

THE CLINICAL PSYCHOLOGIST



A publication of the Society of Clinical Psychology (Division 12, American Psychological Association)

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EDITORIAL

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nguerda@miami.edu

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l.eva.smith@gmail.com



By Mark Sobell, Ph.D., APBB
Nova Southeastern University, FL

PRESIDENT'S COLUMN

Thank you to those who participate



First off, a big thank you to our three invited speakers, Nadine Kaslow, David Barlow, and Jusef Ruzak, for their outstanding presentations at the APA convention in Honolulu. Each described ongoing efforts to reach out in innovative ways to help people in need. These sorts of efforts to bridge the gap between research and practice are very seriously needed. The convention, in my view, was surprisingly well attended, and it is hard to complain about the weather in Hawaii (even if you come from South Florida).

One thing being President of this organization has brought home to me is how we really do cover a lot of ground. In that regard, it takes many people to get things done and as my term expires I want to thank all those who participate in governing the Society and its many parts. There are many things going on and we appear to be entering a transition period of sorts. One major transition is that the way convention hours are distributed has changed at the APA level, with the upshot being that all divisions have lost some hours. In our case, the loss was about 26% of the hours we had last year, and we have some adapting to do because the formulas for hour allocation within the division, that have served us well for years, will have to change. Another major transition in the offing, although at this time no one knows exactly what will be involved or how it will work, is that APA is going forward with working towards a change in their overall governance structure. One of the main ways the Good Governance Project, as it is called, is sure to affect divisions is that one of the goals is to shrink, modify, or replace the Council of Representatives. This will be but a small part of the overall changes that will be proposed, but it clearly will affect us as there is agreement that the current Council of Representatives is simply too large and unwieldy. The task force charged with coming up with specifics of a proposal has just recently been formed, so it will be quite a while before we hear more. The only thing clear at this time is that things are moving forward and there definitely will be changes.

We have changes coming within the Society as well. Our web pages editor Damion Grasso has been doing an extraordinary job of overseeing redesign of our web pages and their content. Over the coming months the web face of the Society will demonstrate a long needed modernization and streamlining for ease of use. Also, the Society is hard at work developing a Continuing Education initiative to regularly provide our members with high quality resources. We are also looking at updating our much consulted website on Research Supported Psychological Treatments, so that is something else to look for down the line.

(continued on page 2)

President's Column (*continued*)

Well, Presidents come and go, but let me close by saying a big thank you to our Administrative Officer Lynn Peterson, who, by the nature of her job, is our

historian and go to person, and sometimes the only one who can retrieve what went before so that we don't go exploring the cow pasture without boots. 🐮

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DIVISION 12 CENTRAL OFFICE: Lynn G. Peterson, Administrative
Officer (not Board member): PO Box 1082, Niwot, CO 80544

Tel.: 303-652-3126 / Fax: 303-652-2723 / Email: div12apa@comcast.net

GRAPHIC DESIGN: Jason Crowtz

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To subscribe, contact: Lynn Peterson, Administrative Officer, Division 12 Central Office, P.O. Box 1082, Niwot, CO 80544-1082, USA
Tel: 303-652-3126 / Fax: 303-652-2723 / E-mail: div12apa@comcast.net



Using Technology to Extend the Reach of Psychological Services


Alinne Z. Barrera, Ph.D.

& Ricardo F. Muñoz, Ph.D.

Palo Alto University,

Palo Alto, California

The corresponding author for this article is Alinne Z. Barrera, Ph.D., Palo Alto University, 1791 Arastradero Road, Palo Alto, California, 94304; Phone: (650) 433-4854, Fax: (650) 433-3888, E-Mail: abarrera@paloaltou.edu.

 As of 2010, there were approximately 450 million adults worldwide suffering from psychological disorders (WHO, 2010), with the current lifetime prevalence of depressive disorders ranging from 3 to 16.9% (World Federation for Mental Health, 2012). Despite existing evidence, many individuals go without psychological treatment even after consulting with a health provider (Wang et al., 2007; World Federation for Mental Health, 2012). Individuals who reside in low and middle income countries trend toward greater underutilization of mental health services, as do those who suffer from more severe pathology (Kohn, Saxena, Levav, & Saraceno, 2004). The limited number of trained professionals and reduced budgetary allocations to the provision of mental health services is a likely contributor to this global mental health disparity (WHO, 2009) and underscores the need for non-traditional methods of providing psychological services.

Healthcare service delivery is an evolving process that is reflective of scientific advances and societal standards of care. Early medicine attributed illness to supernatural causes and engaged in rituals to exorcise ailments. Philosophers later proposed that illness was a result of natural causes with close observation and constant monitoring being the preferred method of determining the best course of treatment – practices that are instrumental to our current healthcare delivery. Those needing medical consultation called on physicians who then opened their homes to their patients or arrived at their front door for a more personalized level of care. As the need for healthcare services expanded,

systems of care changed, and, in fact, continue to change to this day in response to personnel shortages (Bodenheimer et al., 2013). The mental health field has also seen changes in how psychological disorders are conceptualized and treated. An increased focus has been directed toward understanding the etiology of highly prevalent disorders and prevention efforts have targeted at-risk populations. In this article we urge clinicians to consider integrating technology-based tools into their clinical practice and to consider using them as resources to disseminate mental health information and enhance the therapeutic experience of the communities they serve. Over the past 15 years, our team of clinical psychologists and trainees have developed and tested depression and smoking cessation internet-based screening and intervention websites, mobile device applications, MP3 recordings, and mobile phone SMS programs (See Barrera, Wickham, & Muñoz, 2013; Aguilera, Garza, & Muñoz, 2010; Aguilera & Muñoz, 2011; Garza & Muñoz, 2010; Leykin, Muñoz, & Contreras, 2012; Muñoz, Barrera, Delucchi, Penilla, Torres, & Pérez-Stable, 2009). These tools have been used in global samples of internet users and, more recently, as an adjunct to outpatient psychological services at a local public sector hospital. Furthermore, they were created by our relatively small team with limited financial support, and accessed by those with few financial resources. Throughout the years, the mission of this team has remained unchanged, that is, to provide psychological resources to those most in need; our methods, however, have been modified, adapted, and upgraded to reflect changes in the community where we are located. Some of these changes have involved national and global conditions (e.g., the economic downturn and associated budget shortages) that resulted in increasing barriers to service delivery; while others (e.g., technological advances) have created opportunities to expand our efforts to wider and more diverse communities. As a team, we dream of future possibilities should more clinicians and researchers join forces to maximize the potential of technology, while systematically developing, testing, and delivering evidence-based interventions that reflect the highest level of care.

As long as health services are limited to consumable methods, we will be forced to ignore large proportions of those who need assistance. Consumable services are

services which are consumed when administered. For example, a nicotine patch is spent after it is used for one day. A one-hour therapy session uses up the provider's time completely: that hour can never be used again to serve any other patient. Note that this is not just an issue of money. Even if the therapist provides the service at no charge, the hour is still spent forever. To reduce health disparities, we need to develop methods of administering evidence-based psychological interventions that are not consumable, that can be used again and again by people anywhere in the world, without losing their therapeutic power (Muñoz, 2010). Telehealth advances, which allow providers to consult with individuals far from their offices, have made it possible to transcend space. However, the time spent on a phone consultation or an online interview is still gone at the end of the session. Internet interventions that have been shown to be effective can also transcend time: they can be used by thousands of people anywhere in the world at the time of their choosing. Even if the developer of the intervention is no longer practicing, her or his work can continue to help those in need.

In order to help as many people as possible using technology, clinical psychology and other health care professions need to venture beyond skeumorphic thinking. Skeumorphs are derivative objects that "look comfortably old and familiar, or are simply habits too deeply ingrained to wash away" (Wikipedia: <http://en.wikipedia.org/wiki/Skeuomorph>). For example, candelabra were originally intended to shed more light by putting several candles together. Electric candelabra are skeumorphs; light can be provided without creating light sources shaped like candles. Smartphone cameras often use a picture of a shutter and even the sound of a shutter. However, shutters are not needed to take digital photographs. Similarly, psychologists generally think of administering psychological care in the form of individual face-to-face sessions, or in group sessions. But behavior change does not require face-to-face meetings and weekly sessions. Behavior change tools such as internet intervention sites and mobile applications could theoretically produce faster and more enduring change, because they can affect personal behavior in the person's natural environment. And, of course, they could improve face-to-face traditional care by providing support to patients between treatment sessions.

Internet interventions can be used if needed inter-

ventions are not available in the person's location (for example, if there are no trained cognitive-behavioral therapists in a particular town); while patients are on waiting lists; during treatment, as an adjunct (for example, a CBT intervention for depression as an adjunct to pharmacotherapy for depression being provided by a primary care physician); after treatment, to prevent relapse or recurrence; for patients who cannot travel to clinics; for patients who fear stigma if treated, but have access to the Web or apps at home; for patients whose providers do not speak their language; and to extend health care beyond treatment into prevention (for example, to provide depression prevention services, which, though they can reliably reduce incidence of major depressive episodes, are currently not routinely available. See Muñoz, Beardslee, & Leykin, 2012).

Access to and use of technology is a growing global process. In 2010, 81% of those polled in 16 countries owned a cell phone and 50% owned a computer, which represents a 36% and 18% increase, respectively, over the previous 10 years (PEW, 2010). Currently, 34.3% of the world's population uses the internet (Internet World Statistics, 2012) with a majority (98%) accessing it at least once a day (Internet Society, 2012). More and more people are accessing the web from their mobile devices (Duggan & Smith, 2013). Internet users agree that knowledge acquisition and access to information are beneficial characteristics of the World Wide Web, and that the internet has the potential to improve the global impact of health, poverty, and basic human rights (Internet Society, 2012). Technology is already transforming healthcare systems and personal care. The growing access to mobile devices (e.g., smart phones, tablets) that allow users to find, check, and monitor their health is expanding the ability of individuals to maximize their access to healthcare resources. In the U.S., 72% of internet users search for health information online, with a majority of their inquiries focused on symptoms and treatments (Fox, 2013). Critical to the integration of technology with standard healthcare practices is the fact that health providers remain central to the quest for health information - when confronted with illness, 70% of online health information seekers relied on a medical provider for guidance and care. Now is the time to connect technology with more traditional health care approaches, and to make it available to a wider audience, especially considering that one in four internet users polled encountered a "pay to view" barrier to obtaining the health information they

wanted or needed. For a small percentage (2%), the cost was not a barrier and they proceeded to acquire the information they wanted or needed. However, 13% abandoned the search all together without any guiding information or potentially helpful mental health resources (Fox & Duggan, 2013).

Technology provides the opportunity to reach individuals in ways never before possible. Where available, the internet allows health providers to deliver interventions to individuals who may not otherwise seek services and/or who are unable to given their geographic location, limited resources, or cultural barriers. Internet interventions have been widely tested to address mental and physical health problems with growing efficacy for programs that have a cognitive-behavioral therapeutic orientation. In most cases, these internet interventions can be accessed 24/7 from any region of world, thus reaching global communities needing and wanting health-related skills to improve their overall well-being. Internet interventions allow individuals stigmatized by an illness to access information and make the initial steps toward recovery in the privacy of their own home. It is also a resourceful tool to deliver interventions to at-risk communities who typically do not present or qualify for healthcare services until the onset of a disorder, or who simply have limited access or information about the disorder to know that treatment is warranted.

We will describe two of the programs developed by our team, a prevention of postpartum depression (PPD) internet intervention, the Mothers and Babies/*Mamás y Bebés* Internet Project (Barrera, Wickham, & Muñoz, 2013), and the MoodText SMS program which is a clinical tool that sends automated mood monitoring messages to group therapy patients (Aguilera & Muñoz, 2011).

The Mothers and Babies/*Mamás y Bebés* Internet Project was designed to examine the efficacy of a stand-alone Internet-based prevention of PPD intervention that did not require access to a provider to be used (Barrera, Wickham, & Muñoz, 2013). The study used a fully-automated website to recruit, screen, and randomize pregnant women to a web-adapted mood management course (Mothers and Babies Course/*Curso de Mamás y Bebés*; Muñoz, et al. 2007) or to an information brochure (Wisner, Logsdon, & Shanahan, 2008). The study website successfully reached a large number of pregnant women from 183 countries who were interested in learning skills to reduce their risk

of PPD (Barrera, Kelman, & Muñoz, 2013). Analyses of the recruitment efforts demonstrated that a majority of participants were accessing the site in regions of the world where access to the internet, especially among women, is significantly lower than in countries like the United States. Spanish-speaking participants resided mostly in South America, Mexico, and Spain, while English-speakers were predominantly from India, South Africa, Pakistan, the United Kingdom, and Nigeria. Furthermore, participants who enrolled in the study also reported elevated rates of depression during their lifetime. In fact, almost one third (31%) met DSM-IV diagnostic criteria for a current or past major depressive episode during the baseline assessment. These findings suggest that a) pregnant women from all around the world are interested in learning about and participating in online depression interventions; b) online resources reach communities where access to technology is limited; and c) online materials need to be culturally-relevant given the widespread reach of the internet.

Technology-based programs and devices can also serve as a tool to enhance the therapeutic impact of traditional face-to-face psychotherapy. The MoodText program is a clinical tool that uses mobile-telephone SMS messages to reinforce clinical constructs taught in traditional face-to-face group psychotherapy (Aguilera & Muñoz, 2011). Researchers and clinicians decide on the content and frequency of the messages and use patient responses to track and monitor emotions and behavioral changes. The MoodText program was designed and tested at a public sector hospital with low-income Spanish- and English-speaking medical patients referred to a CBT-based depression group. Participants enrolled in this usability-feasibility study (N=12), engaged with the program, were highly satisfied with the text-message content and frequency, and most (n=8) reported that it helped them to attend the group regularly. This study provides initial evidence of a promising, simple, and cost-effective method of integrating mobile phone technology into standard mental health care in a community of individuals who have historically under-utilized mental healthcare services.

Although the mental health field has been slow to adopt advances in technology into the delivery of mental health services, access to technology as stand-alone resources where there are no providers and as an adjunct resource where there are mental health providers is an innovative approach that is gaining popular-

ity in many regions of the world where there are few resources, including trained health providers. We envision these digital sources of psychological interventions as tools that could even be used by natural helpers in remote communities: A village leader who is provided with a laptop or tablet and access to the Internet, could help people with depression, substance dependence, weight problems, anxiety, and so on, to access Internet sites or apps that could help screen for these problems and provide evidence-based self-help interventions that have been shown to be effective. Obviously, these forms of help cannot be expected to help all who suffer from these conditions. But neither do face-to-face interventions help all who receive them. Even if technological tools helped a limited proportion of the population in need, they could potentially multiply the reach of clinical psychology across the world and help reduce unnecessary suffering.

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Looking for back issues of The Clinical Psychologist?

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A Critical Examination of the Movement toward Evidence-Based Mental Health Treatments in the U.S. Department of Veterans Affairs

Hannah Holt and Larry E. Beutler, Palo Alto University

Louis G. Castonguay, Penn State University

George Silberschatz, UCSF School of Medicine

Bryan Forrester and Rainey Sealey Temkin, Palo Alto University

Abraham W. Wolf, Case Western Reserve University

Nancy A. Piotrowski, Capella University

Jeffrey A. Hayes, Penn State University

John C. Norcross, Scranton University

Marvin Goldfried, State University of New York at Stony Brook

Irving B. Weiner, University of South Florida

Thomas W. Miller, University of Kentucky

The corresponding author for this article is Larry E. Beutler, Ph.D., 2620 Piedra Verde Ct, Placerville, CA 95667; E-mail: larrybeutler@yahoo.com


Abstract

Over the last decade, the U.S. Department of Veterans Affairs has increased veteran access to evidence-based mental health treatments through the dissemination of treatment guidelines and training workshops for VA clinicians. Because the VA is the largest healthcare system in the U.S., and one of the largest employers of psychologists, its policies have significant bearing on the broader delivery of mental healthcare. Several key concerns about the VA's evidence-based treatment program have arisen: a) What standard does the VA use to determine

whether a treatment is considered evidence-based? b) Do the VA treatment guidelines account for differential response to therapy within diagnostic groups? c) Does the VA encourage clinicians to use cross-cutting treatments in ways that have been shown to improve outcomes? and d) How can these decisions affect the training of psychologists? This article attempts to address the importance of these concerns.

Key Words:

EVIDENCE-BASED PRACTICE
TREATMENT GUIDELINES
PSYCHOTHERAPY OUTCOMES
TREATMENT MATCHING
RANDOMIZED CLINICAL TRIALS
CLINICAL TRAINING

 In 2004, the U.S. Department of Veterans Affairs (VA) developed the Mental Health Strategic Plan (MHSP), with the intent of providing evidence-based treatments to veterans suffering from common diagnoses such as posttraumatic stress disorder, substance use disorders, and depression. Responding in part to the President's New Freedom Commission on Mental Health (2003), the VA devised an action plan to improve mental health treatment for veterans, including enhancing access to care and increasing use of evidence-based treatments. Evidence-based treatment policies, in turn, were further refined in the 2007 VA Handbook 1160.01 Uniform Mental Health Services (http://www.mirecc.va.gov/VISN16/docs/UMHS_Handbook_1160.pdf) and the 2012 VHA Handbook 1160.05, Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions.

The VA has been making a concerted effort to bridge the gap between science and practice and more effectively to begin implementing psychotherapy research and the use of evidence-based treatments within the system (Smith, Karlin, Ruzek, Chard, & Zeiss, 2012). Such intentions are undeniably noble: Veterans (and, indeed, all patients) deserve the best researched treatments, and the VA has historically been a leader in employing and training clinical psychologists (Baker & Pickren, 2011). At the same time, this movement has elicited some debate and provoked controversy, many of which are addressed

in this article.

In 2012, a group of 19 current and recent presidents of APA Divisions 12 (Society of Clinical Psychology), 29 (Psychotherapy), 50 (Society of Addiction Psychology), and the Society for Psychotherapy Research (International), and the North American Society for Psychotherapy Research (NASPR; see Appendix A) was convened to examine the VA's policies for identifying and implementing evidence based treatments. This paper originated from group discussion on these issues.

To start, the group found much about the VA efforts impressive. The attempt to ensure that all veterans receive evidence-based care is an important step forward. The construction of a national program to train VA clinicians in several effective therapy approaches is exemplary. Additionally, increasing the salience and availability of evidence-based practice in such a widespread training environment for psychologists and other counselors has long-standing value to overall mental health instruction. However, several key aspects of the VA's program caused concerns.

The intentions were noble indeed, but the difficulties reside in the details of identifying, dissemination, and implementing "evidence-based treatments."

Unknown Standards to Determine Whether a Treatment is "Evidence-based"

The first concern raised by the group pertained to the standards the VA uses for determining whether a particular treatment is deemed to be evidence-based. In none of the VA documents is a standard definition specified. The VA/DOD document emphasizes that, in determining what constitutes Evidence Based Practice (EBP), studies using a randomized clinical trial design were given the most weight. However, beyond making this general point, an entire evidence based treatment program was erected without publicly articulating an explicit standard to decide how certain psychotherapies are promoted and others ignored. Far greater transparency is warranted.

It seems evident that the VA work groups which were commissioned with defining EBPs have followed the lead of many others by relying heavily on studies that employed randomized controlled trials (RCTs). There is no doubt that the introduction of RCT designs into psychotherapy research has been

advantageous and has advanced the field considerably. Nonetheless, to the degree that the VA gave this methodology priority over other statistical and methodological procedures, in defining "evidence-based treatments," we are concerned that their effort resulted in an excessively narrow view.

RCT comparisons have convincingly demonstrated that many psychological treatments are more effective than minimal or no-treatment conditions, but precious few treatments have been found to be uniquely effective for any specific or diagnostic population. The most systematic, head-to-head comparisons of different treatments have found that there is not a consistent superiority in favor of any of the established treatments across most diagnostic groups (e.g., Beutler, 2009; Wampold, 2001; Wampold et al., 1997). Indeed, the American Psychological Association recently passed a "Resolution on the Recognition of Psychotherapy Effectiveness." That review and resolution concluded that no one form or brand of therapy is consistently more effective than another and that treatment provided in the context of clinical trials is frequently no more effective than is routine clinical care (Campbell, Norcross, Vasquez, & Kaslow, 2013).

As a result, many scholars have questioned the merit of continuing to rely on RCTs as the "gold" standard for determining what are and are not scientifically effective treatments. We believe, with many other scholars (e.g., Barkham & Margison, 2007; Barkham, Stiles, Lambert, & Mellor-Clark, 2010; Beutler & Forrester, in press; Castonguay, Barkham, Lutz, & McAleavey, 2013; Rawlins, 2008; Persons & Silberschatz, 1998) that it is time to consider other research methodologies as complementary and equipoise to RCTs in developing clinical guidelines from research evidence.

Failure to Account for Differential Response within Diagnostic Groups

The second concern expressed by our ad hoc group is that VA guidelines fail to account for differential response within sample and diagnostic groups. This problem is manifested in several ways. First, the VA guidelines are based on prior VA/DoD Work Group reviews of studies that do not necessarily apply to Veterans. Their recommendations fail to recognize that individuals presenting for treatment at a VA may differ significantly from samples from

which these specific treatments were developed. Many of the studies evaluating treatments do not include Veterans in their samples, raising concerns about generalization. Indeed, some evidence (Mohr et al., 2011) suggests that Veterans may be more refractory to treatment than other populations and that they respond differently than non-veteran cohorts to some treatments. Many Veterans present with multiple diagnoses; complex co-morbidities are the norm, complicating their treatment and, perhaps, attenuating responsiveness to EBTs.

A related issue arises from the failure of the VA guidelines to sanction “evidence-informed practice.” This approach, which has been embraced by the American Psychological Association (Kazdin, 2008), has several advantages over adopting a more narrow reliance on RCTs: it encompasses treatment models that are informed by research findings, that may be applied without strictly adhering to manualized protocols, and that are used more often in routine care than evidence-based treatments in practice.

Absence of Cross-Cutting Treatments that Work

A third concern raised by our ad hoc group is that the VA implementation guidelines (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2801) largely ignore the importance of tailoring interventions to individuals in a way that has been shown to improve outcomes. McHugh and Barlow (2010) point out that the VA guidelines are flexible and thus, may allow the clinician greater latitude than other guidelines in selecting specific treatments that might work. However, this is only an advantage if there are also empirical guidelines, or at least research-informed suggestions, on how to select among the available treatments on the list and tailor them to the individual patients (Beutler, 2009). Such research-driven guidelines have been available for years and promise to exert as much, if not more, impact on psychotherapy success than the particular brand-name treatments employed (e.g., Norcross, 2011).

Unknown Influences on the Training of Psychologists

A fourth concern raised by group members is that the VA guidelines have the potential for broad impact on the training of psychologists and other mental health professionals, but remain largely silent and non-

specific on this point. The VA is the largest training environments for psychologists (U.S. Department of Veterans Administration, nd). As such, the policies affecting these system decisions about what is evidence-based practice in VA settings will affect the training and supervision of psychologist trainees (as well as others who are in training). To this end, considerations about how to teach fledgling providers, the decision-making process for selecting and/or adjusting treatments in line with best practices all deserve transparent discussion and critical attention for its far-reaching impact on training and trainees.

Suggestions

To combat these four concerns and other problems that may arise with the VA guidelines, we offer several suggestions. We do so in recognition of the noble intentions of the VA movement to disseminate and implement EBPs in psychological care and in appreciation for the crucial, ongoing work in improving such care for our veterans.

Among the empirical findings that should be considered in strengthening these guidelines are those that have emerged from practice-oriented research (see Castonguay et al., 2013). Conducted in naturalistic settings with the participation of practitioners, this type of research has led to the identification of a number of clinical processes (such as the progressive phases of treatment outcome and the impact of feedback) that are not tied to specific theoretical approaches or clinical diagnoses. The salutatory effect of real-time, client feedback is impressive in reducing dropout and in preventing deterioration (Lambert, 2011).

Treatment guidelines derived from empirically based principles of change (e.g., Beutler, Clarkin, & Bongar, 2000; Castonguay & Beutler, 2006) may also offer an avenue that preserves therapist flexibility while allowing for close monitoring of compliance. The several approaches (e.g., Beutler & Clarkin, 1990; Castonguay & Beutler, 2006; Goldfried, 1995; Prochaska & Norcross, 2013) based on establishing guiding principles rather than theories of practice are closely tied to the research literature and apply across various treatment types and diagnostic groups, rather than reflecting a single therapeutic model. Notably, the effect sizes supporting the efficacy of using these cross-cutting, principle-based approaches to affect therapeutic change are very

promising (Norcross, 2011).

Similarly, while clinical decision-making is affected by bias and fallible heuristics, actuarial data has been shown to result in more accurate predictions (e.g., Garb et al., 2005; Grove et al., 2000; Worthen & Lambert, 2007). Approaches that use actuarial data (such as outcome and process monitoring) to help therapists identify weak interventions, can help therapists to flexibly adapt and tailor their interventions to their client's need and progress. Instruction and practice in such methods also offer huge potential benefits to clinical trainees and their future clients who will benefit from their abilities in these areas.

It would also be well for the VA guidelines to consider evidence from a broader review of psychotherapy research. There is much evidence that various common factors (e.g., responsiveness to *participant* moderators, *relationship* factors, and technical interventions) are linked with treatment outcome (e.g., Beutler & Harwood, 2000; Castonguay, & Beutler 2006; Beutler, Clarkin & Bongar, 2000; Norcross, 2011). Accordingly, empirically driven policies to improve mental health care should make use of such factors to meaningfully inform treatment decisions. *Participant* factors are individual characteristics of both the patient and therapist that can inform treatment implementation. Research indicates, for example, that therapists should avoid being highly directive when working with clients who are reluctant to accept the views or suggestions of others (Beutler & Harwood, 2000). Adapting treatments to client transdiagnostic characteristics of preferences, culture, and religion/spirituality, for three more examples, demonstrably improves the success of psychotherapy (Norcross, 2011).

Relationship factors include a wide array of interpersonal behaviors (e.g., alliance, empathy) from which transtheoretical guidelines can be derived regarding how therapist should (or should not) behave in therapy. Meta-analyses involving thousands of studies demonstrate the predictive and curative value of the alliance, empathy, goal consensus, collaboration, and positive regard. These are among the highest and most robust effect sizes in all of the psychotherapy literature, and should be integrated into any effort to create evidence-based treatments (Norcross, 2011).

Technique factors are characteristics of the specific interventions used in therapy. While many of these

factors have been associated with particular orientations, some of them reflect the similar strategies of interventions (e.g., facilitating the client's acquisition of a new view of self), while others may be best viewed as "faux unique" (by playing a role in treatment other than that to which a given theory assigns them; see Castonguay, 2013). The use of principles of change, rather than manuals of procedures, offers guidelines for combining these three sets of factors—and thus, suggests a way to assimilate into clinical practice, a wide range of empirical evidence.

A focus on –participant and relationship factors can be assimilated into evidence-based practice, and a wider range of empirical evidence harvested into treatment guidelines.

A focus on treatment principles and actuarial outcomes, rather than theoretical models or discrete interventions in psychotherapy research began when researchers had to account for why some patients improve, some experience no change, and some deteriorate in all treatments. The fact that the average effect of treatment across different theoretical orientations (and for many clinical problems) is about zero has become known as the "dodo bird effect" (Wampold, 2001). Indeed, the recurring conclusion that diverse psychological treatments produce essentially equivalent outcomes to one another and to well designed, "treatment as usual" conditions (Wampold, 2001; Wampold, et al., 1997) provides a strong argument for the VA to extend their recommendations to include evidence-based practice guidelines for tailoring treatment to individual patients.

Providing training in EBTs to clinicians and enhancing veteran access to these treatments are admirable steps toward bridging the gap between research and practice. However, there is increasing research evidence that we – and the VA – can improve the effectiveness of psychotherapy by widening the scope of empirically-based guidelines and by systematically adapting treatments and relationships to client factors. Because the VA has such profound influence on mental health care and training, their treatment policies bear on the practice of psychotherapy at large. Critical discussion of these policies is therefore vital to the general conversation about encouraging best practices in psychotherapy practice and training, and about implementing research findings into clinical practice for Veteran and non-Veteran patients alike.

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Note:

The ideas that stimulated the creation of this paper represents the work of an ad hoc committee of 19 individuals who were Presidents or Past Presidents of APA Divisions and/or other professional organizations



A Critical Examination [...] (continued)

related to the practice of psychotherapy. They were:

Lynne E. Angus, Ph.D., C. Psych.—Past President, Society for Psychotherapy Research, International (SPR), Professor, Faculty of Health, York University. E-mail <langus@yorku.ca>

Larry E. Beutler, Ph.D., ABPP—Past President Divisions 12 and 29, Past President of SPR (international), Wm McInnes Distinguished Professor Emeritus, Palo Alto University, 1791 Arastadero Rd, Palo Alto, CA 94304. E-mail <larrybeutler@yahoo.com>

Louis G. Castonguay, Ph.D.—Past President of SPR (international), Professor of Psychology, Penn State University. E-mail <lgc3psu@gmail.com>

Robert Elliott, Ph.D.—Past President of SPR, Editor, *Psychotherapy Research*, 1994-1998. E-mail <fac0029@gmail.com>

Marvin Goldfried, Ph.D.—Past President of Division 29, Past-President, SPR, Past President, Division 12, Distinguished Professor, Department of Psychology, Stony Brook University. E-mail <marvin.goldfried@stonybrook.edu>

Jeffrey A. Hayes, Ph.D.—Past President of North American Society for Psychotherapy Research (NASPR), Associate Editor, *Journal of Counseling Psychology*, Professor, Penn State University. E-mail <jxh34@psu.edu>

Clara Hill, Ph.D.—Past President of SPR, Professor, University of Maryland-College Park. E-mail <hill@psyc.umd.edu>

Adam O. Horvath, Ph.D.—Past President of NASPR, Faculty of Education and Department of Psychology, Simon Fraser University. E-mail <Horvath@fsu.edu>

Marsha M. Linehan, Ph.D.—Past President, Division 12, Professor, University of Washington. E-mail <linehan@u.washington.edu>

Thomas W. Miller, Ph.D., ABPP—Past President, Division 18, Professor Emeritus and Senior Research

Scientist, Center for Health Intervention and Prevention, University of Kentucky. E-mail <tom.miller@uconn.edu>

John C. Norcross, Ph.D., ABPP—Past President Division 12 and 29, Editor, *Journal of Clinical Psychology: In Session*, Distinguished Professor of Psychology, University of Scranton. E-mail <norcross@scranton.edu>

David E. Orlinsky, Ph.D.—Former President of SPR, Professor, Department of Comparative Human Development, The University of Chicago. E-mail <d-orklinsky@uchicago.edu>

Nancy A. Piotrowski, Ph.D.—Past President, Division 50, Lead Addiction Psychology & Core Faculty, General Psychology, Capella University. E-mail <Nancy.Piotrowski@Capella.edu>

George Silberschatz, Ph.D.—Past President of SPR (international), Clinical Professor, Department of Psychiatry, UCSF School Of Medicine. E-Mail <George.Silberschatz@ucsf.edu>

James L. Sorensen, Ph.D.—Past President, Division 28, Professor of Psychiatry, UCSF at San Francisco General Hospital. E-mail <James.Sorensen@ucsf.edu>

Leon VandeCreek, Ph.D., ABPP—Past President, Division 29, The Ellis Institute, Wright State University. E-mail <leon.vandercreek@wright.edu>

Irving B. Weiner, Ph.D., ABPP—Past President, Division 12, Professor of Psychiatry and Neuroscience, University of South Florida. E-mail <iweiner@health.usf.edu>

Elizabeth Nutt Williams, Ph.D.—President Division 29. Email <libbynuttwilliams@comcast.net>

Abraham W. Wolf, Ph.D.—Former President Division 29, Professor of Psychology in Psychiatry, School of Medicine, Case Western Reserve University. E-Mail <axw7@case.edu>. ■■

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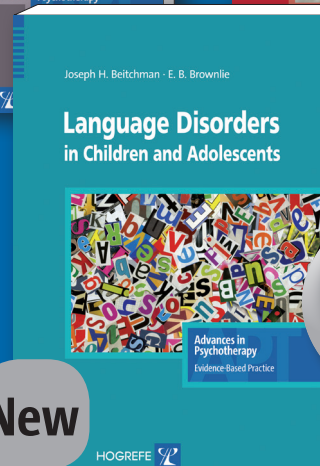
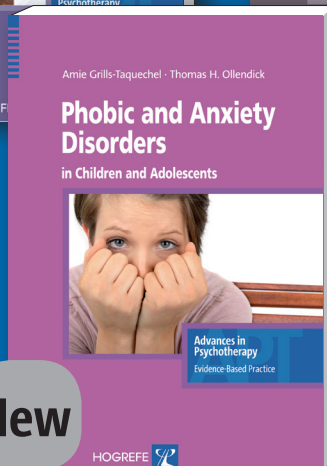
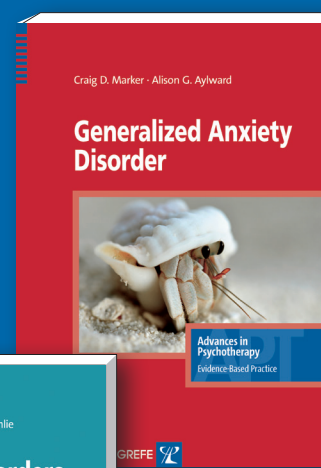
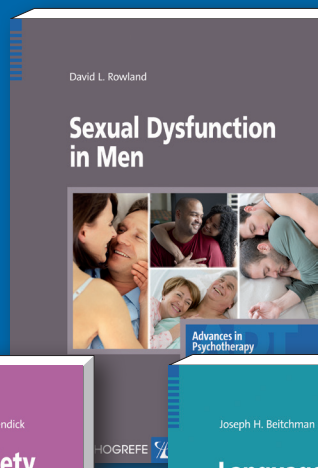
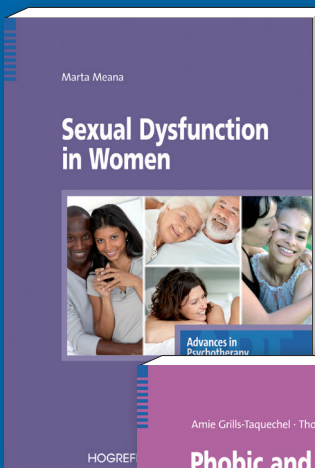
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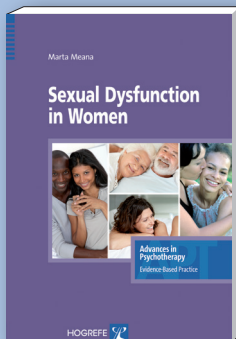
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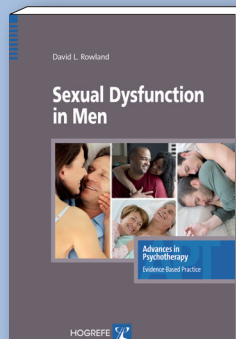
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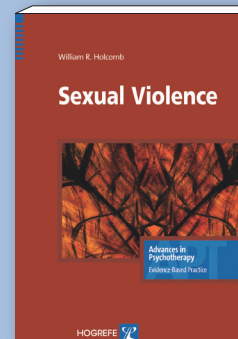
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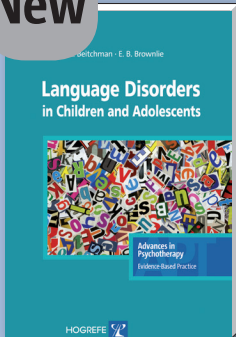
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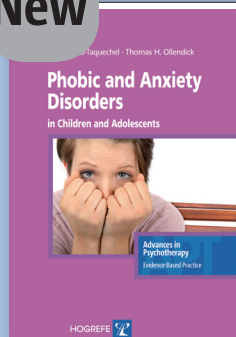


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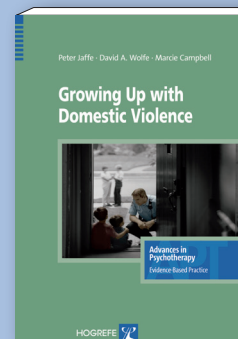
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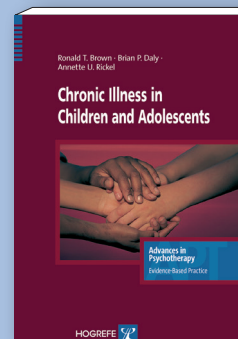
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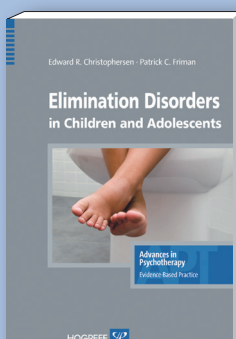


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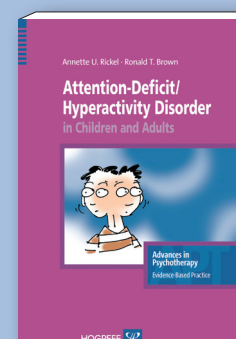
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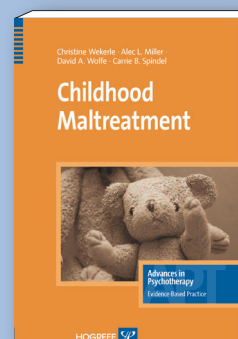
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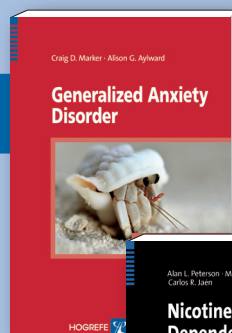
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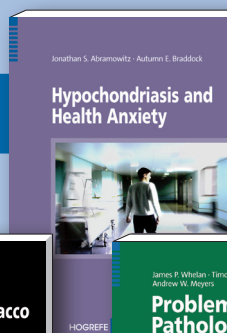
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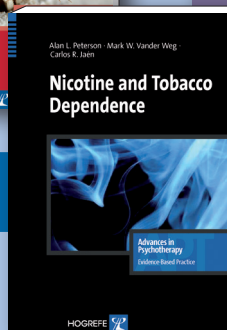
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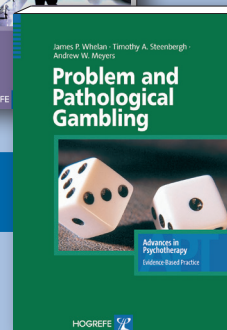
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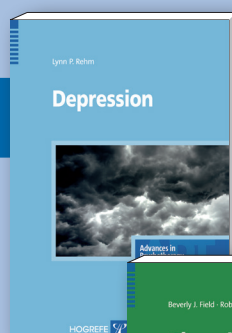
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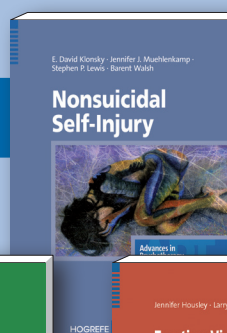
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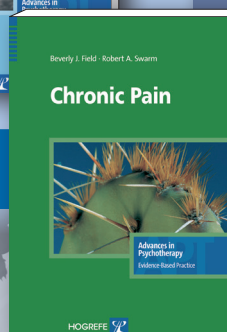
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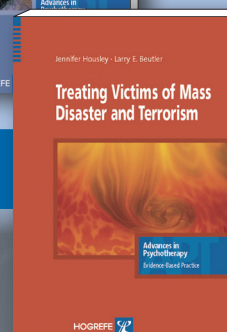
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Does Clinical Practice Inform Clinical Research?

Lee D. Cooper & Amie R. Schry

Department of Psychology, Virginia Tech

The corresponding author for this article is Lee D. Cooper, Ph.D., Psychological Services Center, Virginia Tech, 3110 Prices Fork Road, Blacksburg, VA 24061-0355; Phone: (540) 231-7709, Fax: (540) 231-4250, E-mail: ldcooper@vt.edu

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Key Words: CLINICAL RESEARCH
CLINICAL PRACTICE
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RESEARCH INFLUENCES



The scientist-practitioner model (i.e., Boulder model) has been at the center of clinical psychology as a field and as a training model. A core tenet of the Boulder model is a bidirectional process of which clinical practice is based on current and valid research findings, and research is based on current needs of the clientele or the practitioner (Beutler, Williams, Wakefield, & Entwistle, 1995; Westen, 2007). However, survey research literature indicates a significant gap in the path of research to clinical practice. Practicing clinicians rarely read and keep current with the research literature (e.g., Safran, Abreu, Ogilvie, & DeMaria, 2011; Stewart & Chambless, 2007), and the use of empirically supported treatments (ESTs) in their practice is relatively low and sparse (e.g., Stewart & Chambless, 2007).

Although researchers are trying to bridge this gap by increasing dissemination and training on ESTs (Goldfried, 2012; Lochman et al., 2012), clinical practitioners have noted their concerns regarding the other path of practice to research; namely, researchers are not aware or influenced by “front line” clinical work issues and problems (Chambless & Ollendick, 2001; Safran et al., 2011). Furthering this gap for practitioners has been the promulgation of the clinical science training model

(e.g., Baker, McFall, & Shoham, 2008). The clinical science model, either intentionally or unintentionally, is interpreted as stating that the critical pathway of knowledge to practice should be unidirectional starting with researchers and ending up with practitioners (Westen, Novotny, & Thompson-Brenner, 2004).

In this context, and in support of a bidirectional approach to research and practice (Beutler et al., 1995; Overholser, 2007), the purpose of this study was to survey clinical researchers to see if they believe in a bidirectional approach and whether their research is informed by clinical practice. If researchers do not believe in and/or are not practicing a bidirectional model, then practitioners have a valid point that science and practice is a unidirectional process. Interestingly, the authors could not find any published studies or survey research examining whether practice activities influence one’s research, and if so, in what way.

Method

Participants

Researchers who study clinical psychology phenomena ($n = 72$) were recruited via e-mail to participate in a study on the relationship between clinical practice activities and research. Of the total sample, 62 individuals reported that they are currently involved in clinical psychology research and were included in the analyses. A recruitment e-mail was sent to directors of clinical training at 172 colleges and universities, and 33 (19.2%) of these schools had at least one faculty member complete the survey. Additionally, an e-mail was sent to 51 researchers who have published a number of studies on clinical psychology topics but are not affiliated with a college or university with a graduate program (e.g., medical school faculty). The first author selected these individuals from the author list obtained from a Microsoft Academic Search using the search terms “empirically supported treatment,” and 10 (19.6%) of these individuals participated in the study. Participants had a mean age of 46.10 years ($SD = 9.96$) and had been involved in clinical psychology research for an average of 15.50 years ($SD = 10.53$). Males and females were approximately equally represented (51.6% female). The majority of the sample self-identified as not Hispanic/Latino(a) (93.5%). Additionally, most participants reported that they were Caucasian (88.7%). All but one

participant (98.4%) had a highest degree of a PhD, and most participants' degrees were in clinical psychology (95.2%). A range of faculty positions were represented in the sample (Assistant Professor: $n = 17$ [27.4%]; Associate Professor: $n = 19$ [30.6%]; Full Professor: $n = 25$ [40.3%]; Other: $n = 1$ [1.6%]), and most participants were licensed psychologists (licensed: $n = 51$ [82.3%]; not licensed: $n = 11$ [17.7%]).

Measure

A brief questionnaire was designed for the purpose of this study to assess the influence of clinical practice activities on research in clinical psychology. After completing demographic (e.g., age, race/ethnicity) and classification (e.g., degree type, training model) questions, participants were asked a series of questions about influences on their own research and their opinion about whether clinical practice should influence research. First, participants were asked to rate the importance of several factors on their research using a 5-point scale (1 = Not at All, 2 = Slightly, 3 = Moderately, 4 = Quite a Bit, 5 = A Lot); participants could also select that a particular influence did not apply to them (e.g., "conducting therapy in clinical practice" did not apply to those who have never been in clinical practice). Participants were also asked to rate their belief that clinical practice should inform clinical research on a 5-point scale (1 = Not at All, 3 = Not Sure, 5 = Definitely). Participants who are currently active in clinical practice were asked to indicate whether their own clinical practice had informed their research in specific ways (e.g., conducting research on assessment issues experienced in clinical practice). Using the same 5-point scale described above, participants who are active in clinical practice rated their agreement with the statement, "Clinical practice has informed my clinical research." Participants were then asked about their involvement in consultation activities (i.e., activities in which they have contact with clinical practitioners regarding their clinical work [e.g., supervision of therapists, providing workshops for clinicians, discussions with clinical practitioners]), and those who are active in consultation activities were asked the same series of questions as were asked regarding clinical practice, including rating their agreement with the statement, "My clinical consultation activities have informed my clinical research."

Procedures

Study procedures were approved by the Institutional Review Board at the authors' university. All data were collected anonymously using an on-line survey. The website for the survey was included in the recruitment e-mails, and participants could complete the survey any time during the one month period the survey was open. Participants provided informed consent prior to beginning the survey.

Statistical Analyses

All data were downloaded and entered into Predictive Analytic Software (PASW), Version 18, for analysis. When ratings were compared for separate groups (e.g., clinical science vs. scientist-practitioner), independent samples *t*-tests were run. When participants' ratings on items were compared, paired samples *t*-tests were run. Since statistical analyses involved comparisons of means, Cohen's *d* was used as the effect size measure.

Results

Descriptive statistics for the rating of research influences are presented in Table 1. Overall, one's own past research and articles on clinical research were rated as the most important influences on one's current research, followed by conducting therapy in clinical practice and supervision of clinical work. Additionally, overall, participants endorsed the belief that clinical practice should influence research ($M = 4.60$, $SD = .61$; 96.8% of participants responded 4 or 5). To examine whether a person's current orientation (i.e., clinical science, scientist-practitioner, scholar-practitioner, or other) influenced their belief in whether clinical practice should influence research, an independent samples *t*-test was run. Because only five participants selected "scholar-practitioner" or "other" for their current orientation, these participants were excluded from the analyses, and those who selected "clinical science" or "scientist-practitioner" were compared. Those who selected a clinical science orientation ($n = 26$, $M = 4.62$, $SD = .57$) did not differ from those with a scientist-practitioner orientation ($n = 31$, $M = 4.58$, $SD = .67$), $t(55) = .208$, $p = .836$, Cohen's $d = .06$. Furthermore, we examined whether level of faculty position was related to belief in whether clinical practice should influence research using a one-way analysis of variance (ANOVA). The one participant who selected "other" for their faculty position was

excluded from this analysis. Assistant professors ($n = 17$, $M = 4.53$, $SD = .62$), associate professors ($n = 19$, $M = 4.74$, $SD = .45$), and full professors ($n = 25$, $M = 4.56$, $SD = .71$) did not differ in their belief ratings, $F(2) = .63$, $p = .537$.

Twenty-seven (43.5%) participants reported they are currently active in clinical practice activities, and they reported engaging in clinical work an average of 24.59 hours per month ($SD = 20.09$). An independent samples t -test indicated there was no difference in rating of the belief that clinical practice should inform research based on whether a person was currently engaged in clinical practice ($n = 27$, $M = 4.74$, $SD = .45$) or not currently engaged in clinical practice ($n = 35$, $M = 4.49$, $SD = .70$), $t(58.12) = -1.74$, $p = .087$, Cohen's $d = .42$. Of those active in clinical practice, the number and percentage of individuals who reported their clinical practice influences their research in each way are presented in Table 2. A paired samples t -test was run to compare individuals' belief that clinical practice should inform research ($M = 4.74$, $SD = .09$) and their agreement with the statement that their own practice has informed their research ($M = 4.44$, $SD = .13$), $t(26) = 2.30$, $p = .03$, Cohen's $d = .51$, which indicates individuals' hold stronger beliefs regarding clinical practice influencing research than they practice in their own research.

The 35 (56.5%) participants not currently engaged in clinical practice were asked about barriers to being involved in clinical practice. Most of these individuals ($n = 31$ [88.6%]) reported current demands on their time as a barrier preventing them from being involved in clinical practice. Other barriers endorsed by participants were lack of interest ($n = 9$ [25.7%]) and clinical work would be too much extra work ($n = 4$ [11.4%]).

Fifty-five (88.7%) participants reported they are currently involved in clinical consultation activities, with most (65.5%) reporting they engage in consultation activities at least once a month. Of those active in consultation activities, the number and percentage of individuals who reported these consultation activities influence their research in each way are presented in Table 3. A paired samples t -test indicated participants' beliefs that clinical practice should inform research ($M = 4.62$, $SD = .59$) was significantly higher than their agreement with the statement that their consultation activities have informed their research ($M = 3.78$, $SD = 1.20$), $t(54) = 5.18$, $p < .001$, Cohen's $d = .89$.

Discussion

While multiple studies have examined whether

practitioners stay current on research findings in clinical psychology and use ESTs, no studies have examined whether clinical researchers are influenced by clinical practice activities. Based on our survey study, clinical researchers indicated that, on average, they strongly believe research should be influenced by clinical practice (mean rating of 4.60 on a five-point scale). Also, clinical researchers did not differ in their belief that practice should influence research based on training model. Furthermore, faculty position, often based on tenure and promotion, did not significantly affect ratings of the belief that practice should influence research. These findings indicate both relatively new and established researchers across training models continue to believe in a fundamental tenet of the Boulder model (i.e., research should be informed by the needs of the clinical practice field).

In terms of actual impact, the two most highly rated research influences were one's own previous research (mean rating of 4.66 on a five-point scale) and articles on clinical research (mean rating of 4.42 on a five-point scale). From an absolute frame, this finding does support a biased view that researchers are more influenced or concerned about their own insular research field. Additionally, this finding indirectly supports the view that the science-practice bridge is unidirectional: the primary pathway of influence is past research rather than currently needed practice activities (e.g., Addis, Wade, & Hatgis, 1999). This finding is not surprising given that building upon existing literature and developing a systematic research program are the primary and core influential factors of any top tier research training program and professional advancement. However, if one takes a relative view of influences, direct practice is one of several possible influences. This relative view is noted because the next two most highly rated research influences were conducting therapy in clinical practice (mean rating of 3.30 on a five point scale) and supervision of clinical work (mean rating of 3.20).

In this sample, slightly less than half (43.5%) of clinical researchers reported being currently active in clinical practice, indicating that a number of clinical researchers remain involved in direct practice as well. For those involved in clinical practice, the most common ways practice influenced their research were through researching specific clinical phenomena, treatment issues, or assessment issues. This finding is encouraging in that almost half of clinical researchers

engage in both research and practice and base their research on their clinical practice to some degree, thus enacting the Boulder model ideal. However, when ratings of how much individuals believe clinical practice should influence research were compared to their ratings of how much their own clinical practice has influenced their research, a medium sized difference is found. As such, researchers are less influenced by their own practice than their reported belief.

For those clinical researchers not currently involved in clinical practice, the most commonly endorsed barrier was a lack of time, with other barriers including lack of interest and practice being too much extra work. This finding is consistent with the view that research is time-intensive, especially in research-based institutes fueled on grant monies, and academics have to invest time in research, teaching, and service in the pursuit of tenure and promotion, and as such, few productive researchers would even have the time to practice themselves (Overholser, 2007; Vespia, 2006). Interestingly, whether a person was active in clinical practice was not related to their belief that clinical practice should influence research.

In an interesting parallel to whether researchers are directly involved in practice, a much larger percentage of surveyed researchers (88.7%) reported participating in consultative activities. Of these researchers who engage in consultation activities, 89.1% reported that these activities influence their research and 10.9% reported that these activities do not influence their research. Consultative activities included conducting supervision, providing workshops, and communication with practitioners for the purpose of this study. The most common ways that consultation was reported to influence research were identical to those identified by those involved in clinical practice (i.e., research on specific clinical phenomena, treatment issues, and assessment issues). Moreover, the order of the percentage of researchers who reported their clinical activities influenced their research in specific ways was equivalent for direct practice and consultation (see Table 2). As was found with clinical practice, rating of the belief that clinical practice should influence research was significantly greater than the rating that consultation activities have influenced one's own research, with the effect size being large. It is a debatable topic of whether consultative activities constitute a form of interaction with practice that adequately informs research of actual clinical

problems and issues. While it has been argued that clinical supervision does not require the same level of client exposure, clinical skills, and decision making as direct service does (Overholser, 2007), other authors have clearly described a supervision model and process that includes significant client-therapist observations, along with many of the same skills and decision making as a practitioner (Holloway, 1995). Moreover, researchers rated supervision (mean rating of 3.20 on a five point scale) as roughly equivalent in the degree of influence on their research (see Table 1) to conducting therapy (mean rating of 3.30 on a five point scale), but rated consultation with practitioners (mean rating of 2.85 on a five point scale) lower in influence than conducting therapy. Future work may want to examine the exact ways in which consultative activities influence research in order to bring further empirical support on this avenue of bidirectional influence.

These results seem to mirror more recent articles on the responses that practitioners give when asked about the value of research, the influence of research on their practice, and the barriers to incorporating evidence based practices (Stewart, Stirman, & Chambless, 2012; Teachman et al., 2012). That is, practitioners believe in the value of research on practice, are open to learning how research can influence and inform their practice, but note a number of barriers including the long term ineffectiveness of "one shot" workshops, inadequate or simplified continuing education offerings, lack of time and effort to read and understand quantitatively thick journal articles, and time and financial constraints. Similarly, in the current study, we found that researchers believe that practice is important to research and are open to practice influencing research, but they report barriers to engaging in clinical practice while maintaining a research career. Hence, the current state of the science-practice gap now appears less based on conflicting beliefs of the value of research to practice and vice versa, but more on the pragmatics of whether an individual can competently and effectively integrate two complex and challenging bodies of professional work. The results of the current study suggest that direct practice influencing research may be one of multiple avenues on the science-practice bridge that also includes consultation, supervision, training, and systematic dialogue, all of which serve to integrate both sides of the science-practice gap (Vivian et al., 2012).

A limitation of this study is the sample represented a subset of psychologists who were identified as con-

ducting clinical research and responded to a recruitment email about practice informing science. A select group of clinical researchers may have responded to this survey because they are committed to the Boulder model and strive for practice to inform their own research. It is possible researchers who agreed to participate are not representative of the larger population of clinical researchers and that a more diverse sample would show different outcomes.

In sum, the results of this survey study indicate that clinical researchers strongly believe that clinical practice activities should influence clinical research. A fair percentage of researchers surveyed (43.5%) actually do engage in direct practice. The most common barrier stated is the time and effort needed to do both research and practice in a competent and effective manner. Moreover, those surveyed responded that their own research is more influenced by their own prior research and peer reviewed journal articles. Based on the results of the direct practice questions, practitioners may have a valid point about a lack of direct experience and understanding of problems and issues directly faced by clinicians, thus supporting the belief that science and practice is a unidirectional process. However, a large percentage of researchers (79.0%) report engaging in consultative practices that inform their research. As such, the current study indicates that practice influences on research may be multifaceted and varied, and illuminates multiple avenues of bi-directionally that are critical to consider for the efforts to close the science-practice gap. Hopefully, the information gathered from this survey and the implication of multiple ways for practice activities to influence clinical research will help raise awareness that researchers are finding ways to better integrate both sides of science-practice gap.

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Table 1

Descriptive Statistics for Ratings of Influences on Research

	<i>n</i>	<i>M</i>	<i>SD</i>
Conducting therapy in clinical practice	60	3.30	1.31
Conducting assessment in clinical practice	60	2.93	1.33
Supervision of clinical work	60	3.20	1.26
Consultation with practitioners	59	2.85	1.28
My own past research	62	4.66	.60
Clinical research articles in peer-reviewed journals	62	4.42	.88
Clinical practice articles in peer-reviewed journals	62	2.74	1.27
Clinical training articles in peer-reviewed journals	62	2.32	1.10
Continuation of mentor's research area(s)	61	2.54	1.35
Personal or family history	61	1.77	1.15
Teaching	62	2.98	1.24
Newspaper articles	61	1.52	.83

Table 2

Number and percentage of participants who endorsed each way in which clinical practice activities influence research

	Clinical Practice (n = 27) n (%)	Consultation (n = 55) n (%)
Research based on specific clinical phenomena (e.g., understanding the development of a disorder)	21 (77.8%)	34 (61.8%)
Research based on treatment issues (e.g., lack of evidence based procedure and protocol)	17 (63.0%)	32 (58.2%)
Research based on assessment issues (e.g., lack of a reliable and accurate measure)	15 (55.6%)	27 (49.1%)
Research based on co-morbid issues (e.g., noticing a high rate of drug use in clients with a particular diagnosis)	10 (37.0%)	21 (38.2%)
Research based on non-specific treatment issues (e.g., motivation, adherence,	9 (33.3%)	19 (34.5%)
Research based on process issues (e.g., therapist-client alliance)	9 (33.3%)	13 (23.6%)
Not applicable – this type of clinical practice has not informed my scientific work	0 (0%)	6 (10.9%)

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Ethics, Injury, and Illness II: Considering Catastrophe

George J. Allen, Ph.D.

University of Connecticut



Much has been written about the importance of self-care for members of our profession. Our colleagues have published a substantial number of articles (e.g., Barnett, Baker, Elman, & Schoener, 2007; Norcross, 2009) about the necessity of managing the stresses associated with our professional work. There appear to be two prevalent themes in these writings. First, self-care represents an ethical imperative for psychologists (Allen, 2013; Wise, Hersh, & Gibson, 2012). Second, self-care needs to be woven comfortably into our habitual activities so as to not become an added burden to our functioning. As one illustration, Wise, et al. (2012) employed a research-based positive-psychology-mindfulness framework to recommend four principles for enhancing well-being via (a) intentionally choosing healthy choices, within (b) a mindset that emphasizes resilience-strengthening attitudes and actions (they called this “flourishing”), while (c) valuing reciprocity in caring for ourselves and others, and (d) integrating self-care into our daily routines.

There has been considerably less written, however, about how to effectively and proactively deal with larger catastrophes (e.g., serious illnesses or accidents adversely affecting ourselves or loved ones) that can wreak havoc in our personal and professional lives. I suspect that this omission may be due to the subtle but pervasive influence of our tendency to carry several implicit beliefs about our well-being. Two influential sets of such beliefs center on “just world theory” and the “above average effect.”

In its most basic form, just world theory (Lerner & Miller, 1978) argues essentially that good people (like us!) who practice correct activities are protected from experiencing bad events. Lucas, Alexander, Firestone, and Lebreton (2008) found that “belief in a procedurally just world was associated directly with lower perceived stress, and also indirectly with adaptive health behaviors and fewer physical health complaints” (p.

849). One corollary of these findings is that we most likely expect good health outcomes when we engage in health-promoting activities.

The “above average effect” (Alicke, Klotz, Breitenbecher, Yurak, & Vredenburg, 1995; Brown, 1986) refers to the tendency of a majority of people to judge their situations and abilities to be better than their peers. In a comprehensive review of such “flawed self-assessment,” Dunning, Heath, and Suls, (2004) concluded that “there is a pervasive tendency for people to perceive themselves as having significantly lower risk of a host of physical health problems than their peers” (p. 79) and that a such unrealistic optimism was associated with holding an “incorrect belief that if the problem has not yet appeared, it is unlikely to occur in the future” (p. 79).

The fact that psychologists have identified and sophisticatedly investigated the operation of “just world” and “above-average” effects does not make us immune from their influences. My personal come-uppance against these beliefs came in the form of a viral infection that led to hospitalization and rendered me bedridden and totally ineffective for almost two months. Throughout this illness, I was thankful that I was retired and no longer had the multitude of professional commitments that I had carried earlier in my life. I did wrestle continually with the (likely fever-driven) questions about what I should have, could have, would have done to meet my former commitments in such a weakened state. My grappling yielded some question sets that may be profitable to address before catastrophe strikes.

1. Who will help me manage (or take over) my professional affairs? Which of my colleagues will volunteer to teach my classes, see my clients, or at least inform them about my condition and future availability?
2. What kinds of verbal or written contractual arrangements should I negotiate with my colleagues in case of my disability? What should be the scope of their responsibilities? For how long? What would be fair compensation?
3. At what point is the well-being of my clients best served by providing them with referrals to col-

leagues? Do I have a written list of possible referrals to share?

4. How can I frame conversations so as to balance accuracy about my impaired condition without creating undue alarm or distress among my clients or colleagues?
5. What have I done to ensure the fiscal well-being of my loved ones? Do I have adequate financial reserves to pay ongoing bills? Do I carry sufficient disability and long-term care insurance?

These are not easy issues to address, especially when we enjoy a healthy state of being. Living in a context of good health, however, is the ideal time to plan for potentially catastrophic happenings. I sincerely hope that all of you continue to live in a just world and remain above average in terms of your physical health and well-being.

As one consequence of my own infirmity, I recruited a highly valued, younger colleague to serve as co-editor of future columns. As a brief introduction, Allison Ponce, PhD is Associate Professor of Psychiatry at Yale University Medical School. Her professional activities span issues pertaining to homelessness among adults with serious mental illness to clinical supervision to the assessment of core competencies in professional psychology. She has been highly involved in the activities of national and state psychological associations. I am delighted to welcome her and look forward to a fruitful collaboration.

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SECTION UPDATES

Guerda Nicolas, Ph.D., and Roxanne Donovan, Ph.D.—Editors

Section IV: Clinical Psychology of Women

Submitted by Elaine A. Burke, Psy.D.

 We would like to provide an update on the activities of Section IV of Division 12 (Clinical Psychology of Women). Our section is dedicated to addressing women's concerns in the field of clinical psychology. Members of our section are very interested in issues related to women from a variety of diverse backgrounds, particularly multicultural and global women. We are also very passionate about what we think are important and cutting-edge concerns related to women psychologists and/or the clinical treatment of women. Last summer during the APA Convention in Honolulu, Hawaii, our section hosted two symposia. The first one addressed the role of indigenous women in maintaining and preserving the culture in their communities following a history of trauma. This symposium included women who were members of these cultures and who also worked with Hawaiian, Native American, and Alaskan Native people. The symposium included an experiential component in which participants were taught how to do the hula, which is an essential part of maintaining Hawaiian culture among Hawaiian women. The second symposium addressed the challenges that women in leadership encounter in professional organizations. Several members of our executive board participated in this presentation. Both of these symposia were very well-attended and well-received.

We have a very active section and there are a number of ways in which our members interact with other members. The section publishes a newsletter with two issues per year in which the activities of the section are described as well as articles of interest to the membership. We are introducing a new peer-reviewed section of our newsletter, and have identified a planning committee. We will be seeking the submission of articles related to clinical psychology and women for potential publication in our newsletter. The section has incorporated various forms of technology in order to assist our members in communicating with each other including a listserv, a website, a Linked-in group and Facebook. Executive board members have been utilizing Skype and phone conferences to communicate and


plan for the section. We have been collaborating with other groups who are interested in women's issues, including Division 35 (Psychology of Women). Our executive board members in the Chicago area, who are also members of the Illinois Psychological Association, have sponsored events with a speaker and dinner. We are pleased that these events have resulted in additional members.

Our program committee has been active in developing section sponsored programming for the American Psychological Association's Annual Convention in Washington, D.C. next summer (2014). We recently learned that our symposium submission titled Global Violence toward Women: Interventions and Strategies for Change was accepted. It is a collaborative, interdivisional program sponsored by Divisions 12 (Clinical Psychology), 35 (Women), and 52 (International Psychology). Our section is also sponsoring a symposium on various forms of psychotherapy with women. In addition to our section board meeting, we are also hoping to have a social hour for our members and other people interested in our section during the APA convention.

We encourage networking and collaboration among our membership who represent a diverse cross-section of women in the field of clinical psychology. If you are interested in learning more about our section or to become a member please contact me at eburke23@hotmail.com.

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, Ph.D.

 The Association of Psychologists in Academic Health Centers (APAHC) welcomes 2014 President, Ronald T. Brown, PhD, ABPP, with thanks to Dr. Barbara Cubic for her presidential initiatives. Dr. Brown is the second president of the University of North Texas at Dallas where he is responsible for the academic, financial, fundraising, and community relationship functions of the university. He has been a long-term contributing member of APAHC, and we look forward to his tenure.

The Early Career Committee is sponsoring a series of conference calls for early career psychologists. The first

Section updates (*continued*)

call was led by Dr. Zeeshan Butt who spoke on Leadership Engagement at your Institution. APAHC continues a productive relationship with the AAMC (The Association of American Medical Colleges) with a variety of projects and the opportunity to impact medical training as well as the involvement of psychologists in medical school settings. Plans are underway for the next APAHC conference in 2015 in Atlanta, with the theme: "Academic Health Centers in the Era of Interprofessionalism: Multifaceted Contributions of Psychology."

APAHC is broadening resources available on our website at: <http://www.div12.org/section8/>, including resources related to teaching, writing, conducting research, and grant writing in the Behavioral Sciences. APAHC members place high value on the resources provided as a membership benefit. Recently, Drs. Ed Christophersen and Zeeshan Butt developed the Promotions Primer with a focus on career advancement and academic promotion. This resource was also highlighted through a recent publication in the *Journal of Clinical Psychology in Medical Settings*, December 2012, Volume 19 (4), 349-352: Introducing a Primer for Career Development and

Promotion: Succeeding as a Psychologist in an Academic Health Center. At the same time, APAHC is exploring social media opportunities and policy development for the organization. Members continue to benefit from valued APAHC publications, including the Grand Rounds newsletter, and our flagship journal: *Journal of Clinical Psychology in Medical Settings*.

Congratulations to APAHC on the 30th Anniversary of the organization (previously known as AMSP or Association of Medical School Psychologists)! In addition, it is important to highlight the 20th Anniversary of our longstanding and well regarded *Journal of Clinical Psychology in Medical Settings*, founded by Ron Rozensky, PhD, ABPP, who served as the Editor for 13 years; the journal is now online, with Jerry Leventhal, PhD as editor.

APAHC welcomes new members, including student members. Membership dues are low and this is a great way to add on to the benefits offered as a Division 12 member. For further information about APAHC/Division 12 Section 8, please check our website at: <http://www.div12.org/section8/index.html> or contact me directly at Sharon.Berry@childrensMN.org. 📧

BECOME A DIVISION 12 MENTOR

Section 10 (Graduate Students and Early Career Psychologists) has developed a **Clinical Psychology Mentorship program**. This program assists doctoral student members by pairing them with full members of the Society. We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A

small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit www.div12sec10.org/mentorship.htm, and visit www.div12.org/mentorship to become a mentor today!



ON BECOMING A FELLOW OF THE SOCIETY OF CLINICAL PSYCHOLOGY

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The Society of Clinical Psychology, APA Division 12, welcomes within its membership psychologists who are interested in and who identify with the field of clinical psychology—its practice, research, service, and/or missions. Besides being an esteemed member of Division 12, there are within our Society those who should consider being nominated and elected to fellow status. Many such members have not taken steps to apply for fellow status. Sometimes this is due to extreme modesty in evaluating one's own achievements, intimidation by the thought of the application process and being reviewed by peers, modesty in asking others for endorsement, or simply time constraints. Yet becoming a fellow of Division 12 holds many rewards and benefits well worth applying and focusing on successful election to fellow status.

There are two categories of fellow status: initial fellows and previous fellows. Initial fellows are those who have not yet been elected to fellow status in any APA division and need to apply for this in the division. Endorsements by three fellows are required. Current fellows are usually willing to mentor the initial applicant through the process and thus make it more user-friendly. Previous fellows are those who, having been fellowed by another division, can state how their work and experiences also qualify them to become fellows of Division 12. All members who are not yet Division 12 fellows or fellows of any other division need to consider applying for fellow status in Division 12. All who are current fellows are encouraged to give a helping hand to deserving potential fellows who might otherwise be overlooked: Nominate others who should be recognized for their outstanding and unusual clinical research, practice, or service.

What are the benefits and rewards of becoming a fellow of the Society of Clinical Psychology? The deserved recognition, appreciation, and greater visibility of one's research, practices, and service by one's peers are highly important to most of us. Research can certainly be disseminated without being a fellow, but having one's

work seen in the light of becoming a fellow within the Society of Clinical Psychology burns a far brighter and visible light on one's accomplishments and achievements. Often the more modest members within our Society feel overlooked and even isolated by the lack of colleagues recognizing and appreciating their work and nominating them for fellow status.

The networking and cross-research connections may be much increased when members become fellows. Collegiality is usually increased as fellows more identify with the field and their contributions to clinical psychology. Greater opportunities to share what one has done in clinical psychology usually come with fellow status. Often more opportunities to enter divisional offices come after one is fellowed. Fellows are often more sought for mentors of peers and early career psychologists, as well as in teaching and advisor capacities. Fellows have often been cited and referenced before being fellowed but may find even more of such citations and references after their fellow status has been achieved.

Sometimes our members overlook Division 12 sectional interest groups, such as sections on children, women's issues, ethnic minority issues, and research. Special achievement within these groups may well merit fellow nomination and election. Further, opportunities for intra- and interdivisional interests may foster new opportunities and challenges for research, practice, and publication. Our Society has more abundant and untapped talents and skills than we have sufficiently appreciated and that need to be acknowledged.

The greater collegiality and sense of appreciation by peers in adding deserving fellows to the Division enhances division cohesiveness and solidarity and contributes to the strength of the field of clinical psychology itself. Look in the mirror and at your colleagues and nominate the worthy for fellows!

—Carole A. Rayburn, Ph.D. Fellows Chair, Division 12

JOIN A DIVISION 12 SECTION

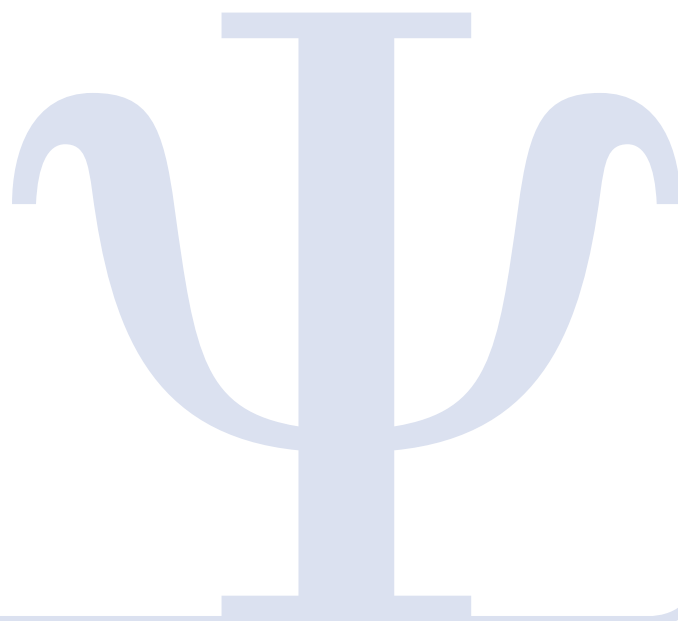
Division 12 has eight sections covering specific areas of interest.

- Clinical Geropsychology (Section 2)
- Society for a Science of Clinical Psychology (Section 3)
- Clinical Psychology of Women (Section 4)
- Clinical Psychology of Ethnic Minorities (Section 6)
- Section for Clinical Emergencies and Crises (Section 7)
- Section of the Association of Medical School Psychologists (Section 8)
- Section on Assessment (Section 9)
- Graduate Students and Early Career Psychologists (Section 10)

To learn more, visit Division 12's section web page:

www.div12.org/division-12-sections

To learn more about the
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Instructions to Authors



The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Division 12 of the American Psychological Association). Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Division. Topic areas might include issues related to research, clinical practice, training, and public policy. Also included is material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. Examples of submissions include: position papers, conceptual papers, data-based surveys, and letters to the editor. In addition to highlighting areas of interest listed above, *The Clinical Psychologist* includes archival material and official notices from the Divisions and its Sections to the members.

Material to be submitted should conform to the format described in the sixth edition of the Publication Manual of the American Psychological Association (2010). An electronic copy of a submission in Word format should be sent as an attachment to e-mail. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries and submissions may be made to editor
Guerda Nicolas at: nguerda@miami.edu.

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