



Division 12

CLINICAL SCIENCE

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

Developing clinical psychology as an experimental-behavioral science



Newsletter

Winter Issue

2010 Executive Board

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Table of Contents

Presidential Reflections

T. Ollendick.....2

Feature Articles

Evidence-Based Treatments, Part III: Further Musings

T. Ollendick.....4

Division 12 Resolution.....8

Motion for Div.12 to Consider.....8

APA's Practice Assessment Fee: Part II

T. Tumlin & J. Grohol.....10

The Pre-Doctoral Internship Crisis

R. Brock, K. Wilson & F. Farach.....14

Updates from the Board

Secretary/Treasurer Report.....7

Division 12 Update.....9

SSCP Distinguished Scientist Award Winner.....18

Board of Scientific Affairs Update.....19

Clinical Scientist Training Initiative Application.....21

Presidential Reflections

Thomas Ollendick, Ph.D., *Virginia Tech*

As my term of office as president comes to a close, it is time for reflection and to give thanks to all of those who made the year so rewarding for me and to welcome in new members of the Board. First, comes the reflection. I have long been a member of SSCP and, along with the Association for Behavior and Cognitive Therapies, this Society has been my professional home. There is so much to like about SSCP, both as a scientist and as a practitioner. Until recently, I maintained a small private practice in clinical psychology and I often found myself questioning what I was doing as a clinician and how effective I was being with my clients. I also found myself trying out new assessment strategies and treatments for the many children, youth and families who sought me out for clinical services. Many of my research ideas and several of my publications found their origins in my ongoing clinical practice; conversely, much of my clinical armamentarium was informed by my ongoing research and that of many, many others. My clinical practice was my laboratory, and I believe my clients were better off as a result (though such testimony is only that and devoid of strong empirical support). To serve as president of this Society has been a distinct honor and privilege for me. In some small way, I hope I have helped advance clinical psychology as an experimental and behavioral science during my presidency.

Of course, many individuals are to be thanked for their ongoing work and keeping us “on task” throughout the year. Past-President Howard Garb was an invaluable resource for all of us. His wisdom and knowledge of SSCP and its internal workings were greatly appreciated. Further, his work with the American Psychological Society (APS) has helped position us to not only maintain our affiliate status with them but to also be an active player in the organization and its programs. He and Varda Shoham, our richly talented incoming president, have done much to culture, solidify, and expand our good working relations with APS. In fact, one of our more notable accomplishments this year has been our enhanced relations with such a prestigious organization. As you might imagine, being sandwiched between Howard and Varda made life easy for me – what good bookends they made! Dave Smith has also been a real tour de force for us this year as our Secretary/Treasurer. Not only has he maintained the monies in our coffers, he has helped to increase our reserves and encouraged us to branch out and use some of our monies for new and exciting ventures (see below). Dave has also been instrumental by overseeing the Membership Committee (chaired by Doug Mennin) and by developing our response to Division 12’s motion regarding empirically supported treatments (Newsletter, this issue, and our website).

Our Members-at-Large, Kelly Wilson and Bethany Teachman, have also been very active this year – fulfilling one of my ambitions to help our Society become more proactive. Kelly, along with Graduate Student Representatives Becca Brock and Frank Farach, has been very active, serving on our Ad Hoc Committee to address the crisis in internship placements – there are a significant number of highly qualified individuals from our programs not securing internship placements – due at least partially to the glut of students in doctoral programs and reductions in actual internship placements. Becca, Frank and Kelly provide us with the first installment of the results of their survey in this issue of the newsletter. For too long, we have had our heads in the sand regarding this crisis. Something must be done about it and we hope this survey will be the first of many activities related to helping resolve it. Our other Member-at-Large, Bethany Teachman, has also been very active, both by helping out with our External Nominations Committee (chaired by Gayle Beck) and by developing the Promoting Clinical Science Committee, whose main function is to

implement a small grant program from the Society – the Clinical Scientist Training Initiative Grant Program. See this issue of the newsletter for more details. This is an exciting development and one that will put our limited reserves to very good use. In addition to these activities, Bethany, Kelly, Becca and Frank have been very active with the Student Listserv and related activities.

Dave Tolin is also to be thanked for his very important but sometimes thankless job as Division 12 Representative. As the Section III Representative of Division 12 of APA, he is the liaison between our Board and the Board of Division 12. I say that this job is thankless at times because he is sometimes caught in the middle between our deliberations and those of the Division. Although we are often on the same page as the Division, we are not always. Dave is the politician par excellence who helps resolve our differences and accent our commonalities. His is not an easy job.

Five other persons are to be thanked as well. Although none of them serve on the Board, they are very active and contributing members of the Society. Denise Sloan has served as Chair of our Dissertation Awards Committee – a position she has held for the past several years. This committee handles one of our most important activities for our student members – awards for outstanding scholarship at the doctoral level. Thanks, Denise. Gayle Beck has chaired our External Nominations Committee and has performed in an exemplary manner. This committee identifies and recommends clinical scientists – whether members of SSCP or not – for important committees and awards in APA, APS, and similar organizations. She and her committee have been extremely active. Thanks to you, Gayle. Doug Mennin has chaired our Membership Committee; to him and his Committee we owe a debt of gratitude. They have actively recruited new student and full members of the Society. Thanks to their vision, our membership continues to increase. Also, Mitchell Prinstein is thanked for his incredibly good vision as the Chair of our APA Program this year. Mitch arranged for an Invited Address by Matthew Nock, a young star in the field of clinical science and for two symposia – one on DSM-V and the other on ethical issues attendant to the use or failure to use evidence-based treatments in clinical practice. The programs were well received and well attended! Finally, thanks are extended to Erika Lawrence, Editor of our newsletter, *Clinical Science*. She has had the vision this year to orient our newsletter around issues related to evidence-based treatments – both their promises and pitfalls. This, of course, has been a topic near and dear to me and I have been privileged to have my presidential columns centered on this topic. Erika has done a very good job in bringing these newsletters to you and, at the same time, being very patient with those of us who are late for their columns to her! Thanks, Erika.

At this time, I also want to welcome new Board members for 2011: Rick Heimberg, Professor and Director of the Adult Anxiety Clinic at Temple University will be assuming his duties as President-Elect; Bunmi Olatunji, Assistant Professor of Psychology and Psychiatry at Vanderbilt University will be commencing his duties as Member-at-Large; and Sara Stasik, a fourth year doctoral student in clinical psychology at Notre Dame, who will be beginning her term as Graduate Student Representative. As Past-President soon to be, I look forward to working with each of these incredibly talented individuals. At the same time, the following individuals will be rotating off of the Board: Howard Garb, Past-President; Kelly Wilson, Member-at-Large; and Frank Farach, Graduate Student Representative. They all have served well and had the deep appreciation of the Board and the Society for their good service.

As is evident, the year has been a very good and productive one. When you are fortunate to be surrounded by good people, good things happen. I thank all of the above individuals for their dedicated service and for making this such a rewarding and fulfilling year for me and, I hope, for SSCP. It has been an honor to serve as your president.

Presidential Column

Evidence-Based Treatments, Part III: Further Musings

Thomas N. Ollendick, Ph.D., *Virginia Tech*

In my first two presidential columns, I reviewed the history of the movement toward evidence-based treatments and identified three primary questions associated with their use in clinical and research settings: (a) Is it possible that some treatments are more effective than others? (b) Do the use of treatment manuals lead to mechanical and inflexible interventions and the resultant loss of innovation and autonomy in clinical work? and (c) Do treatments shown to be effective in clinical research settings transfer to “real-life” clinical settings? Based on a brief review of the existing psychotherapy outcome literature, I concluded that: (a) some treatments are more effective for some problems and disorders than others, (b) manualization of treatments need not be a stumbling block to providing flexible yet effective psychotherapy in both research and clinic settings, and (c) the portability of treatments from the research setting to the practice setting is feasible and they appear highly promising (although more evidence of such is clearly needed). In my last presidential column for 2010, I share other comments and reflections about evidence-based treatments.

What Would an “Ideal” Evidence-Based Treatment Look Like?

In a recent paper, Neville King and I (King & Ollendick, 2008) articulated several features of “elegant” evidence-based interventions. We suggested that such treatments should be characterized by the following six features. First, we suggested that an “elegant” treatment should be embedded in a sound theoretical rationale *and* a solid conceptualization of the clinical problems presented to us. Typically, the theoretical rationale of an intervention is assumed or taken to be self-evident on the basis of a superficial fit with an established school of psychotherapy such as psychodynamic therapy, cognitive-behavior therapy, interpersonal therapy, or family

therapy. However, we believe, along with others, there is a need to go beyond brand names in psychotherapy and use our understanding or conceptualization of the clinical problem as a more appropriate rationale for selecting specific psychosocial interventions. Conceptualization of the client’s problems involves consideration of research on factors that lead to or contribute to the pattern of functioning we and our clients wish to change, what processes are involved, and how these processes unfold for a given individual. The selection of a treatment intervention should be based on the “goodness of fit” of the intervention to the problem areas that need to be addressed. Problems call for interventions that address the basic processes that underlie the problem, and that can be predicted to work better for those problems. Conceptually, based on the nature of the presenting problems, some psychotherapies should, and do, work better for some problems than others.

Second, and related to the first, we suggest that we need to arrive at a clear definition of the problems presented to us *and* a clear appreciation for the target client group with whom we are working. In the first instance, it is important to identify the problem areas in operational terms. For example, problems such as poor assertion, shyness, obesity, relationship/marital discord, and parent-child conflict can be assessed objectively through multi-method and multi-informant assessment strategies that yield relatively clear operational definitions for us. For other problems such as separation anxiety, panic disorder, major depression, and borderline personality disorder, our diagnostic systems are generally useful and the various “symptoms” can be used as behavioral targets of change. So, too,

the target client population needs to be specified in terms of socio-demographic variables (e.g., age, gender, sexual orientation, socio-economic level, and cultural/ethnicity factors) and problem characteristics (co-occurrence with other disorders, history of psychopathology). Attention to these matters takes us back to our most fundamental question in psychotherapy research: What works for whom, when, where and why?

Third, we suggest that “elegant” interventions be characterized by certain program features including realistic goal setting, flexibility, and time limited interventions. Interventions should have clear personally relevant goals for clients and their families. Interventions should also be developmentally sensitive and take into account varying levels of cognitive, affective, and social development across the lifespan. Eight year olds differ from 16 year olds; however, so too do 30 year olds differ from 60 year olds. In addition, elegant interventions should be action-oriented with an emphasis on coping skills training and competency building. Moreover, such interventions should be structured, time-limited, and multi-component to address the many facets of any one set of clinical problems. Finally, the ideal intervention anticipates future setbacks and stressors and has a relapse prevention training component. In doing so, ideal interventions involve teaching or empowering clients to be their own therapists.

Fourth, to advance the science of evidence-based treatments, we suggested that “elegant” interventions be manually based and “principle-driven”. As noted in my earlier presidential columns, treatment manuals serve two primary purposes: (1) they provide an operational definition of what actually occurs in treatment, and make it possible for us to determine whether the treatments were delivered as intended (i.e., treatment adherence/integrity), and (2) the use of manuals allow mental health professionals to know more precisely what was actually done in treatment and, in the final analysis, what procedures were supported in a given clinical trial. Debates continue on the wisdom and folly of treatment manuals. Based on the overall success of treatment manuals in controlled trials, we maintain that treatment manuals are an important feature of an “elegant” psychosocial intervention. Of course, these treatment manuals need to be based on theoretically-driven principles and designed to address the clinical problems that are under consideration. As but one

example, Sheila Woody and I identified five treatment principles that cut across various evidenced-based treatments for the anxiety disorders. Therapists should:

- Challenge misconceptions through discussion and explicitly questioning the evidence
- Actively test the validity of erroneous and maladaptive beliefs through behavioral experiments
- Use repeated exposure to the feared situation to reduce the intensity of the fear response
- Eliminate avoidance of feared situations
- Improve skills for handling feared situations

Of importance, within these five principles are strategies to address the three modalities of responding typically seen in the anxiety disorders: cognition, affect, and behavior. Of additional importance, these five principles do not stand in isolation. They each serve to promote the goals of the others, which is one likely explanation for why tested treatments seldom use strategies using just one of the principles. For example, eliminating avoidance of feared situations (behavior domain) not only promotes a return to normal and adaptive functioning, but it also promotes exposure to feared situations (affective domain) and probably serves to change maladaptive ideas about bad things that might happen in those situations (cognitive domain). Similar principles underlying the effective treatment of other problems also need to be determined (see Castonguay & Beutler, 2006).

Fifth, King and I (2008) suggested that the “elegant” intervention should have considerable research support for its clinical use and that it should also possess evidence of clinically significant outcomes, not just statistically significant ones. In my first two columns, I attempted to illustrate the first point in reviewing the efficacy of various interventions for specific problems and illustrating that some treatments work better for some problems than others. Further, as well as being statistically significant, treatment-related changes must produce clinically significant changes for clients. Long term positive treatment

outcomes should also be demonstrated for claims of long term maintenance to be considered valid. Although we do have some evidence-based treatments, we have long way to go before we can rest on our laurels.

Sixth, and finally, we suggested it is not sufficient for psychosocial interventions to be effective in the treatment of emotional and behavioral problems. As well as being effective, interventions should also be acceptable to our clients and society at large. As noted by Montrose Wolf (1978) in his classic paper on the social validation of behavioral interventions, clinicians must respect the rights of individuals who are treated and determine the acceptability of proposed interventions. At the pragmatic level, it is obvious that the attitude of our clients and significant others towards our interventions can have an important bearing on treatment adherence and cooperation. As noted by Wolf (1978) "if participants don't like the treatment then they may avoid it, or run away, or complain loudly, and thus, society will be less likely to use our technology, no matter how potentially effective and efficient it might be" (p. 206). Recently, the American Psychological Association (APA, 2006) emphasized this point in suggesting that client characteristics including their preferences for treatment be examined and incorporated into selection of treatment strategies. While I do not disagree with this recommendation, I do suggest a word of caution. In my own work, for example, with highly anxious and phobic individuals, there are not many clients who "prefer" to be exposed to the very things that are anxiety-producing to them. Many of them would prefer to just "talk about" their problems and/or receive medications for them. Yet, we know, as illustrated above, that effective interventions rely on exposure as a therapeutic principle that addresses the core developmental issues of anxiety and its related disorders. Sometimes the best medicine is not the preferred medicine. Still, and obviously, much work needs to be done to prepare clients for such exposures and to work with them about their concerns and their "preferences" for less direct interventions.

In brief, an "elegant" intervention that is evidence-based contains many elements, in our opinion. We are only at the beginning stages of examining extant treatments for these features and much work remains to be done.

A Word on Ethics and Evidence-Based Interventions

Reviews of the literature make it clear: evidence-based treatments have not been identified for some problems and that the necessary translation research from research to clinical settings has not yet occurred for others. What should we do in our clinical practices in the absence of firmer support for our interventions?

Unfortunately for the individuals we serve, we probably need to continue "treatment as usual" until such support becomes available; however, it seems to us that these treatments as usual, as well as other evolving treatments, urgently need to be submitted to systematic inquiry in controlled trials before their ongoing and routine use can continue to be accepted. The simple fact of the matter is that we do not have sufficient evidence at this time for the efficacy of several psychosocial treatments for *many* problems. Yet, I must pose the question: How long can we continue to provide such treatments in the absence of evidentiary support? Will we be using the same unproven and perhaps even harmful interventions 10 years from now?

In considering these questions, I leave us with an ethical issue to ponder. As psychologists, the identification, promulgation, and use of evidence-based treatments is certainly in accord with our ethical standards that assert that as psychologists we should rely on "scientifically and professional derived knowledge when making scientific or professional judgments." Yet, the use of evidence-based treatments represents a two-edged sword. On the one hand, it might seem unethical to continue to use a treatment that has not been empirically supported; on the other hand, inasmuch as relatively few evidence-based treatments have been identified and disseminated, it might be unethical to delimit or restrict practice to those problem areas and disorders for which treatment efficacy has been established. What, after all, should we do in instances in which individuals present with problems for which evidence-based treatments have not yet been developed? Quite obviously, there are no easy solutions here. However, some guidance is provided by Kinscherff (1999) in an

early and provocative article entitled “Empirically supported treatments: What to do until the data arrive?” In addition to the general advice that clinicians should develop a formulation of the case and select the best approaches for helping a client from among the procedures in which the clinician is competent, he suggests: “Clinicians should remain informed about advances in treatment, including empirically supported treatments, and maintain their own clinical skills by learning new procedures and strengthening their skills in areas in which they are already accomplished. Because there are limitations to how many treatments any one clinician can master, a key professional competence is knowing when to refer for a treatment approach that may be more effective for the client” (p.4).

I am in total agreement with Kinscherff. Further, I assert that the ongoing practice of invalidated treatments for problems for which we have evidentiary support is not only bad practice, it is unethical practice. Surely, the individuals we serve deserve the very best of what we have to offer them. It is our responsibility as practicing professionals to keep abreast of developments about which treatments work and which ones do not and if we are not proficient in those treatments that do work to refer our clients with these problems to professionals who are. We hold other professionals to similar standards, whether they are educators, medical doctors, or other human service professionals. Why do we not hold ourselves to similar standards?

American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271-285.

King, N.J. & Ollendick, T.H. (2008). The elegant psychosocial intervention: A heuristic conceptual framework for clinicians and researchers. *Behavioural & Cognitive Psychotherapy*, 36, 253-261.

Kinscherff, R. (1999). Empirically supported treatments: What to do until the data arrive (or now that they have)? *Clinical Child Psychology Newsletter*, 14, 4-6.

Wolf, M.M. (1978). Social validity: The case for subjective measurement or how applied behavior and analysis is finding its heart. *Journal of Applied Behavior Analysis*, 11, 203-214.

Woody, S.R. & Ollendick, T.H. (2006). Technique factors in treating anxiety disorders. In L. Castonguay & L.E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 167-186). NY: Oxford Univ. Press.

Secretary/Treasurer Report

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

Membership continues to grow, thanks largely to SSCP's outstanding Membership Committee (Douglas Mennin (Chair), Elizabeth Hayden and Ashley Pietrefesa). The Membership Committee continues to attract new members through its ongoing social media initiative, including SSCP's Facebook page. If you are Facebook member and have not done so already, we would like you to do two things today:

1. Go to <http://www.facebook.com/pages/SSCP/333436279606> and become a fan of the page.
2. Cut and paste the following into your Facebook status and ask like-minded friends to do the same.

"I am a member of the Society for a Science of Clinical Psychology. To become a member or just to become a fan of science-based clinical psychology go to <http://www.facebook.com/pages/SSCP/333436279606> You will find a link to the main sscp page. Click "Like" to become a member. Pass the word."

The Membership Committee is also currently investigating reduced dues rates for retired members, incentives for members who recruit new members, and incentives for new members.

Finances (as of December 20, 2010)

Current funds: \$33,005
Total income: \$10,225 (since 6/1/2010)**
Total expenditures: \$4,843 (since 6/1/2010)

** Includes interest

Society funds also continue to grow. Our major annual expenses include the dissertation, poster, and distinguished scientist awards (\$4,500.00) and society dues and management expenses (e.g., APS affiliation, credit card server, membership database management, and billing, \$2,500.00). In response to the Society's healthy financial state, the Board is developing an award for innovation in research training in clinical psychology, as a program-level award in the spirit of our current student and distinguished scientist awards.

At its January 2010 meeting the Board of Division 12 of the APA passed a resolution entitled “A position statement of the Society of Clinical Psychology Division 12 of the American Psychological Association” (the *Clinical Psychologist*, Winter 2010). Section 3 of Division 12 hopes to clarify the resolution by offering the following emended version of the previously passed resolution and requests that the Division 12 Board pass this new position statement as a substitute for the prior one.

Original Resolution from Division 12

WHEREAS, The Society of Clinical Psychology is firmly committed to identifying and promulgating treatments that work. Indeed, the Society was among the first organizations in mental health to compile a list of empirically supported treatments on the basis of supportive results from randomized clinical trials (RCTs). As scientific knowledge and research designs mature, and as researcher-practitioner collaborations increase, we have reached a point where it is desirable and feasible to extend the research methods used and the constructs investigated. A multiplicity of sophisticated research strategies, including but not limited to RCTs, now allows us to improve the effectiveness of psychological treatments.

THEREFORE, To advance this broad view, the Society of Clinical Psychology defines the mechanisms of psychotherapy as those factors, processes, and interventions that are designed to effect and maintain beneficial changes in client/patient functioning. These change mechanisms include treatment methods, participant characteristics, the quality of their interactions (relationships), the context and culture in which the interventions occur, and other contributors yet to be discovered. This inclusive and evidence-based definition is designed to ensure that: 1) research on psychotherapy and the designation of empirically supported therapies consider treatment methods as well as the participants, their relationship, and contextual factors; 2) a wide variety of research methods are used as appropriate to the questions asked; and 3) research increases

Working Draft of Motion for Division 12 Board Consideration:

Substitute Resolution

WHEREAS The Society of Clinical Psychology is firmly committed to identifying and promulgating interventions that work. Indeed, the Society was among the first organizations in mental health to compile a list of empirically supported treatments (ESTs) on the basis of supportive results from randomized clinical trials (RCTs). The Society is equally firm in its commitment to understanding how and under what conditions interventions work. Although RCTs address whether interventions work, it is desirable to also extend the research methods used and the constructs investigated to determine how, and under what conditions, these interventions work. Impressive developments in scientific knowledge, research designs, and researcher-practitioner collaborations now make this complementary, expanded goal feasible.

THEREFORE, to advance this broad view, the Society of Clinical Psychology advocates research into the processes of psychotherapy – those empirically supported factors, variables, and interventions that effect and maintain beneficial changes in client/patient functioning. RCTs provide an extremely valuable way to determine whether preventive and tertiary interventions work well, and to determine the relative efficacy of different interventions. At the same time, other methodologies are also needed to provide a comprehensive picture of the factors that influence and explain psychotherapy outcomes. Research approaches that focus on the necessary and sufficient processes of change – both intervention-specific techniques and common factors

Original Resolution continued

our understanding both of the cross-cutting/common and unique principles on which effective treatments rest and enhance the optimal use of participants, interactional, cultural, and technical factors in effecting change.

Division 12 Update

David F. Tolin, Ph.D., ABPP
*The Institute of Living and Yale University
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The Board of Division 12 met in Chicago on October 1, 2010 for a strategic planning meeting. Some highlights:

Organizational Structure: The role of sections and committees within the division was discussed. The following proposal was considered: every Section would get 1 or 2 Convention hours, and the remainder of convention time would be distributed proportionally to membership in D12 (Sections with larger numbers of D12 members would receive more convention time); and the 50% rule (requiring that at least 50% of all Section members also hold membership in D12) would be enforced in the future, possibly in 1-2 years to allow Sections to address the recruitment issues. Further discussion and vote will take place at the next meeting.

The agendas of the Sections and the agenda of the Division are becoming increasingly different. Some Sections have historically aspired to be Divisions. John Norcross argued that the best strategy may be to stress that the value of D12 lies in its professional identity, the integration of science and practice, and the fact that the best in the field belong to D12. An emerging trend might be that Psy.D.s will become D12 members whereas Ph.D.s will become members of specialty organizations such as APS or ABCT rather than D12 members.

Membership: There is tension between membership in specialty groups such as ABCT and membership in D12. Larry Beutler argued for promoting a generalist model to provide an integrative identity, parallel to the need for medical generalists rather than medical specialists. A new image for clinical psychology appears to be needed. This requires clarity on how to best market membership in D12. Some of the possible approaches to be considered include: (1) A retreat to clarify the mission, identity, and strategy of D12; (2) Obtaining a marketing consultation; and (3) Spot analysis.

(See next column)

Substitute Resolution continued

(e.g., patient/client characteristics, therapist characteristics, the quality of the therapeutic relationship, the context and culture in which the interventions occur, and other contributors yet to be discovered) are essential for determining what makes interventions work. Thus, as a field, we need to value both those research designs that allow clear claims about the causal status of a given intervention, as well as those designs that can explain how specific and common factors affect outcomes. Moreover, greater research is needed on the effects of the social, cultural, and political contexts in which a given intervention occurs. Research on both the efficacy and effectiveness of interventions is essential to build a comprehensive, evidence-based understanding of which interventions are most likely to help a given person, couple or family. This inclusive and evidence-based approach ensures that: 1) research on how preventive and tertiary interventions work and moderators of outcomes consider not only intervention strategies but also the participants, therapists, the therapeutic relationship, and contextual factors; 2) a wide variety of research methods are used as appropriate to the questions asked; and 3) research increases our understanding of both the common and unique principles on which effective interventions rest in order to enhance the use of participants, interactional, cultural, and technical factors in effecting change.

Division 12 Update (continued)

Clinical-Research Interface: Dissemination of evidence-based practice and clinician researcher collaboration remain the main concerns at this interface.

In the upcoming D12 Board meeting, the following section-related issues will be discussed:

1. What should be the minimum number of members required for a Section?
2. To what extent should time allotted at Convention be weighted in proportion to the size of the Section?
3. To what extent should D12 or the Sections be responsible for travel expenses for D12 Board meetings?
4. Should the by-laws requirement that at least 50% of Section members must also be members of Division 12 be enforced or revoked?

APA's Practice Assessment Fee: Part II

Timothy Tumlin, Ph.D., *Independent Practice, Darien, IL*
& John M. Grohol, Psy.D., *CEO & Founder, PsychCentral.com*

Article will also appear on PsychCentral.com

The controversy over the American Psychological Association's (APA) fundraising for its political-action affiliate has escalated with the filing of two class-action lawsuits alleging APA defrauded its membership to collect more money for its advocacy group. The lawsuits claim that for at least eight years APA deceived its members into believing that voluntary donations to the political group were required to remain in the 118-year-old organization.

The organization has been under fire since it was disclosed in April that donations to the APA Practice Organization are not required for licensed psychologists in order to maintain an active membership in the APA. The news surprised a great many members who had long believed that paying the "practice assessment" fee to APAPO was a condition of membership in APA. Among those surprised were members of the council which sets the organization's policies and a former president currently on its board of directors.

The contributions to APAPO have become a significant portion of what licensed psychologist practitioners have paid since the affiliate was formed in 2001 to expand APA's political lobbying muscle. For example, next year's dues to APA are about \$287 while the fee for APAPO – billed to most licensed practicing members - adds another \$140. About 50,000 of APA's 85,000 full members were billed the practice assessment.

The first lawsuit to be filed against the two organizations was amended Dec. 3 so that it now includes plaintiffs from California, Illinois, Florida, New York and Ohio. "Since at least the year 2002, Defendant APA has falsely represented to its members in connection with renewal of annual membership contracts that a 'mandatory' special assessment over and above the annual dues was required ... without adequately disclosing that this 'mandatory' assessment in fact was completely voluntary and was solely for membership in an additional organization, the APAPO," the lawsuit stated.

The filing also claims that "Recognizing that many of its members would not want to voluntarily pay to fund this lobbying and advocacy organization, APA embarked on a deliberate deception designed and intended to maximize lobbying funds outside of the proper lawful function of a 501(c)(3) entity like APA and misrepresented to members in APA that as part of annual membership renewal there was a 'mandatory' practice assessment, which APA allocated to APAPO."

The second lawsuit, filed Nov. 4, includes a plaintiff from Tennessee and states "The APA misled its membership to obtain money for a political organization that would not have been collected had everyone known it was not mandatory for APA membership." Both were filed in the District of Columbia, where APA is headquartered. Each must next be certified as appropriate for class-action status. The APA has retained the international law firm of WilmerHale to represent the organization, according to attorneys in the case.

Responses from the two organizations, which share boards, staff and offices, have been limited to three joint statements. The first statement, issued May 5, did admit a problem in communicating the nature of the assessment, stating, "The manner in which APA, APAPO and Division dues have been combined on past dues statements does not make clear that the mandatory practice assessment payment is required for APAPO membership but not for APA membership." It did not address other questions about how the APA characterized the assessment in ways that are alleged to be misleading. For example, an explanation of the assessment on the organization's website was found to be unclear on the issue. In addition, payment of dues online would not allow members to decline to pay the voluntary fee, and some members said they were explicitly told by APA staffers that the assessment was indeed required for APA membership.

A second joint statement from the APA and APAPO was issued in response to the filing of the first lawsuit. The statement, issued Nov. 3, denied the core complaint of the lawsuit, saying “APA and APAPO have not sought to deceive their members into paying dues for the benefits of membership in APAPO” The organizations issued a third statement on Dec. 6 reiterating that “allegations in the complaints are false and completely without merit. We will defend against them aggressively. APA and APAPO have never misled their members into paying dues or assessments.”

After their initial statement admitting that APA’s annual dues form had been unclear, APA officials have not offered an explanation as to how so many members could have believed the assessment was mandatory. APA spokesperson Rhea Farberman declined to be interviewed for this article and instead referred inquiries back to the Dec. 6 statement.

The ranks of APA members who believed the assessment was mandatory include James Bray, Ph.D., a former member of the APA Board of Directors who served as APA President in 2009. “I think the question is that people don’t feel like that was made explicit enough clear about that relationship,” said Bray in an interview about the assessment. “And until this stuff arose, I as a member of the Board of Directors just assumed that you were required to pay it.”

Among other prominent psychologists with the same mistaken belief is Gerald Davison, Ph.D., professor of gerontology and psychology at the University of Southern California. As an APA member since 1965, the former president of APA’s Society of Clinical Psychology, and the author of a widely used textbook on psychopathology among other publications, Davison has been one of the leaders in the field for decades. “I’m certainly among those who didn’t see it as voluntary for many years,” he said. “And I don’t think I have trouble understanding clear prose.”

A poll conducted for this article also found that many members of the APA’s Council of Representatives, the legislative body that sets the policies of the organization and chooses many of its key staff and

responses, 25 of them licensed psychologists. Of those practitioners, 48 percent said they had believed that the assessment was mandatory for APA membership and 40 percent said they knew it was not. Other said they didn’t recall.

Some of the practitioners on the council who were polled anonymously expressed anger and disappointment while others downplayed the significance of the controversy. One practitioner on the council criticized both the apparent deception and APA’s response to its revelation: “It is clear to me that it was a widely held belief that the practice assessment fee was mandatory for continuing membership in APA if one was a licensed psychologist. I think that a formal internal investigation of how this belief was promulgated is critical,” the council member said. “The persistent defensive and evasive posturing by APA regarding this issue is offensive. The question is not whether the APAPO does good work or whether the money collected through the special assessment fee has been put to good use. The question is whether APA was negligent of assuring that fully informed consent was provided in the context of soliciting and collecting the fee.”

“I always thought that the assessment was mandatory,” wrote another council member. “I think it should be clearer that it isn’t, but it should also be clear what all the assessment fee does for practitioners. I would have paid it anyway, but I don’t think it was written in a way to convey that it was optional.”

A non-licensed council member also expressed dismay over how APA has managed the controversy. “I expect APA to operate at the highest level of integrity and clarity of communication, same as the APA ethical standards and expectations for practitioners. However, I am extremely disappointed with the way that APA has either created ambiguity and misleading communications about this fee or has taken advantage of the lack of clarity.” The council member added, “I have lost respect for APA leadership as a result of this and am also disappointed in how it’s being handled.”

Other council members who responded to the poll were more supportive of APA’s actions. “I think that APA has been entirely honest in this regard and that some are making this a mountain out of a mole hill,”

an unlicensed member wrote. However, the respondent appeared to mistakenly believe that the assessment is mandatory for APA members, writing “It is and continues to be required of those in practice who wish to be APA members and, moreover, the APAPO has done remarkable work for practitioners. We should all support it!” One licensed member admitted to not paying attention but was not bothered by the question. “I don’t feel this is a big problem. I just paid the fee, but I am so busy I often don’t look into specifics of fees I have to pay.”

The roots of the controversy go back to 1985 when changes in the leadership of the APA began to steer the organization into a direction of greater active political activism and a focus on licensed practitioners. The APA Practice Directorate was formed then, and its first Executive Director for Professional Practice, Bryant Welch, Ph.D., was appointed.

Welch recalled that in 1985 a special assessment of \$50 per year was levied for practitioners, which funded special legal and legislative initiatives such as obtaining the right for psychologists to receive Medicare reimbursement. He said that at that time the fee was mandatory for practitioners and was administered without controversy, if not roundly welcomed. The role of practice advocacy grew rapidly along with its budget, taking on such projects as a national campaign for prescriptive authority by lobbying state legislatures. However, the emphasis on practice was not welcomed by all, and many psychologists left the organization to form what is now called the Association for Psychological Science.

By the end of the 1990s the APA was spending so much money on political activities that it was in jeopardy of violating its tax-exempt status with the Internal Revenue Service, which had revised its rules governing non-profit organizations. The association receives tax benefits through its status under 501(c)3 a tax law governing scientific, religious and charitable organizations. The statute allows a limited amount of political activity. According to Bray, “APA found out that it actually wasn’t in compliance, or was at risk for not being in compliance, with the kinds of lobbying activities it was doing on behalf of practitioners.”

The solution was to create the APA Practice Organization (APAPO), which is governed by the 501(c)6 statute, a different tax-exemption status for non-profit groups which allows for more political activities. It is

also used by organizations such as chambers of commerce. However, the two organizations are legally distinct and all parties have agreed that the APA cannot legally require its members to give money to, or join, the APAPO.

Thus, when the APAPO was created on Jan. 1, 2001, it represented a significant change from the previous 16 years, when the APA charged licensed practitioners higher dues to pay for practice advocacy. The new assessments paid to the APAPO – first called a “special assessment” and then by 2005 named the “practice assessment” – could no longer be required of APA members. If they chose to “join” APAPO then the assessment would be required, but APA members could not be forced to do so. According to statements from APA officials, no member has ever been expelled from the APA for refusing to “join” APAPO or pay the practice assessment fee.

The controversy and lawsuits arose over the question of how clearly and accurately the APA has informed its licensed practitioner members that since 2001, they were no longer required to pay the assessment, nor are they required to “join” or contribute money to the APAPO because it is a separate organization. In reviews of APA’s communications since 2001, no use of terms such as “voluntary” or “elective” has been found to describe the assessment fee. Even in joint statements of the board released as late as December, 2010, the authors state that practitioners “are billed” this amount and are “expected” to pay it.

The confusion appears to have begun from very beginning of the change that created the APAPO. One of the earliest explanations of the new assessment is contained in a September 2000 article by Sara Martin in the *Monitor on Psychology*, which is published by the APA. In it she describes the creation of the APAPO. She reports that the APA’s tax status limited the organization to spending \$1 million per year on lobbying in addition to other restrictions. She wrote that the rationale for the change was to participate in more activities related to political action committees and lobbying.

As noted by Ms. Martin, who is now editor of the *Monitor*, “The APA Practice Organization will be funded by the special assessment that licensed APA members already pay, which has traditionally funded practice advocacy.” The article did not say that

payment of the assessment to the new organization would be elective.

Retrieved web pages from APA's site appear to indicate that payment of the assessment is required, usually by stating members "must" pay it or are billed it. A 2002 version of the APA page entitled Membership Special Assessment, states:

"At the third year of APA membership, an annual assessment of \$110 is billed to all licensed health care psychologists who provide services in the health or mental health field or who supervise those who do. Special assessments support the work of APA's Practice Directorate, which supports the concerns of practitioners in psychology. Licensed or certified Members, Fellows, and Associate Members who must pay the Special Assessment include..."

Other retrieved APA web pages concerning the assessment contained vague language about the assessment but with no explanation that it is not required for APA membership. For example, a 2003 web page said, "Beginning in the 3rd year of dues payment, all APA Members and Associates who are licensed or certified are assessed an annual assessment to help fund APA Practice Organization." In addition, pages that appeared on the APA website in 2007 and 2008 continued to have a similar message, such as: "If an APA member is a licensed psychologist and is engaged in the provision or supervision of health or mental health-related services an additional fee applies as specified above."

Questions also arose over the wording of dues statement over the years. For example, the 2010 paper dues invoice from the APA states:

- Practice Assessment for Licensed Health Care Psychologists
- Supports the APA Practice Organization, a companion organization created by APA to promote the professional interests of practicing psychologists. For more information and U.S. tax deductibility see instructions.
- Line 10: 2010 Practice Assessment (for licensed psychologists who provide or supervise health or mental health related services)

The 2011 dues statement, which reflects changes made by APA after the controversy erupted, states:

- APAPO Practice Assessment for Licensed Health Care Psychologists
- Required to receive the benefits of the APA Practice Organization, a companion organization created by APA to advocate solely on behalf of practicing psychologists. Nonpayment does not affect membership in APA. For more information on U.S. tax deductibility see instructions.

Another area of confusion is the APA's web page for paying dues online. In the past, APA members who did so report that the website would not allow them to decline the practice assessment. That practice continued for the 2011 dues as well. In response to complaints that this practice was continued for 2011, the Practice Directorate issued an unsigned statement that "for APA practitioner members who do not wish to support the advocacy efforts of the APAPO or receive its benefits, they may indicate non-payment of their Practice Assessment now by calling the Membership Service Center."

Eight months after the controversy began there appears to be little explanation from the organization's leaders as to how so many of APA's members could have believed that paying the assessment was required to stay in the organization. That story may come out in the course of the two class-action lawsuits. However, regardless of their outcome, former APA Practice Director Welch sees a silver lining in the furor over the assessment. "I think some good could come of this if the Practice Organization were required to become an independent, democratically run organization with leaders elected at large by those who pay the assessment," said Welch in an email for publication. "In APA the ONLY person elected by the membership at large is the president. All other positions are heavily controlled by APA governance careerists who often are out of touch with the rank and file and get drawn into the APA culture."

The Predoctoral Internship Crisis

Examining Views of the Psychology Community & Identifying Possible Solutions

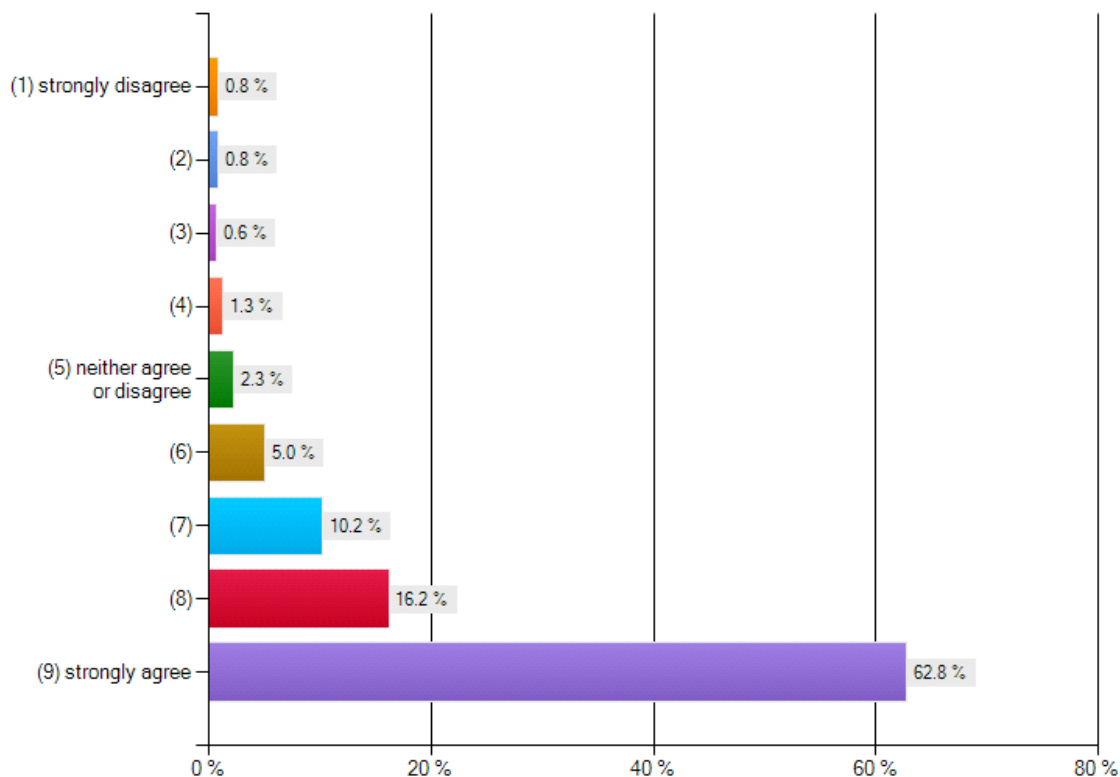
Rebecca L. Brock, M.A., *University of Iowa*, Kelly Wilson, Ph.D., *University of Mississippi*, & Frank Farach, Ph.D., *University of Washington*

In response to the worsening match rate of the psychology predoctoral internship (77% of students matched in 2010), an Ad Hoc Internship Committee 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 to assess the extent to which the current internship process is perceived as problematic and to begin to identify possible solutions for addressing the worsening match rate.

Below are some preliminary results from this survey. We plan to analyze the findings in much more depth and to share them with the SSCP membership and others in the near future. The majority of respondents thus far (N = 622) have been graduate students (44.1%); however, responses were also received from current interns (16.6%), internship directors (1.5%), internship supervisors (6.4%), postdoctoral fellows (13.7%), directors of clinical training in doctoral programs (3.9%), and faculty members in doctoral programs (13.7%). Twenty-three percent of respondents were members of SSCP.

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

The worsening match rate – only 77% in 2010 – 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

Approximately **1 in 4** post-doc fellows (25%) and interns (25.3%) completing the survey reported they did not match to an internship site the first time they applied.

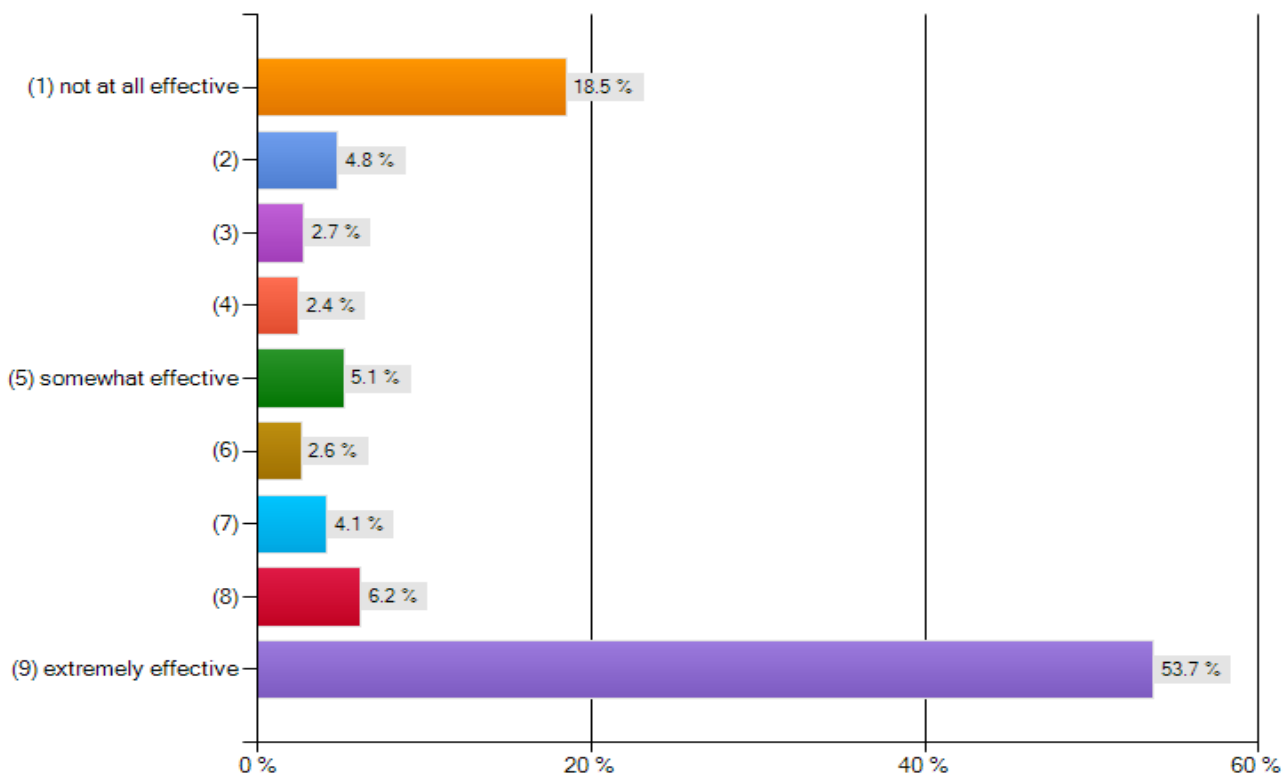
The majority of graduate students who completed the survey (64.3%) indicated that, when interviewing at their current graduate programs, no one explained to them that a predoctoral internship is not guaranteed and there is a possibility they may not match to an internship. The majority of current interns (51.6%) also reported they were not informed of this possibility. In contrast, the majority of directors of clinical training (68.2%) and current faculty members of doctoral programs (61.8%) reported that applicants are routinely informed of the possibility that they may not match to an internship program.

Identifying Solutions for Addressing the Worsening Match Rate

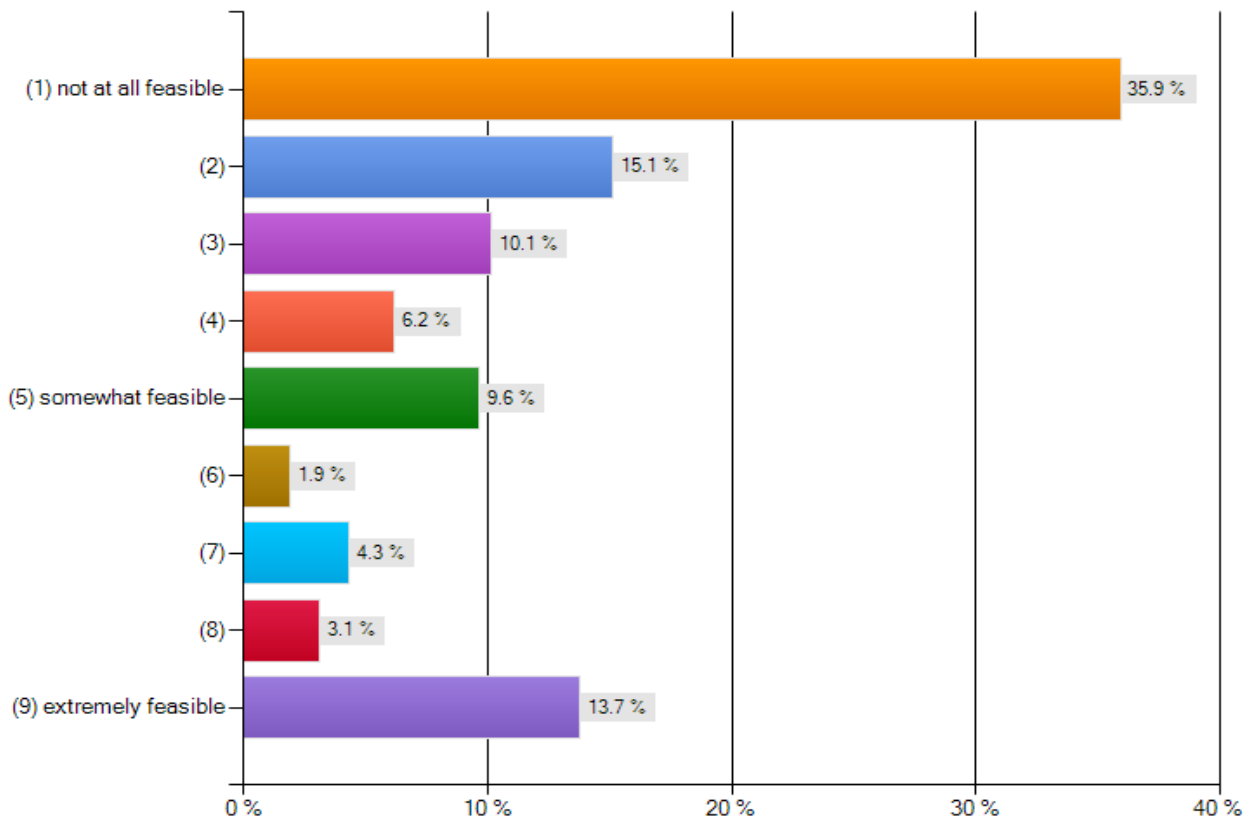
Several potential solutions for addressing the worsening match rate were presented and respondents were asked to rate the degree to which they believed each solution would be both effective and feasible.

Results of the 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.

How effective do you believe that this would be for addressing the worsening match rate?

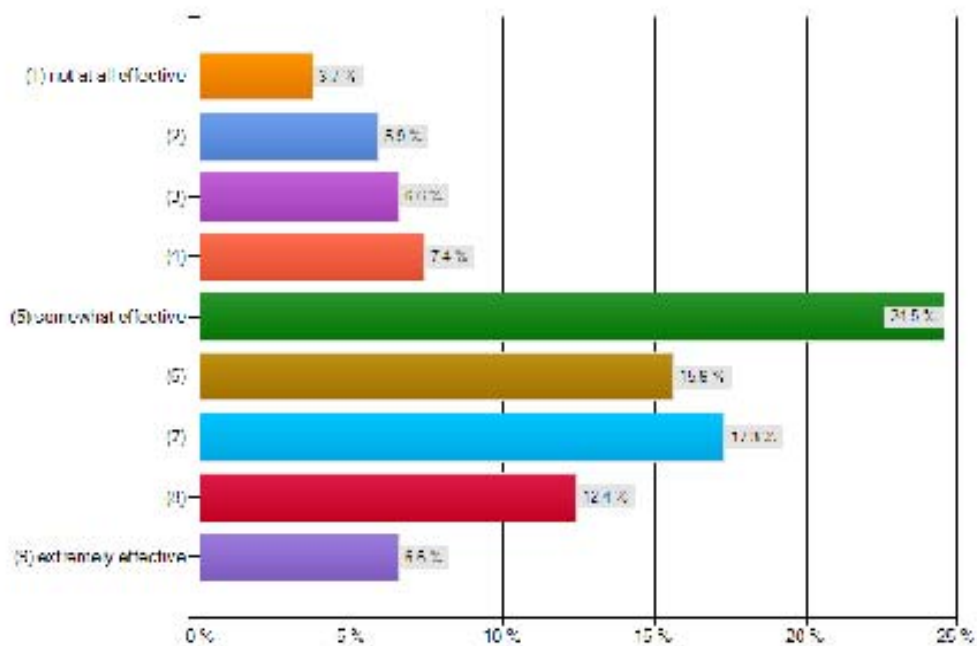


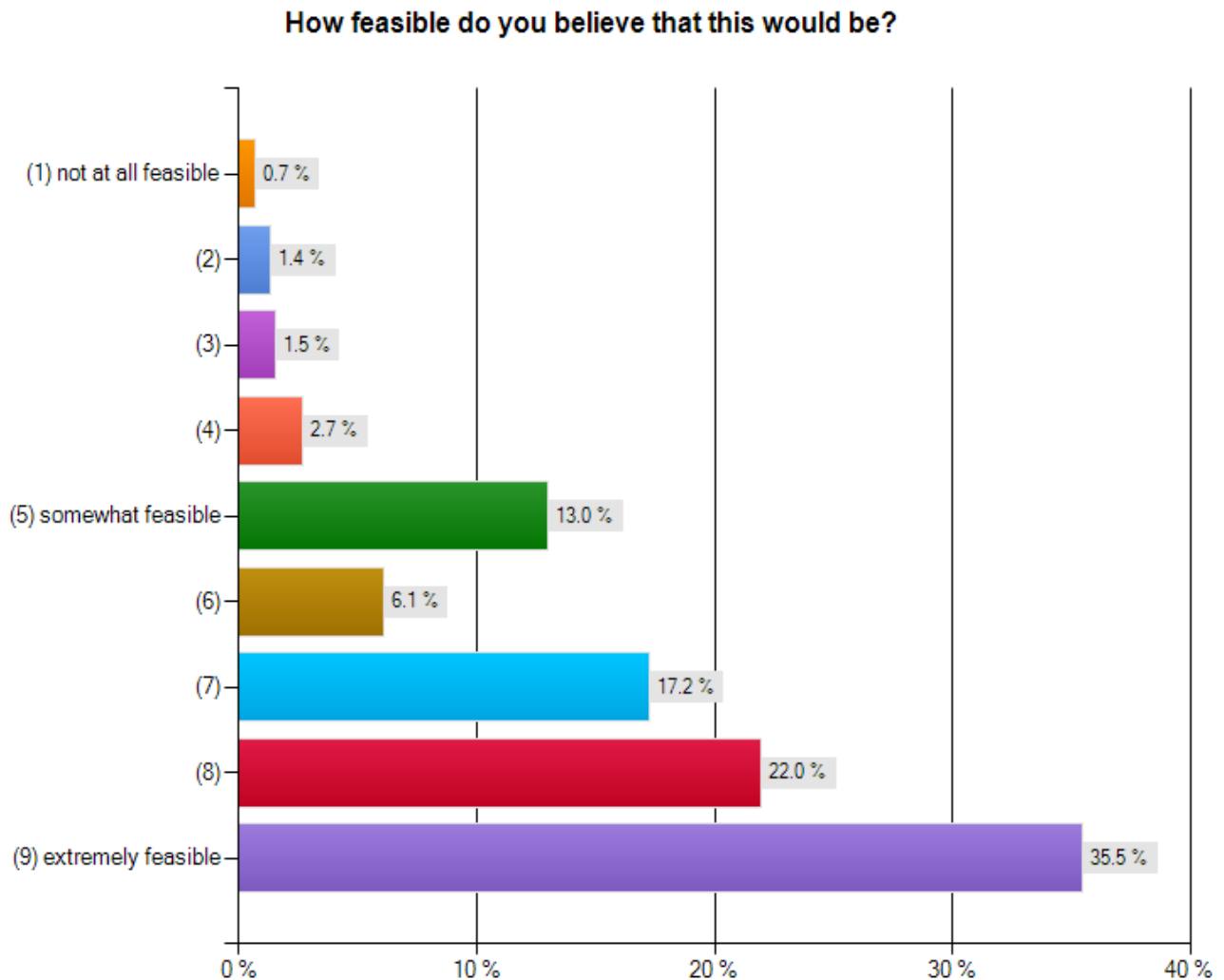
How feasible do you believe that this would be?



The most feasible solution that was identified included *requiring internship sites to provide clearer guidelines with regard to what constitutes a competitive candidate at their program so that students can make more educated decisions about whether to apply to certain sites*; however, this solution was viewed as being only moderately effective.

How effective do you believe that this would be for addressing the worsening match rate?





One-hundred ninety respondents also shared their own ideas for addressing the worsening match rate. Some of the most common responses included: (a) admitting fewer students into graduate programs, (b) applying more stringent requirements for accreditation of doctoral programs, (c) making the accreditation process less expensive and cumbersome for internship sites, and (d) replacing the internship requirement with a requisite number of clinical hours to be completed at some point during graduate training.

In summary, results of the SSCP internship survey suggest the following preliminary conclusions. First, the worsening 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 a highly effective solution but relatively infeasible. Third, requiring internship sites to provide clearer guidelines to applicants about what constitutes a competitive candidate was viewed as the most feasible solution, but was also viewed as being only moderately effective for addressing the match crisis.

The survey is ongoing, and we invite all in the psychology community to participate:

Invitation to Complete the Internship Survey:

We are gathering information about the internship process and possible solutions to some of the problems associated with this process.

We invite psychology graduate students, interns, post docs, and faculty in both psychology departments and at internship training sites to participate in this endeavor by completing an online survey.

The survey takes about 10 to 15 minutes. The survey is anonymous and is approved by the IRB of the University of Mississippi.

Please feel free to forward this link to psychology graduate students, interns, post docs, and faculty in both psychology departments and at internship training sites.

If you would like to participate in this study, click on the link below:
http://www.surveymonkey.com/s/psych_internship

The recipient of the 2010 SSCP's Distinguished Scientist Award is Richard (Dick) Bootzin, a former SSCP President, a scientist of the highest caliber, a citizen of our field, an indefatigable advocate for clinical science, and a mentor in every sense of the word.

To appreciate Dick Bootzin's achievements in clinical science, one must consider not only his astounding productivity, but also the depth and breadth of his scholarship. Prof. Bootzin is an internationally recognized pioneer of psychosocial treatments for insomnia and one of the world's leading figures on sleep disorders and their treatments. He is widely recognized for changing the course of the field. His 1972 seminal paper on Stimulus Control as a treatment for insomnia was a scientific breakthrough that left a lasting impact on clinical science and practice. Stimulus Control is the only non-pharmacological treatment for insomnia that is sanctioned as "Standard" by the 1999 national guidelines on the diagnosis and treatment for insomnia. There is hardly any multi-component treatment for insomnia that does not include Prof. Bootzin's pioneering work.

Beyond his specialty area, Prof. Bootzin's scientific contributions are broad and extensive, with several frequently cited publications on several inter-related themes ranging from basic principles of behavior change to expectancy and placebo effects. Prof. Bootzin has authored, edited, or co-edited 13 books, and authored or co-authored over 140 journal articles or chapters. His 1975 book (*Behavior modification and therapy: An introduction*), published when he was an Assistant Professor at Northwestern, remains one of the best introductions to behavioral principles of change. He has published highly influential methodological papers, including critiques of treatment research (e.g., his classic 1979 paper with J.R. Lick) that were critical to advancing knowledge in this field. His methodological contributions continue today, including two recent edited volumes that promise to have a high impact on the field (Bootzin & McKnight (Eds., 2006). *Strengthening research methodology: Psychological measurement and evaluation*. Wash. DC: APA Books; Treat, Bootzin & Baker (Eds., 2007). *Advances in psychological clinical science: Integrative perspectives in honor of Richard M. McFall*. NY: Psychology Press). Prof. Bootzin also has written extensively about the history of clinical psychology and professional development for clinical psychologists (e.g., Bootzin (2003). *Clinical psychologists in academia*. In Darley, Zanna & Roediger III (Eds.), *The complete academic* (pp. 329-344). Wash., DC: APA).

The SSCP Board was happy to grant the Distinguished Scientist Award to Dick Bootzin, and we are looking forward to his award presentation at the 2011 APS conference in Washington DC.

Summary of BSA Meeting: October 21-24, 2010

Robert A. Brown, Ph.D., *University of Maryland Columbia*

The APA Board of Scientific Affairs met as part of the Consolidated Board meetings in Washington, DC, 10/21-24/2010. I attended part of the meeting as the SSCP liaison.

Carol Goodheart, APA president, gave an introductory plenary address. Among the things she noted were: The new History of Psychology Archives is now open in Akron, OH; an APA website will be launched in 2010 entitled "Family Caregivers Briefcase"; a practice website known as PsycLink, a practice Wiki, is either launched or about ready to be launched; and there will be a link on PsycLink to a practice outcome site vetted by APA. Norman Anderson, APA CEO, also announced a new independent federal organization entitled the Patient-Centered Outcomes Research Institute. The APA strongly advocated for APA nominees to the Board of Governors but was unsuccessful. It is now advocating for a psychologist to be appointed to the Scientific Methodology Committee.

Much of the meeting was given over to Board and Committee nominations and recommendations for a variety of awards. Liaisons are excused for these portions of the meetings, so (warning, editorial comment) for SSCP to have a strong voice in finalizing these nominations it would be exceedingly helpful to have one of our members on the Board. I have selected out below what I consider to be the issues most salient to clinical scientists. The first few items below are based on discussions with Steve Breckler, Executive Director for Science.

The development of treatment guidelines was noted but not discussed. A steering committee has been named by BSA, the Board of Professional Affairs, and the Committee for the Advancement of Professional Practice, and has been approved by the Board of Directors. The SSCP seems well represented. The appointees are as follows: Steven D. Hollon (Chair), Vanderbilt; Patricia A. Areán, UCSF; Michelle G. Craske, UCLA; Kermit A. Crawford, BU School of Medicine; Daniel R. Kivlahan, Veterans Affairs Puget Sound Health Care System; Jeffrey J. Magnavita, Glastonbury Psychological Associates; Thomas H. Ollendick, VPI; Thomas L. Sexton, Indiana U.; and Bonnie Spring, Northwestern University. The Steering Committee will meet in December to (1) to develop the process by which to select the particular area(s?) on which the guidelines will focus initially, e.g., anxiety, depression, etc, and (2) to develop the process by which the writing panels will be selected. The writing panels will do the actual work of putting together the guidelines for specific disorders to

be approved by APA. Both of these will require input from the various stakeholders.

The revision of the Standards for Education and Psychological Testing is nearing completion, should be ready for public comment by early 2011, and can be accessed at www.teststandards.org. This is not a major overhaul.

The ICD-10 "tweaking" is underway, and there is a group working on developing ICD-11. Only international organizations can have a direct seat at the table for the revision, and APA is working with the International Union of Psychological Science to fund former APA staffer Geoff Reed to work with WHO in Geneva. It is not clear how ICD-11 will interact with DSM-V, and it is not clear what this will mean for clinical science. The APA and the Science Directorate could profit from the input of SSCP, and they will try to help facilitate that if the Section is interested.

The new draft of the APA strategic plan stresses recognition of psychology as a science and the importance of expanding science in evidence based practice. Perhaps more importantly for the near future, it makes the development of treatment guidelines one of the seven major factors in the strategic plan. That this is part of the strategic plan means that this effort will have APA-wide support for resources. On the other hand, BSA members were highly disappointed at the lack of attention to science in the overall plan, but Breckler indicated that there is ample room for science in its implementation.

There is an "outcomes" initiative developed by APA president Carol Goodheart. The focus is on outcomes that are feasible and available for the practitioner's point of view. There is a task force appointed to work on this, but it is not clear where it is going.

Gary VandenBos is setting up a new data base which should do for psychological testing what psycinfo has done for books and articles. It will include summaries and, where permissible, full-text articles on tests and testing.

There is a project called the Research Domains Category Project within the NIMH Division of Adult Translational Research and Treatment Development. They are working on new ways of classifying mental disorders to provide greater flexibility for researchers studying comorbidity.

There was a great deal of discussion on psychology as a STEM (Science, Technology, Engineering, and Mathematics) discipline, and much frustration expressed that psychology's

not having this designation leads to a lack of respect (and bias against funding) at NSF. While the issue is not as critical for funding at NIH, having this designation would also increase the “real science” reputation of psychology in that institute also. The issue is of such importance that it will be the theme of the upcoming Science Leadership Conference. Some members may feel that the increase in the numbers of clinicians not being fully trained in psychological science may be contributing to that perception, but this was not aired in the meeting.

The unapproved draft minutes of the Committee on Human Research were distributed. The minutes included discussions of penalties for students not showing up for experiments, instituting a regular column in Psychological Science Agenda entitled Perspectives on Research Ethics Issues, revisions of the Guidelines for Research with Humans at the High School Level, and the 2007 APA Presidential Task Force on Institutional Review Boards and Psychology Science. It would seem useful for the Section to have regular reports on this committee if that is not already in place.

There were a number of items on the “cross-cutting” agenda, which comprised those to be discussed among different involved boards. There were a number of education items, including a work group product on standards for high school teachers and courses in psychology and another for undergraduate education. In case the former seems to be a focus on issues not salient to clinical science, it may be helpful to note that fully 30% of high school graduates have taken a course in psychology. There is a committee on APA/ABA relations, focusing on such topics as child custody, competency of older adults, teen violence, and the death penalty of juvenile offenders. There is also a draft on masters level training that is out for comment by December 1, 2010. The item notes that in 2007 there were 5153 doctoral, 21,037 MA/Ms, and 90,039 undergraduate degrees awarded in the U.S. There are also opportunities to comment on a variety of guidelines, including psychological practice in health care delivery systems (formerly hospital privileges); evaluation in child protection matters; preventive practice, research, education and social advocacy for psychologists, parenting coordination, and specialty practice in forensics.

For those few of you who have read this far, I have hard copies of the agenda books, and they may be available on-line from APA. I will be glad to share whatever information I have with any interested members.

Training Initiative Grant Application continued from page 21

newsletter (Clinical Science). In addition, a summary of the project (written by the winning program) will be due approximately one year after receiving the funds and would be published in the SSCP newsletter. This grant program is designed to be consistent with both the SSCP goal of enhancing clinical science training, and the accreditation requirements laid out by APA and PCSAS concerning the clear articulation of program goals and assessment of progress on meeting those goals. Thus, winning programs not only receive funds to improve their training and an opportunity to publicize that SSCP has selected the program as a winner of a Clinical Scientist Training Initiative, but the initiative may also assist with preparation of a self-study and other materials required to demonstrate adherence to a clinical science training mission.

Deadline: Applications are due by March 31, 2011. Please e-mail applications to sscp.traininginitiative@gmail.com. We expect to distribute funds during the summer, 2011.

Clinical Science is published as a service to the members of Section III of the Division of Clinical Psychology of the American Psychological Association. The purpose is to disseminate current information relevant to the goals of our organization. Articles published in *Clinical Science* represent the views of the authors and not necessarily those of the Society for a Science of Clinical Psychology, the Society of Clinical Psychology, or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

Clinical Scientist Training Initiative Application

The Society for a Science of Clinical Psychology (SSCP) wishes to announce the first 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. Practicum sites may also apply. Two awards will be offered per year to help fund programs that would like to do a better job providing strong, scientifically-grounded training.

Funds may be used to either start new programs or support or augment existing initiatives. Sample applications of the grant funds include (but are not limited to):

- Purchasing outcome assessments, recording equipment, software to monitor/measure treatment change, training manuals, or other materials for clinical training purposes at your site.
- Supporting travel and training expenses to have a clinic director/clinical team leader receive training in an evidence-based practice not currently offered at your site.
- Supporting travel and training expenses to bring an expert(s) in to teach evidence-based practices to your training site.
- Creating some mechanism for ongoing collaboration between two or more training sites in a way that enhances the use of evidence-based treatments at one or both sites.

The proposal should be no more than 2 pages maximum (minimum Arial 11 pt font and 1 inch margins). Please e-mail applications to sscp.traininginitiative@gmail.com with the following:

- Project title
- Institution requesting funds (only one application per department), and contact person for the application.
- Narrative description of project - please describe the project goals and the way those goals will be met. Be specific about what the benefits of the project will be in terms of enhancing the integration of clinical science and practice.
- Budget - provide an itemized budget indicating how grant funds will be used (up to \$1500 maximum).
- Timeframe - describe the anticipated time course of the project (we would like a summary of the project a year after the grant funds are received).
- Additional funding - please note if seeking/anticipating funding from other sources, and whether this additional funding is necessary for implementation of the project.
- Sustainability - if appropriate, describe how this project will be sustained following the end of the award period.
- Outcome evaluation - describe how you will determine if the project meets its goals (i.e., how will you measure the program's effectiveness?).

Criteria for evaluation

- Feasibility of proposal.
- Likelihood that if the project is completed, clinical science will be enhanced.
- Availability of resources, including clinical scientist faculty members, who can support and/or sustain the project after completion of the award period.

Notes

- Priority given to training programs that are new or demonstrate a recent development toward science-practice integration.
- Priority will be given to training programs that will help to bring clinical science to an underrepresented population (including programs with diverse trainees or those that provide services to diverse or rural clients).

continued on previous page (page 20)