



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 2006 Issue

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### INSTRUCTIONS FOR AUTHORS

*Clinical Science* is published as a service to the members of Section III of the Division of Clinical Psychology of the American Psychological Association. The purpose is to disseminate current information relevant to the goals of our organization.

**Feature Articles** may be submitted to the editor via e-mail. They should be approximately 16 double-spaced pages and should include an abstract of 75- to 100- words.

**Brief Articles** may also be submitted, and should also include a 75- to 100-word abstract.

All articles should be submitted as an attachment to an e-mail and formatted according to the *Publication Manual of the American Psychological Association, 5th edition*.

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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.

## President's Column:

**Antonette M. Zeiss, Ph.D.**  
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This will be my last column as President of SSCP. Dan Klein will begin his Presidency on January 1, 2007, and I will stay on the Board as Past-President for one more year. Jack Blanchard will leave the Board, after serving three years as President-Elect, President, and Past-President. Jack has been an active and effective advocate for SSCP throughout his term, and we will miss him.

My first two columns covered how the principles for which SSCP stands have served me well in thinking about how to influence policy and program development on a national level, in my role as Deputy Chief Consultant for Mental Health in VA Central Office. This last column completes that discussion, drawing on material from my Presidential address at the APA conference in New Orleans in August. My purpose is to emphasize the kind of impact that SSCP members can have in championing the implementation of a science-based approach to mental health care; each SSCP member has a unique forum for efforts toward that goal.

In my last two columns, I described VA's efforts to implement the President's New Freedom Commission on Mental Health Report throughout the VA system, based on a comprehensive Mental Health Strategic Plan. That plan has over 260 action items; within those items, four large categories can be identified that give a sense of VA's priorities. First, we have been committed to filling gaps in mental health and substance abuse care, so that an adequate quantity of service is available with some consistency across the country. The other three categories emphasize quality of services. The strategic plan is intended to guide transformation of the system to support a Psychosocial Rehabilitation model with a Recovery orientation, an approach well supported by research on improving function in individuals with serious mental illness, moving beyond a focus solely on reducing symptoms. The strategic plan also emphasizes developing a care system that integrates primary care and mental health care. The research evidence for this also is strong, particularly with older adults. Finally, each of the other three goals is intertwined with the overarching goal of providing evidence-based care and speeding the translation of research evidence into clinical services for those seeking mental health care.

I also have laid out a model for understanding the process of changing a system, based on an empirical model (Moulding, Silagy, & Weller, 1999). That model lays out five steps toward systemic change:

1. Assessment of stage of readiness to change of practitioners or population
2. Assessment of specific barriers to guideline use (or more generally, to adoption of an evidence-based guide to service provision)
3. Determination of appropriate level of intervention to change the system
4. Design of dissemination and implementation strategies to create systemic change
5. Evaluation of the implementation strategies to determine impact on the system

In this final column, I want to address the last issue, i.e., how a data-driven evaluation system can be used to support change toward utilization of evidence-based practices. The purpose of this step is to ensure that change efforts result in more effective care.

VA has a systematic approach to measuring the impact of systemic changes and uses those data to guide continuing efforts. There are several components, but key are system-wide Performance Measures. These Performance Measures are set as policy at the VA Central Office level and are applied system-wide with specific, mandated targets for performance level. Meeting the targets on the Performance Measures determines the level of bonuses received by VA managers at regional levels, so they have salience and they do affect the behavior of managers.

Specific Performance Measures are selected to capture high priority areas of service delivery, and mental health is well represented. Thus, whatever the level of personal commitment of managers to supporting mental health services, it is clear and obvious what their systemic responsibilities are, and there are meaningful personal consequences to ensuring effective mental health service delivery. In addition to monetary consequences, Performance Measure outcomes are made available across the system, so regional managers can see how they are doing compared to other parts of the VA system, and know that all other managers – and line staff – can see it, too. Data

obtained also can be used at the Central Office level to target regions that may need more resources or other interventions to bring them up to the expected level.

Mental health Performance Measures are diverse. Some support closing gaps and ensuring consistent availability of care. For example, one measure mandates that at least 10% of all visits will be for mental health services in VA Community Based Outpatient Clinics (CBOCs) that serve at least 1,500 unique patients. The current target for acceptable performance is for 90% of the CBOCs in each VA region (the level at which managers are assigned) to meet this target. When this measure was first used in 2004, 73% of CBOCs across the country met the target. By the most recent data collection, in September, 2006, 92% of CBOCs nationally were meeting the criterion. Some of that change has come about because my office used data to target failing regions and provided funding for additional mental health staff. Managers were motivated to make use of those funds because of their own need to improve performance and meet their goals.

That Performance Measure speaks especially to the quantity of care provided. Other measures speak to quality of care, based on research evidence. For example, there are measures for several mental health problems that follow the progress in addressing mental health concerns, beginning with ensuring routine screening, ensuring that positive screens are evaluated and a diagnosis is made, ensuring that treatment is initiated when there is a mental health diagnosis, and ensuring that treatment is sustained at the level expected for efficacious care. For example, for veterans identified with substance abuse problems, one Performance Measure mandates the frequency of follow-up visits, within a specific time period, in order to promote a level of care known to be related to positive treatment outcomes. Similar measures exist for depression care, for treatment of serious mental illness (such as schizophrenia or bipolar disorder), and in providing care for homeless veterans. As with the data for the per cent of visits in CBOCs devoted to mental health care, all performance measures show change across the nation over the period of just a couple of years. VA has followed the change model: needed changes have been identified using evidence as much as possible, strategies for change were developed, and those strategies have been implemented. The evaluation process could be said simply to capture the impact of those steps, but it also can be argued that the frame in which evaluation is done and the public uses of evaluation also are a mechanism of change in their own right.

Another tough challenge in VA is determining how to measure the fidelity of treatment offered as we promote

such as Cognitive Processing Therapy for PTSD or Cognitive-Behavioral therapy for depression. There are almost 2,000 Psychologists providing care in the VA system, along with a similar number of Psychiatrists, more Social Workers, and many Psychiatric Nurse providers. Training to be provided in evidence-based psychotherapy will be extensive, including not only didactic training but also ongoing supervision, including review of tapes and consultation at important decision points. During training, we can include measures of fidelity, although not as complex as those used in limited efficacy trials. How to ensure that ongoing therapy remains faithful to good clinical protocols, rather than drifting over time, is a very tough problem.

That's not solely a VA problem, though – it's a problem about all clinical service provided. Even when graduate students are trained to a very high level of skill in an evidence-based approach, there are no current systems to ensure that they continue to use those skills over time. Continuing education as it is currently understood has limited relevance to that issue. SSCP members have strongly advocated that CE credit should only be offered for training based on research evidence, and I support that. In some ways it is a side issue, since other evidence suggests that attending a CE workshop has little or no actual impact on care subsequently provided. I challenge SSCP and Division 12 to continue to think about how CE should be structured such that it actually changes behavior and increases the likelihood of either learning and using new intervention skills (based on research evidence, of course) or sustaining ones learned while still in supervised training.

In each previous column, I have invited members to think about actions SSCP could promote to meet its goal of "establishing public policy." How can we implement the shared ideal that scientific principles should play a role in establishing public policy for health and mental health concerns? I have enjoyed sharing what I am trying to do to accomplish that, within the context of the only national health care system in the United States. While I hope that information contributes to the growing national recognition of the strength and effectiveness of VA care, that is not my primary purpose. My primary goal has been to show how my efforts within the VA system have been guided by a great philosopher of change, Gandhi, who said, "Be the change you want to see in the world." I challenge and encourage all SSCP members to look at their own careers and challenges and take that message to heart.

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## Feature Article:

# The Quest for a Science of Clinical Psychology: A Progress Report\*

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The Society for a Science of Clinical Psychology (SSCP) was founded for the express purpose of promoting clinical psychology as an experimental behavioral science. It seems appropriate, therefore, to take this occasion to examine how this important quest is faring. In general, the news is both good and bad. The bad news is that, considering the field as a whole, the scientific foundations of clinical psychology seem to be eroding. The good news is that, within a select segment of the field, the scientific foundations seem to be stronger than ever. Thus, the field seems to be going in two different directions at once. It is fractionating and morphing, with the eventual outcome still uncertain. Nevertheless, in my view, there is reason to be optimistic about the long-term prospects for the success of the quest to build a science of clinical psychology. Here is my assessment:

### **First, the Bad News**

Clinical psychology no longer makes any pretense of being a unified field. Today there are three distinct training models, each recognized as legitimate by the Committee on Accreditation (CoA); each with its own vision, philosophy, and set of goals; and each laying claim to the label "clinical psychology." The boulder model, which has been around since the 1940s and is the model adopted by most doctoral training programs, is aimed at training Ph.D. *scientist-practitioners* for careers in both research and practice (Baker & Benjamin, 2000). Thus, all graduates from boulder model programs presumably have been trained as scientists, although most actually pursue careers as practitioners and do little if any research beyond their dissertations. In sharp contrast is the model associated with the Psy.D. degree. This model, which emerged in the late 1960s, makes no claim of training research scientists; rather, it is focused explicitly on training *practitioner-scholars* exclusively for careers as practitioners (Peterson, Peterson, Abrams, & Stricker, 1997). Finally, there is the clinical science model, which actually has been around as a variant of the boulder model since the inception of the field, but became a distinct training model only in the mid-1990s. It has much in common with the boulder model, but is focused more narrowly on training Ph.D. *clinical scientists*

for careers devoted primarily to translational research aimed at advancing both basic knowledge and applied methods relating to the etiology, assessment, prevention, and treatment of mental and behavioral health problems (McFall, in press).

The fact that all three models claim to represent clinical psychology, yet offer differing visions of the field, has created a climate of confusion and tension. Essentially, the proponents of these three models are vying for control over the identity and future of the field. The differences between Ph.D. and Psy.D. training, in particular, are more than mere differences in emphasis; they involve fundamental issues, include critical epistemological differences on such matters as the rules of evidence, or how to decide whether something is valid or true. Furthermore, clinical psychologists from these different perspectives no longer can agree about what constitutes good science. Advocates of the Psy.D. perspective believe that traditional empirical approaches to science, as taught in most Ph.D. programs, are flawed and have been discredited. These advocates distrust nomothetic generalizations and espouse instead a more idiographic, "local clinical scientist" approach to knowing that relies heavily on clinical judgment and experience.

To help put this internal struggle among clinical psychologists into perspective, it is useful to look at recent data on the workforce in clinical psychology (APA Research Office, 2005). Of the roughly 100,000 individuals with doctorates across all areas of psychology, 75% are employed full time, the majority (40%) either being self-employed or working in for-profit settings. Surprisingly, over 40% of the employed psychologists are working in positions not directly related to psychology.

At the dawn of clinical psychology as we know it, following World War II, there were only about 4000 Ph.D. psychologists of all types in the United States. Doctoral training in psychology soon experienced a remarkable period of growth, with the number of doctorates awarded annually nearly doubling between 1970 and 2000, for instance. But



the production of Ph.D.s stabilized in the 1980s, with approximately 4000 Ph.D.s awarded annually between 1988 and 2001, nearly half in clinical. Significantly, however, over that same period the production of Psy.D.s was increasing by 169%! In terms of sheer numbers, science-based training, as provided by boulder model and clinical science model Ph.D. programs, began losing ground to practitioner-only Psy.D. training, with its non-research focus and non-traditional epistemology.

Meanwhile, workforce analyses (Robiner, 1991; Robiner & Crew, 2000; APA Task Force on Workforce Analysis, 2004) began to warn about a growing overproduction of doctoral level practitioners in clinical psychology, relative to the demand for such practitioners. This widening supply-demand gap, was being exacerbated by a national trend for social workers to displace doctoral level psychologists as the primary providers of mental health services. In 1991, for instance, masters level social workers were providing only 5% of all mental health services; by 1997, they were providing 56% of such services (Clay, 1998). Despite clear evidence of a growing supply-demand mismatch, and a consequent shrinkage in the job market for doctoral level clinical psychologists as service providers, Psy.D. doctoral programs have continued to train practitioners at an accelerating rate.

In general, the growth in practitioner training over the past thirty years is due to the increased number of doctoral training programs in clinical psychology, but in particular it is due to the growth in Psy.D. (non-research) training programs. According to the APA Office of Program Consultation and Accreditation (2005), of 227 doctoral program in clinical psychology accredited by the CoA, 112 were accredited for the first time since 1980—that is, *after* the demand for such training had started to decline. Psy.D. programs currently represent about 25% of the accredited clinical programs, yet they account for roughly 42% of the health-service doctorates in psychology. Thus, they are producing a disproportionate share of the doctorates. Moreover, despite the declining demand for doctoral level clinical practitioners in psychology, the number of accredited Psy.D. clinical programs has been growing at an accelerating rate. There were only four accredited Psy.D. programs in the 1970s; 14 new programs were accredited in the 1980s; another 22 were accredited in the 1990s; and 17 more were accredited between 2000 and 2005. This expansion of Psy.D. training has taken place primarily outside the traditional university setting, in “free-standing” for-profit programs. As long as there is a pool of applicants willing to pay the tuition and fees, these programs may have little incentive to limit their production of Psy.D. psychologists, even though few good job opportunities may await their graduates.

Studies comparing practitioner-oriented Psy.D. programs to research-oriented Ph.D. programs have led one of the

architects of the Psy.D. model to raise serious concerns about quality control in some Psy.D. training programs (Peterson, 2003). Here are some of the worrisome data, as distilled from several sources (APA Research Office, 2005; Cherry, 2000; Maher, 1999; Norcross, Castle, Sayette, & Mayne, 2004; Peterson, 2003; Yu, Rinaldi, Templer, Colbert, Siscoe, & Van Patten, 1997): Psy.D. programs, as a group, are less selective in their admissions than Ph.D. programs, accepting a mean of 50% of their applicants, compared to an acceptance rate of 11% in Ph.D. programs. On average, the Psy.D. students have lower mean GREs and GPAs than the Ph.D. students. Psy.D. programs have larger class sizes than Ph.D. programs (means of 48 and 9, respectively). Psy.D. programs also have fewer full-time faculty than Ph.D. programs, yielding a student-faculty ratio nearly twice that of Ph.D. programs. There is a negative correlation between the quality of the faculties in Psy.D. programs and the number of doctorates they produce. Psy.D. programs provide lower levels of financial support and have higher costs than Ph.D. programs, resulting in Psy.D. students carrying much higher average debt loads than Ph.D. students. Although Psy.D. training programs are supposed to free students from the demands of research training so they can devote more time to practice activities, Cherry et al. (2000) found that scholar-practitioner students in Psy.D. programs actually gain less practical experience than Ph.D. students in either boulder model or clinical science programs. Finally, Yu et al. (1997) found that graduates from Psy.D. programs earn lower mean scores on state licensing exams than graduates from Ph.D. programs. While it is impossible to disentangle cause from effect in such data, the overall picture certainly is not flattering to Psy.D. training programs.

The growth in Psy.D. training and the associated concerns over quality control seem to have exerted a subtle, but detrimental influence on the CoA's accreditation guidelines, procedures, and decisions. This effect is understandable, given the CoA's difficult task of ensuring that all accredited training programs—especially the new, non-conventional Psy.D. programs—are providing their students with “broad and general” training in psychology. The CoA must perform this task in a way that will withstand judicial review if there are any future lawsuits. Such pressures seem to have pushed the CoA away from making crucial qualitative judgments; instead they increasingly are relying on more easily quantifiable accreditation criteria, such as standardized checklists of required courses, content areas, and hours devoted to applied training experiences. These criteria may be easier to apply and defend, but they also tend to be less relevant indices of how well individual programs are able to provide high quality doctoral training, particularly science training, that will prepare them for meaningful careers that contribute to advancing the field and improving the human condition. Paradoxically, this push toward standardized checklist criteria has been taking

place at the same time as—and perhaps in response to—clinical psychology's growing fractionation along the fault lines that separate the three training models.

The faculties at many research-oriented Ph.D. clinical programs complain that they must sacrifice good science training in order to satisfy the CoA's less meaningful, more standardized requirements. This sacrifice not only undermines high quality research training, but erodes the scientific foundations of the field. Indeed, growing discontent with the current accreditation system and with its likely impact on the field was a significant factor leading to the convening of a 2005 summit meeting on accreditation held at Snowbird, Utah, and attended by representatives from all interested groups. The Snowbird Summit produced a draft proposal for a number of major changes in the accreditation system (Schilling & Packard, 2005). However, some of the proposed changes have been criticized by many research-oriented psychologists as moving in the wrong direction and failing to promote and protect science training. Such discontent has prompted a group of research-oriented clinical training programs to develop an independent accreditation system for programs committed to training clinical psychologists as scientists. While the outcome of this new accreditation movement is uncertain, it is another reflection of the underlying tensions within the field.

Perhaps the most discouraging news is that advances in scientific knowledge and in empirically grounded methods relating to the etiology, assessment, prevention, and treatment of mental and behavioral health problems have had so little impact on the quality and availability of optimal care in the mental health system. Many of the treatments that have been shown in controlled research to be efficacious for specific disorders still are not available to most of the individuals seeking help from clinical practitioners. This fact exposes the disturbing disconnect between research and practice—a disconnect that clearly is detrimental to the public's health and well-being, but that seems resistant to remedy, despite the efforts of the National Institutes of Health and other agencies that have been funding mental health research for so many years.

### **Now, the Good News**

From the analysis thus far, one might be tempted to conclude that the quest to build a science of clinical psychology is failing. But the news is not all bad. Despite serious problems within the broader field of clinical psychology, a subset of clinical researchers has been making solid scientific progress on a number of fronts. They have been illuminating the etiology of clinical disorders, improving the validity and utility of clinical measures and methods, developing an array of effective clinical interventions, translating basic psychological knowledge into promising solutions for applied clinical problems, building bridges to other areas of psychology

and other scientific disciplines, working toward a conceptual integration across levels of analysis, and incorporating all of these advances into the training programs for the next generation of clinical scientists. To document each of these generalizations would be impossible, given the present space limitations, but examples can be found by perusing the latest research reported in any of the leading clinical research journals, such as [Journal of Abnormal Psychology](#), [Journal of Consulting and Clinical Psychology](#), or [Psychological Science in the Public Interest](#).

Along with SSCP, the Academy of Psychological Clinical Science (APCS), founded in 1995, has played an important role in furthering the quest for a science of clinical psychology. Whereas SSCP's membership is comprised of individual clinical scientists, APCS's membership is comprised of university-based Ph.D. training programs in clinical and health psychology (45 currently) and research-oriented clinical internship training programs (9 currently). APCS's mission is to advance psychological clinical science through training; research and theory; expanding resources and opportunities; application; and dissemination (see <http://psychclinicalscience.org> for APCS's history, mission, and membership). Among other things, APCS has taken the lead in the effort to develop an independent accreditation system for research-oriented doctoral training programs.

Unquestionably the most powerful force behind improving the scientific foundations of clinical psychology has been the advent of managed care in public health. Mental health represents less than 10% of the total health care budget in the U.S., but it is being swept along with the rest of the health care system in the managed care revolution. The changes in health care are being driven largely by marketplace economics, with its emphasis on the core concepts of market competition, accountability, and cost effectiveness. Admittedly, these underlying concepts sometimes have not been applied in the most appropriate and sensitive ways, but in principle they should be congruent with the ideals behind the quest for a science of clinical psychology. Managed care may prove to be psychological science's most powerful ally.

In a managed care system, for example, cost-effectiveness reigns. If masters level social workers show that they can provide essentially the same services as doctoral level psychologists, but at a lower cost and with comparable results, then they will prevail in this new competitive marketplace. With increased accountability, mental health practitioners will be reimbursed for services only if they can justify their treatment decisions and track their treatment outcomes. The ideal managed care system, like science, is driven by evidence. The impact of this new reality is reflected in the APA's recent adoption of a presidential task calling for psychologists to use "empirically supported

treatments”; instead, it redefines “evidence” so broadly—including a heavy emphasis on clinical judgment, which research repeatedly has shown to be of questionable validity (Garb, 2005)—that it does little to constrain the current activities of most clinical practitioners. But the fact that professional psychologists are talking about “evidence” is evidence that the contingencies of managed care are starting to influence their language, if not yet their professional practices.

Research-oriented psychologists have tended to look the other way, or to wink, when their colleagues have engaged in questionable professional activities for which there was little or no empirical support. Fortunately, under the strictures of the managed care environment, it is becoming more acceptable to challenge colleagues’ activities. Bickman (1999) did this in an article titled, “Practice makes perfect and other myths about mental health services,” in which he identified six commonly held beliefs among clinical psychologists that research evidence has exposed as myths. He said it is a myth to believe that effective mental health services are assured by (a) clinical experience, (b) degree program training, (c) continuing education, (d) licensing, (e) accreditation, or (f) clinical supervision. Research evidence challenging many common clinical practices and beliefs has been available for years—e.g., Meehl’s (1954) classic book on clinical vs. actuarial prediction—but psychologists increasingly seem to act on their ethical obligation to let the scientific evidence guide their professional behavior. This is an encouraging, if long overdue trend, which is helping to reinforce the scientific foundations of the field.

In this spirit of critically examining cherished professional beliefs and activities, and being willing to go wherever the evidence takes us, clinical psychologists need to reevaluate the designs of both the mental health care system and doctoral training programs. Specifically, the current mental health system is *credential based*, meaning that, by law, only individuals with specific credentials—i.e., a degree, experience, a license—may provide mental health services. Once individuals have acquired these credentials, however, they are free to practice as they choose, with almost no accountability. But if a provider’s degree, experience, and license do not predict treatment outcome, as Bickman’s (1999) review indicates, then does it make scientific sense for the mental health system to be credential based? If the most critical determinant of treatment outcome is the choice and administration of an appropriate procedure to deal effectively with a given clinical problem, then this suggests that the mental health system probably should be *procedure based*, rather than credential based, as is the trend in medicine. After all, isn’t it our primary professional obligation to ensure that clients receive the most effective procedures available for their problems, and to ensure that these procedures are delivered with the highest fidelity and at the lowest cost, even if this means

that doctoral level psychologists do not deliver those procedures? Shouldn’t we design the system based on the evidence, rather than designing it to serve personal or guild interests? In such a mental health care system, perhaps the most important role for doctoral level clinical psychologists would be one that exploits their unique training and skills as scientists, rather as providers of routine primary care. Such a shift in roles, in turn, would have far-reaching implications for the design of doctoral training programs. It would put the primary emphasis on ensuring that every student receives the highest possible level of science training, with all obstacles to such training being eliminated. Just imagine how these changes would contribute to making progress in the quest to build a science of clinical psychology.

In conclusion, the good news is that despite all of the current tensions in the field, some of which I’ve described, other powerful forces are moving the field in a positive direction. The quest remains a struggle and the eventual outcome remains uncertain, but I am happy to report that the quest is alive and well.

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\*This article is based on the author's invited address as recipient of the Distinguished Scientist Award from the Society for a Science of Clinical Psychology presented at the annual convention of the Association for Psychological Science in New York City, May 27, 2006. The address, in turn, was based on the author's chapter on doctoral training in clinical psychology (McFall, 2006).

## SSCP Graduate Student Posters at the 2007 APS Convention

SSCP hosts an annual graduate student poster session at the Association for Psychological Science (APS) Annual Convention. The 2007 APS convention will be held in Washington, DC. There will be a \$200 cash award for the best student poster at this session.

To be eligible to submit an SSCP poster, the first author of the poster must be a graduate student and must be a member of SSCP at the time of submission. The call for submissions to the SSCP graduate poster session will be open online **November 1, 2006 - January 31, 2007**. To submit posters to the SSCP poster session simply submit online through the APS web site (be sure to follow online directions to have the poster submission considered as a "SSCP Poster"): [www.psychologicalscience.org/convention/](http://www.psychologicalscience.org/convention/)

The SSCP poster submission can deal with any area within scientific clinical psychology (e.g., the etiology or correlates of psychopathology, assessment/diagnosis, clinical judgment, psychiatric classification, psychotherapy process or outcome, prevention, psychopharmacology). The research and analyses presented in the poster submission must be completed (i.e., submissions containing such language as "Findings will be presented...." will not be considered). Please be sure to provide enough relevant detail in the summary so that reviewers can adequately judge the originality of the study, the soundness of the theoretical rationale and design, the quality of the analyses, the appropriateness of the conclusions, and so on.

If you have any questions please contact Jack Blanchard, Past-President of SSCP and APS Program Committee Member, [jblanchard@psyc.umd.edu](mailto:jblanchard@psyc.umd.edu).