APA
III
Division12

CLINICAL SCIENCE

Society for the Science of Clinical Psychology
Section III of the Division of Clinical Psychology of the American Psychological Association
developing clinical psychology as an experimental-behavioral science

Newsletter

Summer 2006 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.*

Editor: William Horan, horan@ucla.edu

President's Column:

Antonette M. Zeiss, Ph.D.
VA Central Office, Washington, DC
Email: Antonette.Zeiss@va.gov

In my last column, I wrote about my shift to a role in mental health in the Department of Veterans Affairs health care system where I can influence policy and program development on a national level. I shared the principles that guide my work in that role, emphasizing the impact of SSCP on those principles. Elaborating those principles is the subject of this second Presidential column, with the emphasis on VA actions to implement a science-based agenda for mental health care. I offer this in hopes it will be of interest in its own right, since how the largest health care system in the US approaches mental health care has broad implications, but also – and especially – because it relates to roles I hope SSCP will continue to play and expand in championing implementation of a science-based approach to mental health care.

The SSCP web site presents the vision of our role as an organization clearly: **"The common bond of the membership is a commitment to empirical research and the ideal that scientific principles should play a role in training, practice, and establishing public policy for health and mental health concerns."** That summarizes the theme for my Presidential year. It is hard to imagine any SSCP member who would not espouse the idea that we support a science of clinical psychology or that science should guide our training efforts and clinical practice. I am encouraging SSCP members to do more – to provide active support for the use of clinical research in setting and implementing public policy. This is a goal shared by current leadership in Division 12 of APA, and we have the opportunity for action within Division 12 to continue the progress that began with the task force on identifying evidence-based treatments.

Toward that end, I want to continue discussing current efforts within VA to create policy related to mental and behavioral health care for implementing a stronger evidence-based approach to care. As I described in my last column, the process for VA began with the development of the President's New Freedom Commission on Mental Health Report (PNFCMHR) in 2003, which began by noting that "The [mental health care] system is fragmented and in disarray." Many - perhaps most - in SSCP would agree with this statement. The Commission provided multiple action recommendations organized around six goals to create a transformation of mental health care in the US. All of the goals (reviewed in my last column) are ones that SSCP members likely would support, but one is *exactly* related to our mission: "Goal 5. Excellent mental health care is delivered and research is accelerated." "Excellent mental health care" is defined primarily as evidence-based mental health care, and the PNFCMHR calls for an acceleration of the process of translating research findings into available care. Specific radical changes prescribed in that report, shown in bullet points below, mirror the elements our SSCP website lays out as our "common bond": "commitment to empirical research and the ideal that scientific principles should play a role in training, practice, and establishing public policy for health and mental health concerns":

- Accelerate research in mental illness and promote recovery and resilience
- Accelerate the move from science to service and overcome the 15- to 20-year lag between discovering effective treatments and incorporating them into routine practice
- Advance evidence-based practices (EBPs) using dissemination and demonstration projects and create a public-private partnership to guide implementation, including changes in reimbursement policies to more fully support EBPs
- Improve and expand the workforce (those in training and current professionals) to promote provision of evidence-based mental health services and supports

In my last column, I described (1) VA's efforts to create its own action agenda to implement the PNFCMHR throughout the VA system and (2) the evolution of that Action Agenda into a comprehensive Mental Health Strategic Plan. I described the progress reviewed above as Steps 1 through 3 of a general approach for implementation of a science-based clinical agenda

Step 1. Identify a set of values and goals that define your health care setting and how they relate to the outcomes you hope to accomplish. Place those values, goals, and outcomes within a broader context that you believe should describe the health care system overall. In this case, I

specifically recommended broad use of the President's New Freedom Commission Report on Mental Health in this step.

Step 2. Translate the broad guiding principles you identified in Step 1 to a set of specific actions to be taken.

Step 3. If your health care setting is large and complex, extend Step 2 to ensure that a comprehensive, overall plan is created, with thought regarding how changes in one part of the system will affect other parts of the system and toward defining what resources will be needed to take the intended actions to improve care delivery (in SSCP's specific case, enhanced implementation of evidence-based mental and behavioral health care).

Step 4 is my current task at VA: actually implementing a well-developed policy and plan of change. I won't go into all the details of that action, as they relate specifically to a set of resources and challenges in VA, but I do want to mention some actions, in the context of the road map concept. One essential piece of implementation is that you must have resources devoted to it: money, professional time, support staff time, and administrative support. The power of VA's current efforts is that it has such support. The Undersecretary for Health is committed to development of more effective evidence-based mental health care and he has made significant financial support available for implementation of the Mental Health Strategic Plan (approximately $300 million cumulatively over VA fiscal years 2005 and 2006, above and beyond the basic VA mental health budget of over $3 billion). The funding and administrative support are being used to expand mental health services in a variety of areas, including substance abuse, treatment for PTSD, integration of mental health staff into primary care, and development of psychosocial rehabilitation services with a recovery orientation for veterans with serious mental illness. The keystone in every area is that in order to be selected for funding, any new program must demonstrate how its clinical services will be guided by the research evidence in the relevant area. In addition, I have the opportunity to work on specific funding for increasing knowledge and skills to provide cognitive behavioral therapy among VA mental health care providers – psychologists, but also psychiatrists, nurse practitioners, RNs, and social workers. One such project was recently funded, guided by Patricia Resick, Ph.D., to train VA staff with basic knowledge of Cognitive Processing Therapy so they can become trainers in their local areas for line staff providing care for PTSD. This is one specific VA example, but the principle of Step 4 is the same in any setting – find and use resources to plan and implement specific actions which will result in increased provision of evidence-based care.

The toughest step is the next one: ensuring that the changes result in more effective care. It is most difficult in complex systems – how do you maintain quality control in a widespread, complex system, and how do you assess the impact of far-flung change efforts? The goal is broad implementation – changing the care available to everyday help seekers, in this case in VA, but for other SSCP members, in other broad constituencies. I want to do more than just provide research evidence that one approach is more efficacious than another. I want that knowledge to be used everywhere; I want it to mean that those who seek treatment will have at least a chance to find a therapist who will offer evidence-based care skillfully and knowledgeably. In my next column I will speak about VA attempts to measure the impact of systemic changes, and how VA uses those data to guide continuing efforts. Providing "evidence-based" treatment doesn't just mean training people in the techniques used in randomized controlled therapy trials – it also means obtaining and attending to evidence about how well those services are delivered and how well they work in new contexts.

In my last column, I invited members to think about the actions SSCP can promote to meet its goal of "establishing public policy." I heard from few, but SSCPNET has seen vivid debate on what SSCP's mission, goals, affiliations, and activities should be – and that is a good thing. Let me reiterate the three questions I asked before, with one new twist, and again invite SSCP members to think about where they stand and then reply, to SSCPNET or to me personally.

1. Which of the principles in SSCP's "common bond" guided you to join this organization, and how do you pursue these principles in the work you do?
   - Commitment to empirical research
   - Ideal that scientific principles should play a role in training
   - Ideal that scientific principles should play a role in practice
   - Ideal that scientific principles should play a role in establishing public policy for health and mental health concerns
2. Which of these principles have you *not* included in your professional roles, and why not?
3. Are you interested in expanding - in any way - to embrace more of SSCP's "common bond" as part of your professional life? In particular, are you interested in participating in the project being discussed with APA Division 12 to examine shared actions that could address increased implementation of a science-based approach to clinical practice?

I look forward to hearing from you about these questions or other issues you think SSCP should be addressing. I also look forward to sharing more about the task of using an evidence-based approach to evaluating the rustles of implementing policy change in the next SSCP Newsletter.

Update on Division 12 Activities:

E. David Klonsky
Stony Brook University
eklonsky@notes.cc.sunysb.edu

I appreciate the opportunity to update SSCP on the activities of Division 12 (Society of Clinical Psychology). The most recent meeting of the D12 board took place in June and several activities have direct relevance for SSCP.

Marsha Linehan is chairing a new D12 task force with the aim of focusing media attention on the importance of evidence-based treatment. SSCP officers have been discussing a similar initiative and will work to coordinate efforts with D12.

Since switching publishers to Blackwell, D12's journal *Clinical Psychology: Science and Practice* has substantially reduced the time it takes to review manuscripts. Average time from submission to decision is six or seven weeks. Of note, plans are underway for *CP:SP* to accept empirical papers in addition to the review and commentary articles traditionally accepted.

Danny Wedding provided an update on the "Advances in Psychotherapy – Evidence-Based Practice" series. This series, which is supported by D12 and published by Hogrefe & Huber, provides practical, evidence-based guidance on the diagnosis and treatment of the most common disorders seen in clinical practice. Volumes on Bipolar Disorder, Heart Disease, and Obsessive-Compulsive Disorder are currently out, and volumes on Childhood Maltreatment, Schizophrenia, and Mass Disaster are in press. Information about the series and future volumes is available at http://www.hhpub.com/books/series/52.html.

D12 is developing a new Section. Section 10 will be called the Section on Graduate Student and Early Career Psychologists. The purpose of Section 10 will be to address the unique needs of graduate student and early career psychologists entering the profession and facing early career challenges in clinical psychology. It is also hoped that the new Section will draw in new members to D12.

Finally, as noted recently on SSCPnet, SSCP is working with D12 to develop an agenda for promoting evidence-based clinical psychology. At this stage we are discussing how SSCP, D12, and the D12 Committee on Science and Practice can interface to formulate and implement recommendations. Relatedly, D12 has expressed an interest in strengthening ties to SSCP. Several ideas are being explored, including the feasibility of SSCP editing a special issue of D12's journal *CP:SP*.

Join SSCP or renew your membership on-line!

On-line applications and renewal forms are available at the SSCP website:

www.sscpweb.org

Secretary & Treasurer's Update:

Denise Sloan
Temple University
dsloan@temple.edu

SSCP Dissertation Grants

As in previous years, SSCP will be offering dissertation grants this year. The amount of the award will be $500 and we expect to be able to award five grants this year. The deadline for submission will be November 1, 2006. Instructions for submitting will be available soon on the SSCP webpage (www.sscpweb.org).

SSCP Executive Board: Seeking Nominations

SSCP is seeking nominations for energetic, dedicated individuals for the offices of **President-elect** and **Secretary/ Treasurer**, beginning January 2007. These offices provide an opportunity for influencing the field and politics of clinical psychology as well as broadening your network of connections with your colleagues.

Both the **President-Elect** and the **Secretary/Treasurer** shall be a SSCP member. The position of Secretary/Treasurer is a three-year term. Questions about the Secretary/Treasurer position should be directed to Denise Sloan (dsloan@temple.edu). Questions about the president-elect position can be directed to either Toni Zeiss (Antonette.Zeiss@va.gov) or Dan Klein (dklein@notes.cc.sunysb.edu).

To be nominated for either position please send your name or that of a colleague to Denise Sloan **by August 31**. Email Denise at: dsloan@temple.edu.

SSCP Program at the American Psychological Association Convention, August 2006

Saturday, August 12

1 -1:50 pm SSCP Presidential address: Implementing Large-Scale Transformation to Support Provision of Evidence-Based Mental Health Services
Antonette Zeiss, Ph.D.
Morial Convention Center Rm. 278

2-3:50 pm SSCP Board meeting – members invited, as room is available
Marriott Hotel, Div. 12 Hospitality Suite

Sunday, August 13

11 -11:50 am Invited Address: Preventing Psychopathology: The Importance of Identifying High Risk Traits in At-Risk Children
Ted Beauchaine, Ph.D.
Morial Convention Center Rm. 241

1-1:50 pm Symposium: Translation of Depression Research to Evidence-Based Practice
Moderator: Dan Klein, Ph.D.
Presenters: Forrest Scogin, Ph.D., Depression in Older Adults,
Shannon Stirman, Ph.D., Depression and Suicidality
Morial Convention Center Rm. 260

Awards and Recognition:

2006 APS Student Poster Awards

Melanie A. Dirks

Mentors: T.A. Treat & V.R. Weersing

Yale University

Situation- and Judge-Specific Factors in the Conceptualization and Measurement of Youth Social Functioning

The present work advances a situation- and judge-specific model of social functioning by assessing youth responses to problematic interpersonal situations and evaluations of those responses by multiple relevant classes of judges. This model is tested with a sample of economically disadvantaged elementary- and middle-school students, an understudied population at high risk for poor social functioning and associated difficulties such as clinical symptoms and academic failure. Study 1 demonstrated the situation-specificity of the descriptively coded responses of 110 youth to six peer-provocation situations. Notably, youth matched aggressive responses to aggressive provocations, whereas non-aggressive responses occurred more uniformly across situations. Study 2 indicated that youth (n=77) evaluated responses involving physical, verbal, and relational aggression more positively than parents (n=51) and teachers (n=9), whereas parents and teachers evaluated "telling an adult" more positively than youth. The three judge groups concurred in their positive evaluation of "seeking an explanation for the provocation." Implications for theoretical, measurement, and intervention models of social functioning are discussed.

Courtney L. Bagge

Mentors: K.J. Sher & J.L. Krull

University of Missouri-Columbia

Age-Graded Effects of Alcohol on Adolescent Suicide Attempts

The present study characterizes the extent to which the alcohol-suicidality relation varies across severity of attempt (i.e., any suicide attempt vs. medically attended attempt) and determines how these relations change as a function of sex and adolescent development. Data were drawn from the 2003 Youth Risk Behavior Survey, a nationally representative sample of students (ages 15 to 18; *N*=10,753). Alcohol involvement (past-month frequency of drinking) was parameterized by two dummy codes: low-alcohol (one to nine days; 40.8%) and high-alcohol (ten or more days; 7.4%). Past-year suicide attempt was operationalized by two categorical variables: 1) a two-level variable comparing any attempt (7.7%) to no attempt and 2) a three-level variable comparing any medically attended attempt (1.9%) and non-medically attended attempt (5.8%) to no attempt. We conducted a series of multinomial logistic regression analyses where alcohol served as a predictor of suicide attempts while controlling for covariates. Higher-order interactions with alcohol were modeled. High alcohol involvement is a significant risk factor for suicide attempts independent of age. Relatively low levels of alcohol use are also significant risk factors for suicide attempt. However, these relations are specific to early adolescence when drinking is more deviant, especially among girls. These patterns are pronounced with attempts associated with increased severity (i.e., medically attended). Alcohol is a developmentally sensitive indicator of suicide risk.

SSCP Paid Membership List

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David O. Antonuccio
Martin M. Antony
Marc S. Atkins
Courtney Bagge
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David H. Barlow
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Jack J. Blanchard
Aaron T. Beck
Cynthia D. Belar
Jessica Benas
Jeffrey S. Berman
Amit Bernstein
Joyce N. Bittinger
Ryan Bogdan
George Bonanno
Anna Brandon
Glenn S. Brassington
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Arthur C. Houts
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