

APA



Division 12

# CLINICAL SCIENCE

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



*Developing clinical psychology as an experimental-behavioral science*

## NEWSLETTER

### FALL 2013: VOLUME 16, ISSUE 3

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Articles published in *Clinical Science* represent the views of the authors and not necessarily those of the Society for a Science of Clinical Psychology, the Society of Clinical Psychology, or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

## PRESIDENTIAL COLUMN

### MICHELLE G. CRASKE PH.D.

### UNIVERSITY OF CALIFORNIA LOS ANGELES

My last column was devoted to ways in which SSCP is actively pursuing its mission of advancing scientific enquiry and fostering the systematic application of principles of behavioral and social processes derived from empirical research in the practice of clinical psychology. To briefly summarize, these include various awards, such as Distinguished Scientist Award, Leonard H. Cohen Outstanding Mentor Award, and the Early Career Research Award, combined with student Dissertation and Poster Awards (which were awarded at this year's APS and are announced in this newsletter), the Clinical Scientist Training Initiative Program, and our scientific research programs at APA and APS. In addition, to support training in intervention science, we have joined with the Academy of Psychological Clinical Science and founding members from the University of Delaware to support the mission of the Delaware Project on Clinical Science Training.

In my final column as President, I would like to discuss another initiative that is consistent with the SSCP mission. Specifically, I refer to the American Psychological Association (APA) initiative to develop Clinical Practice Guidelines. Clinical practice guidelines are intended to improve mental, behavioral, and physical health by promoting clinical practices based on the best available evidence. Such guidelines are needed given the research-to-practice translational gap that results in much of the public failing to receive treatments shown empirically to be effective. What sets the APA initiative apart from the many other clinical practice guidelines that exist is the high standards being used to generate the guidelines to ensure that they are as unbiased and evidence-based as possible. In this regard, the Advisory Steering Committee (of which I am a member) that was formed to guide the policies and procedures for the APA Clinical Practice Guidelines (see Hollon et al., in press, for committee membership and details of policies and procedures) has adopted the standards published by the Institute of Medicine (Institute of Medicine, 2011a, 2011b). According to the Institute of Medicine, practice guide-

line generation involves a comprehensive systematic review of the empirical literature that is presented to a guideline development panel who considers the quality of evidence, the relative benefits and harms associated with the clinical practices reviewed, and patient preferences and then generates recommendations that are informed by the empirical literature but take clinical experience into account. I thought it would be informative to describe the steps being taken by APA as they develop their practice guidelines in accord with the IOM standards, as testament to their science-driven, evidence-based nature. These steps are currently being applied to the topics of depression, posttraumatic stress disorder, and obesity.

The IOM standards for guideline development panels begin with the importance of transparency, so that eventual guideline users can understand the way the recommendations were derived. APA plans to post the processes followed in guideline development on a public website, along with the methods by which guideline development panel members are recruited. Potential conflicts of interest also will be posted so that guideline users can evaluate the perspectives that the panelists brought to bear. Conflict of interest is managed by prospective panelists and members of the advisory steering committee being asked to disclose potential financial, professional and intellectual conflicts of interest during the selection process and during meetings, all of which will be published as part of the final guideline. The composition of the guideline panel will be multidisciplinary, and diverse with respect to theoretical orientation, professional activity (e.g., clinicians and research methodologists), ethnicity, race and gender. The panel also includes pay or patient representatives. The interaction between the guideline panel and the team that conducts the systematic review of the evidence will be limited to reduce the risk of bias; in other words, the systematic review team will meet initially with the guideline development panel to define the scope of the review and then return on an as needed basis to explain the

nature of the findings and to respond to requests for additional information.

The guideline panel will rate their recommendations, based on consideration of the benefits and harms, using a streamlined version of Grading of Recommendations Assessment, Development and Evaluation (GRADE). Strong recommendations indicate that the benefits clearly outweigh the harms (or vice versa), whereas weak recommendations indicate a less clear balance between benefits and harms. The guideline panel will generate key action statements that recommend specific clinician behavior that will allow assessment of implementation. As a method of external review, APA plans to solicit comments from selected external reviewers (e.g., scientific and clinical experts, representatives of federal agencies or professional organizations) and to share drafts of the clinical practice guidelines with the general public during comment periods prior to publication. Finally, the aim is for the guidelines to be updated when there are significant changes in: evidence of benefits and harms; outcomes that are considered important; available interventions; evidence that current practice is optimal; the value placed on different outcomes; or resources available for health care.

The Institute of Medicine standards for conducting systematic reviews represent current best practice in the field. To initiate the systematic review, a team with requisite skills (including expertise in information search and quantitative methods) is assembled and input is solicited from guideline users and stakeholders. APA plans to contract with independent groups experienced in conducting systematic reviews. Disclosure is important for managing bias or potential conflicts of interest and a protocol is developed that includes a detailed description of the objectives and methods that will be followed in the review and a plan for submitting the protocol for independent peer review by outside methodological and content experts. The topic for the systematic review is formulated using an analytic framework that provides a conceptual overview of the questions of interest, including the patient and contextual factors that might influence the outcomes of interest (moderators) and the causally active treatment processes or patient mechanisms (mediators) by which those effects are produced. Then, a

set of structured questions operationalize the analytic framework, and for this purpose, APA plans to use PICOTS, a mnemonic that stands for populations (P), interventions (I), comparisons (C), outcomes (O), time (T), and settings (S). A specific PICOTS question might take the following form: For patients with major depressive disorder (P) is interpersonal psychotherapy (I) superior to treatment as usual (C) in terms of the reduction of acute distress (O) across the course of acute treatment (T) in outpatient settings (S)? The systematic review is then organized around the PICOTS questions.

To find and assess individual studies, an 'information specialist' will conduct a comprehensive systematic search based on explicit inclusion and exclusion criteria to address each PICOTS question. Special attention will be given to minimizing biased reporting of research results, to overcome study publication bias and outcome reporting bias. The IOM standards also address the process of screening and selecting studies, specifying inclusion and exclusion criteria a priori and piloting their use, and using two or more independent screeners. The search strategy will be documented and at least two independent readers will extract key information from each study. The systematic review team will critically appraise each study with respect to risk of bias using standards for evaluating internal validity. APA plans to use the assessment tool developed by the Cochrane Collaboration to assess possible sources of bias in randomized trials (Higgins & Green, 2008): (a) adequate generation of allocation sequence; (b) concealment of allocation to conditions; (c) prevention of knowledge of the allocated intervention (blinding); and (d) methods for dealing with incomplete outcome data. External validity will also be appraised, with regard to the characteristics of the target population, the nature of the interventions used (frequency, duration, and format), and the outcomes measured (what gets assessed and when). Finally, the IOM notes that it is important to assess the fidelity of treatment implementation (i.e., treatment was delivered as intended).

The third step is to synthesize the body of evidence. The IOM recommends using a prespecified method to systematically assess the body of evidence. APA plans to use a simplified version of the GRADE system. The IOM also recommends conducting a qualitative syn-

thesis of the body of evidence as a whole that includes descriptions of the clinical and methodological characteristics of the studies (including whether important subgroups were excluded or included), the strengths and limitations of the studies as a whole, flaws in the design of important studies (or groups of studies) that could bias the results as a whole, and the relevance of individual studies to the primary questions of interest. The IOM also calls for making an explicit decision regarding whether to conduct a quantitative review (meta-analysis), using expert methodologists to develop and execute the meta-analysis. Forest plots and funnel plots will be used to facilitate interpretation of the evidence. The final set of IOM standards concern reporting the systematic review. As recommended, APA plans to use a structured format that includes an abstract, executive summary, and summary written for the lay public.

As can be seen, APA has begun a major undertaking in generating evidence-based clinical practice guidelines that conform to the standards set by the IOM. This initiative will place APA ahead of other practice guidelines by ensuring that the process is guided by the best available empirical evidence and by unbiased evaluation of such evidence. I welcome this APA initiative as I believe it will provide a major pathway through which practitioners will be encouraged to incorporate principles of behavioral and social processes derived from empirical research into their practices.

## References

- Higgins JPT, Green S. eds. 2008. *Cochrane Handbook for Systematic Reviews of Interventions*. The Cochrane Collaboration.
- Institute of Medicine (2011a). *Clinical Practice Guidelines We Can Trust*. Washington DC: National Academies Press.
- Institute of Medicine (2011b). *Finding What Works in Health Care: Standards for Systematic Reviews*. Washington DC: National Academies Press.
- Hollon, S.D., Arean, P.A, Bufka, L.F., Craske, M.G., Crawford, K.A., Galper, D.I., Kivlahan, D.R., Kurtzman, H., Magnavita, J.J., Ollendick, T.H., Sexton, T.L., & Spring, B. (in press). *Development of Clinical Practice Guidelines*. *Annual Review of Clinical Psychology*.

**SSCP APS  
STUDENT POSTER  
AWARD WINNERS:**

\$200 prize and APS  
membership

**CASEY SARAPAS**

*UNIVERSITY OF ILLINOIS AT  
CHICAGO*

ATTENTIONAL CONTROL AS A  
MECHANISM OF UNPREDICTABLE  
THREAT SENSITIVITY

**JENNA D. JOHNSON**

*LINFIELD COLLEGE*

FORCE OF BEAUTY OF OBJECT OF  
DESIRE? THE PRIMING EFFECTS OF  
MAKEUP VIDEO ADVERTISEMENTS  
ON SELF-OBJECTIFICATION IN  
COLLEGE WOMEN

**CONGRATULATIONS!**

**DISTINGUISHED  
CONTRIBUTIONS:**

\$100 prize and APS  
membership

Jennifer A. Silvers, *Columbia Univ*

Merav H. Silverman, *Univ of Minnesota*

Jeanne Savage, *Virginia Commonwealth U*

Benjamin G. Shapero, *Temple Univ*

Jonathan P. Stange, *Temple Univ*

Ashley L. Watts, *Emory Univ*

Laurie E. Steffen, *Univ of New Mexico*

Peter F. Hitchcock, *Drexel Univ*

Samantha L. Connolly, *Temple Univ*

Natasha Tonge, *Children's Hosp Philadelphia*

Elizabeth Raposa, *UCLA*

Elizabeth A. Gordon, *Temple Univ*

Anne N. Banducci, *U Maryland, College Park*

Jennifer A. Hershfield, *Northwestern Univ*

Thank you to the judges: Michelle  
Craske, Lea Dougherty, Sherryl  
Goodman, Richard Heimberg, Var-  
da Shoham, Dave Smith, Bethany  
Teachman, and James Wood.



# SSCP DISSERTATION GRANT AWARD WINNERS



## CONGRATULATIONS!

Dylan G. Gee

*University of California, Los Angeles*

Advisor: Tyrone D. Cannon

Amygdala-Prefrontal Function  
and Clinical Course among Ad-  
olescents and Young Adults at  
Clinical High Risk for Psychosis

Jessica Ribeiro

*Florida State University*

Advisor: Thomas Joiner

Acute Over-Arousal and the  
Acquired Capability for Suicide:  
Understanding Acute Suicide  
Risk through the Lens of the In-  
terpersonal Theory of Suicide

Donald J. Robinaugh

*Harvard University*

Advisor: Richard J. McNally

Constructive Episodic Simu-  
lation of Future Events in Be-  
reaved Adults With and Without  
Complicated Grief



Evan Kleiman

*George Mason University*

Advisor: John H. Riskind

The Stress Generation Theory  
Explains Unanswered Questions  
in Suicide Research: An Inte-  
grated Transactional Diathesis-  
Stress Model of Suicide

## SSCP TREASURER'S REPORT STEWART SHANKMAN, PH.D. UNIVERSITY OF ILLINOIS- CHICAGO

BALANCE as of October 23, 2013:  
\$24, 036.48

### FINANCIAL HIGHLIGHTS:

EXPENSES: Peterson Management Solutions (-\$950.00)

INCOME: Dues from Division 12 (+\$697.50)

PENDING: Institutional Training Grant (\$-1500, University of California, San Diego)

NOTES: *Responses for board election are coming in slowly. A reminder was sent as only around 50% of members and 20% of students voted. I also participated in the Div 12 call that explains how we should do our taxes at the end of the year. The gist of the 25 minute call was a) make sure that the expenses and income add up to your balance at the end of the year and b) get them that information on time.*

## SSCP BOARD DINNER APS 2013



**L TO R: Howard Garb, Victoria Smith, Lea Dougherty, Michelle Craske, Doug Mennin, David Smith, Bethany Teachman, Ian Gotlib, Sherryl Goodman, Lauren Alloy, Richard Heimberg, Flora Garb**

# THE PSYCHOLOGICAL CLINICAL SCIENCE ACCREDITATION SYSTEM (PCSAS)

RICHARD M. MCFALL, PH.D.,  
EXECUTIVE DIRECTOR, PCSAS

Oltmanns and Krasner's (1993) paper on the history of the Society for a Science of Clinical Psychology (SSCP) described how the organization was created in 1966 "during a period of conflict and innovation" by founders who "shared a broad intellectual commitment to the importance of empirical research, its integration with clinical practice, and the central role that science must play in the training of clinical psychologists." Oltmanns and Krasner praised SSCP for providing "a voice for science in clinical psychology and a home for those who are involved in advancing clinical psychology as an applied science." They also noted, however, that in 1993 "Contemporary psychologists are confronted by the same issues that stimulated the formation of SSCP."

It is disconcerting, indeed, to realize that many of the issues and controversies that led to the creation of SSCP still plague clinical psychology even today, nearly 50 years later (Baker, McFall, & Shoham, 2008). SSCP's founders believed "that the scientist and the practitioner not only can be reunited but must be in order to continue the profession of clinical psychology as a viable, useful, and unique one in society." In light of clinical psychology's increasing heterogeneity and the rapidly changing health care system, this assessment by SSCP's founders is even more relevant today. To realize SSCP's mission of transforming clinical psychology into a unified, integrated, science-centered discipline, SSCP and other advocates for a science of clinical psychology must redouble their efforts, build stronger and broader alliances, and mount a more concerted, coordinated, and effective campaign.

Fortunately, SSCP is not alone in promoting psychological clinical science. There always have been advocates for clinical science within the American Psychological Association (APA) and Division 12. The Association for Psychological Science (APS), founded in 1988, has joined the coalition, has assumed a leading role, and has proved to be a staunch and potent supporter of psychological science, including clinical science. The Academy of Psychological Clinical Science (APCS, the "Academy"), founded in 1995, has emerged as yet another ally, supporting the cause from a slightly different angle. That is, whereas the members of SSCP, APA, and APS are individuals, the Academy's members are doctoral programs and internship programs in clinical psychology—currently more than 60—all admitted to membership based on their commitment to clinical science training.

Most recently, in 2007, the Academy launched the Psychological Clinical Science Accreditation System (PCSAS), a new organization dedicated exclusively to the accreditation of science-centered Ph.D. programs in clinical psychology. As the Executive Director of PCSAS, I welcome this opportunity to tell SSCP members about PCSAS, although I suspect many members already are familiar with PCSAS.

I'll begin with a brief overview of the new accreditation system, then summarize PCSAS's accomplishments to date and highlight some of the organization's future directions and anticipated challenges.



Interested readers are encouraged to visit the PCSAS website ([www.pcsas.org](http://www.pcsas.org)) for further information. The website's "Relevant Publications and Links" page offers links to a number of supporting documents, including (a) an explication of the Clinical Science Model of training, and (b) the PCSAS POPP Manual, which provides a detailed account of PCSAS's purpose, organization, policies, and procedures.

### Overview

PCSAS's mission is to serve the public's interest by using the leverage of accreditation to promote superior science-centered doctoral education and training in clinical psychology. Its specific sub-goals are to expand the scientific knowledge base regarding the etiology, assessment, amelioration, and prevention of mental and behavioral health problems; to increase the quality and quantity of clinical scientists contributing to the advancement of public health; to foster accountability and evidence-based practice in public health; and to increase the prevalence and availability of cost-effective mental and behavioral health care. PCSAS accreditation also is intended to serve as a badge of excellence that will help prospective students, policy makers, consumers, and the general public identify high-quality, science-oriented doctoral programs in clinical psychology, and distinguish graduates of these programs from graduates of other types of programs. PCSAS also hopes that it will exert a positive influence on the field, encouraging more doctoral programs to adopt the clinical science model and to strive for excellence.

PCSAS considers psychological clinical science to be an applied science, dedicated both to generating new knowledge regarding the nature of psychological problems and to translating this knowledge into applications that improve the human condition. Therefore, PCSAS's accreditation standards are grounded in the conviction that public health will be served best by clinical psychologists who are trained both as research scientists, capable of using their special knowledge and skills to advance basic knowledge, and as applied scientists, armed with the skills and knowledge to function independently in applied roles—i.e., developing, evaluating, disseminating, supervising, and delivering the most cost-effective, empirically supported interventions, assessments, and prevention services. In effect, PCSAS is dedicated to promoting the ideal—originally envisioned at the 1949 Boulder Conference—of doctoral training in clinical psychology that truly integrates science and practice. Whereas that ideal was merely an aspiration when the Boulder Model was adopted, because the scientific foundations of the field were meager in 1949, major advances in psychological clinical science over the intervening years have made the ideal of integrative training a realistic option.

Students trained in the clinical science model understand that research and application are reciprocally reinforcing and interdependent facets of a fully developed career in psychological clinical science. Clinical scientists are not limited to "either-or" career choices—i.e., science vs. practice, or research vs. application. Their integrative training prepares them to play leading roles in multidimensional careers: promoting adaptive functioning through ethical, cost-effective clinical services that are supported by the best scientific evidence; advancing knowledge through basic and applied scientific research aimed at understanding psychopathology and at improving mental and behavioral health; actively promoting the translation of research evidence into practical health care solutions; educating, training, and supervising others in cutting-edge clinical science; and evaluating and overseeing the delivery of mental and behavioral health care.

Students trained in this ideal model also appreciate that the specialty of clinical psychology cannot survive if it lives in a silo surrounded by a moat. Cutting edge clinical science training requires a breadth of knowledge that taps into the very best theories, methods, and findings from across all areas of psychological science and beyond. Of course, students must be grounded in the core content of clinical psychology (psychopathology, assessment, intervention, prevention, measurement and evaluation), but they also become more powerful and productive scientists with additional hybrid training in such areas as neuroscience, genetics, cognitive science, immunology, pharmacology, epidemiology, behavioral economics, quantitative modeling, social systems, human development. Of course, no single individual can be an expert in all things, so clinical scientists must develop coherent focal domains of expertise, honestly acknowledge their limitations, and then collaborate across traditional boundaries in order to extend the scope and impact of their work.

Just as no individual can be an expert in everything, no doctoral training program can provide high quality clinical science training in everything. Programs are constrained by their faculty's size and expertise; their institution's resources; their context and geographical location; and their students' interests, backgrounds, and abilities. Such constraints also make it unreasonable to expect all doctoral programs to train their students in exactly the same way. PCSAS does not evaluate all applicant training program against standardized criteria with rigidly prescribed course requirements. PCSAS recognizes that there are many ways to skin a cat—for example, that formal courses are not the only way to learn things; that no one way of training clinical scientists has proven to be superior. Therefore, PCSAS's reviewers make qualitative judgments of each applicant program, based on the coherence and logic of the applicant's stated mission, rationale, specific goals, methods, content, structure, resources, and—of utmost importance—training outcomes. Applicant programs are given the latitude to structure their training as they think best, given their local resources and specific objectives, in an effort to achieve PCSAS's shared overarching goal of training first-rate clinical scientists. Of course, the programs are expected to explain their logic and make a compelling case for their choices.

### Operation and Milestones

**Structure.** PCSAS was incorporated by the Academy as an independent, non-profit, non-governmental body dedicated to the rigorous, objective, and empirically based accreditation of Ph.D. programs in psychological clinical science. PCSAS accreditation is awarded only to doctoral programs in the U.S. and Canada that grant Ph.D. degrees in psychology with a core focus on the specialty of psychological clinical science. The programs must be housed in departments of psychology, or their equivalent, within accredited, non-profit, research-intensive universities. The programs also must have a proven track record of successfully providing high-quality research and application training that is thoroughly integrated. The primary index of the quality of training is the historical record of the career paths of the program's graduates.

PCSAS is an independent entity, with carefully constructed firewalls to guard against all undue influences over its accreditation decisions. Although founded by the Academy, the Academy plays no direct role in PCSAS's accreditation process. Academy membership is not a requirement for accreditation; nor is it given weight in accreditation decisions. Similarly, although APS has provided PCSAS with encouragement and support, APS has no ownership stake in PCSAS and no control over its activities, policies, or decisions. Even the PCSAS Board of Directors, which is legally responsible for establishing

the organization's policies, procedures, criteria, and guidelines, has formally delegated the responsibility for all accreditation reviews and decisions to the organization's Review Committee (RC). Thus, although the Board has the legal responsibility of ratifying the RC's decisions, it does this by ensuring the fidelity and integrity of the procedures leading to the RC's decisions; however, the Board cannot overturn the RC's accreditation decisions in individual cases.

PCSAS accreditation is a two-step process. First, interested programs must establish their eligibility to apply by submitting a three page "Letter of Intent," in which they explain how they satisfy PCSAS's eligibility criteria. The letter is accompanied by an Initiation Fee (\$2,000) and a formal agreement to accept PCSAS's accreditation decision. Potential applicants normally are notified of their eligibility decision within a few days of submitting this letter. The next step is submission of the formal application, along with an Application Fee (\$8,000). The Review Committee typically meets in December and May, with submission deadlines of September 1st and February 1st. As part of their review, applicants are site visited by a two-person team. The sine qua non for earning PCSAS accreditation is a clear track record of the program having produced a majority of its graduates over the past ten years who have pursued careers as clinical scientists. This does not mean that the graduates necessarily will be academic researchers; as noted earlier, there are multiple career paths for clinical scientists. PCSAS's eligibility requirements, application procedures, and accreditation criteria are explained in detail on the PCSAS website.

Achievements. Accreditation is PCSAS's sole business. PCSAS started accepting applications in the summer of 2009, and has accredited 21 programs in the U.S. and Canada, with at least five more programs being deemed eligible to apply, and with several more programs indicating strong interest (see Accredited Programs on the PCSAS website). The list of PCSAS-accredited programs, to date, is impressive, and should serve as an attractor, encouraging other high-quality science-centered clinical programs to follow suit.

A major PCSAS goal from the outset was to establish the legitimacy of the new accrediting agency by earning "recognition" from the Council for Higher Education Accreditation (CHEA). On September 25th, 2012, CHEA's Board of Directors voted to grant formal recognition to PCSAS. This decision prompted the Office of Veterans Affairs, in turn, to launch the necessary paperwork to revise its regulations to recognize PCSAS. Until now, the VA regulations have limited access to VA psychology internships and staff positions to the students and graduates of APA accredited clinical programs. The proposed revision is working its way slowly through the system, but it received a boost, in the summer of 2013, when the U.S. House of Representatives passed a funding bill covering the Department of Veterans Affairs for 2014. The bill included unusual instructions, which reflect the growing stature of PCSAS, and which also increase the likelihood that PCSAS will gain recognition in other parts of the federal training structure—e.g., the Department of Defense, NIH, and elsewhere. Specifically, the instructions said: "The Committee understands that the VHA is in the process of modifying its regulations to permit the training and employment of psychologists at the VHA who are graduates of PCSAS-accredited programs, and urges the VHA to promulgate the regulatory changes as soon as possible in order to increase the number of mental health clinicians available to veterans using the VA healthcare system."

From its inception, PCSAS has operated "in the black," thanks primarily to the generous financial support of the Academy, individual donors, and the PCSAS Founders' Circle. Founders' Circle members

are universities that have pledged to contribute \$15,000 per year for five years in underwriting support. To date, the Founders' Circle has 17 members (see Financial Support on the website for a list of contributors). To ensure the accreditation system's financial stability and long-term viability, PCSAS is eager to add new members to the Founders' Circle. If your institution is a potential candidate, please let me know, and I'll be happy to explain what is involved. In addition, PCSAS always is looking for contributions from individuals or other entities committed to promoting psychological clinical science education and training, and to advancing science-centered mental and behavioral health care. PCSAS is a 501(c)(3) corporation, so these contributions are tax deductible, within the limits of the tax code.

Future Challenges. The next major goal for PCSAS will be to gain recognition by the psychology licensing boards within each of the 50 States and the Canadian provinces, thereby ensuring that graduation from a PCSAS-accredited program is accorded equivalent status to graduation from an APA-accredited program in terms of satisfying the educational requirements for license eligibility. This campaign is in the process of being rolled out over time, starting with a small number of promising pilot states. It is expected to gain momentum as it progresses.

Another major goal is for PCSAS to become securely self-supporting through fees and dues by increasing the number of accredited programs. Thanks to the underwriting support received to date, it will be several years before PCSAS must be entirely self-supporting, but programs that intend to apply should not put it off. It is important to act now, rather than delaying, in order to support PCSAS's mission.

Finally, for PCSAS to achieve its long-term mission, it must pursue a vigorous and effective outreach campaign, clearly and convincingly explaining how PCSAS accreditation can contribute to improving the public's health and welfare. This is not a simple story; accreditation too often is dismissed as little more than a parochial turf battle. But PCSAS was not created as an end in itself; it was created for a higher purpose: to improve mental and behavioral health care by improving the scientific education and training—the scientific knowledge and competence—of those who develop, oversee, deliver, evaluate, and refine such care. To explain this mission, PCSAS representatives have published articles; met with the news media; given invited talks and interviews; met with numerous governmental officials and organizations; and corresponded at length with a variety of individuals, agencies, organizations, and foundations. Because it is crucial for PCSAS to define itself, rather than allowing itself to be defined by others, we are eager to clarify any confusion and correct all misinformation regarding PCSAS. Thus, I am grateful to SSCP for this invitation to provide a brief description of PCSAS. I would be happy to answer any questions readers may have, and would welcome the opportunity to visit with any program interested in exploring the idea of applying for PCSAS accreditation ([mcfall@pcsas.org](mailto:mcfall@pcsas.org)).

In general, PCSAS has made remarkable progress, in a relatively short time, in its campaign to advance the fundamental values that it shares with SSCP—namely, “the importance of empirical research, its integration with clinical practice, and the central role that science must play in the training of clinical psychologists” (Oltmanns & Krasner, 1993).

## References

Baker, T. B., McFall, R. M., & Shoham, V. (2008). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. *Psychological Science in the Public Interest*, 9(2), 67-103.

Oltmanns, T. F., & Krasner, L. (1993). A Voice for Science in Clinical Psychology: The History of Section III of Division 12. *The Clinical Psychologist*, Volume 46, Number 1, pp 25-32. (Also see a link to the paper at the SSCP Website).

**About the Author:** Richard M. McFall, Ph.D. is Professor Emeritus, Indiana University Department of Psychological and Brain Sciences, where he was Director of the Doctoral Training Program in Clinical Science prior to his retirement. Since 2008 he has served as Executive Director of the Psychological Clinical Science Accreditation System. His research has focused on developing a social information processing model of social competence and maladaptive behavior. In 2000 he was elected President of SSCP, where his published presidential address (“Manifesto for a Science of Clinical Psychology”) gained considerable attention.



## CLINICAL SCIENCE EARLY CAREER PATHS SERIES I

### JASON PRENOVEAU, PH.D.

When people find out that I began my training as an M.I.T. chemical engineer, they tend to ask how I wound up as a clinical psychologist. When I think about this question, it gets me thinking about balance. One of the main balancing acts during my scientific training and early career has been the balance between focusing on my current passions and openness to exploring new ones. As an undergraduate, I was focused on medical school, psychiatry, and developing a chemical engineering (and biology) background so I could be a psychiatrist who helped to develop novel drugs and drug delivery mechanisms. Although I was not so open to alternate passions or pathways at the time, another form of balance led me to take a job with a big oil company upon graduation: my debt to asset balance!

My plan was to work for a couple years, pay off some college loans, and quickly return to my psychiatry pathway. However, when the time came to apply for medical school, my company offered me a position in Australia. My passion for travel made me open to exploring this new direction, especially since it was only a six-month assignment. I loved Australia, the people I was working with, and my job! My six-month assignment was extended to a year and this was followed by promotion to a position where I would need to stay at least two more years. During this time, my experiences led me to believe that perhaps my passion lay more with psychological science than psychiatry. Although it meant another postponement of my focused plan, I was open to exploring this possibility further and took a position as a research assistant in Dr. John Forsyth's fear and anxiety laboratory.

My experiences in John's lab flamed my passion for basic research in experimental fear conditioning. Openness to exploration had led me to a new pathway: I would become a clinical psychologist and do basic fear and anxiety laboratory research that I could translate to prevention and treatment outcome research. During graduate school, my passion for this research continued to grow under the guidance of Dr. Michelle Craske. Michelle is an amazing role model for any clinical scientist, especially one who wants to do translational research. Although I was focused on experimental fear conditioning, Michelle encouraged me to be balanced and to explore other research directions and opportunities. This helped me to be open to exploring quantitative psychology, specifically measurement and psychometrics.

This openness led to the development of a new passion for me and fortunately I had several wonderful mentors in this area: Drs. Peter Bentler, Steve Reise, and Rick Zinbarg. Further, as I developed my skills in this area, it opened up an additional opportunity: the chance to be a statistics teaching assistant. As a graduate student, I knew that faculty members taught courses, but I had always viewed this as a necessary evil. In order to be able to spend most of my time doing what I was passionate about (research that would contribute to improving people's lives!), I would have to spend a little of my time teaching classes. In fact, while my growing quantitative skills were what provided the opportunity to teach statistics in graduate school, it was my debt/asset balance made me open to accepting the position. I am thankful that I did because it helped me to identify teaching as one of my passions. Although it is likely that I would have learned this later on, coming to this realization in graduate school definitely changed my early career trajectory because it made me open to considering teaching-focused positions instead of only considering research-focused ones.

Although I had wonderful clinical training experiences during graduate school, I was still focused on research more so than clinical work when I was applying for internships. Thus, I was excited about several positions that involved clinical work but were more research focused in nature. However, I included UCLA's counseling center (where I had done an externship) on my list as I had received such great clinical training there. Openness to this possibility resulted in me matching at UCLA's counseling center. The wonderful clinical training I received there has strongly shaped my therapy and supervisory style and helped to awake a passion in me for clinical practice and supervision that I would not have guessed was present. For those of you still in graduate school, I have another note about balance: do not try to balance internship, completing your dissertation, and job searching in the same year! I suspect my internship year would have been much more balanced had I completed my dissertation before internship.

I had to think about a different kind of balance when considering my next step after internship: balancing family and career. Although a post-doctoral position would expose me to new mentors, new research paradigms, and open up a wider range of career opportunities, this would mean asking my wife to move twice more for my career in the coming years. Thus, I decided to go on the job market for a faculty position during internship rather than pursuing a post-doctoral position. Given my graduate experiences, I was open to pursuing my passions for teaching and research at a variety of institutions, not just at an R01 institute, which had been my focus upon entering graduate school. This openness resulted in me interviewing and accepting a faculty position at Loyola University Maryland.

The position at Loyola has helped me to strengthen my teaching skills while developing a number of undergraduate and graduate courses. Although the position is more teaching focused, Loyola does have a strong commitment to student and faculty research. Thus, I have continued to pursue my passion for clinical science by establishing a program of research at Loyola that actively involves Undergraduate, Masters, and Doctoral students. Additionally, I continue to collaborate with several of my research mentors and have established new collaborations with individuals who work at more research-intensive institutions. This allows me to be actively involved in research that is greater in scope than the type of work that could typically be independently conducted by a researcher at a smaller, liberal-arts school. Thus, for me, Loyola has helped me to achieve a great balance between my teaching and research passions.

I am focused on my current classes and research projects, but looking ahead I am staying open to the other possibilities that are out there. For example, I have felt a little out of balance by the lack of clinical work I have been doing in recent years. Thus, I am looking forward to doing more clinical work as well as beginning to supervise student therapists at Loyola's Clinical Centers. I also haven't been out of the country in years and haven't done much to satisfy my passion for travel. Loyola's International Programs have several positions for faculty at different locations around the world. These positions would involve a lot more administration work and less teaching and research. Although I don't think this is the distribution I am looking for, it's hard to know whether or not it will be a good fit for me without being open to trying. So, I am still working to find the balance between focus and openness. I am thankful to have had the opportunity to share some of my training and early career path experiences with you, and wish you all the best in finding the balance that is right for you!

**About the Author:** Dr. Jason Prenoveau is an Assistant Professor of Psychology at Loyola University Maryland. His research focuses on the etiology, phenomenology, and treatment of disorders of anxiety and fear.

## CLINICAL SCIENCE EARLY CAREER PATHS SERIES II

### ROBIN NUSSLOCK, PH.D.

I can recall the moment that I knew with certainty that I wanted to devote my professional career to using the methodologies of clinical science to investigate the nature of human emotion and cognition. I was in my sophomore year at the University of Wisconsin-Madison. In passing I saw an advertisement for an undergraduate research assistant position in Richard Davidson's Laboratory for Affective Neuroscience for a study investigating the effect of meditation on neurophysiological indices of emotion. I was fortunate to be offered the position, and it was at my first lab meeting that my life changed. I observed individuals discussing topics in which I had a lifelong interest from an entirely new perspective. Instead of relying exclusively on introspection, I saw the capability of applying rigorous neuroscientific and clinical methodologies to investigate the mind. I was hooked. I had found my passion and that passion has served as the drive behind my career thus far.

I was fortunate to stay at the University of Wisconsin-Madison for my Ph.D. in clinical psychology where I was mentored by Lyn Abramson and worked closely with Lauren Alloy at Temple University. The University of Wisconsin provided excellent training in clinical scientific research and in thinking as a clinical scientist, more generally. It was also during graduate school that I identified the pillar of my research program. This program involves using multi-modal techniques to examine abnormalities in reward-processing and reward-related brain function in mood and anxiety disorders. This research topic is a perfect fit for me for a number of reasons. First, it is in line with my longtime interest in using contemporary technology to study the mechanisms of human emotion and cognition. Second, it is in line with my goal of translating research on these mechanisms to our understanding of psychiatric symptoms and treatment.

Following graduate school I completed my clinical internship and post-doctoral fellowship in neuroimaging at Western Psychiatric Institute at the University of Pittsburgh Medical Center where I had the pleasure of working with Ellen Frank and Mary Phillips. Western Psych is an ideal clinical science environment. Basic science, translational science, and treatment based outcome research occur in parallel and there are numerous cross-disciplinary opportunities. Furthermore, there is a commitment to training the next generation of clinical scientists in basic research, professional development, and grantsmanship.

I am currently an assistant professor of psychology at Northwestern University. Having the opportunity to develop and manage my own lab has been one of the highlights of my life – albeit a lot of work! Life as an assistant professor affords me many professional opportunities, including research, teaching, and mentoring graduate and undergraduate students. As part of mentoring students, I am frequently asked for input on professional decisions. Throughout the course of my career I have identified four themes that I see as helpful for students wanting to pursue a career as an academic clinical scientist.

First and foremost, find your passion. The happiest and most productive people I know in our field are those who view their occupation as a calling rather than a career. It takes courage to identify your professional passion and to coordinate your life in a manner to pursue this passion. Yet staying close to the initial spark that drew you toward psychology will help you stay motivated over the course

of the journey. For some, this passion may take you toward clinical work, others toward academia, and others perhaps toward public policy or an equivalent. Regardless, if you are being honest with yourself and making decisions accordingly it will be the right path for you.

Second, foster resiliency. Clinical science, and particularly academia, involves a lot of failure experiences. Everyone gets papers rejected, grants turned down, and critical feedback. As one mentor of mine stated, successful academics are like Bobo dolls from the early studies of behaviorism. When they are pushed down they get back up. It is not that they are necessarily more intelligent or more creative. Rather, when they have an inevitable failure experience they are willing to get back up and resubmit the grant or the paper or start a new project or endeavor. Part of 'getting back up' to me at least involves the ability to stay connected to that initial spark that originally drew you toward the field. Thus, big picture perspective is important as it will help you face the inevitable headwinds along the way.

Third, find collaborators. In this day and age it is impossible to be a master of all trades. One person might spend years learning neuroimaging, another learning advanced statistics, and another learning clinical research techniques. Yet highly impactful clinical science is frequently interdisciplinary. Working with collaborators and doing team-based science will allow different skill sets to complement each other for the greater good.

Fourth, have fun. I feel fortunate to be in a profession that is deeply in line with my value system and my life's purpose and passion. Furthermore, many of my closest friendships were developed during graduate school or with my internship cohort. Taking time to enjoy the process with friends and colleagues, to think big and talk about big ideas, and to find ways to stay close to that initial spark that first drew you toward the field will set the foundation for a productive and exciting career as a clinical scientist.

**About the Author:** Dr. Robin Nusslock is an Assistant Professor of Psychology at Northwestern University. His research focuses on abnormalities in reward-processing and reward-related brain function in mood and anxiety disorders.

# STUDENT PERSPECTIVES SERIES I

## THE PSYCHOLOGICAL CLINICAL SCIENCE ACCREDITATION SYSTEM (PCSAS): A RESPONSE TO A GROWING DIVERGENCE IN CLINICAL PSYCHOLOGY TRAINING

YEVGENY BOTANOV  
UNIVERSITY OF KANSAS

Recently, the Psychological Clinical Science Accreditation System (PCSAS) was recognized by the Council for Higher Education Accreditation, marking an important milestone in the training of doctoral level clinical psychologists. Consequently, examination of clinical psychology training and the rationale for the development of the PCSAS are warranted. The first major evaluation of doctoral training in clinical psychology led to the Boulder Conference of 1949, which convened in response to a growing need for a body of regulations to guide training programs. The primary outcome of the conference established the scientist-practitioner model, which posits that professional psychologists should be knowledgeable in both scientific research and clinical practice, and that their professional work should reflect an integration of these two principles. In 1973, the practitioner-scholar model was proposed at the Vail Conference. This was in response to increased concerns from professionals and students alike that traditional university-based scientist-practitioner programs were not providing the appropriate clinical training for professional practice. The practitioner-scholar model emphasized clinical practice above scientific research. Despite these differences, both models strove for the same ideal – to train competent clinical psychologists. However, the aforementioned events may have sowed the seeds for a present day splitting in clinical training.

The training of clinical psychologists experienced rapid growth and transformation in the years following the Vail Conference. Among the changes was a dramatic increase in the number of freestanding professional schools that primarily embrace the practitioner-scholar model, and their graduates began to outnumber those from traditional scientist-practitioner programs. Subsequent research has identified a variety of differences in student characteristics and outcomes between the two program types. For instance, while the number of applications they receive does not differ significantly, acceptance rates for the scientist-practitioner programs are generally four to five times lower (Norcross, Ellis, and Sayette, 2010). Moreover, the undergraduate mean grade point averages and Graduate Record Examination scores of their matriculated students are significantly higher (Templer & Arikawa, 2004; Norcross, et al., 2010). Students from practitioner-scholar programs have larger student-to-faculty ratios, larger cohort sizes, and substantially higher levels of educational debt (Association of Psychology Postdoctoral and Internship Centers [APPIC], 2011). Finally, internship match rates, a particularly important aspect of training, favor scientist-practitioner programs (Parent & Williamson, 2010).

Strikingly, one of the few available measures of clinical competence and training, the Examination for Professional Practice in Psychology (EPPP), shows significant differences between training models. Graduates from practitioner-scholar programs perform worse on the EPPP and have lower EPPP pass rates (Templer & Tangen, 2013). Long-term outcomes also differ as graduates of



practitioner-scholar programs are less likely to receive American Board of Professional Psychology (ABPP) certification, to be president of state psychological associations, or to direct APPIC internship sites (Templer et al., 2000). In response to criticism that factors apart from program type are responsible for these uneven outcomes, Graham and Kim (2011) controlled for characteristics of universities and students and still found significant differences favoring scientist-practitioner programs on internship match rates, ABPP certification, and EPPP scores.

Norcross and colleagues (2010) elegantly underscored the practical and functional differences in clinical training models with the following:

“In the most extreme comparison, students applying to APA-accredited clinical programs face the prospect of 50% acceptance rates and 1% full funding in freestanding PsyD programs versus 7% acceptance rates and 89% full funding in research-oriented PhD programs. Students confront the prospect of 5 years of training with three quarters of their faculty subscribing to psychodynamic, systems, and humanistic theories, on the one end, to 6.2 years with three quarters of cognitive-behavioral faculty, on the other (p. 103).”

Until very recently, the APA was the only federally recognized accrediting body for these two program types despite their diverging philosophies and outcomes.

From a trainee's perspective, the increasing divergence in training and the growth in accredited programs (currently over 230 accredited programs in clinical psychology [APA, 2013]) demand a clearer designation between training models. The PCSAS and the closely aligned Academy of Psychological Clinical Science are attempting to maintain scientific research as a core tenet in the training of clinical psychologists. As stated by the PCSAS, the new accreditation system is not intended to supplant the APA's Commission on Accreditation (CoA) but instead to complement it. Whereas the CoA provides the minimal standards for general training in clinical psychology and supports a variety of approaches to graduate education, the PCSAS can now provide complementary accreditation for minimum standards of clinical science training.

The PCSAS also allows for greater training flexibility for programs that espouse scientifically based training. While the PCSAS does not accredit internships, as discussed by Atkins (Clinical Science, Winter, 2013), it does pave the way for novel and innovative models of science based training of predoctoral interns. Additionally, PCSAS accreditation is fully compatible with maintaining the CoA-standards required for the majority of state licensing boards. Thus, the PCSAS embodies the spirit of the Boulder Conference by supporting the training and licensure of highly competent scientist-practitioners. Additionally, the PCSAS seems well-situated to enable needed change and innovation in response to a continually evolving mental health field and national- and state-level health care reforms (for review, see Hatcher, 2013). In particular, the ongoing emphasis on evidence based practice and continued demand for empirically supported treatments buttress the need for an accreditation system of scientifically based training.

The call for changes in clinical training is not new. Parties with a range of clinical, academic, and political interests have advocated for changes throughout the decades. Indeed, numerous training-focused conferences held between and after the Boulder and Vail conferences have underscored needed reexamination of the pedagogical issues within the field. Among those not addressed in the present article are calls for more stringent APA accreditation standards, for freestanding professional schools to limit enrollments and raise admission standards, for resolution of the “internship imbalance,” for internships to be postdoctoral, and for state licensing boards to eliminate postdoctoral supervised practice as a licensure requirement. While many of these proposed initiatives face difficulties and may never come to fruition, the efforts of PCSAS to promote quality clinical science training constitute one area

of needed change that has been directly addressed.

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**About the Author:** Yevgeny Botanov is a clinical psychology doctoral candidate at the University of Kansas and currently completing a predoctoral internship at Northwestern University Feinberg School of Medicine. His research examines modification of lifestyle factors to treat depression, in particular the role of light therapy, photoperiod, and chronotherapeutics in wellbeing and treatment of affective illness.

## STUDENT PERSPECTIVES SERIES II

### RDoC: REDEFINING MENTAL HEALTH RESEARCH

DYLAN G. GEE

UNIVERSITY OF CALIFORNIA, LOS ANGELES

With the release of the DSM-5 and the increased focus on the Research Domain Criteria Project (RDoC) within the past six months, it is an intriguing time to be a trainee in clinical psychology. On the heels of the DSM-5's publication, the NIMH's announcement that it will fund research according to the RDoC initiative has stirred debate among psychologists. As with any paradigm shift, RDoC raises important questions for the field. How will the principles of RDoC motivate and shape future research? Will RDoC and DSM-5 coexist or compete? What are the implications of RDoC for trainees? A closer look at the RDoC initiative sheds light on these questions and sets the stage for a new era of mental health research.

While the DSM has been called the "Bible" for the field of clinical psychology, our current diagnostic system relies entirely on symptoms and has yet to interface with recent scientific breakthroughs in genomics and neuroscience. Our understanding of mental disorders lags behind that of illnesses such as cancer or heart disease. Despite important discoveries about the pathophysiology of aberrant behavior, biological findings on psychopathology tend to lack specificity, precluding their integration into the DSM. For example, alterations in a given neural circuit often characterize multiple disorders, or they differ among subgroups with the same disorder. In addition to the lack of biological markers that have been identified, heterogeneity within categories and high rates of comorbid diagnoses suggest that discrete categories of DSM disorders as they currently exist do not accurately reflect nature. When it comes to research, grouping all patients with a disorder such as major depression may introduce heterogeneity into the search for biomarkers. On the other hand, separating patients with different disorders, such as schizophrenia and bipolar disorder, may obscure shared genetic risk or relevant neural dysfunction. In this way, despite the utility of the DSM in clinical assessment and treatment, the reliance on its categories for research may hinder progress in identifying biological phenotypes.

In an effort to bridge the gap between advances in scientific methods and classification of mental disorders, the NIMH launched the RDoC initiative to motivate research that will contribute to a "biologically valid" framework for understanding mental disorders. By deconstructing current categories, research can focus on the shared cognitive and biological features that underlie psychopathology. From a dimensional perspective, RDoC focuses on understanding many levels of analysis (e.g., genes, molecules, cells, neural circuits, physiology, behavior, and self-report) that underlie five domains that are central to mental function – negative valence systems, positive valence systems, cognitive systems, systems for social processes, and arousal/regulatory processes. For example, identifying the genetic, neural, and physiological mechanisms underlying deficits in working memory would cut across different disorders characterized by working memory deficits, such as schizophrenia and ADHD. Identifying the mechanisms underlying these more fine-grained constructs offers an innovative approach to elucidating the nature and causes of mental disorders.

RDoC has immediate implications for research in our field, as it redefines the research agenda

supported by the NIMH. While many extant studies have focused on specific disorders, the RDoC framework implies important shifts in study design and conceptualization. For example, now it may be more appropriate to include all patients seeking treatment at a clinic for anxiety, as opposed to separately studying patients with generalized anxiety disorder or specific phobia. Similarly, research on psychosis may benefit from focusing on the broader spectrum of psychotic disorders, instead of uniquely studying patients with schizophrenia and schizoaffective disorder. Another approach may be to select research samples based on biological criteria related to the process of interest. For example, research on neural dysfunction associated with impaired fear extinction might identify participants who surpass a threshold related to amygdala connectivity. In other words, comorbidity is less likely to be grounds for exclusion and may even increase statistical power to answer certain questions within this new paradigm.

In the longer term, the RDoC initiative and the research that it inspires should have important clinical implications for both diagnosis and treatment. DSM-5 and ICD-10 remain the standards for diagnosis but could be informed by RDoC findings in future iterations. Research stemming from RDoC may identify new subtypes of current disorders or even lead to the incorporation of new disorders that cut across current diagnostic categories. As evidence on the relationships between genes, the brain, and behavior becomes stronger, it can be expected to inform future classification systems. In addition, RDoC and its potential to advance clinical science have critical implications for treatment. For example, identifying biological indicators may enhance personalized medicine and provide insight into the best treatment for a given individual. Moreover, randomized clinical trials will increasingly focus on mechanisms, such as a relevant neural circuit, to inform treatment response. Finally, it may yield novel targets for intervention, enhancing the translation of clinical research into practice. At this early stage, the RDoC initiative likely raises more questions than it answers, but the interaction between RDoC and currently prevalent conceptualizations of mental health will undoubtedly lead to a deeper and possibly transcendent understanding of the complex levels of analysis at work in delineating pathways to mental illness.

**About the Author:** Dylan Gee is a doctoral candidate in Clinical Psychology at UCLA. Her interests include the development of emotion regulation and amygdala-prefrontal circuitry as they relate to the onset and course of psychopathology.

## UPDATE FROM THE STUDENT REPRESENTATIVES

VICTORIA C. SMITH, UNIVERSITY OF MARYLAND COLLEGE PARK

KRISTY BENOIT, VIRGINIA TECH

As your student representatives, we would like to take this opportunity to update you on a couple of our recent initiatives.

1. New Website: In conjunction with our communication managers, Carol Chu and Christina Emeh, and our listserv facilitator, Rosanna Breaux, we have created a new home for the SSCP student website at <http://sscpstudent.blogspot.com>. On it you will find announcements, job postings, information on funding opportunities, student articles, the student journal club, and links to resources that we have been developing for students (e.g., past listserv Q&A events, tips on the internship process, etc). Check it out today, and as always, please send us any comments or suggestions you may have!

2. Student Journal Club: Our student journal club is up and running for its second semester. We are currently focusing on articles around the theme of emotion regulation. Pairs of students with similar research interests have signed up to choose an article and jointly present a brief summary and discussion questions. Our new website enables easy posting to facilitate discussion. You can view recent articles and posts at <http://sscpstudent.blogspot.com/search/label/JOURNAL%20CLUB>

If you would like to become involved please email [kristyballen@gmail.com](mailto:kristyballen@gmail.com). We're always looking for new members!

3. Student Social at ABCT: We are in the process of organizing a student social for SSCP student members who will be attending ABCT in Nashville. Our tentative plan is for Thursday, November 21st from 5:30-7:30pm, with free drinks and/or appetizers for attendees. We are still working out the details of the location. In addition, we are excited to announce that due to the great generosity of Alan Kraut, the Executive Director of APS, we will be offering 5 randomly chosen door prizes of 1 year complimentary membership in APS, good through December 2014 (whether you are a current APS member or not). Also, bring along your non-SSCP friends so we can share with them the benefits of student membership, and we will hand out an additional door prize of complimentary 2014 SSCP student membership to one of them. Stay tuned to the student listserv for more details and information on how to RSVP. We look forward to seeing you there!

### Follow us on Social Media!

[https://twitter.com/\\_SSCP](https://twitter.com/_SSCP)

<https://www.facebook.com/pages/Society-for-a-Science-of-ClinicalPsychology/333436279606?ref=hl>

### Contact Us!

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

Kristy Benoit: [kristyballen@gmail.com](mailto:kristyballen@gmail.com)

Victoria Smith: [vsmith@umd.edu](mailto:vsmith@umd.edu)



## **WORKING FROM WITHIN: AN EVIDENCE-BASED PRACTICE APPROACH TO BRIDGING RESEARCH AND PRACTICE IN CLINICAL TRAINING PROGRAMS**

An evidence-based practice (EBP) approach to clinical psychology refers to the integration of the best available research with clinical expertise and client values and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). There has been a growing discussion in the field regarding what constitutes an EBP approach and how to implement it in pre-doctoral clinical training programs (Bauer, 2007; Beidas & Kendall, 2010; Collins, Leffingwell, & Belar, 2007; Spring, 2007). This is a relevant imperative, as EBP places intrinsic value in conducting clinically relevant research as well as empirically informed clinical work that is responsive to client and therapist variables and their interaction. In other words, an EBP perspective values both research and practice. Accordingly, adopting an EBP framework as a heuristic for research and clinical training could reduce the potential for polarity within and between emerging clinical scientists who are the future of the field.

Toward this end, the APA Division 12 Committee on Science and Practice spearheaded a special section devoted to “Bridging the Gap between Science and Practice” that was published in *Psychotherapy* (2012, Volume 49, Issue 2). One article focused specifically on this training context of EBP and provided suggestions for curriculum development, practicum, and clinical supervision across the main EBP components, that is, the integration of (1) research evidence, (2) clinical expertise, and (3) client values and preferences (Hershenberg, Drabick, & Vivian, 2012).

Modeling the value of empiricism, we are currently conducting a survey to systematically assess the extent to which (1) trainers and trainees agree with various views regarding the integration of EBP in clinical training, (2) programs might already implement some of these suggestions, and/or (3) trainers and trainees find these suggestions feasible. It is our intention that trainers and trainees at various developmental stages take this survey, including directors of clinical training, graduate students, interns, postdoctoral fellows, and supervisors across training sites.

We are excited about the opportunity to conduct this survey as a follow-up to the Hershenberg et al. (2012) training article, particularly given that there may be different views on how/whether to embrace an EBP approach to clinical training, as well as discrepancies between what might work “in theory” (i.e., high rates of agreement) versus what is actually practical (i.e., low rates of feasibility). There is also a chance that those in leadership roles (e.g., directors of clinical training and/or psychology training clinics) might over-estimate – at least compared to trainees and supervisors - the extent to which programs currently implement these practices.

Gathering these data will hopefully provide us with ideas on ways to best move forward and ease some of the tension that exists within our field. We are optimistic about the potential for an EBP approach to training to do just that.

You’ll find the survey announcement and link on the next page.

Rachel Hershenberg & the APA Division 12 Committee on Science and Practice: Deborah A.G. Drabick, Peter Norton, Denise Sloan, Cynthia Suveg, and Dina Vivian

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## SURVEY REQUEST

We are gathering information about Evidence-Based Practice Models for pre-doctoral psychology training programs. Consistent with EBP and obtaining the best available research, the goal of this survey is to systematically assess clinical trainers and clinical trainees' agreement and current involvement in EBP practices, particularly those suggested by Hershenberg, Drabick, & Vivian (2012), *Psychotherapy*, 49, 123-134 in a special section dedicated to bridging the gap between science and practice.

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

The survey takes about 15 minutes. The survey is anonymous and is approved by the IRB of Stony Brook University.

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

If you would like to participate in this study, click on the link below:  
<https://www.psychdata.com/s.asp?SID=153287>

Rachel Hershenberg, Ph.D.

Dina Vivian, Ph.D.

APA Division 12 Committee on Science and Practice

## **CONSORT-SPI: CONSOLIDATED STANDARDS FOR REPORTING TRIALS FOR SOCIAL AND PSYCHOLOGICAL INTERVENTIONS**

**Get involved in the development of a new reporting guideline for social and psychological interventions!**

**An international initiative of researchers, journal editors, and stakeholders in intervention studies is working with the Consolidated Standards for Reporting Trials (CONSORT) Group to develop CONSORT-SPI: an official Extension for Social and Psychological Interventions.**

**We are currently looking for interested stakeholders to help with the development of the guideline. Stakeholders involved in researching, publishing, funding, commissioning, or providing these interventions are invited to contact us to participate.**

**Please email the Project Executive at [CONSORT.study@spi.ox.ac.uk](mailto:CONSORT.study@spi.ox.ac.uk) or complete the CONSORT-SPI participant form if you are interested!**

**<https://docs.google.com/spreadsheet/embeddedform?formkey=dEVveENpTEFwbFV0dDFUWktBN1N1eUE6MQ>**

**Further information about the project, please read this recent manuscript in *Journal of Child Psychology and Psychiatry*:  
<http://onlinelibrary.wiley.com/doi/10.1111/jcpp.12106/abstract>**