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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

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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. We welcome proposals for **feature articles** (16 double-spaced pages) and **brief articles.** All articles should include 75-100-word abstracts and be formatted according to the *Publication Manual of the American Psychological Association, 5th Ed.* Submit articles via E-Mail to Erika Lawrence
E-Mail: erika-lawrence@uiowa.edu

Presidential Column, Part I

Treatment Fidelity: The Elusive Independent Variable of Empirically Supported Behavioral Treatments

Varda Shoham, Ph.D.

Univ. of Arizona Psychology Dept. and the National Institute of Mental Health

As a treatment researcher, I am excited about the enormous progress in establishing experimentally-supported behavioral treatments for a wide variety of problems. I am also humbled by how much we still do not know about psychosocial intervention – how they work, for whom they work best, and how to retain the independent variable, the treatment itself as it makes its way to from efficacy investigations to community applications. In my presidential columns I will address three major challenges facing psychosocial treatment research: (a) controlling the elusive independent variable of psychosocial treatment research by assessing, enhancing, and maintaining treatment fidelity (or "what's in the name?"); (b) targeting theory-derived patient-level moderators that interact with treatments to produce different outcomes for different patients ("for whom treatments work?"); and (c) examining therapist- and patient-level mediators and mechanisms of clinical outcomes ("how these treatments work"). Each of my presidential columns will address one of these challenges and how they relate to each other.

In the spring of 2010, shortly after I became President Elect of SSCP, I accepted an invitation by National Institute of Mental Health (NIMH) Director Thomas Insel to serve as his Special Assistant for matters of behavior change. I was given a golden opportunity to work with NIMH program officers on a Funding Opportunity Announcement aiming to assess and enhance the fidelity of psychosocial interventions, and this is the focus of my first presidential column. Our work led to a Request for Application (RFA) that was published on March 31, 2011. In this column I will provide some of the highlights of this RFA, but if you intend to apply, it is important that you read the full announcement (*http://grants.nih.gov/grants/guide/rfa-files/RFA-MH-12-050.html*).

Treatment Fidelity: The Elusive Independent Variable of Psychosocial Intervention

The first challenge I will address is the fidelity with which psychosocial treatments are applied in community settings. After all, questions such as "how and for whom does it work" are not meaningful when we do not know what "it" is. Treatment fidelity (also known as treatment integrity) refers to implementing an intervention in a manner consistent with an established manual. Assessing treatment fidelity is akin to performing a manipulation check of an independent variable in a true experiment, which increases the confidence in concluding that patient outcomes are due to the treatment. If patients improve despite low treatment fidelity, it is likely that something other than the treatment led to such improvement.

Treatment fidelity is a key factor in effective dissemination. Although efficacious behavioral treatments for many mental disorders exist, research suggests that people who seek treatment in community settings rarely receive them. To reduce this widely acknowledged science-to-service gap, we must develop and test methods to enhance and maintain treatment fidelity.

Why is Fidelity So Important?

Only a small fraction of community-based clinicians who routinely provide an empirically-supported behavioral treatment (ESBT) such as cognitive-behavior therapy are able to do so with adequate fidelity (e.g., one study found as little of 5%, based on direct observation; Santa Ana et al., 2008; *Journal of Substance Abuse Treatment, 35,* 369-379). This may reflect the insufficiency of commonly used ESBT training and dissemination methods such as workshops and lectures, which by themselves effect little substantive change in clinician behavior. Moreover, even documented acquisition of fidelity skills under close supervision does not guarantee continuing fidelity maintenance.

The fidelity of an ESBT is important for several reasons. First, in contrast to psychopharmacology,

the integrity of a psychosocial intervention depends disproportionally on clinician behavior: What the clinician does and does not do (based on an ESBT manual) defines a complex, multi-component independent variable – the treatment itself – encompassing domains such as adherence, competence, and differentiation from other treatments.

Second, if ESBT fidelity predicts outcome, fidelity failures may explain some of the fairly dramatic reduction in effect sizes associated with transporting ESBTs from university-based efficacy trials to effectiveness studies in community settings (e.g., Henggeler, 2004; *Journal of Family Psychology, 18*, 420-423). Unfortunately, while successful fidelity acquisition and maintenance are feasible in randomized efficacy trials, surprisingly little is known about how to extend effective methods of ESBT training and fidelity maintenance used in controlled studies to community practice (e.g., how much and what kind of direct observation and feedback is sufficient?).

Third, a sharpened focus on fidelity has the potential to increase knowledge about specific targets for behavior change, which could make ESBTs more efficient and attractive for broader adoption. For example, the complex, multi-component nature of some ESBT treatment packages may itself pose a barrier to successful community implementation. In the absence of specific knowledge about how these treatments work – which components are active and which are inert – a common practice is to train therapists in all elements of the package, emphasizing active and inert components equally.

The recently published NIMH RFA seeks research that aims to develop theory-derived, multi-component fidelity measures; to examine component-outcome relationships; and to explore methods for enhancing and maintaining the most promising fidelity components. The ultimate goal of this initiative is to narrow the science-practice gap by improving treatment fidelity, thus making high-quality ESBTs more readily accessible to patients in the community.

We have used a "phased innovation" funding mechanism whereby projects begin with an assessment-development phase and then, contingent upon achieving the milestones set for that phase, projects advance to a provider-level intervention development phase where investigators explore interventions designed to train, enhance, and maintain clinicians' fidelity. Findings from the first phase could begin to illuminate which fidelity components of an ESBT are most and least crucial to immediate (e.g., session) or longer-term (e.g., end-point, follow-up) patient outcomes. Although discarding components on the basis of how well they relate to outcome would be premature, the intervention-development phase presents opportunities to experiment in a more focused manner with methods for enhancing and maintaining fidelity components that do correlate with outcomes, which could lead to subsequent refinement of an ESBT.

Assessing Treatment Fidelity Components

Because enhancing and maintaining fidelity presumes its valid and reliable assessment, the first challenge is to develop methods for assessing theory-derived fidelity components. Moreover, because valid assessment will ideally link theory-derived fidelity components to clinical outcomes, a by-product of this funding initiative may be increased knowledge about how these treatments work (i.e., their mechanisms of action). This would guide further research and subsequently facilitate paring these treatments down to their most essential elements.

The following examples, while far from exhaustive, illustrate possible fidelity components and their relationships to theory-derived change mechanisms:

- In Prolonged Exposure (PE) treatment for PTSD, the fidelity component "skillful elicitation and normalization of patient reactions to the trauma" should activate effective emotional processing by the patient (change mechanism), leading ultimately to symptom reduction;

- In Cognitive-Behavior Therapy (CBT) for depression, the fidelity component "skillful Socratic questioning about cognitive reactivity to negative moods" should activate effective reconsideration by the patient of his or her negative cognitions, leading to symptom reduction;

- In Contingency Management (CM) therapy for child conduct disorders, the fidelity component "skillful feedback to parents about providing positive or negative consequences for child behavior" should activate effective parental monitoring, leading to symptom reduction;

- In Motivational Enhancement Therapy (MET), the fidelity component "skillful exploration of pros, cons, and ambivalence to change" should elicit patient "change talk", leading to behavior change.

Research questions relevant in the fidelity assessment phase include, but are not limited to, the following (for other examples or research questions, see

the funding announcement):

– What are the crucial treatment-specific elements (components) that need to feature highly in fidelity assessment for a given ESBT, based on associations with outcome?

- What are the most reliable and valid methods of assessing these components?Needless to say, measurement in this area presents formidable challenges, not the least of which is the inherently interactional nature of many fidelity components, where intervention quality reflects not only what the therapist does but also how the client responds, and how the therapist takes this response into account while staying faithful to the ESBT's theory of change. On the therapist side, fidelity measures will need to include clearly defined behavioral anchors for each point on a given scale; and on the patient/response side, investigators will need to consider whether to emphasize intermediate outcomes, longer-term outcomes, or both, as this will influence the possibility of detecting putative mediators or mechanisms of change. Finally, given the ultimate goal of assessing fidelity in a variety of community practice settings, selection and/or refinement of fidelity tools should consider efficiency and respondent burden.

Enhancing and Maintaining Treatment Fidelity

The provider-level intervention-development phase is intended to yield valuable knowledge about how to help community therapists maintain high-fidelity intervention over time in ways that are relatively cost effective. The goal of this work is to inform strategies for enhancing ESBT fidelity in community settings (e.g., via peer- and supervisor-based assistance models, ongoing collaborative learning networks).

Research questions relevant in the provider-level intervention-development phase include, but are not limited to, the following (for other examples or research questions, see the funding announcement):

– How can fidelity feedback systems work to optimize the delivery of a particular ESBT? Who should provide the feedback? Is there value added by live supervision? What methods and schedules of reinforcement (feedback) most facilitate fidelity maintenance in community settings? Do fidelity ratings by the therapists themselves add performance value to other training monitoring methods?

- What technology could be applied to make fidelity monitoring more immediate, efficient, and economical? For example, under what conditions can observations (reports) by supervisors, therapists, and even clients serve as reliable and valid proxies for fidelity ratings by independent expert observers?

– How much supervision, for whom and by whom, is sufficient to maintain high levels of treatment fidelity;

– How can off-line case simulation methods (e.g., case formulation exercises, interactions with standardized patients via video teleconferencing) contribute to fidelity acquisition and maintenance (e.g., by providing therapists with safe opportunities for dry-run experimentation with fidelity components)?

At the conclusion of the project investigators should be able to show preliminary evidence regarding the effectiveness of procedures for enhancing and maintaining ESBT fidelity in community settings. Tangible byproducts of this effort include empirically-supported training and supervision manuals, and if applicable, other materials such as demonstration videos, and technology aids. At the end of the day, we hope for a documented increase in the percent of patients receiving high-fidelity ESBTs.

The APS convention in DC is around the corner: May 26th - 29th

Thanks to our SSCP representative on the planning committee, Howard Garb, we have an amazingly rich clinical science program at the convention. Check it out at:

http://www.psychologicalscience.org / index.php/convention

If you are planning to be at the conference, don't miss the SSCP membership meeting on Friday morning, 8:00-10:00 (Holmead room). We'll have continental breakfast curtesy of APS, and discuss what we have done thus far and where we're going in the near future.

Closing the Gap between Research and Practice: Clinical Experiences in Using an EST to Treat Panic Disorder

Marvin R. Goldfried, *Stony Brook University*

It is well known that research and practice take place in different worlds, and that the challenge has always been to close the gap between the two—making each relevant to the other. As the practice of psychotherapy becomes increasingly more accountable to governmental agencies and third party payers, the need to close this gap has become more important now than ever before. Indeed, the dissemination of research findings to the practicing clinician is the theme of the 45th ABCT convention in 2011.

The fact of the matter is that there has been a long history of mutual dissatisfaction between researchers and practitioners. I have heard some of my academic colleagues lament the fact that some of our graduates were "lost to clinical practice." Indeed, it is the opinion of many academic scholars the only way the field will advance is through controlled research. From the point of view of the practicing therapist, the dissatisfaction has been that the research does not always meet their needs, and that it is far too "academic."

The question of how to best close the clinical-research gap has been the subject of considerable debate, but only some research. Based on their recent survey of clinicians, Stewart and Chambless (2010) found that providing practitioners with case illustrations increases the likelihood of successful dissemination of findings. Although these and other strategies can certainly be helpful, I believe that the reluctance on the part of practitioners to make use of research findings needs to be dealt with at a more basic level.

I have long believed that in our desire to disseminate research findings to the practitioner, we may have unwittingly alienated them. I base this on some of my contacts with practicing therapists, as well as published statements by clinicians who have expressed their resentment toward researchers. Perhaps most dramatic example of this is the case of two CBT colleagues who were dedicated readers of the latest research literature (*Fensterheim & Raw, 1996*). However, when the first report of the Divisions 12 Task on empirically validated (later called empirically supported) treatments was published (*Task Force on Promotion and Dissemination of Psychological Procedures, 1995*), these practicing therapists indicated that they felt betrayed by their research colleagues. Referring to what they correctly foresaw as the movement toward practice guidelines, they indicated that they were concerned about who should make the decision about how much flexibility is allowable, of how large should be the Procrustean bed. We doubt that it will be the practicing therapist who does so. So, once again, the standards and methods of clinical therapy will be set by those who do the least amount of clinical practice (*Fensterheim & Raw, 1996, pp. 169-170*).

I like to think that those of us who have been trained as scientist-practitioners, especially those who are entering the field, have a somewhat different view of the need to close this gap. Indeed, two clinical graduate students — the future of clinical psychology — have recently offered their perspective on this problem, posing the question of how to best disseminate research findings to the clinician:

> "How do researchers and clinicians work together to develop efficacious treatments?" . . . [W]e the researchers should not be disseminating *onto* the clinicians but rather engaging in dialogues *with* the professional community as we create new interventions. We believe that if we continue to frame this issue as an "us" versus "them" predicament, we will perpetually be stuck where we are, and, even worse, may continue to grow further polarized rather than closer together (*Hershenberg & Malik, 2008, pp. 3-4*).

The suggestion that the field would benefit most by developing a way to establish a collaborative relationship between researcher and clinician is not new. Indeed Chambless and Goldstein's wrote about it years ago in their book *Agoraphobia: Multiple perspectives on theory and treatment* (*Chambless & Goldstein, 1982*). It is also an important theme in Foa and Emmelkamp's *Failures in behavior therapy,* in which they indicate that "Contact with clients has taught us that clinical practice is not as simple as that portrayed in textbooks. . . . It seems that once a technique was endorsed as effective, it became almost taboo to admit that sometimes the expected positive results were not

obtained" (*Foa & Emmelkamp, 1983, p. 3*). This is especially the case in using empirically supported treatments when dealing with complex clinical cases, which call for an "increased dialogue between scientists and practitioners at a field-wide level" (*Ruscio & Holohan, 2006, p. 158*). Although the two-way bridge initiative described below is one way of doing this, there are clearly other approaches to fostering clinical-research collaboration (*e.g., Barkham, Hardy, & Mellor-Clark, 2010; Castonguay et al., 2010; Eubanks-Carter, Burckell, & Goldfried, 2010; Sobell, 1996*).

Clinical Experience in Using CBT to Treating Panic Disorder: Results of a Survey

In the attempt to close this longstanding gap between research and practice, the Society of Clinical Psychology, Division 12 of the APA, has recently begun an initiative to build a two-way bridge between research researchers and practitioners. Although much as been said about the need to disseminate research findings to the clinician, it is also important for the clinician to have a way they can disseminate their clinical experiences to researchers—as well as other practitioners. Indeed, there has been a mechanism in place in medicine to do such a thing. Once a drug has been approved by the Food and Drug Administration (FDA) based on clinical trials, physicians have a way to report back to the FDA on their experiences in using the drug in clinical practice. In establishing a two-way bridge for therapists, the Society hopes that it will not only provide clinically based issues in need of future research, but will also motivate practitioners to become interested in what the research has to say—a strategy that has successfully been used by Sobell (*1996*).

In the first of several ongoing surveys of practicing clinicians that use ESTs in their clinical practice, we have just completed a study on the use of CBT for the treatment of panic disorder. Although there is considerable evidence to support the efficacy of CBT in treating panic, it has been acknowledged by researchers that there nonetheless exists a need to further improve our interventions with this clinical population *(e.g., McGabe & Antony, 2005; Otto & Gould, 1996; Sanderson & Bruce, 2007*).

In developing the survey, we were interested in those treatment, therapist, patient, and contextual variables that were associated with the clinical effectiveness of CBT in treating panic. We were fortunate to obtain the cooperation of a group of experienced clinicians who helped develop these items, and are most grateful to the following: Dianne Chambless, Steven Fishman, Joann Galst, Alan Goldstein, Steven Gordon, Steven Holland, Philip Levendusky, Barry Lubetkin, Charles Mansuto, Cory Newman, Bethany Teachman, Dina Vivian, and Barry Wolfe. A special committee within the Society of Clinical Psychology was formed to spearhead this initiative, consisting of clinicians and researchers with a long-standing commitment to closing the gap between research and practice: Louis G. Castonguay, Marvin R. Goldfried, Jeffrey J. Magnavita, Michelle G. Newman, Linda Sobell, and Abraham W. Wolf.

The questionnaire items included a number of categories of variables that might interfere with the clinical effectiveness of CBT in reducing symptoms, and included: patient symptoms related to panic; other patient problems or characteristics; patient expectations; patient beliefs about panic; patient motivation; the patients' social system (home, work, other); problems/ limitations associated with the CBT intervention method; and therapy relationship issues. The rationale for focusing on variables that might undermine clinical effectiveness has been characterized by Foa and Emmelkamp (*1983*) as representing the key to potential research questions, derived from clinical practice, and in need of further investigation.

The survey itself, which took approximately 10 minutes to complete, was advertised to practicing therapists internationally by means of listservs, emails, Web sites, and newsletters. They were provided with the following on-line instructions:

> Once a drug has been approved by the Food and Drug Administration (FDA) as a result of clinical trials, practitioners have the opportunity to offer feedback to the FDA on any shortcomings in the use of the drug in clinical practice. The Society of Clinical Psychology, Division 12 of the American Psychological Association, has established a mechanism whereby practicing psychotherapists can report their clinical experiences using empirically supported treatments (ESTs). This is not only an opportunity for clinicians to share their experiences with other therapists, but also to offer information that can encourage researchers to investigate ways of overcoming these limitations.
>
> This questionnaire provides the opportunity for therapists using cognitive-behavior therapy (CBT) in treating panic disorder to share their clinical experiences about those variables they have found to limit the successful reduction of symptomatology. By

identifying the obstacles to successful treatment, we can then take steps to overcome these shortcomings.

Your responses, which will be anonymous, will be tallied with those of other therapists and posted on the Division 12 Web site at a later time, with links made to it from other relevant Web sites. The results of the feedback we receive from clinicians will be provided to researchers, in the hope they can investigate ways of overcoming these obstacles. We received a total of 326 completed questionnaires. The age range of respondents was indeed wide, ranging from 25 to 81 years of age (with the median of 45 years). There were comparably broad levels of experience; approximately one-third had 10 years of clinical experience or less, and another third had 20 or more years of experience. Therapists indicated that the typical duration of their treatment was between three and six months, although a substantial number of respondents indicated that they saw patients for six months to a year. Consistent with the research findings, 80% indicated that they were successful in using CBT to reduce panic symptoms.

Of all of those patient symptoms that may make treatment difficult, chronicity was reported by 62% of the respondents as playing a major role. Other symptoms that made clinical effectiveness less than optimal included the presence of PTSD, functional impairment, severity, and the tendency to dissociate. There were other patient characteristics that also created clinical problems, such as patients' inability to work between sessions, as well as their unwillingness to give up their safety behaviors. Of particular interest was the report that the complexity of the case makes symptom reduction more difficult, an observation reported in the past by Chambless and Goldstein (1982).

The most typical patient expectations that interfered with treatment were that they would be free of all anxiety, that the therapist would be responsible for making them better, and that medication was needed in order for their symptoms to be reduced. Treatment was also limited in its success if patients believed that their fears were realistic, such as a concern that they might have a heart attack. Therapists reported patient motivation to be a hindrance, with close to 67% indicating that this was problematic at the very beginning of treatment, and also contributed to premature termination.

The patient's social system was reported as an important factor that could undermine successful treatment, such as problems at home or at work. This finding reminds us that if we are to be successful in treating panic disorder, it is important to intervene when necessary in dealing with contextual antecedents and consequences of panic, and the support or interference that significant others may make in the treatment.

Therapists were asked if they experienced any problems and limitations that were associated with the CBT intervention itself. Close to 61% said that not enough information was provided on how to deal with patients' unwillingness to give up their safety behaviors. An interesting finding, however, was that experienced therapists found this to be less of a problem than did therapists with less experience. Still other shortcomings of the treatment protocol were found to be associated with logistical problems that interfered with *in vivo* exposure, the lack of guidelines for dealing with comorbid problems, and difficulties associated with having the patient simulate panic symptoms during the session.

The therapy relationship was also highlighted as a potential source of clinical problems. A little over 60% of the clinicians indicate that they did not think that the therapy alliance was strong enough to bring about clinical change. It was also reported by more than half of the respondents that effectiveness was limited because their patients did not feel that their distress was understood or sufficiently validated. Related to this was the most interesting—and troubling—finding that over 28% admitted that their personal frustration with therapeutic process and their negative feelings toward the patient interfered with successful treatment.

There were some other interesting findings with regard to differences in therapists' experience level, with experienced clinicians being more likely to focus on the resolution of these stressful conflicts in the patient's life that might lead to the panic, as well as on the developmental roots of their panic. Some intriguing research questions are raised here, such as whether experience contributes to clinicians going beyond the treatment protocol, or whether the more experienced clinicians may have had other orientations before learning to make use of CBT.

The findings of the survey are most interesting, and indeed raise as many questions as they answer. However, it should be kept in mind that this is precisely the purpose of the survey, namely to provide

potentially researchable hypotheses that are derived from clinical experience.

This is an overview of the survey findings. The detailed findings appear in *The Clinical Psychologist,* the newsletter of the Society of Clinical Psychology [American Psychological Association (APA) Division 12 Committee on Building a Two-Way Bridge between Research and Practice (2010); *http://www.div12.org/tcp_journals/TCP_Fall2010.pdf#page=10].*

The Next Steps

Although the initiative of building a two-way bridge between research and practice has originally been developed by the Society of Clinical Psychology, it has now been extended to become a collaborative project between the Society and Division 29—The Division of Psychotherapy. Moving beyond the treatment of panic disorder, the next two surveys involve the use of ESTs—in these cases also CBT—in the treatment of *social anxiety* and *general anxiety disorder*. Many of the items included in these two new surveys are the same as those used for the survey on panic, which will allow us to obtain information on clinically based issues that go beyond a given clinical problem.

Your help in making this initiative successful is needed, and I invite the reader to take out approximately10 minutes to complete each of the two surveys. The survey on social anxiety can be found at *http://www.surveymonkey.com/s/6L9CLHN*, and the survey on general anxiety disorder is at: *http://www.surveymonkey.com/s/Z8QPRH7*.

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Update from the Student Representatives

Rebecca L. Brock, *The University of Iowa* and Sara Stasik, *University of Notre Dame*

As your student representatives, it is our job to create a more active student community within SSCP and to help SSCP better serve student interests. We take this role very seriously, and are always looking for ways to create more positive experiences for student members.

In February, we launched a survey to collect feedback from current and recent student members of SSCP. Information collected from this survey helped us to identify several initiatives to pursue during our terms. We would like to take this opportunity to highlight some of our primary goals for the year.

1. **Increasing student listserv membership.** We are working closely with Phil Masson, manager of the student listserv, to reach more student members of SSCP and to encourage them to join the student listserv. The student listserv functions as a forum for students to discuss career, research, clinical, and policy issues. Only students have access to the listserv and it is intended to be a relaxed and informal venue for discussion.

If you are a student member and have yet to **join the student listserv**: Please send a request to Phil Masson at pcmasson@ucalgary.ca to join. Also, we invite you to forward this information to students in your department to ensure that they are aware of this opportunity.

2. **Increasing the utility of the student listserv.** In order to ensure that the student listserv is meeting the needs of its members, we are proud to introduce a new service position within SSCP: *the student listserv facilitator*. The student listserv facilitator will be responsible for posting engaging discussion questions, disseminating information from major organizations such as APA, APS, and ABCT, and facilitating guest discussions. We solicited volunteers for this position via the student listserv and are excited to welcome Kristy Benoit on board!

Kristy Benoit, *SSCP Student Listserv Facilitator*

Kristy is a fourth year clinical psychology student at Virginia Tech, working with Dr. Tom Ollendick. She is broadly interested in childhood anxiety disorders, with more specific interests lying in the areas of the intergenerational transmission of anxiety, parental beliefs and behaviors, information processing biases, and interpersonal factors. As the new SSCP student listserv facilitator, she looks forward to making the listserv a more active and helpful resource for students. Her goal is to make it a place where students can find pertinent information, contribute to and learn from discussions of interest, and more generally, be a part of a wider community of research-oriented clinical psychology students.

3. **Developing the student website and SSCP facebook page.** A large portion of students completing our survey indicated that they were not aware of many of the resources available to them as student members of SSCP. Of those who were aware of these resources, many indicated that they are not particularly useful in their current form. Accordingly, a major goal of ours is to more fully develop the student website and SSCP facebook page so that they include information in line with student interests. Currently, you can find information about opportunities available to you as student members and can access the *Clinical Psychologist Internship Directory*. Be sure to check them out and contact us if you have suggestions to make them more useful!

Student Website: http://sites.google.com/site/sscpwebsite/students

SSCP Facebook Page: http://www.facebook.com/pages/SSCP/333436279606

4. **Addressing the internship imbalance.** Another match cycle has come to a close, and it was devastating for us to see so many of our fellow students not matching to an internship. We can assure you that the SSCP executive board is taking this issue very seriously. As your student reps, we are continuing to serve on an ad hoc internship committee – along with Frank Farach, Ph.D. and Kelly Wilson, Ph.D. – to help address this problem. This past year, we launched a survey soliciting information about possible solutions for addressing the internship imbalance. We had an overwhelming response, and some of the preliminary results of this survey were presented in the last issue of *Clinical Science.* Our next step is to re-launch a revised version of this survey, taking into account the new "Phase II" of the match and the thoughtful feedback that we received from the original survey. Be on the lookout for this in the coming months.

Contact Us!

We would love to hear from you with any suggestions, comments, questions, or concerns regarding SSCP student membership or resources for students.

Becca Brock: rebecca-brock@uiowa.edu **Sara Stasik:** sstasik@nd.edu

Clinical Scientist Training Initiative Winners

The SSCP Training Initiative Committee
Bethany Teachman, Matt Nock, Julie Wetherell, Matt Lerner

The Society for a Science of Clinical Psychology (SSCP) wishes to announce the winners of the first annual "Clinical Scientist Training Initiative" grant program. Applications were invited for small, non-renewable grants for training programs at the predoctoral, internship, or postdoctoral levels to launch new projects or support ongoing initiatives designed to more effectively integrate science and practice into their training program.

Three proposals were selected for funding. Each will receive $1500 to support their project, and the student and faculty developers of the initiative also receive a complimentary one-year Association for Psychological Science membership. Congratulations to this year's winners!

1. **Clinical Science in Practice: Creating a Sustainable Research Database** (*George Mason University Psychology Department):* Purpose: The award will be used to support a graduate student to develop a computer database that will serve both to monitor clinical outcomes and as a research database at the Department's Center for Psychological Services

2. **Provision of Empirically Valid Clinical Supervision** (*Tampa V.A. Hospital*): Purpose: The award will be used to develop and evaluate a region-wide training program in competency-based supervision of clinical psychology trainees

3. **Integrating the Evidence-Based Practice Process into the Training of Clinical Psychologists** (*Northwestern Univ. Feinberg School of Medicine, Department of Psychiatry and Behavioral Sciences, Division of Psychology*) Purpose: The award will be used to develop the infrastructure for students to collect outcome data by purchasing two tablet computers (e.g., iPad) that patients will use in the clinic waiting room. The funds will also be used to educate students in the measurement technology used by PROMIS (*http://www.nihpromis. org/default.aspx*) to assess clinical outcomes.

See the winner's full proposals below. Thank you to all who submitted an application, and please watch for the announcement for next year's award.

Integrating the Evidence-Based Practice Process into the Training of Clinical Psychologists

Northwestern Univ. Feinberg School of Medicine, Dept. of Psychiatry & Behavioral Sciences, Division of Psychology. Contact: Jason J. Washburn, Ph.D., ABPP, Dir. of Education & Clinical Training, Clinical Psychology Doctoral (PhD) Program

The Clinical Psychology Doctoral Program at Northwestern University Feinberg School of Medicine was originally established in 1970 as a practitioner-scientist program with the goal of graduating clinicians who would be proficient in psychoanalytic models of psychotherapy. Over the last ten years, the program has evolved to integrate clinical science and practice. In 2000, the program transitioned from a practitioner-scientist program to a scientist-practitioner program. In 2003, the program began to integrate cognitive behavioral treatment into the then exclusively psychodynamic training model. In 2010, the program hired a new director and adopted an evidence-based practice (EBP) model for clinical training.

Several aspects of the program are in the process of being modified so that they are consistent with an EBP model. We are requesting funds from the *Society for a Science of Clinical Psychology* to assist with integrating the EBP process into one aspect of our clinical training, the Clinical Qualifying Exam (CQE). Our existing Clinical Qualifying Exam (CQE) consists of a clinical case presentation and oral defense, as well as a scientific paper that relates in some way to the case presented (e.g., literature review of the primary disorder). Currently, these two CQE components do not integrate clinical science and practice; we do not require that the clinical case presentation and oral defense even reference clinical science, and the scientific paper is not required to integrate the clinical case.

We propose to integrate the EBP process into students' first clinical training, the CQE clinical case presentation, and the CQE scientific paper. Specifically we propose to train students and their clinical supervisors in the EBP process (i.e., Ask, Acquire, Appraise, Apply, and Analyze and Adjust). This training will coincide with the beginning of our student's first psychotherapy practicum placement at Northwestern Memorial Hospital's Stone Mental Health Center ("Stone"), a state-funded (Medicaid) psychosocial rehabilitation program for diverse, low-income adults with serious and persistent mental illness. Dr. Bonnie Spring, chair of the Council for Training in Evidence-Based Behavioral Practice (www.ebbp.org) and a member of our core faculty, will assist with developing and implementing this training. Students will be required to use and document the EBP process with at least one individual psychotherapy case while at Stone. Documentation of the EBP process will be integrated into both the CQE case presentation and scientific paper.

As part of the "Analyze and Adjust" step of the EBP process, students will be required to routinely assess clinical outcomes with their psychotherapy cases. This proposal requests funds to develop the infrastructure for our students to collect these clinical outcomes. Specifically, we will purchase two tablet computers (e.g., iPad) that patients will use in the clinic waiting room. The iPads will connect wirelessly to the PROMIS Assessment Center (http://www.assessmentcenter.net). We will also use funds to educate students in the measurement technology used by PROMIS (http://www.nihpromis.org/default. aspx) to assess clinical outcomes.

Clinical Science in Practice: Creating a Sustainable Research Database

George Mason Univ. Psychology Dept. Contact: Robyn S. Mehlenbeck, PhD, Director, Center for Psychological Services, Clinical Associate Prof., Dept. of Psychology

Purpose: To enhance the clinical science program and training at the Center, this award will be used to support a graduate student to develop the clinical research protocol and database. IRB approval has already been obtained to collect data from child and adult clients. The goal of the database is to inform clinical treatment, better understand individual differences and therapeutic processes that influence treatment response (from symptom amelioration to psychological and social well-being), and develop a base for future intervention studies in the Center. The database will provide a platform for our program to increase the integration between clinical science and treatment delivery from the beginning of graduate student training.

Background: George Mason University's doctoral program in clinical psychology is in the midst of an active transition from a Scientist-Practitioner model of training to a Clinical Science model. As part of this transition, we have made several changes to the curriculum over the past two years, including the creation of an advanced statistics track, the development of required evidence based clinical practica for our second year students (led by core faculty members), and advanced training in evidence-based treatment for third year students (led by program faculty members) in place of third year "externships" at community sites. Furthermore, all of our recent faculty hires have a strong clinical science focus, and our entire faculty now emphasizes the importance of excellent research and clinical training.

In the last year alone, our clinical faculty (*n*=9) had 44 scholarly articles and chapters published, participated in approximately 13 conference presentations, and were PI's or Co-I's on 13 nationally funded research grants.

We also are imparting this focus to our students, increasing their involvement in translational research and clinical trials. During the past year, our students contributed to 54 conference posters, 18 conference presentations, and 20 peer-reviewed publications. Moreover, three of our five current 3rd-year students have been awarded NIH-sponsored F-31's. One of our four 2nd-year students and two of our seven 1st-year students are currently in the midst of preparing F-31 applications. All of these projects focus on clinically relevant projects, including interventions for inmates to reduce recidivism, acute and chronic effects of nicotine, and daily interactions of military personnel with PTSD and their spouses.

With our increased focus on clinical science, our clinical training places an emphasis on evidence-based practice. In this context, our Center for Psychological Services, a sliding scale fee clinic that serves a diverse community from across Northern Virginia and the District of Columbia, has begun a substantive transformation. This change began with the hiring of Robyn Mehlenbeck as the new Director in June 2010. Arriving from an academic medical center that emphasized clinical science (Brown University Medical School), Dr. Mehlenbeck's goal was to increase the synergy between the research and clinical training in the clinical psychology doctorate program. At our Center, we now offer comprehensive assessments, cognitive assessments, individual therapy, family therapy, group therapy, and couples therapy, each of which is explicitly tied to best practice based on the scientific literature. A new library at the Center includes over 60 treatment manuals for students to reference, and our newly created 2nd- and 3rd-year practica described above are run out of the Center. Our transition has become quickly recognized in the community, as evidenced by our new collaborations with Inova Fairfax Hospital for Children, Inova Behavioral Health, Dominion Hospital and other community based social service agencies. The demand for our services has grown, leading to a wait list for all services offered.

To implement a research protocol in a clinical setting that serves to facilitate treatment using evidence-based assessment techniques, as well as empirically investigate research questions that are key to therapeutic outcomes is the epitome of a clinical science program. Faculty and students alike have already contributed to the questions and assessment measures included in the IRB approved protocol. For example, several students will be examining how treatment affects psychological outcomes beyond symptom reduction and impairment. For instance, one student, in conjunction with his advisor, will be examining how the content of clients life goals change over the course of treatment, and whether they become more approach-focused (e.g., "trying to be a better listener") and less avoidance-focused (e.g. "trying to be less anxious when talking to people"). This study will combine idiographic and nomothetic methods in the context of clinical treatment. Another student has proposed to examine how assessment data and treatment gains differ as a function of client race, ethnicity and SES. Future faculty and students will be able to submit addenda to add to the database as appropriate. Similarly, the database will be accessible to students and faculty and can be used to facilitate new intervention studies to be run out of the Center.

The Clinical Research Database is critical to all of these endeavors. Objective outcomes related to the database include the development of innovative interventions in the Center and community, helping students learn how to best evaluate clinical outcomes, disseminating information to the community on evidence-based practice, and applying for available clinical training grants.

Provision of Empirically Valid Clinical Supervision

Tampa VA Hospital, c/o: Glenn Curtiss, PhD

Clinical psychology is a practice-based science. While the psychological services provided have been fairly well researched and empirically established, the clinical supervision we provide to clinical trainees has historically been provided without the benefit of much empirical guidance.

The purpose of the proposed project will be to develop and evaluate a region-wide training program in competency-based supervision of clinical psychology trainees. The project will foster a science-informed process of supervision that clearly delineates the competencies required for good practice. If funded, we will develop a region-wide training program in empirically-based supervision, evaluate it, and ensure its continuation. The overarching purpose of the project will be to develop and evaluate a self-sustaining network of competency-based supervision for psychology trainees. We will train our trainers and trainees so that the program will have far-reaching impact. This project will enhance clinical science by ensuring that the clinical services we provide both inspire further investigation of supervision practices and perpetuate empirically-based clinical supervision. We believe it is conceptually inconsistent to train clinical students to conduct empirically-based treatments but to supervise those students using idiosyncratic techniques and methods. Doing so merely perpetuates a culture of unscientific practice.

Methods*:* We will host a full day workshop, led by an expert in empirically-based supervision, to train our entire region of psychology supervisors in best practices. Because the purpose of this proposal is "Train-the-Trainer," 70% of the attendees will be designated as future trainers prior to the training. The workshop will focus on 8 key areas:

(1) Review of extant research to define the particular constellation of characteristics that distinguish a good therapist from a good supervisor (e.g., including conflict resolution, disclosure, mentoring, culture, gender, and format)

(2) Outline of a science-informed process of supervision that clearly delineates the competencies required for good practice (in both trainees and supervisors)

(3) Dealing with a supervisee with problematic behavior as defined through the evaluation process, including identification, remediation, addressing of legal issues, dismissal, and preventative strategies.

(4) Ethical values-based practice

(5) Enhancing diversity competence and development of multicultural competence through understanding theories of racial and minority development and assessment techniques.

(6) An overview of the empirical research on alliances, a discussion of the alliance construct, and an approach and technique to address alliance strain and ruptures.

(7) Review of principles derived from positive psychology, informing the learning process and leading to increased competence and self-efficacy

(8) Program evaluation for supervisors

Hypotheses: (1) As compared to the previous year, the total score on the supervisor evaluation form across trainees will significantly increase following the intervention workshop. (2) Ninety percent of trainers will follow through with training their colleagues at their home institutions.

Participants: Dr. Carol Falender is an internationally known expert in competency-based supervision. If funded, Dr. Falender has agreed to come to the Tampa Bay area to conduct a one-day workshop on providing supervision. She is a clinical professor in the Psychology Dept. at UCLA, and a lecturer on supervision, training, and supervision ethics. She is the co-author of Clinical Supervision: A Competency-Based Approach with Edward P. Shafranske, and co-editor of the Casebook for Clinical Supervision: A Competency-Based Approach, both published by the American Psychological Association. She has lectured and published widely on the science behind clinical supervision.

We will have participation from all psychology training programs in our region, including the Univ. of South Florida (graduate program in clinical psychology), Florida Inst. of Mental Health (large regional practicum placement and training site for psychology), Tampa VA (internship and postdoctoral training site), Bay Pines VA (internship and postdoctoral training site), & Gainesville VA (internship and postdoctoral training site). Attendees of this workshop will commit to 'train their trainers and trainees' in the program curriculum.

Highlights of Clinical Science Events at the APS Convention

1. **SSCP Academy Joint Forums on Clinical Science**
   (*Thursday, May 26: International Ballroom East*)
   Perspectives on diagnostic systems (*1:30-3:00pm*)
   Training in evidence-based practice (*3:30-5:00pm*)

2. **Opening Ceremonies**
   (*Thursday, May 26, 6:00-8:00pm: International Ballroom*)
   SSCP Distinguished Scientist Award presented to Richard R. Bootzin

3. **SSCP Membership Breakfast Meeting**
   (*Friday, May 27, 8:00-10:00am: Holmead room)*

4. **SSCP Poster Session**
   (*Friday, May 27, 10:00-11:00am: Columbia Hall, Boards 1 - 52)*
   Following membership meeting

5. **SSCP Distinguished Scientist Award Address, Richard R. Bootzin**
   (Friday, May 27, 3:00-3:50pm: Monroe room)

6. **SSCP Presidential Address, Varda Shoham**
   (*Friday, May 27, 4:00-4:50pm: Monroe room*)

7. **A day-and-a-half of Clinical Science at APS**
   (*Saturday, May 28 and Sunday, May 29*)

SSCP-SPONSORED SYMPOSIA AT THE APS CONVENTION

FRIDAY, MAY 27TH

Symposium: 9:00-10:20am
Individual Differences in Response to Aversive Life Events: Methodological and Theoretical Advances in the Study of Outcome Heterogeneity
Isaac R. Galatzer-Lev, George A. Bonanno, Christopher T. Burke, Zahava Solomon, & Robyn Le Brocque

Symposium: 12:00-1:20pm
Empirically-Based Interventions for Students with Autism Spectrum Disorders: Improving Social Competence from Preschool through Middle School
Amy L. Sussman, Linda R. Watson, Marcus L. Thomeer, James M. Laffey, & Amy M. Wetherby

Symposium: 3:00-4:20pm
Using the Tools of Cognitive Science to Advance Clinical Theory and Practice
Shari A. Steinman, Bethany A. Teachman, Christine B. Cha, Nader Amir, & Richard McNally

SATURDAY, MAY 28TH

Invited Symposium: 9:00-10:20am
What Does the Research Say About the Effect of Openly Gay Service on the Military?
Howard N. Garb, Laura L. Miller, Tobias B. Wolff, & Emily Sussman

Invited Symposium: 10:30-11:50am
Multilevel Phenomena and Multilevel Theorizing
Gregory A. Miller, Michael S. Gazzaniga, & Michael J. Kozak

Invited Symposium: 1:00-2:20pm
Dissemination of Evidence-Based Practice: The Science of Psychotherapy in the Community
Ryan Beveridge, Timothy Fowles, James F. Alexander, Ann F. Garland, Michael S. Robbins, & Varda Shoham

SUNDAY, MAY 29TH

Symposium: 9:00-10:20am
Craving and Consciousness: Theory, Data and Treatment Implications
Reinout W. Wiers, David J. Kavanagh, Katie Witkiewitz, Michael A. Sayette, & Kenneth J. Sher

Symposium: 10:30-11:50am
An Evaluation of a Media-Based Intervention for Military Families With Children
Shelley MacDermid-Wadsworth, German E. Posada, David Cohen, Thomaseo E. Burton, Neelu Chawla, Stephen Cozza, & Lester Patricia