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# 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

Fall 2004 Issue



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## INSTRUCTIONS FOR AUTHORS

*Clinical Science* is published as a service to the members of Section III of the Division of Clinical Psychology of the American Psychological Association. The purpose is to disseminate current information relevant to the goals of our organization.
**Feature Articles** may be submitted to the editor via e-mail. They should be approximately 16 double-spaced pages and should include an abstract of 75- to 100- words.
**Brief Articles** may also be submitted,and should also include a 75- to 100-word abstract.
All articles should be submitted as an attachment to an e-mail and formatted according to the *Publication Manual of the American Psychological Association, 5th edition.*

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## Special Section

# Should the SSCP remain affiliated with the APA?

In recent years, the values and beliefs of the SSCP have been in conflict with those of our parent organization over several major issues facing the field of psychology. In some instances, such as the SSCP's position against prescription privileges for psychologists, these differences have generated considerable controversy. The divergence between the policies of APA and the beliefs of many of our members have led some to question whether or not the APA is the appropriate home for our organization. In this special section, two former SSCP presidents, Kenneth Sher and Scott Lilienfeld, provide opposing answers to the question of whether SSCP should remain affiliated with the APA. This purpose of this Special Section is to initiate an open, constructive dialogue about the future of our organization.

## SSCP should remain a division of Section 12 of APA

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As I sit down to write this commentary, it is with considerable ambivalence. Like many of our members, I have often found dealing with various actions of APA…well, maddening. There have been a number of issues in recent years that have seemed to put the values of SSCP members in direct conflict with various positions or actions of our parent organization and resulted in many of our members becoming disaffected with APA (and possibly SSCP itself simply because of our affiliation with APA). I want to state at the outset that I think that remaining a Section of APA does not and should not preclude us from continuing to strengthen ties between us and other like-minded organizations (e.g., the American Psychological Society, the Academy of Psychological Clinical Science). Indeed, I'd like to see our connections with these other organizations continue to grow and strengthen. However, despite the constant frustration with the actions of various individuals and components of APA, I believe it is crucial that we maintain our affiliation and increase our influence and presence there if we want clinical psychology to continue to have a strong science base and enjoy the confidence of other health providers, the general public, insurers, and governmental organizations. Indeed, given the rift between science and practice, which may be as large as it has ever been, the need to try to influence APA may have never been greater.

As I see it, here are some of the major problems with APA as as an organization.

1. It has a Byzantine organizational structure that makes it very difficult for individuals and small groups like our Section to accomplish much.

2. Within this organizational structure are many members who relish the politics of APA and taking active roles in APA's governance. This is not a problem in principle but it can be for us because (it seems) few of our members are cut from this cloth and find the extraordinary bureaucracy and the inside political finagling to be tedious, irritating, and ultimately infuriating. Although I'm aware of some "Mr. Smith's" among us who can go to Washington, do their civic duties, and return to their offices after providing some meritorious, effective service, I don't believe there are many of us with the necessary frustration tolerance to be willing to take this on. I hope my colleagues who do have the interest will become more involved with SSCP and help us become more effective than we are now.

   Even those of with the necessary stamina "to fight the good fight" will be confronted with the dilemma of how to get elected to a committee or an office and not feel like a sleazeball. I was recently on a slate for an APA governance committee and was told both by an APA staff

member and a couple of colleagues on APA Council that I should "campaign" or otherwise promote my candidacy. I couldn't get myself to do it. (This is not to say that it would have affected the outcome of that particular election and, fortunately for SSCP, the candidate who did win is excellent and represents the values of SSCP.) Self-promotion and campaigning makes many of us uncomfortable…if one is not a political type, self-promotion seems…well…unseemly. Many of us are academic psychologists and our culture is to promote ideas, not ourselves. I don't mean to suggest that self-promotion is bad, but that many of us are not that good at it and our reticence to be "political" represents another barrier to influence within APA.

3. APA is not primarily a scientific organization, at least not in 2004, and is dominated by interests in the area of professional practice. Given that only a minority of APA members consider themselves scientists (last number I heard was 22%), it is little wonder that science is not at the top of the agenda. The fact that practice concerns dominate the agenda of APA is not a bad thing in itself, after all, it represents the needs of a majority of members. The problem is that within the practice community, many members and leaders in APA are not committed to evidence-based practice and to having a strong science base. That is, the interests of many members are not complementary to our interests but, instead, are antagonistic to the SSCP agenda. Thus, our biggest conflict is not with the basic science interests in APA but with what should be our closest allies, a large subset of our fellow clinical psychologists.

4. Special interests groups seem to sprout up almost continually, giving an impression that APA is too willing to be "politically correct" and indiscriminate as to what constitutes the discipline of psychology.

But, against this background, there are many positives as well.

1. In my experience, most of the individuals I have worked with at APA (both members involved in governance and APA staff) have been hard working professionals who share the values of SSCP colleagues.

2. There is strength in numbers and, as the organization representing more than 150,000 psychologists, APA has a big voice.

3. APA does many things right. Its journals are, for the most part, first class. Staff members in the Science and Education Directorates appear sincerely dedicated to fostering psychology as a science and share similar backgrounds, training, and values. Especially within the Science Directorate, the voice of SSCP has been actively encouraged and I sincerely believe we are influential beyond our small numbers. Although, according to the APA structure, Division 12 is considered a "practice" division, Science Directorate staff members routinely seek out comments and positions from SSCP officers concerning various policy issues.

4. Whenever I have gone to APA to ask for help on one thing or another, I have found someone there with a willing ear and sound information.

5. Scientific clinical psychologists have had many important victories. Through the hard work of SSCP members like Jerry Davison and Jake Jacobs, there appears to be considerable reform in the works concerning approval of Continuing Education sponsors and for insuring sound content of APA-sponsored CE credits. At this time, there appears to be some interests holding up needed reform but I am hopeful that the reform will be coming.

**Why we need to be more active**

Because most of us are not very involved in APA governance, many issues, especially those surrounding practice and education, seem to come out of nowhere. The issue of prescription privileges is a case in point that has caused much anguish and frustration among some SSCP (and other) APA members. In fact, the steps leading to APA adopting prescription privileges emerged from the hard work of many individuals in favor of this position who moved the initiative through the Byzantine governance structure within APA. To the promoters of prescription privileges, we were seen as "spoilers" who wanted to undo a hard won victory. Although I personally believe the debate was more sheltered than it should have been and that the promoters didn't truly want a broad ranging debate, I think we need to accept at least partial responsibility for not being sufficiently engaged to let our voices be heard at critical times.

Although I am not personally against prescription privileges in principle, I am extremely concerned with the little bits I pick up, here and there, about how training might be implemented. One would hope that any type of postdoctoral training would require a solid undergraduate or higher training in biochemistry, genetics, and biology; prerequisites that would promote deeper understanding of basic and clinical pharmacology. One would hope that such training programs would impose rigorous admission standards like our best university-based clinical psychology programs and hold students to the highest academic/clinical standards. One would hope that such training would be full-time over the course of two or three years in first-rate medical schools where supports for in-depth learning and interaction with other health care educators could take place. We must fight against "fly-in" programs where practitioners take month-long breaks from their clinical practice or from multiple educational vendors each selling a piece of the training curriculum. I'm not arguing that psychologists should go to medical school and learn many things ultimately irrelevant for their practice (e.g., obstetrics, orthopedics, ophthalmology,

oncology…and those are just the o's) but they should be part of a rigorous program that requires residence in an academic institution with the infrastructure and intellectual environment that characterizes the best medical and doctoral programs. Prescription privileges may be a "done deal" but its implementation is not and we must insure that APA doesn't sell out to guild interests (both practitioners and educational vendors) at the expense of quality. If we are not part of APA, we are effectively silencing ourselves on the one of the most important issues facing our profession.

Indeed, I'd like to argue that rather than withdraw from APA, we should become more involved, trying to influence the decision-making bodies on defining issues and doing so in a more proactive rather than reactive way. There are clearly many critical issues currently being debated that could have an important impact in the field. One debate involves the importance of evidence-based practice with many psychologists eschewing the value of science or, alternatively, broadening the notion of science to include all kinds of "data" to make the common-sense and scientific notions of "evidence" virtually meaningless. I believe it is critical that we do not allow some scientifically challenged colleagues to idiosyncratically redefine concepts like evidence and empiricism in self-serving ways that benefit neither science nor practice. If we do, we have not only lost the battle but have lost the war and the profession of psychology will suffer irreparably.

**Concluding comments**

I do not intend to sound naïve; I do not believe that deeply vested guild interests will openly embrace well reasoned, scientifically derived practices when they are perceived as threatening their professional stature and income. As Guido (Joe Pantoliano) said to Joel (Tom Cruise) in Risky Business, "never f*ck with another man's livelihood." I believe that many psychologists believe that the focus on evidence-based treatment potentially messes with their livelihood and that, with respect to accountability, their own or their clients' testimonials as to effectiveness should be sufficient to warrant reimbursement for private and governmental third-party payers. Because well trained psychologists understand the extent that cognitive biases (e.g., illusory correlation, confirmation bias, self-justification) influence our everyday behavior, we are reluctant to place much value in clinical judgment in lieu of objective evidence. We have to blame ourselves somewhat for this problem because we were often the teachers of those who seem to have forgotten (or never learned) the lessons our science has taught us. We need to keep bringing the science of psychology to bear not only on practice but on education; without the influence within APA, I doubt we'll be able to do this effectively. Thus, not only do I believe we should stay a part of APA, but we should become more involved in APA. If we (and other likeminded members) bail out of APA, who will there be to keep parochial guild interests (that are frequently anti-scientific) in check? Who will lobby for the highest academic and scholarly standards?

# Should SSCP file for divorce from APA?

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Had the question constituting this article's title been posed of me two years ago when I was president of the Society for a Science of Clinical Psychology (SSCP; Section 3 of APA Division 12), I would have responded with a tentative "No." Today, my response is an unqualified "Yes."

In the brief space I have available, I will explain the reasons for my position, as well as for my change of heart. Specifically, I will argue that that there are three major reasons why SSCP should formally dissociate itself from APA: the APA (1) does not brook, let alone encourage, open dissent from its divisions and sections, (2) is not firmly committed to scientific basis of clinical psychology, and (3) consistently places political considerations above science. As a consequence, APA no longer serves the interests of SSCP, which is first and foremost a scientific organization. SSCP can perform a much more useful service by exerting pressure on the APA from without than from within.

**APA's Intolerance of Dissent**

As President of SSCP, I sent a letter in early 2002 to the then governor of New Mexico, Gary Johnson, urging him not to sign a bill that would establish New Mexico as the first U.S. state to permit psychologist prescriptive authority (despite my letter, Johnson signed the bill several days later). The APA was in strong support of this bill and had lobbied for it. In my letter, I made clear that I was writing on behalf of the SSCP membership, which had voted overwhelmingly in June of 2001 in favor of a position statement

against prescription privileges. In my view, the New Mexico bill was gravely flawed, as it recommended far fewer hours of training in psychopharmacology compared with the APA model guidelines, which many prominent SSCP members had even found to be problematic. I forwarded a copy of my letter to the SSCP listserv, and received a number of complimentary responses from SSCP members.

Yet it was not long before my letter created a firestorm. Shortly after sending it, I was contacted by the then President of APA Division 12, Larry Beutler, who informed me that the APA leadership regarded my letter as a potential violation of APA policy (it is worth noting that Larry did not share this view). The rationale for this claim was that APA by-laws require all divisions and sections to comply with established APA policies. Why "complying" with APA policies necessitates *agreeing* with such policies was not at all clear to me. Nor was APA able to satisfactorily articulate the basis for this rather inscrutable interpretation of its by-laws, which had been offered by its general counsel, James McMugh. Nevertheless, at Larry's request, I agreed to hold off on sending further letters on behalf of SSCP that took issue with APA's stance on prescription privileges while the question of whether my letter violated APA by-laws was being debated within the APA leadership (ironically, the letter I sent to Governor Johnson did not question APA policy, because the New Mexico Bill recommended a substantially lower number of training hours than had APA itself, but that's another matter).

SSCP's problems with APA did not end there. The following year (2003), when Kenneth Sher assumed the SSCP presidency, APA officials discovered that the SSCP position statement against prescription privileges was posted on the SSCP Web Site (it had been posted there for a few years, but they apparently had never noticed it). The APA leadership immediately demanded that this position statement be removed from our Web Site given that it disagreed with APA's stance in support of prescription privileges. The SSCP Executive Committee voted in favor of complying with APA's demand, a vote on which I and then SSCP President-Elect Don Fowles dissented (the SSCP Web Site now states that "The SSCP statement on prescription privileges has been removed from our website because it was found to contravene official APA policy. APA members can still access the statement at the following address: http://members.apa.org/rxp)."

APA's intolerance of dissent from within its ranks is as profoundly troubling as it is self-serving. If APA insists on disallowing open disagreement with its stated policies, the raison d'etre for SSCP existence is largely or entirely undermined. After all, if SSCP cannot adopt public positions (or even post position statements) at variance with APA policy, it necessarily becomes impotent to exert direct influence on issues that run counter to APA views.

When I pointed this fact out to then APA president-elect Bob Sternberg, Bob denied that APA's policy of prohibiting open dissent on the part of its divisions or sections stifles SSCP's freedom of speech. Bob observed that although APA divisions and sections cannot disagree openly with APA policy, individual APA members, as well as members-at-large of APA divisions and sections, are free to do so on their own. Ironically, Sternberg's argument makes as a compelling case as one could imagine for SSCP independence, because it distinguishes sharply between the rights of SSCP as an organization and those of individual SSCP members. The implications are clear: SSCP should disaffiliate itself from APA, while encouraging its members to voice agreement or disagreement with APA policy as they see fit.

Perhaps the most frequent argument I have encountered for SSCP's continued association with APA is that SSCP can continue to exert influence on APA policy from within. Nevertheless, history suggests that this reasonable sounding argument is in fact specious. In recent years, APA has consistently demonstrated an unwillingness to consider alternative points of view when reaching policy decisions. APA's decision to embrace psychologist prescriptive authority affords a clear-cut case in point. As Elaine Heiby noted (see Heiby, DeLeon, & Anderson, 2004, p. 338),

*The American Association of Applied and Preventive Psychology, the Society for a Science of Clinical Psychology, the Council of University Directors of Clinical Programs, and the Committee Against Medicalizing Psychology have officially opposed APA policy and have officially supported and encouraged psychologists who wish to prescribe through already established avenues. The Council of Graduate Departments of Psychology's position before APA RxP policy was adopted was that RxP should not be implemented until all university-based departments of psychology support it and find it feasible.The objections of these five organizations obviously were not heeded. According to DeNelsky (2001), the procedure that led to APA's RxP policy suspended council rules "before the vote so that full debate and review of this important policy issue with APA governance did not occur" (p. 5)*.

In other words, the APA leadership in essence performed an "end run" around strenuous objections to APA policy and adopted a pro-prescription privileges position without allowing a full discussion of its advantages and disadvantages. Thus, there is no compelling reason to believe that exerting pressure from within APA will be useful in influencing APA policy, because APA's track record of facilitating discussion of competing points of view has hardly been encouraging. *That is because the APA does not wish to encourage the open expression of any views that could impede its lobbying efforts*. Moreover, I am unaware of any tangible evidence that SSCP as an organization has exerted any discernable influence on any major APA policies.

It is crucial to note that should SSCP become independent from APA, this divorce would in no way preclude constructive interactions with APA governance. The SSCP leadership could and should continue to maintain open lines of communication with APA, and even collaborate with APA as needed on developing mutually beneficial policy initiatives. In addition, SSCP should offer to send liaisons to APA committee meetings to provide helpful input and feedback. Nevertheless, for SSCP's interactions with APA to be fruitful for both organizations, SSCP must be able to adopt and promote positions that differ from those of APA.

**APA's Lack of Commitment to Clinical Science**

Even prior to APA's decision to crack down on SSCP's dissent concerning psychologist prescription privileges, I harbored reservations regarding SSCP's affiliation with APA. Most of these reservations concerned APA's lack of commitment to science as opposed to guild interests. Regrettably, my reservations have only mounted over the past few years.

There is widespread agreement that one of the foremost challenges confronting clinical psychology, if not *the* foremost challenge, is the widening gap between researchers and practitioners. Researchers are spending less and less of their time communicating with practitioners, and vice-versa. Moreover, survey data indicate that most practitioners do not read peer-reviewed journal articles with any regularity (Beutler, Williams, & Wakefield, 1993). Perhaps even more worrisome, a disconcertingly large number of practitioners continue to administer techniques, such as crisis debriefing, recovered memory techniques, and rebirthing, which have been shown to be ineffective or even potentially harmful (Lilienfeld, Fowler, Lohr, & Lynn, in press). Many others administer methods, such as Thought Field Therapy, sensory-motor integration, neurolinguistic programming, and laughter therapy, whose efficacy has never been adequately tested in controlled trials (Lilienfeld, Lynn, & Lohr, 2003).

Yet no recent APA president has made the researcher-practitioner gap a priority, let alone even a focus of concern. Simply put, the researcher-practitioner gap has barely been on APA's radar (for example, for the past several years the APA has been conspicuously silent on the issue of recovered memory techniques). To the contrary, some recent APA presidents apparently believe that the importance of this gap has been exaggerated. For example, recent APA past-president Robert Sternberg (2003) castigated psychologist and science writer Carol Tavris (2003) for arguing that the scientist-practitioner gap is a serious crisis confronting clinical psychology. According to Sternberg, practitioners who administer scientifically discredited treatments constitute a small minority of APA members: "The overwhelming majority of practicing psychologists are well trained, professionally competent, and equipped to give advice. Certainly, there are irresponsible people in all professions, but it is inflammatory and unjust to cite them as typical." Still other recent APA presidents believe that scientific findings concerning treatment efficacy should not be permitted to dictate clinicians' selection of interventions. For example, former APA President Ronald Fox (2000) has maintained that "Psychologists do not have to apologize for their treatments. Nor is there an actual need to prove their effectiveness" (pp. 1-2). And more recently, APA President-Elect Ronald Levant (2004) contended that clinical judgments and experience should be accorded equal weight with scientific findings in selecting psychological treatments. As Beutler (2004) observed, Levant's position ignores the massive body of research evidence demonstrating that a host of cognitive biases render the subjective validation of treatments ("I know it works, because I've seen it work in my clinical experience") a flawed and dangerous enterprise.

Much like Nero fiddling away while Rome burns, APA continues to vigorously pursue psychologist prescriptive authority while insouciantly neglecting the deteriorating scientific basis of our profession. Surely, reasonable people can disagree on the advantages and disadvantages of prescriptive authority. Nevertheless, it is difficult to deny that APA's priorities concerning prescription privileges are grossly misplaced. APA should first ensure that existing clinical practice is scientifically grounded before considering whether to extend clinical practice into an entirely new venue. Narrowing the researcher-practitioner gap should come first; debating prescription privileges should come later.

**APA's Placement of Politics Above Science**

Finally, the APA has demonstrated an unwillingness to place the cause of science above politics. When Bruce Rind and his colleagues published a meta-analysis in the APA journal Psychological Bulletin indicating that the correlations between child sexual abuse and adult psychopathology were far weaker than most researchers had assumed (Rind, Tromovitch, & Bauserman, 1998), several powerful conservative members of the U.S. Congress, including representative Tom Delay (R-Texas), demanded an apology from APA. Apparently, these politicians, most of whose comments suggested that they had never read the original article, felt that APA was on the road toward normalizing pedophilia. Rather than defending the importance and integrity of the peer-review process that led to the publication of Rind et al.'s article, APA buckled. APA CEO Raymond Fowler wrote a letter to Tom Delay apologizing for APA's handling of the Rind et al. article and promising Delay that APA would be more careful in its handling of politically sensitive manuscripts (Lilienfeld, 2002a).

Then, when I submitted an article to the flagship journal of APA, the American Psychologist, delineating the chronology of the Rind et al. affair and criticizing APA for its capitulation to the U.S. Congress (Lilienfeld, 2002a), my article was peremptorily "unaccepted" by American Psychologist editor Richard McCarty after having already been formally accepted in writing by Action Editor Nora Newcombe (oddly, this

acceptance was initially seconded in writing by McCarty himself!). Without informing either Newcombe or me, McCarty solicited an independent round of peer review and kept both of us waiting for several months, and then informed us that my previously accepted article was now unacceptable for publication (Lilienfeld, 2002b). It is worth noting that in my article, I had criticized the actions of the APA Science Directorate, which McCarty had headed at the time, as well as the actions of Raymond Fowler, who was not only APA CEO but editor-in-chief of the American Psychologist. I have also since learned from several sources close to APA that my article was regarded as a "hot potato" within this organization because I had criticized the actions of Delay and several other members of Congress whom APA had worked hard to placate. My article was eventually accepted for publication in the American Psychologist, but only after intense pressure was applied to the leadership of APA from SSCP members and hundreds of other psychologists around the country who were dismayed that APA would place politics above science.

The APA's handling of the Rind et al. affair, and my subsequent article detailing this affair, underscore APA's reluctance to stand up for science when political considerations are at stake. Notably, no recent APA Presidents publicly condemned the APA's handling of my article, although several presidents from previous decades, including Paul Meehl and Bonnie Strickland, did. In fact, one recent APA president and the current APA president-elect authored an article in American Psychologist excoriating the scores of psychologists who had applied e-mail pressure on the APA leadership to retract its decision to "unpublish" my article (Levant & Seligman, 2002).

Another indication of APA's willingness to place politics above science has been its adoption of stances on political issues that are markedly undetermined by scientific findings (O'Donohue & Dysken, 1989). For example, the APA has taken explicitly political positions on abortion, adolescents' rights to make informed decisions concerning abortion (Gardner, Scherer, & Tester, 1989), the legality of boxing, Zionism, the nuclear freeze, the Equal Rights Amendment, the content of television programming, and most recently, gay marriage (Elias, 2004). In the interests of full disclosure, I should perhaps note that I am in full agreement with most of APA's consistently liberal stances on these issues as a private citizen, including abortion and gay marriage.

Nevertheless, by adopting positions on issues that can at best be only informed, not dictated, by research findings, the APA blurs the crucial boundaries between politics and science. Moreover, the APA invites the very politicization of scientific research that it justifiably decries (Lilienfeld, 2002b). For example, earlier this year the APA leadership forcefully (and laudably) contested efforts on the part of several conservative members of Congress, particularly representative Pat Toomey (R-Pennsylvania), to reverse the funding of several peer-reviewed grants concerning human sexuality (Mumford, 2004). Yet the APA should hardly be surprised when conservative members of Congress turn the tables by politicizing science, as these politicians are merely following in APA's errant footsteps. If APA wishes to live by politics, it must be willing to die by politics.

**Concluding Thoughts**

SSCP should file for an amicable divorce from APA. The APA has made it abundantly clear that it will not tolerate open disagreement by SSCP, and it has displayed a discouraging track record of considering alternative views when formulating policy decisions. The APA has also demonstrated a lack of commitment to perhaps the foremost crisis confronting clinical psychology, namely, the growing gap between researchers and practitioners. Instead, APA has displayed a consistent propensity to subjugate scientific considerations to guild interests, as illustrated by its aggressive promotion of prescription privileges in conjunction with its turning of a blind eye to the equally aggressive promotion of pseudoscientific techniques by a nontrivial minority of its membership. Finally, the APA has blurred the boundaries between science and politics, electing to adopt political stances on issues that are inherently value-laden.

The APA has ceased to represent the core interests of science. The Society for a Science of Clinical Psychology should bid it adieu, and instead seek to foster closer ties with organizations (such as the American Psychological Society) that share its core interests and values. Only by applying consistent pressure to the APA from the outside can SSCP members hope to one day yearn for a successful remarriage.

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# 2004 SSCP Directory of Clinical Psychology Internships

Edited by

William P. Horan & Jack J. Blanchard

The *Directory* was created by SSCP as a resource for graduate students, faculty members, and internship sites on research opportunities and opportunities to receive training in empirically supported treatments at predoctoral clinical psychology internships. The *Directory* is one aspect of SSCP's efforts to promote the integration of science and practice in clinical psychology.

Access the *Directory* on-line at the SSCP Website:
www.sscpweb.org

# Feature Article

## The Role of Empirically Supported Treatments for Severe Mental Illness in Shaping Recent Public Mental Heath Policy in New York State

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Historically, treatment interventions for severe mental illness (SMI) with demonstrable efficacy have been scarce, particularly in the area of psychosocial treatments. It was not until 1992 that the Agency for Health Care Policy and Research and the National Institute of Mental Health funded the Schizophrenia Patient Outcomes Research Teams (PORT), which were established to gather and evaluate available research on the treatment of schizophrenia. The results of the PORT paved the way for the "evidenced based" literature in the area of SMI (Lehman & Steinwachs, 1998) by demonstrating that a number of efficacious-treatment interventions for schizophrenia do in fact exist. With regard to psychosocial treatments, Mueser and colleagues (2001) subsequently reviewed the treatment outcome literature on community-based treatments for schizophrenia and identified six evidenced based practices (EBP's), which include:

1. *Assertive Community Treatment (ACT)*: This is an assertive model of case management particularly targeted for those with SMI who are noncompliant with treatment.
2. *Supported employment*: Competitive employment remains a desirable goal for those with SMI and as such individual placement and job coaching are the current practice.
3. *Integrated treatment for SMI and substance-use disorders*: Treating both disorders simultaneously rather than separately is now a standard procedure.
4. *Family Education*: Primarily these are treatment models for families of persons with SMI that are supportive and educational.
5. *Wellness management and skills training*: Sometimes referred to as illness management, these learned psychosocial skills are helpful in reducing symptoms and improving interpersonal skills.
6. *Cognitive treatments*: This is the application of cognitive therapy for the SMI.

The concept of "evidenced based" treatments is well known and accepted in other disciplines, most notably medicine, yet evidenced based practices for SMI appear substantially under-utilized. The Report of the Surgeon General (1999) indicated that close to half of the individuals with a diagnosis of SMI fail to seek and thus do not receive treatments known to have positive outcomes. The same report revealed that less than one-third of adults with a diagnosable mental disorder receive any mental health services in a given year. Why is the field of mental health, and more specifically psychology, unable to translate available treatments with documented efficacy to individuals with SMI who are in need of treatment? The answer to this question is certainly very complex. However, two areas that may bridge the gap between research on efficacious treatments and clinical practices in the real world are the role of psychologists in developing public policy that incorporates research into treatment programs and the integration of research on efficacious treatments into graduate psychology training programs.

Developments in New York State over the past five years provide an excellent example of how psychologists can play a key role in shaping public mental health policy and graduate training. While recent events in New York State demonstrate how EBP's may be used to inform the development of rational public policy, this process has also highlighted several obstacles that the field of psychology faces in training future clinicians to work in the area of SMI. To provide a context for theses recent events, it will be useful to first present a bit of background on the structure and history of public policy decision making in New York.

The New York State Office of Mental Health (OMH) has for most of its existence (over a hundred years) been headed by a Commissioner who was a psychiatrist. The Commissioner is responsible for setting overall public mental health policy for the entire state and yields considerable influence in the implementation of public mental health policy. Research findings have historically had limited influence on policy decisions. Around 2000, a shift in leadership occurred in the context of the emerging evidence based practice movement. The administration of a newly appointed Commissioner, James Stone, MSW, initiated a major movement within the OMH to incorporate EBP's into policy. These practices were to be disseminated to the entire State and the OMH would provide an active and supportive role in the implementation. While the key administrators who operationalized this policy were not psychologists but were instead a Social Worker and a Nurse, it was recognized that psychology had been severely underutilized and perhaps unappreciated in the

OMH. The OHM leadership was instrumental in adding a number of psychologists to the Central Office to advise and consult on EBP's and their implementation. This was a significant step as it gave credence to the role of psychologists in reviewing and evaluating research as well as dissemination and implementation of EBP's. Psychologists continue to have a significant role in policy development and decision-making processes in the OMH.

As the EBP movement progressed, the OMH sponsored a major national conference on EBP for the severely mentally ill in 2001. Many prominent researchers and administrators from throughout the country introduced and reinforced the benefits of implementing interventions that have demonstrated therapeutic efficacy (http://www.omh.state.ny.us/omhweb/ebp/). The OMH developed a revised mission statement that reflected the importance of implementing these practices. Although these practices included both psychosocial and pharmacological treatments it was an opportunity for the OMH to articulate, in a public forum, the values that underlie these initiatives. These values include the concept that consumers have a right to interventions that have been shown to be effective and that the OMH was committed to working with consumers on the recovery process.

Armed with treatment interventions that are effective and a belief in the value of scientifically based practices, the OMH initiated a process to implement the EBP's throughout the State. Nationally, those interested in applying EBP's (including researchers and some State offices) developed a plan to "roll-out' each of the EBP's by developing for each of the identified practices a "tool kit" that would provide a plan of implementation. New York State OMH agreed to utilize this implementation process and to participate in the evaluation of the tool kits. These tool kits provide training tips on implementation practices that have proven to be helpful and effective. The OMH took a bold step by making a policy decision to not only incorporate and support the EBP's as a matter of policy but also to provide training in both the psychosocial and pharmacological EBP's. It was further determined that as the OMH initiated ACT teams throughout the State (28 in total), all teams would be trained in all the EBP's. As the OMH was also the certifying agency in the State, adherence to the standards (referred to as fidelity) of the EBP's was required to be certified by the State (certification is necessary to receive reimbursement). It should be noted that psychologists played a prominent role in directing this process. This role included consultation, training and research. Psychologists from both the State service and private practice were involved in each aspect of the implementation plan serving on consultation teams that visited other sites to witness established programs throughout the United States. They not only helped design training programs but also were also very visible as direct staff trainers. Finally, psychologists served on research teams that devised the plan to evaluate the training and also to collaborate with others throughout the United States in research and tool kit implementation. The OMH collects evaluation data on the implementation process as well as data on fidelity to the evidenced based standard, team functioning and client outcomes.

As an adjunct to implementing the process, it was determined that an outreach to the academic community was necessary. This effort was motivated by the knowledge that it has become increasingly difficult to attract newly trained professionals to work with the severely mentally ill. It was decided that an outreach to three academic disciplines, namely Social Work, Psychology, and Psychiatry Departments, was necessary and could not only be of help in the dissemination of EBP's but also potentially generate interest among a new cadre of trained professionals. The plan was for each of the three disciplines to be contacted by OMH and begin a dialogue aimed at incorporating EBP's for the SMI into the training curriculum. Several discipline specific representatives from the OMH were asked to meet with respective academic departments throughout the State. Approximately sixteen departments were contacted (eight in Social Work, five in Psychology and three in Psychiatry).

The concept was well founded, reaching out to the academic world to reinforce relevant research findings in a teaching environment that would, hopefully, train and motivate more graduates to work with the SMI while simultaneously increasing the awareness among trainees in general about the existence of effective treatment interventions for this population…seems to make sense eh?…well, not so fast! As the designated OMH liaison to Psychology departments, my experience was interesting and disappointing. Perhaps the disappointment would have been tempered had the other liaisons met with less success or enthusiasm, but this was not the case. The most successful developments occurred in graduate Social Work Departments. A number of schools were very eager to work with the OMH and agreed to develop a pilot program within months. Incentives to the program were minimal; small stipends would be made available to include EBP's for the SMI in curriculum development with a longer-term goal of establishing a unique separate course that would be offered on a regular basis.

There was a consensus among the representatives from the different schools about the value of EBP's. As the new Social Work course is currently constructed, it is heavily reliant on research-based practices. In general the Social Work discipline is not typically aligned with research training and analysis. However, the ability to professionally evaluate research is an essential tool for mental health professionals in an era of information overload making this a very worthy endeavor.

Departments of Psychiatry were equally eager to formalize their approach to EBP's for SMI. They were eager to incorporate both pharmacological and psychosocial treatments into their training curriculum. They were quick to point out that Psychiatry has been using "practice guidelines" for some

time and that EBP's were already incorporated in both medical school and residency programs. They were more than willing to discuss course development and implementation strategies.

The experience within psychology departments of engaging faculty to discuss the incorporation of EBP's for SMI into their curricula was difficult if not impossible. As I met with various Psychology Department chairs we discussed current course offerings related to the SMI. Generally there was no specific course covering SMI and the usual response was that the amount of time spent on that topic was "up to the professor". It is noteworthy that the Abnormal Psychology textbooks used in these departments also provided little or no discussion of the EBP's for SMI (or EBP's in general for that matter). It became increasingly clear that unless there was a research interest on the part of a faculty member, EBP's for SMI received minimal attention. One Dean I spoke to indicated that it was possible to graduate with a Doctorate with little or no knowledge of SMI. Although not all Clinical programs at the Doctoral level are designed to train individuals in the area of SMI, it seems a disservice to not only the student but also to the field of psychology to not at least provide a more thorough overview.

Discussions with one psychology department were encouraging, leading to an increased awareness of the importance of EBP's for SMI. These discussions resulted in the OMH offering to pay a small stipend to a faculty member to develop and teach a course that would include EBP for the SMI. In addition, the OMH would provide a small amount of money to be used as part of a scholarship fund to support students on externships that provide training in EBP's. In these externships students are introduced to the SMI population and exposed to effective treatments with this population and are paid for this real world experience. Needless to say, having the real world experience and an introduction to effective treatments could positively influence students to make a vocational choice to continue to work with this population.

In writing this article I recalled that similar obstacles to increasing training in EBP's in psychology programs have been described by others (e.g., Davison, 1998). Although not dealing with SMI, Davison discussed some of the impediments to bringing empirically supported treatments into training programs including, senior faculty invested in teaching similar content (tradition), faculty special interests, and elements of academic freedom. How do we tweak our entrenched colleagues to incorporate more recent evidenced based practices into their curricula? While graduate training models that foster implementation of empirically supported treatments have been reported (Calhoun et al., 1998) the perceived resistance is a threat to our profession as a timely and vibrant scientific discipline.

Recognizing that there are now effective community based treatments for the SMI, it is important to underline the crucial role psychologists have in both disseminating and utilizing these interventions. Psychologists are uniquely qualified to play a role in bridging the gap between clinical research and real world practice. The New York State OMH provides an excellent example of how, with the support of public policy makers, psychologists can promote the use of treatments with demonstrated efficacy in regular clinical practice. Greater efforts need to be made in working with psychology training programs to incorporate exposure to EBP's into training curricula. The experience of New York State OMH provides a basis for optimism that large-scale implementation of training of EBP's can be accomplished, particularly with the active support of psychologists.

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# Update from the Secretary/Treasurer

Denise Sloan, Ph.D.

Department of Psychology

In 2004 SSCP had 286 paid members, with 98 of these members being students. In order to make membership renewal easier, members can now renew their SSCP memberships over the internet using a credit card. This should be especially helpful for members who reside outside of the United States. Membership renewal notices will be mailed out in early Fall, along with election ballots. As a reminder, renewals can be sent to me or can be completed through our website (www.sscpweb.org) using a credit card. Although the option to renew membership over the internet has only been available for a short period of time, a large percentage of members have already chosen this option.

We continue to offer a number of membership incentives to our student members, including student poster sessions held at the annual meetings of American Psychological Science (APS) and American Psychological Association (APA). Both sessions were well attended this past year and, as in previous years, a cash award for best poster was given at each session. Congratulations to this year's winners Alison Esposito and David Klonsky! The quality of the presentations at both sessions was very impressive. We look forward to holding student poster sessions at APS and APA this coming year and seeing the excellent research that is being conducted by our student members.

In addition to the student poster sessions SSCP awards, several dissertation grants are awarded every year. We will be giving out dissertation grants again this year and the call for applications will be made in early Fall, with awards announcements anticipated in December. This year we will be giving five awards of $500. These awards are only made possible through membership fees. Thanks to all of you for making these awards available to our student members.

# Awards & Recognition

## 2004 APS Student Poster Session Winner

**Best Poster:**

**Alison Esposito**

*The Self-Esteem Reactivity of Aggressive Teens*

## 2004 APA Student Poster Session Winner

**Best Poster:**

**E. David Klonsky**

*Why People Self-Harm: Results from a Semi-Structured Interview*