



Division 12

CLINICAL SCIENCE

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the American Psychological Association

Developing clinical psychology as an experimental-behavioral science



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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.

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Presidential Column: Evidence Based Treatments, Part II

Thomas Ollendick, Ph.D., *Virginia Tech*

In my first presidential column, I reviewed the history of the movement toward evidence-based treatments and identified three areas of concern associated with their use in clinical practice: (a) some treatments might be more effective than others; (b) use of treatment manuals might lead to mechanical and inflexible interventions and the resultant loss of innovation and autonomy in clinical work; and (c) treatments shown to be effective in clinical research settings might not be transferrable to “real-life” clinical settings. These concerns are reasonable ones. I elaborate briefly upon them in this column. In doing so, I will make special reference to the treatment of childhood disorders – my clinical and research specialty.

Differential Effectiveness of Psychosocial Treatments

In a recent review of evidence-based treatments for children and adolescents (Ollendick & Shirk, 2010), we reported a rather alarming set of findings. Namely, many of the treatments currently in use in clinical practice have not been systematically evaluated (with the exception of behavioral and cognitive-behavioral treatments) and therefore do not qualify as well-established or probably efficacious treatments based on criteria specified by the Task Force on Promotion and Dissemination of Psychological Procedures of the Society of Clinical Psychology (see earlier column). For example, in the treatment of common problems in youth including anxiety, phobias, depression, eating disorders, ADHD, oppositional behaviors, conduct problems, substance abuse, and autism, *no* randomized controlled trials using “good” experimental designs were identified for psychodynamic, humanistic, or family systems therapies. Moreover, a very promising psychotherapy, interpersonal psychotherapy, was shown to be effective only in the treatment of depression in adolescents, and not for other disorders in adolescence or for any disorder in childhood (see David-Ferdon & Kaslow, 2008 for review). Similarly, traditional family therapy approaches, with the exception of the Maudsley model of family therapy for eating disorders, have not been shown to be effective for other disorders in adolescence or childhood (see Keel & Haedt, 2008, for review). Furthermore, in the case of some childhood disorders such as oppositional defiant disorder, some psychosocial treatments including psychodynamic and family systems interventions have been shown to be *less* effective than behavioral and cognitive-behavioral ones (see Eyberg, Nelson, & Boggs, 2008, for review). Unfortunately, because many of the different treatments have not been evaluated for other specific disorders, we simply do not know if they are effective or not.

We might ask “What is the status of ‘treatment as usual’ in clinical practice settings and should such treatments continue to be used until more empirical support is available?” These questions are crucial if we are to move into an age of accountability and evidence-based practice. Some time ago, Weisz, Huey and Weersing (1998) examined these questions. They selected treatment studies of clinic-referred children who were treated in service-oriented clinics or service agencies by practicing clinicians. Over a period of 50 years, nine studies were identified that compared “treatment as usual” to no-treatment control conditions. Effect sizes associated with these nine studies ranged from $-.40$ to $+.29$, with a mean effect size of $.01$, an effect size well below the average effect size ($+.70$) obtained in meta-analyses of behavioral and cognitive-behavioral treatments in research clinic settings. An effect size of $.01$ indicates that the treated children were no better off than the untreated children following treatment, a finding that is alarming.

Unfortunately, findings regarding treatment as usual are not limited to the clinic studies reviewed by Weisz et al.

(1998). Bickman and colleagues have reported similar outcomes in their examination of a comprehensive mental health services program for children in the United States (Bickman, 1996; Bickman et al., 1995). And, within school settings, Weiss, Catron, Harris, and Phung (1999) evaluated the effectiveness of child psychotherapy as typically delivered (“treatment as usual”) in that setting using a RCT design. Results of the trial provided little support for the effectiveness of “treatment as usual” in this setting (overall effect size of $-.08$), indicating that the treatment was no better than an academic tutoring comparison control condition.

Overall, results from these studies and others show the importance of developing, validating, and transporting effective treatments to clinical, community, and school settings. “Treatment as usual” does not appear to be very effective treatment when it is compared to non-therapy alternatives (e.g., tutoring) or to no treatment at all. Interestingly, these results mirror the findings of Levitt (1957, 1963) – now over 50 years ago - in which treatment in clinical settings was found to be no more effective than the mere passage of time. If we are to move into an age of evidence-based practice and bring legitimacy to treatment outcome research, we must take these findings seriously, as they have important implications for the future of child and adolescent mental health treatment. The findings also suggest some treatments are better than other treatments and it is time to put the “Dodo Bird” effect (i.e., all treatments are equally effective) to rest.

Manualization of Psychosocial Treatments

A second major source of controversy in the empirically-supported treatment movement has been the use of treatment manuals and whether such manuals stifle creativity and autonomy in the clinical enterprise. There are two primary reasons for endorsing the use of treatment manuals: (a) treatment manuals provides a clear description of the treatment and its implementation and, as a result, it becomes possible to determine whether the treatment was actually delivered as intended (i.e., treatment adherence) and how well it was delivered (i.e., treatment competence) and (b) use of a manual allows other mental health professionals to be aware of the actual components of the treatment that were evaluated in the clinical trial.

Over the years, a flood of commentaries – some laudatory, others derogatory - have filled the pages of several major journals, including the *American Psychologist*, *Journal of Clinical Psychology*, *Journal of Consulting and Clinical Psychology*, *Clinical Psychology: Science and Practice*, *Clinical Psychology Review*, *Cognitive and Behavioral Practice*, *Clinical Child and Family Psychology Review*, and *Psychotherapy*. Some authors have viewed manuals as “promoting a cookbook mentality” (Smith, 1995), “paint by numbers” (Silverman, 1996), “more of a straightjacket than a set of guidelines” (Goldfried & Wolfe, 1996), “somewhat analogous to cookie cutters” (Strupp & Anderson, 1997), and a “hangman of life” (Lambert, 1998). Others have viewed them in more positive terms. Wilson (1998), for example, suggested that “use of standardized, manual-based treatments in clinical practice represents a new and evolving development with far-reaching implications for the field of psychotherapy.”

In its simplest form, a treatment manual can be defined as a set of guidelines that inform the user as to “how to do” a certain treatment and, ideally, that specify the principles that underlie that treatment (Ollendick, 1999). They both specify and standardize the treatment at the same time. Although some opponents of manual-based treatment support the evidence-based practice movement, they express other concerns, including the notion that such treatments will stifle creativity and the opportunity for flexibility and clinical judgment. Seligman (1995, p. 967), for example, indicated that unlike the manual-based treatment of controlled, laboratory research – in which “a small number of techniques, all within one modality” are delivered in fixed order for a fixed duration – clinical practice is, by necessity, self-correcting. “If one technique is not working, another technique – or even modality – is usually tried.” This characterization of research-based and clinic-based treatment is simply wrong. A variety of treatments have been “manualized” and used routinely in clinical settings, including those embedded in psychodynamic (e.g., Strupp & Binder, 1984), interpersonal (e.g.,

Klerman, Weissman, Rounsaville, & Chevron, 1984), behavioral (Patterson & Gullion, 1968) and cognitive-behavioral theories (e.g., Beck, 1976); moreover, these manuals allow for flexible use and, for the most part, are responsive to progress or regress in treatment. Kendall and Beidas (2007) capture the essence of this notion in their use of the apt-phrase, “flexibility within fidelity.”

In fact, the movement to manualize treatment practices existed long before the Division 12 Task Force issued its report in 1995. Almost 30 years earlier, Patterson and Gullion (1968) published their now-classic book “Living with Children: New Methods for Parents and Teachers,” a “how to” parent and teacher that has been the foundation for many behavioral treatment programs of oppositional, defiant, and conduct problem children. Not surprisingly, treatment based on this “manual” was one of the first treatments designated as evidence-based and well-established. Once again, prior to the task force report, Luborsky and DuRubeis (1984) commented favorably upon use of treatment manuals in a paper entitled “The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style.” Similarly, Lambert and Ogles (1988) indicated that manuals were not new; rather, they noted, manuals have been used to train therapists and define treatments since the 1960s. The 1995 Task Force recommendation to specify and use manuals in treatment simply reaffirmed a movement that had been present for some years and that had been adopted by the mental health field for studies designed to explore the efficacy of various psychotherapies.

Issues with Efficacy and Effectiveness: The Transportability of Treatments

The third major concern with the evidence-based treatment movement is embedded in the difference between *efficacy* studies and *effectiveness* studies. Efficacy studies demonstrate that the benefits obtained from a treatment administered in a fairly standard way (with a treatment manual) are due to the treatment and not due to chance factors or other factors that threaten the internal validity of the demonstration of effects. These studies are usually conducted under tightly controlled conditions, typically in laboratory or university settings. Most of these studies consist of RCTs and clearly specify the sample characteristics in accordance with the definition of “good” experimental designs. In recent years, concern has been raised about the portability of these “laboratory-based” treatments to the real world of clinical practice. Some argue that the “subjects” in randomized clinical trials do not represent real-life “clients” or that the “experimenters” in these trials do not represent “clinical therapists” in practice settings. Moreover, it has been argued that the settings themselves are significantly different, ranging from tightly controlled laboratory conditions to highly variable conditions in practice settings. This distinction reminds me of the importance of building a strong bridge between science and practice, a bridge recommended 60 years ago at the 1949 Boulder Conference on clinical training. Building this bridge is admittedly not easy, and a gap between efficacy and effectiveness remains to this day.

Nonetheless, it is clear that effectiveness studies that demonstrate the external validity of psychotherapies are very important; moreover, they need to be conducted in a way that allows us to conclude that the treatments are responsible for the changes observed in our clients, not chance or other extraneous factors. In this search for effectiveness, it will be important to emphasize both internal and external validity, as both are equally important. Of course, not all treatments shown to be efficacious in clinical trials research will necessarily be shown to be effective in clinical settings. Reasons for such failure include problems in implementing the treatment procedures in less-controlled clinical settings and the “acceptability” of the efficacious treatments to clients and therapists in those settings. In the final analysis, whether the effects found in RCTs and conducted in research-based settings generalize to “real-world” clinical settings is an empirical question that awaits additional research.

Issues surrounding transportability and efficacy versus effectiveness studies are numerous (e.g., training of therapists, supervision of therapists, homogeneous/heterogeneous samples, development of manuals, adherence to manuals, competence in executing manual-based treatment, and the acceptability of manual-based treatments to clinicians and clients, among others). Although such issues are important ones, they tend to be

overly broad generalizations that may or may not characterize studies conducted in laboratory or clinical settings. Moreover, they may serve to accentuate differences in types of studies rather than to define areas of rapprochement and, inadvertently, create a wider chasm, rather than a bridge, between laboratory and clinic research.

Concluding Remarks

I have raised three primary issues associated with evidence-based practice in this column. Based on a review and commentary of the existing psychotherapy outcome literature, I conclude some treatments are more effective than others, manualization need not be a stumbling block to providing flexible yet effective psychotherapy in both research and clinic settings, and the portability of treatments from the laboratory setting to the practice setting is feasible and appears promising (although more evidence of such is clearly needed). Progress has been made in developing effective treatments for children, adolescents and their families but much more remains to be accomplished. The same can be said about the state of affairs for adults.

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Clinical Science at APA

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Howard Garb, Ph.D., *Lackland Air Force Base*

Yes, you read correctly! It was a terrific year for the dissemination of clinical science at the annual APA convention which took place this past August in San Diego. With three hours of programming afforded to SSCP, and some strategic planning to ensure that we could communicate powerful messages to convention attendees, we were successful in our efforts to promote stronger integration between science and practice in clinical psychology. Below, we offer brief summaries and observations of SSCP's three APA convention programs. It should be noted that because APA accepted all three programs as eligible for CE credits, we had very strong attendance at all sessions.

Perhaps the most lively and "buzzed" about SSCP session offered a panel discussion entitled "Is it Unethical to Practice Non-Evidence-Based Treatment?" We were very fortunate to secure participation from an outstanding group of panelists, including Drs. Scott Lilienfeld (Emory University), Bruce Chorpita (UCLA), Gerald Koocher (Simmons College), and Katherine Nordal (APA). Most readers likely are quite familiar with these panelists and their work. Most relevant to their participation in this panel, Dr. Nordal's currently serves as the Executive Director for Professional Practice at APA, and has long advocated for the rights of practitioners at local, state, and federal levels. Dr. Koocher is an APA Past President, current editor of *Ethics & Behavior*, a scientist-practitioner, and a past contributor to the APA Ethics Code. Many know Dr. Lilienfeld as a Past President of SSCP, the Founder and Editor for the journal, *Scientific Review of Mental Health Practice*, as well as his groundbreaking work differentiating clinical science from pseudoscience, and dispelling popular myths in psychology. Similarly, Dr. Chorpita is a prolific investigator who has become a prominent leader in the evidence-based practice movement for psychotherapy with children and adolescents; he has previously served as the Clinical Director of the Hawaii Department of Health's Child and Adolescent Mental Health Division. Dr. Mitch Prinstein served as the moderator of the session, and provided the panelists with an advance list

of questions that collectively challenged panelists to consider the focal question regarding ethics and evidence-based practice.

Comments during this session revealed important progress in reaching consensus on the role of science in the practice of clinical psychology. Panel members generally agreed that when practitioners fail to consider the current state of the scientific evidence they do a disservice to their clients and the profession. Panelists also generally agreed that when presented with conflicting directives based on scientific evidence, patient preferences, and clinical judgment (i.e., the "three-legged stool" that APA uses to describe evidence-based practice), scientific evidence holds a high priority. However, the panelists (perhaps reflecting diverging opinions in the field), disagreed as to whether scientific evidence should play the primary role in clinical practice, or whether the other "legs" must sometimes "trump" the evidence leg. While some noted that the use of a non-evidence-based treatment (when an available scientifically (supported) validated approach exists) could qualify as negligent, others noted (argued) that patients' preferences regarding therapeutic choice may form a prerequisite to the success of any intervention. Still other comments suggested that psychologists must recognize and communicate the shortcomings in our scientific literature; the selection of a treatment course may best flow from a collaboration between the client and therapist following an explicit discussion of individual client data, research evidence, and clinical theory. Indeed, consent was noted by several panel members as an important component to any treatment. Most agreed that therapists should educate their patients about treatment options, any evidence-base for these options, and ways to balance this evidence with other factors (e.g., limitations to the evidence-base, the clinician's expertise/judgment, and patient's own prefer-

ences); following such a consent process (i.e., one appropriate to the clients level of understanding and responsive to their questions), the selection of a non-evidence-based treatment may qualify as ethically appropriate. Nevertheless, at least one panelist contended that it is unethical to continue to deliver non-evidence-based treatments when better supported treatments become available without providing clients with consent regarding these alternative treatments.

Panelists also conveyed some consensus regarding the need for flexibility when defining “evidence-based treatments.” All agreed that the literature currently does not provide sufficient rigor regarding treatment effectiveness (vs. efficacy), culturally-sensitive adaptations of treatments, or the use of evidence-based approaches with highly complex clinical presentations (e.g., multiple comorbidities). Some panelists suggested that our current evidence-based treatments should serve as a “starting point,” even in these less-tested situations. Most agreed that when we lack data, the preferable course involves adapting an evidence-based treatment, rather than abandoning its core philosophies and techniques. The panelists agreed that our best use of the current scientific data involves reducing uncertainty about our treatment selection decisions.

Although little time was available for audience participation, questions from attendees conveyed a general sense of confusion over differences between scientifically-informed practice and inflexible, manualized treatments. Although generally open-minded about the use of scientifically-informed treatments, some audience members expressed concerns regarding 1) the best manner to adapt evidence-based treatments to specific settings and/or complex clinical presentations; 2) whether doctoral programs’ emphasis on evidence-based practices would lead to a training de-emphasis in basic clinical skills (e.g., empathy, reflective listening) and nonspecific effects (e.g., therapeutic alliance); and 3) where to learn evidence-based practice approaches, particularly among psychologists outside of academic settings or resource-rich communities. Each of these concerns reflected intriguing areas for future potential SSCP programs at APA. It may be that the broader practitioner community has become increasingly comfortable with scientifically-based approaches, but requires further training and instruction to dispel myths about what this will involve for their own practice.

SSCP programming in San Diego also included an invited presentation from Dr. Matthew Nock of Harvard University on “Why Adolescents and Young Adults Hurt Themselves: Advances in the Understanding of Suicidal and Nonsuicidal Self-Injury.” If you have not yet heard of Dr. Nock and his work, you should have. In a remarkably brief period since earning his doctoral degree, Dr. Nock has published over 100 peer-reviewed papers, predominantly in our field’s most prestigious and competitive journals. He has been awarded over \$7 million in grant funds for his revolutionary and innovative work on self-injury, and he is the recipient of early career awards from ABCT, the Society of Clinical Psychology (APA, Division 12), and most recently, the esteemed APA Distinguished Contribution Award for an Early Career Psychologist. In only seven years, he has been promoted to Full Professor with tenure in the Department of Psychology at Harvard. During his talk, Dr. Nock skillfully offered a review of his recent epidemiological and experimental work on self-injury with an emphasis on applied, practice implications. His findings offered clear direction for the identification of proximal risk factors for suicidal behavior (based on an international dataset from 28 countries), a behaviorally-based functional model for understanding (and treating) nonsuicidal self-injury, and translational evidence that elucidates the *in vivo* psychophysiological and social information processing deficits associated with NSSI. Attendees with either little or extensive experience treating self-injurious behaviors gained substantial knowledge from Dr. Nock’s research that will have dramatic impact on their clinical practices.

SSCP also sponsored a symposium on DSM-V, with Michelle Craske from UCLA and Paul Frick from the University of New Orleans as principal speakers, Tom Widiger from the University of Kentucky as discussant, and myself as Chair. DSM-V is scheduled to be published in 2013. Literature reviews, secondary data analyses, surveys of experts, input from advisors, input from the field including comments on www.dsm5.org, and field trials are all underway. The DSM is above all a manual to be used by clinicians, and recommendations for changing criteria are to be guided by research evidence. Some of the proposed changes were described. For example, it was recommended that Agoraphobia be unlinked

from Panic Disorder, and callous-unemotional traits (e.g., lack of remorse or guilt) will likely be integrated into the diagnosis of Conduct Disorder. The overall organization of DSM 5 has not yet been determined. For example, under consideration is the placement of trauma and dissociative disorders, either within the anxiety disorders or as a separate category. Different ideas for making dimensional ratings were discussed, e.g., when diagnosing Anxiety Disorders and Conduct Disorders. Finally, although the field has advanced since the early 1990s, and although the opportunity exists to enhance the reliability, validity and clinical utility of DSM for clinicians and researchers, the task is enormous and it is important that the process be responsive to criticism.

**APA
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Announcement from Marvin R. Goldfried, Ph.D.

Stony Brook University

President, Society of Clinical Psychology (APA Div 12)

The Society of Clinical Psychology, Division 12 of the American Psychological Association (APA), has just posted the results of a survey of clinicians' experiences in using an empirically supported treatment (EST) cognitive-behavior therapy for treating panic disorder. This is part of the Society's attempt to build a two-way bridge between research and practice. The initiative is based on the two-way communication mechanism that physicians in the US have, where they are able to provide feedback to the Food and Drug Administration (FDA) on their clinical experiences in using a drug even after its efficacy has been demonstrated by clinical trials. In a similar way, the Society's initiative seeks to close the gap between therapy research and practice by not only having researchers disseminate their findings from ESTs, but also by having clinicians provide their observations on issues in need of further research that have arisen when using these interventions in clinical practice.

The Society will be extending this effort next by surveying clinicians on their experiences in using ESTs in the treatment of (1) general anxiety disorder and (2) social anxiety disorder (social phobia).

The findings of the clinical survey on panic disorder are currently available on the Society's Web site:

<http://www.div12.org/PanicSurvey>

and will be published in *The Clinical Psychologist* later this year as:

American Psychological Association (APA) Division 12 Committee on Building a Two-Way Bridge between Research and Practice (2010). Clinicians' experiences using an Empirically Support Treatment (EST) for panic disorder: Results of a survey. *The Clinical Psychologist*.

Challenges and Rewards of Teaching and Learning about Evidence Based Practice

Bethany A. Teachman, Ph.D. and Shari A. Steinman, M.A.
University of Virginia

The Teacher's Perspective

I teach Psychological Intervention at the University of Virginia to our second year clinical graduate students. Like many graduate courses, it is a course that tries to do too much in too little time. The course covers both theoretical perspectives and a variety of practical therapeutic techniques for a broad range of clinical disorders. The students take this course when they are first starting to see their own clients in our departmental training clinic. As a result, they are anxious (no, make that very anxious!) and want to know everything at once. This has the benefit of making for a highly motivated and invested class (everyone has done the readings!), but the disadvantage of making small challenges seem like giant hurdles.

I really enjoy teaching this class. The students immediately see the value of what they are learning, and despite having taught the class many times, the discussions, papers and role plays continue to surprise me as I learn something new from each cohort of students.

At the same time, there are some consistent challenges when I teach this class. Given its broad scope, it is always hard for me to select which topics I want to cover – should I teach behavioral activation, mindfulness, interpersonal *and* cognitive therapy when we discuss treatment for depression, or can I cut one so we have more time to work on motivational interviewing techniques to keep the ambivalent client in therapy in the first place? I strive to base my selections on the current evidence for those approaches that have the strongest research support for their efficacy or effectiveness. One of the challenges I face using this approach is that students sometimes mistake evidence based approaches as necessarily being equivalent to CBT. I make sure to cover dialectical behavior therapy, motivational interviewing, interpersonal therapy and other approaches, but each year I have to help students understand that using a so-called CBT approach does not automatically make it evidence-based, just as many other orienta-

tions include therapies that have an evidence base (including some short-term psychodynamic treatments). I struggle to explain to the students that I do not identify myself as a “CBT therapist.” I try to be a clinical scientist with a variety of tools in the toolbox; my goal for myself and for the students is to use the research literature to guide selection of a first line of treatment but to then monitor progress for my individual client to determine whether therapy is progressing well or a change of course is necessary. Often, this means starting with a CBT approach, but this is not always the case.

Moreover, as we all know, lots of clients don't fit into neat boxes where we have a strong research literature to guide selection of a treatment. Thus, again we come back to the importance of looking at evidence at both the nomothetic level (what does the research tell us about what treatment is most likely to be helpful for a person with a given set of characteristics, strengths and problems) and the idiographic level (what data do I need to examine how treatment is going for this particular client; see Woody et al., 2002).

This emphasis on examining evidence at both the group and individual level has been helpful in dealing with one of the other challenges I encounter in trying to teach a course on evidence-based practice. I am fortunate to work with a fantastic and talented set of clinical colleagues, who happen to be very diverse in the therapeutic orientations they practice most frequently (including colleagues who use mainly cognitive behavioral approaches, and others who use interpersonal, psychodynamic or eclectic approaches). This has the positive consequence of exposing our students to a lot of new ideas and diverse approaches early in their training (and setting the stage for some lively and interesting discussions during our clinical lunch seminar!), but the occasionally negative consequence that students can find it somewhat challenging to translate what they learn in my class about a relatively structured, empirically-supported approach to the lessons

they are learning from their direct clinical supervisors who may not always be using empirically supported treatments.

Despite this challenge, I hope we are teaching toward a shared mission. Regardless of what therapy techniques we each use and teach, the entire clinical faculty believes in gathering evidence about the effectiveness of one's treatment. Moreover, we are very careful at the triage and intake evaluation stage; if a client appears to have an Axis I disorder for which there is an empirically-supported treatment, that client will be assigned to a student/supervisor combo that will provide the empirically-supported treatment. At the same time, when a client comes in to treatment without a clear diagnosis but seeks support in managing their relationships and life stress more effectively, they may be matched with a different type of student/supervisor/therapy mix. In both cases, the research literatures on changing thoughts, feelings, behaviors and relationships play a critical role, and in both cases, it is considered essential to clearly state goals in treatment and measure progress toward those goals.

The diversity of perspectives in our learning environment makes it both a rewarding and challenging place to teach the value of evidence-based approaches. Perhaps what I enjoy most about teaching students to be clinical scientists as they become therapists is seeing their joy when their clients start to improve. Of course, it does not happen in every case, but each year I have a previously skeptical student announce with amazement, "Exposure really works!"

The Student's Perspective

When I began seeing clients as a second year graduate student, I felt prepared for first sessions with clients. Although content varied by individual clients, the structure was almost always the same: conduct an intake and begin to build a relationship. I thrive on structure and love organization, so first sessions were right up my alley. Second sessions with clients were a completely different story. There was no generic structure to learn for second sessions, and unlike first sessions, second sessions tend to be very different for clients with different presenting problems. Thus, the week preceding a second session tended to be more anxiety provoking for me than the week before a first session!

In my opinion, learning about evidence based practice was the solution to my second session anxiety. Allowing research (and helpful websites, like <http://www.div12.org/PsychologicalTreatments/index.html>) to guide my treatment selection gave me confidence that what I decided to do in therapy has been done before with individuals like my clients and (more importantly) tends to work for individuals like my clients. Moreover, when I decided to use an empirically supported treatment with a client, I was not just a young

clinician trying something for the first time; I was backed by a large fund of knowledge gleaned from many experts putting several years into testing and refining treatments.

Additionally, using empirically supported treatments provided structure for the elusive second session. After reading a manual, I was able to walk into a session with a plan of what psycho-education I wanted to provide, what techniques I wanted to practice, and what homework I wanted to assign. Given my love for organization, being able to come into a session with a plan made second sessions (and all of the following sessions) much less scary.

However, a challenge I quickly encountered was that clients will not always have the same session agenda as me; though I may plan to create a fear hierarchy and begin exposures with an acrophobic client, if he enters the room announcing his wife left him that morning, chances are that we won't spend too much time on a ladder that session. Learning to be flexible while staying within the boundaries of an empirically supported treatment has been an important lesson for me as a young clinician.

Another benefit of evidence based practice is that there are almost always new skills to learn and new strategies to try with your clients. Therefore, it is possible to find new techniques to try if your original ideas do not produce the results you and your client would like. With several empirically supported treatments available, if your client is not improving, you always have the option of changing the direction of therapy.

A challenge that I encountered when I first started doing therapy was that I would occasionally focus too much on the plethora of available techniques and forget to focus on the basics of therapy, like rapport building and alliance strengthening. These basic skills are an integral part of empirically supported treatments, so it is important that students do not fall into the trap of only concentrating on techniques learned from a manual.

A very rewarding part of my clinical training has been working with clinical supervisors who have very different styles from mine. My supervisor during my second year of graduate school was an unstructured, laid back professor, who challenged my need for strict organization and encouraged me to be more flexible as a therapist. As a result, I feel like I am better able to handle the surprises that come up in therapy sessions (and in life, in general) that result in the

need to change my plans quickly. Additionally, he often reminded me to slow down with the techniques and strategies I used in sessions and spend more time focusing on my relationships with my clients and interpersonal processes happening in the room.

I identify myself as a clinical scientist. I am very passionate about my research, so to me, the most rewarding aspect of using evidence based practice is that I am encouraged to view therapy from the standpoint of an investigator. I was taught to look at each part of the therapeutic process, from selecting a treatment, monitoring progress, and determining when to terminate, as a scientist collecting data and using that data

to determine how to proceed. As a result, I feel more self-assured and secure in the decisions I make in therapy. Given that I utilize similar skill sets in the therapy room and the research laboratory, I feel that both practices mutually enhance each other.

After spending my first three years of graduate school learning about and conducting evidence based practice, I can happily say that I no longer have a fear of the second session.

Woody, S., Detweiler-Bedell, J., Teachman, B. A., & O'Hearn, T. (2002). *Treatment planning in psychotherapy: Taking the guesswork out of clinical care*. NY: Guilford.

SSCP Dissertation Grant Awards

SSCP Dissertation Grant Awards are intended to recognize and support students who have already received approval for their dissertation projects. In addition to the evaluation of the proposal as a whole, we will also consider what additional sources of funding have been received in the context of the overall estimated cost of the project. Awards will be in the amount of \$500, and we anticipate funding up to 5 grants.

Applications must be received by November 14, 2010. Notification of awards will be made in January, 2011.

Eligibility requirements:

1. Student member of SSCP. Annual student membership fee in SSCP is \$10. The membership application form can be downloaded or submitted on-line at: www.sscpweb.org
2. Current enrollment in an APA or CPA approved doctoral program in Clinical Psychology.
3. Dissertation proposal approved by applicant's department (verified in advisor's letter).

The application should include the following:

1. Cover letter indicating applicant's name, school affiliation, mailing address, phone number, e-mail address, title of the project, and a statement that dissertation proposal has been approved.
2. **Research Plan** (MAXIMUM 5 SINGLE-SPACED PAGES INCLUDING REFERENCES)
 - a. Specific Aims. List broad objectives and what the specific research proposed in this application is intended to accomplish.
 - b. Background and Significance. Briefly sketch the background leading to the present application, critically evaluate existing knowledge, and specifically identify the gaps that the project is intended to fill.
 - c. Preliminary studies. Provide account of applicant's preliminary studies (if any) pertinent to the application and/or any other information that will help establish the experience & ability of the applicant to pursue the proposed project.
 - d. Research Design and Methods. Describe the research design and procedures to be used to accomplish the specific aims of the project. Include how the data will be collected, analyzed, and interpreted.
3. **Abstract**. (MAXIMUM 250 WORDS, the abstract page does NOT count toward the 5 pages for the research plan).
4. Outline of budget and listing of additional sources of funding. (How do you propose to spend the award? What funding have you already received? To which additional sources of funding have you applied?) MAXIMUM 1 PAGE.
5. **Curriculum vitae**
6. A brief **letter from dissertation advisor** confirming your good standing in the program and stating that the dissertation prospectus has been approved. This letter should be sent directly from the advisor to denise.sloan@va.gov.

Submit application electronically to Dr. Denise Sloan at Denise.Sloan@va.gov. Please include the entire application, including cover letter, in one document file. A confirmation of receipt will be sent within 2 business days.