help students in their internship search. As the new Student Representative, I am very much looking forward to contributing to the SSCP community, and am excited to help SSCP continue to grow as an active and helpful resource for students.

Rosanna Breaux, University of Massachusetts Amherst
Listserv Facilitator

Hello, my name is Rosanna Breaux and I am elated to serve as the Listserv Facilitator for the SSCP. I am currently a 2nd year Clinical Psychology Graduate Student at the University of Massachusetts Amherst. My primary research interests include parent-child interactions, parental and environmental factors that influence child functioning over time, early interventions in at-risk populations, and what factors lead to better outcomes in such interventions. I am eager to use both currently established and new sources of social media to reach out to graduate students, in order to disseminate important information related to student funding opportunities and positions in the field. I am extremely excited about the opportunity to work with graduate students, faculty, and professionals to engage in discussions on selected areas of interest. I look forward to discussing many important and exciting topics with you all in the future!

Carol Chu, Florida State University
Communications Manager

Carol is currently a first year clinical psychology graduate student at Florida State University. Her current research interests are still fluid—broadly, a mix of interests in cognitions, emotions and suicidal behavior. Specifically, she is interested in memory perspectives and suicidal cognitions, as well as emotional experiences in non-suicidal self-injurious and suicidal behaviors. Carol is excited about her role as one of the SSCP student communications manager, and she looks forward to contributing to the SSCP community's online presence.

Christina Emeh, University of Virginia
Communications Manager

Hi, I'm Christina Emeh and I'm at fifth year student at the University of Virginia. My research interests examine the self-perceptions of children with ADHD. Before coming to graduate school, I was a social worker for a program targeting disconnected youth. One of the main ways that we were able to remain in contact with and reach out to participants was through social media. I found that social media was a great way to connect with youth. As graduate students, many of us use our Facebook and Twitter accounts to generate conversation about articles that interest us, learn about topics that interest others, and procrastinate. My interest in the position as the Communications Manager has two parts. First, I would like to use Facebook and Twitter to connect graduate students and give them a forum to discuss relevant and controversial topics in the field. Second, I hope that students will use the SSCP student pages to receive help and advice from others regarding any problems or concerns they have. Overall, I hope that the pages will be fun and reflect the student perspective of clinical psychology.

Contact Us!
We would love to hear from you with any suggestions, comments, ques¬tions, or concerns regarding SSCP student membership or resources for students.
Kristy Benoit: benoit@vt.edu

SSCP Student Perspectives Part II:

SSCP has asked the student members to share their experiencs in their clinical and research training in clinical science.

Doctoral training in clinical psychology

Brian A. Feinstein
Clinical Psychology Doctoral Student at Stony Brook University

Whether you have just begun your doctoral training or it is nothing more than a distant memory, you can likely attest to the challenge of a graduate education in clinical psychology. Between the coursework, the research requirements, and the clinical responsibilities, the to-do lists can seem never-ending and each day presents new challenges. Still, I am able to appreciate the rigorous training required to complete a doctoral degree in clinical psychology and I am grateful for the opportunity to do so at Stony Brook University (SBU). As I near the completion of my fourth year of doctoral training, I am pleased to have the chance to reflect on my training thus far and to share some of the strengths of the clinical psychology program at SBU with other students and professionals in the field. SBU's clinical psychology program shares a great deal with other clinical science/research-oriented programs – the foundational courses required by the American Psychological Association, the standard independent research requirements, and the practical experience in clinical assessment and intervention. Still, although all programs have their similarities, they also have their differences, and those differences are the reasons why I am so pleased with my training at SBU.

First and foremost, the clinical psychology program at SBU truly embraces the mission of the Society for a Science of Clinical Psychology in its commitment to the integration of clinical science and practice. In the context of a strong research program where the majority of students go on to pursue academic careers, the clinical training also provides students with the competencies to function as highly skilled clinicians. Students receive training in cutting-edge research methods from leading scholars in the field, while being treated as junior colleagues who are encouraged to collaborate with other students and faculty in the pursuit of joint research interests. Notably, there is a sense of mutual respect between students and faculty, which fosters a collegial and supportive environment to pursue one's doctoral training in.

In addition to the rigorous research training, the clinical opportunities offered at SBU are wide-ranging and allow students to explore their clinical interests with a variety of populations. All students begin their clinical training in the Anxiety Disorders Clinic and the Krasner Psychological Center, in-house facilities that train students in evidence-based practices for assessing and treating anxiety disorders and

the varied psychological needs of the broader Long Island community, respectively. As students adjust to the novel challenges associated with the novice clinician role, they can participate in a variety of in-house externships to receive specialized training with specific populations and techniques. For instance, students can receive training in the treatment of chronic depression using the Cognitive Behavioral Analysis System of Psychotherapy, or they can receive training in behavioral medicine assessment and individual as well as group treatment for weight management and obesity through the SBU Obesity Program. These in-house clinical externships, which continue to develop, provide students with a broad range of training experiences in a convenient location that facilitates the balancing of clinical responsibilities with other on-campus duties.

Perhaps more important than the specific clinical opportunities available at SBU, the training itself has an emphasis on therapeutic principles of change, psychotherapy integration, and the integration of science and practice. Rather than training students in each "next best" novel treatment, SBU focuses on the mechanisms underlying behavior change that transcend specific clinical problems and therapeutic approaches (e.g., increasing awareness, facilitating corrective learning experiences). Emphasizing the value of activating these underlying principles of change, regardless of the specific techniques used to achieve them, has the potential to provide students with a deeper understanding of the mechanisms underlying effective psychotherapy and to facilitate a flexible therapeutic style that can fit the needs of a diverse range of clients.

The clinical training at SBU also emphasizes the practice of psychotherapy integration, recognizing the limitations of traditional cognitive-behavioral therapy as well as the usefulness of techniques that are often rejected as experiential, humanistic, or the like (e.g., exploring a client's emotional experience, using a therapist's own reactions in therapy). Students at SBU are trained to embrace evidence-based techniques across different therapeutic orientations in the interest of instigating behavior change through the aforementioned principles of change. Further, in line with the integration of clinical science and practice, students are trained to approach their clinical practice in a scientific manner and to use their clinical experiences to inform their research endeavors. Students are encouraged to regularly collect outcome data on their clients using the Treatment Outcome Package, a computerized self-report measure designed to assess a variety of common clinical problems. Frequent administration of this brief assessment measure allows the therapist to examine a client's change (or lack thereof) in symptomatology throughout the course of treatment. Such an empirical approach to monitoring treatment progress provides therapists and clients with a standard metric to understand a client's level of distress and impairment, and it can alert therapists to problems that clients may not bring up in session that could have a considerable impact on treatment effectiveness.

The clinical psychology program at SBU also provides students with unique opportunities to receive training in teaching methods and clinical supervision, both of which are important areas to gain experience in for students who are interested in academic careers. Students are required to fulfill two teaching assignments – first preparing and presenting four to six lectures in an undergraduate course and then teaching a recitation section of a research and writing course for undergraduates. In addition to these requirements, students are able to participate in a graduate-level teaching practicum, where they receive formal training in teaching methods, and they are able to teach their own courses (both typically offered courses and courses of their own creation). Advanced students are also able to supervise beginning student therapists in their clinical work, while receiving training in supervision methods as well as supervision from faculty members on the supervision that they are providing

their supervisees. These training opportunities in teaching methods and clinical supervision help to ensure a well-rounded doctoral education that will prepare students to engage in all aspects of academic careers.

Finally, SBU's clinical psychology program genuinely embraces a commitment to diversity in all of its endeavors. There are currently three faculty members – Joanne Davila, Marvin Goldfried, and Nicholas Eaton – who are involved in research activities that focus on lesbian, gay, bisexual, and transgender (LGBT) individuals, populations that have traditionally been underrepresented in psychological research. In conjunction with the SBU Center for Prevention and Outreach, several members of the clinical psychology program at SBU also recently developed an online resource to help instructors foster an educational climate that is inclusive and supportive of LGBT students. In addition to these research and outreach activities focused on diverse populations, the clinical psychology program at SBU offers courses exclusively focused on diversity training and integrates sensitivity to diversity throughout all of the courses offered. As such, students are trained to appreciate diversity in a way that permeates their understanding of psychopathology and influences their varied activities as doctoral students.

In sum, the clinical psychology doctoral program at SBU has provided me with the knowledge, skills, and practical experiences to soon enter the professional workforce with confidence that my training has prepared me well for whatever endeavors I choose to pursue. The program's commitment to the integration of clinical science and practice, its broad range of in-house clinical opportunities, its training emphasis on principles of change, psychotherapy integration, and diversity, and its teaching and clinical supervision opportunities are among the many program strengths that have contributed to my great satisfaction with my training thus far. It is my sincere hope that my fellow students in other clinical psychology doctoral programs are able to recognize and celebrate the distinct aspects of their programs that make their training unique and provide them with something novel to contribute to the field at large.

SSCP Dissertation Award Winners

It is with great pleasure to announce the winners of the 2012 SSCP Dissertation Award. We received 26 applications this year. It was truly an impressive set of dissertation projects, and a very difficult decision for the Committee. Each winner won $500. The winners in alphabetical order are:

1. **Dylan G. Gee, University of California, Los Angeles (Advisor: Tyrone D. Cannon).** ***Amygdala-Prefrontal Function and Clinical Course among Adolescents and Young Adults at Clinical High Risk for Psychosis.***

Abstract: Given the severity of psychosis and limitations of extant treatments, early risk detection and early intervention are critical to improving patients' quality of life and ultimately preventing schizophrenia. Emotion-related deficits are severe in schizophrenia and disrupt patients' functioning, social relationships, and quality of life. However, it is unknown whether changes in the neural circuitry supporting emotional behavior play a role in psychosis onset and how they may predict clinical outcomes. As such, the present study tests the theory that abnormalities in emotion-related neural circuitry predate the onset of psychosis (Aim 1). It is hypothesized that, relative to controls, at-risk adolescents will exhibit weaker functional connectivity between the amygdala and prefrontal cortex. Moreover, the present study tests the model that greater deficits among at-risk participants predict a worsening clinical course (Aim 2). It is anticipated that a) weaker brain connectivity will predict subsequent conversion to psychosis and b) at-risk participants who later recover will exhibit brain function resembling that of controls. Studying this at-risk population facilitates the investigation of brain changes during a developmental period important to disease progression. Moreover, understanding sources of socioemotional deficits is critical to informing the development of novel interventions and identifying individuals who might benefit from early intervention targeting emotional functioning. Finally, this research may enhance prediction of illness onset and prognosis. Thus, understanding the nature and consequences of abnormalities in emotion-related neural circuitry could lead to novel treatments and prevention of functional disabilities, as well as more effective identification of risk for schizophrenia.

2. **Evan Kleiman, George Mason University (Advisor: John H. Riskind).** ***The Stress Generation Theory Explains Unanswered Questions in Suicide Research: An Integrated Transactional Diathesis-Stress Model of Suicide.***

Abstract: To date, the majority of research on cognitive models of suicide risk involves cognitive vulnerability-stress (or diathesis-stress) models where vulnerabilities are activated by stressful events. In contrast to these models, transactional models of depression demonstrate that individuals with cognitive vulnerabilities may actually produce stressful events that create and maintain depressive symptoms. Despite the conceptual overlap between depression and suicide, a transactional perspective has not yet been applied to suicide. The purpose of my dissertation is to present and test an integrated transactional cognitive vulnerability model of suicide. Specifically, in this model events first activate cognitive vulnerabilities (vulnerability-stress model) that cause further events to be generated (transactional model), leading to increased suicide ideation. Theoretical support and methods for testing this model are discussed in the proposal.

3. Jessica Ribeiro, Florida State University (Advisor: Thomas Joiner). ***Acute Over-Arousal and the Acquired Capability for Suicide: Understanding Acute Suicide Risk through the Lens of the Interpersonal Theory of Suicide.***

Abstract: According to the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010), the difficulties inherently associated with death by suicide deter many individuals from engaging in suicidal behavior. Consistent with the notion that suicidal behavior is fearsome, acute and heightened states of arousal (e.g., insomnia, nightmares, and agitation) are commonly observed in individuals immediately prior to lethal and near-lethal suicidal behavior. Despite growing empirical evidence and wide expert consensus underscoring the danger associated with these states, the area has been relatively under-researched. Further, there have been no empirical conceptualizations of why acute states of over-arousal would immediately precede lethal or near-lethal suicidal behavior. When considered through the lens of the interpersonal theory, acute states of heightened arousal may be relevant to suicidal behavior particularly when considered in the context of the acquired capability for suicide. We suggest that among individuals who possess the requisite levels of pain tolerance and fearlessness about pain, injury, and death, the acute states of heightened arousal may facilitate suicidal behavior in part because it would provide the necessary energy to approach a potentially lethal stimulus. Among individuals who are low on acquired capability, the arousal experienced during agitation may result in further avoidance. The proposed dissertation project is designed to experimentally test this hypothesis.

4. Donald J. Robinaugh, Harvard University (Advisor: Richard J. McNally). ***Constructive Episodic Simulation of Future Events in Bereaved Adults With and Without Complicated Grief.***

Abstract: There are approximately 2.5 million deaths each year in the United States (Kochanek, Xu, Murphy, Minino, & Kung, 2011). A significant subset (10-15%; Bonanno & Kaltman, 2001) of the millions who survive the deceased will experience marked distress and impairment that will persist years after their loved one's death. This distress may include symptoms of depression, post-traumatic stress disorder (PTSD), or complicated grief (CG), a bereavement-specific syndrome distinct from depression and PTSD that is uniquely associated with increased risk for adverse mental health outcomes and substantial impairment in functioning (e.g., Latham & Prigerson, 2004). In this study, I will examine the cognitive basis of one prominent clinical feature of CG: a sense of hopeless or foreshortened future. Difficulty imagining the future is a central component of hopelessness (MacLeod, Rose, & Williams, 1993) and individuals with CG exhibit a relative impairment in their ability to imagine specific future events (Robinaugh & McNally, in press). However, the boundaries of this dysfunction remain unclear and no study has yet demonstrated that impairments in the ability to imagine the future are associated with hopelessness in bereaved adults with CG. To further examine prospection deficits in CG, I will assess the ability to construct episodic simulations of novel future events (Addis, Musicaro, Pan, & Schacter, 2010) in bereaved adults with and without CG. I hypothesize that, relative to those without CG, bereaved adults with CG will generate novel future event simulations with fewer internal details (i.e., details central to the imagined event), less episodic richness, less cohesiveness, and lower positive valence. I further hypothesize that lower detail will be associated with a greater subjective sense of hopelessness.

Society for a Science of Clinical Psychology (SSCP) & the Academy of Psychological Clinical Science (APCS) Events at the 25th Annual APS Convention Washington, D.C., USA May 23-26, 2013

SSCP Presidential Address: Michelle Craske, Ph.D. (UCLA) "Neurally-based Translational Models for Treatment Optimization"

SSCP Distinguished Scientist Address: Ian Gotlib, Ph.D. (Stanford) "Understanding and Reducing Risk for Depression"

Bruce Cuthbert, Ph.D. (NIMH): "From Revolution to Legislation: The NIMH Research Domain Criteria Project", Discussants: Bob Krueger & Elaine Walker

Edna Foa, Ph.D. (U. Penn): "Disseminating Evidence-Based Treatments for PTSD within Systems and Across Countries: Can Current Treatments Be Applied to Mass Traumas"

Kenneth Kendler, M.D. (VCU): "Philosophical Issues in Psychiatry and Clinical Psychology"

Denny Borsboom, Ph.D. (U Amsterdam): "Network Analysis: An Integrative Approach to Research and Treatment in Psychopathology"

Symposia

"Reflections on Rumination: Honoring Susan Nolen-Hoeksema", Ed Watkins (Chair), James Gross (Discussant), Katie A. McLaughlin, Louisa A. Michl, Lori M. Hilt, Brian T. Leitzke, Seth D. Pollak, Blair E. Wisco, & Amelia Aldao

"Beyond the Guild: Innovative Models to Expand Dissemination Science in Mental Health", Marc S. Atkins & Kimberly Eaton Hoagwood (Chairs), David Chambers (Discussant), Mary M. McKay, Jenna Watling-Neal, Lawrence Wissow

"Paul Meehl's Legacy", Scott Lilienfeld (Chair), Denny Borsboom, Howard Garb, Kenneth Kendler, Bob Krueger

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