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PRESIDENT'S COLUMN

Clinical Psychological Science, Dissemination, & the Society of Clinical Psychology

Terence M. Keane, Ph.D.



Over the past two years as President-Elect and President of the Society of Clinical Psychology (SCP) I've encountered multiple complex problems facing our profession. The Internal Report on torture was certainly complex and continues to adversely affect the APA; yet an ongoing problem of equal importance for clinical psychology is the growing distance between the new knowledge generated in academic psychology and the needs of practitioners in health care settings across the country and the world. Practicing in clinical settings (Medical Centers, Psychiatric Facilities, Private Practice, the Department of Veterans Affairs, Rehabilitation Sites, and other clinics) is changing rapidly as the healthcare system experiences important directions secondary to the affordable care act or Obamacare. The pace of science and particularly clinical science is by its very nature slow and unable to keep up with the demands of this change. Science moves gradually and scientific findings take about sixteen years or more to permeate healthcare practice. We are facing a serious conundrum. Can academic science in psychology influence the delivery of psychological health care? By the time grants are funded; data collected; analyzed; written and published will the findings be relevant to clinicians? How do we proceed to address this challenge for those of us actively engaged in clinical science?

The virtue of working as a clinical researcher in VA is that one is never very far away from the complexities of clinical care delivery, the changing nature of the patients seeking care from the healthcare system, and the demands

(Continued on page 2)

for clinicians to see more and more patients with efficiency and effectiveness.

When speaking to clinicians who are predominantly involved in clinical care and teaching, it is easy to become humble about the most recent exciting findings stemming from my amazing colleagues in the National Center for Posttraumatic Stress Disorder. How do our increasingly molecular findings (at the behavioral and genomic levels of analysis) affect the day to day work of clinicians practicing in America's contemporary healthcare system? My fear is that our scientific findings do not have the impact we desire. The stunning findings of Brian Nosek of University of Virginia that two-thirds of social psychological and experimental studies with humans do not replicate adds to the burden of those of us in clinical psychology to demonstrate that the work we do can improve the mental health in this country and does contribute to enhancing the practice patterns of our students and colleagues who work in these many clinical settings.

Too frequently, I hear that the problem is with the practicing psychologists in the community. If only they paid more attention to the scientific literature. I don't believe this and I never did; surely this growing gap between academic researchers and practitioners is a shared responsibility. As someone involved in clinical psychological science in a healthcare setting for nearly forty years, I am well aware of the pressures on clinicians and the pressures on academics. More patients need to be seen by one group; more papers and grants need to be generated by the latter group. Yet, it is my belief that the burden is on those of us in clinical research to reach out to those in practice to make the scientific work we generate readily and easily consumable. How might we do this? Such is the challenge in front of us.

Chris Fairburn and David Barlow, respectively, are turning to principles of therapy that are transdiagnostic in nature. This seems eminently reasonable to me; practitioners cannot have multi-module manuals guiding the care of every patient they see. The position by Fairburn and Barlow is that there are generalizable principles that transcend the specific nature of the problems observed in a given patient and that these evidence based principles are what need to be taught and practiced. Evidence is

accumulating on this approach, but the devil is always in the details. It will take considerable time to understand if this transdiagnostic approach to human problems will be successful. I am rooting for each of these investigators, because the growing number of diagnostic problems and treatment modules for each of these problems makes for an impossible task for practitioners. Can it be a surprise to any of us that those in practice cannot keep up with the proliferation of treatment manuals? With the newest approaches to psychological and neuropsychological assessment?

Among the most gratifying aspects of my years of service to SCP was watching the team of people led by the indomitable Deb Drabick of Temple University to build a brilliant sequence of continuing education courses for our membership. Following the guidance of Past President, Gayle Beck, this Continuing Education Committee meets monthly to identify talented and capable speakers to deliver 90 minute webinars (for fifteen dollars!). This is an enormously successful effort that will continue well into the future. Perhaps this is one avenue for real time delivery of new information to practitioners? But the number of attendees isn't there yet to think we are positively affecting clinical practice in the country. Of course, it is always one practitioner at a time, with the promise that we will eventually get there. Maybe.

In a recent meeting of the SCP Board of Directors one member who served for many years on the faculty of one of the most prestigious clinical psychology programs in the nation opined that even at that outstanding institution more than sixty percent of the graduate students ultimately found their way into clinical practice rather than conducting clinical science. I thought back to my own graduate training program that was very strong in clinical science and counted an even lower percentage over the four years that I attended Binghamton University. Three out of four were either exclusively or predominantly in clinical practice. Only one-quarter were in academic medical centers doing research or in Departments of Psychology doing research and/or teaching. Is there something imbalanced here in the focus of our training programs in clinical science?

SCP and SSCP have grappled with the problems of

Continuing Education approvals by the APA for decades. This past year saw progress in doing something about the issue of giving APA credit for educational programs that strayed very far from our evidence base in clinical psychology. With Bethany Teachman in the lead, a small committee of people from SCP, SSCP, and ABCT generated a small list of candidates to serve on one of the key APA oversight Boards. Some were, thankfully, elected for three year terms. One thing emerged in service on this ad hoc Committee of the leaders of these three organizations that struck me as fundamentally crucial to our future: the academic Departments of many of the people serving on this committee were not sponsors of APA Continuing Education credits for their communities. When I pointed this out, people's response was that it was very expensive and time consuming to run a CEU program. Frankly, this disappointed me greatly. Is there not a part of the mission of Departments of Psychology to work with members of the discipline in the communities in which they reside? If not these departments, then who will provide this leadership?

In the past two years, the alumni of Binghamton University's Clinical Psychology Training Program created a lecture fund to honor long standing Director of Clinical Training and Director of the Departmental Clinic, Stephen A. Lisman, Ph.D. The Lisman Lecture in Clinical Psychology is to bring outstanding clinical psychologists to the Department for an annual lecture that will enhance the training of the graduate students while bringing together the faculty in the program with clinical psychologists who are practicing in the community. This past autumn, Marsha Linehan, Ph.D. of Seattle delivered an all-important lecture on the science of suicide, an area in which she's made unique and important contributions clinically and scientifically. More than two hundred fifty faculty, clinicians and students gathered in one of the lecture halls on campus to learn from a premier clinician scientist. The Lisman Lecture met one of its key goals: to bring faculty, students, and clinical psychologists from the community together in an educational setting. As a profession, we need more integration of our clinical psychology faculty with members practicing in our communities. Clinical Psychology Programs will benefit from the integration, the community practitioners will benefit from the faculty members, and the mental health care provided

in the communities across the country may improve. Binghamton University's clinical psychology program has reached out into the surrounding community in an effort to provide demonstrable leadership. Many more departments are needed to do the same. Is it possible to start a dialogue about this? Is there room for this type of effort in our most prestigious clinical psychology training programs? Will faculty who do this be supported, rewarded, reinforced for engaging the profession in the communities in which they reside? We do need the dialogue.

Finally, the era of dissemination and implementation science is upon us in clinical psychology. Large scale healthcare systems in America, the United Kingdom, and Australia are engaging in systematic efforts to educate and train clinical psychologists in specific evidence based interventions. VA led the way with efforts at dissemination of psychological therapies in this country under the leadership of Toni Zeiss, Ph.D. who was the first psychologist to head the VA's Office of Mental Health in that national system of healthcare. Brad Karlin, Ph.D., the incoming President of SCP, was fundamental to all of the efforts in VA while he was in a leadership role in Washington. There were and still remain many barriers and obstacles to dissemination at the practitioner level, the healthcare system level, and the actual clinic level of analysis. Yet, researchers are now working hard to understand these barriers to delivery of evidence based psychotherapy and assessment. These efforts are now called Dissemination and Implementation Science; a new and important field of inquiry. The Society of Clinical Psychology is the natural home for Dissemination and Implementation Scientists in clinical psychology. We will begin to engage those actively involved in this growing area of psychology so that they can find a welcoming home in SCP to support their work, their efforts, and their future goals.

It's been my sincere pleasure to serve as the President of the Society of Clinical Psychology for 2015. We surely have a bright future ahead of us and I personally look forward to contributing to the profession for many years to come.

Best of luck to Brad Karlin and to incoming President Elect and Boston University colleague, Michael Otto. 🍷

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Measurement-Based Care: Enhancing Mental Health Care Decision Making and Patient Outcomes

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Measurement-based care (MBC) is the practice of basing clinical care on systematic data collected prior to and throughout treatment. Several well-powered meta-analyses have provided strong empirical support for the value of integrating MBC into psychological treatment. However, a number of critical MBC issues have not been sufficiently addressed and require further attention. These issues include, but are not limited to, what should be measured, how MBC can be effectively and sustainably implemented in routine service settings, and what can and should be done with the data collected through MBC. In the rapidly changing health care landscape, MBC and clinical psychology's version of "big data" will play a prominent role in the way that services are delivered and paid for. The implications of MBC are rapidly expanding as routine process and outcome assessment becomes the norm, information technology advances, and more systems are able to talk to one another. In this article, we briefly introduce some of these broader implications and describe our research team's current efforts in this area, with specific attention to the identification of provider differences, performance measurement, and provider selection.

Keywords: measurement-based care; outcome monitoring; therapist effects; health care decision making

Introduction

In line with the definition recently offered by Scott and Lewis (2015), measurement-based care (MBC) can be defined as the practice of basing clinical care on systematic data collected prior to and throughout treatment. Within behavioral health care, MBC efforts have largely focused on the collection of patient symptom and functioning data, with a primary example being routine outcome monitoring (ROM) and ROM-based feedback (Lambert, 2007). When routine assessment is integrated into clinical care, it not only enhances treatment effectiveness for the individual patient, but also yields valuable, ecologically valid data on the process of change, which can help reduce the practice-research "chasm" (Boswell & McHugh, in press; Institute of Medicine [IOM], 2001).



James F. Boswell

Several well-powered meta-analyses (e.g., Shimokawa, Lambert, & Smart, 2010) have provided strong empirical support for the value of integrating MBC into psychological treatment. Owing to such evidence, ROM and feedback systems have ascended to a prominent role in mental health care policies, practice settings, and research agendas (Bickman, Riemer, Breda, & Kelley, 2006; IOM, 2007). In their seminal article on patient-focused research, Howard, Moras, Brill, Martinovich, and Lutz (1996) presciently noted the potential utility of MBC to supervisors, case managers, and systems of care, in addition to individual patients and clinicians. Castonguay et al. (2013) highlighted the usefulness of the umbrella term practice-oriented research to capture not only patient-focused research, but also similar MBC methods for enhancing practice-research integration and practitioner-researcher collaboration, as well as mental health care decision making. Similarly, Constantino, Boswell, Castonguay, and Bernecker (2013) argued that ROM can promote clinical responsiveness at multiple levels, spanning individuals and health care systems. The research is clear: the integration of routine assessment into clinical care, most prominently ROM and feedback, should be a core component of evidence-based practice that is not bound by any specific theory or diagnosis. However, similar to the status of evidence-based treatments (Nathan & Gorman, 2015), in the area of MBC a number of critical issues have not been sufficiently addressed and require further attention. For example, the predominant focus of MBC efforts has been on patient self-report of symptoms and functioning. Although this is certainly understandable, it is unclear if patients and/or clinicians more highly value these types of outcomes compared to others, such as attaining insight or creating new meaning. In other words, what should be measured in MBC is an open question. In addition, there is the crucial issue of how MBC can best be

integrated into routine treatment and health care settings, which spotlights a key implementation question (Boswell, Kraus, Miller, & Lambert, 2015; Lewis et al., in press). It follows from these “what” and “how” questions that the field must continue to grapple with the broader implications of MBC for behavioral health care (Boswell, Constantino, Kraus, Bugatti, & Oswald, 2015). In the rapidly changing health care landscape, MBC and clinical psychology’s version of “big data” will play a prominent role in the way that services are delivered and paid for. In this article, we briefly introduce some of these broader implications and describe our research team’s current efforts in this area.

Provider Differences

Behavioral health care has traditionally assumed that all providers function as the same social stimulus for all patients. Treatment researchers have viewed the clinician as a “nuisance” variable (Kiesler, 1966), and health plans analyzing claims data have similarly treated clinicians as essentially interchangeable. Concomitantly, research has consistently demonstrated significant variability in skill and outcomes among providers (Baldwin & Imel, 2013), in both naturalistic studies involving MBC (e.g., Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Lutz et al., 2007) and controlled research settings (e.g., Boswell et al., 2013; Huppert et al., 2001; Imel, Baer, Martino, Ball, & Carroll, 2011). Such variability is attenuated, but still clinically meaningful, in controlled research involving manualized, evidence-based treatments, in which clinicians receive targeted training and ongoing supervision. It is important to note that provider differences are not unique to psychotherapy. In a reanalysis of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program’s pharmacotherapy outcomes, differences among psychiatrists accounted for more of the outcome variance than the antidepressant medications they prescribed (McKay, Imel, & Wampold, 2006). Furthermore, observed variability in service delivery and outcomes expands to treatment centers, hospitals, and hospital networks (Scanlon, Lindrooth, & Christianson, 2008).

Research has demonstrated that therapist differences in fidelity to evidence-based treatment protocols can be a function of patient severity (Imel et al., 2011) and trait interpersonal aggression (Boswell et al., 2013). In a study of nearly 700 therapists’ naturalistic treatment outcomes on twelve outcome domains (e.g., depression, anxiety, substance use, sleep, interpersonal functioning, quality of life), involving a sample of nearly 7,000 patients, the majority of therapists demonstrated a differential pattern of effectiveness depending on the problem domain (Kraus et al., 2011). For example, some therapists demonstrated substantial reductions in depressive symptoms across their patients, while others evidenced particular effectiveness in reducing symptoms related to substance abuse. Many therapists

demonstrated effectiveness over multiple outcome domains, yet no therapists demonstrated reliable effectiveness across all domains. Furthermore, a small, but notable 4% of the therapists failed to demonstrate positive outcomes on any domain.



Michael J. Constantino

On the one hand, 4% may not seem like a high prevalence, yet across the population of clinicians and patients, such provider differences carry significant implications for behavioral health care outcomes (Saxon & Barkham, 2012), especially if a clinician’s outcome track record is stable and predictable. Our research team recently replicated and extended the findings of Kraus et al. (2011) in another large clinician and patient sample. However, unlike Kraus et al. (2011), this more recent study applied a rigorous risk-adjustment model that accounted for diverse patient characteristics, such as initial severity on multiple outcome domains. Risk-adjustment controls for the effects of patient characteristics on outcomes that are unlikely to be randomly distributed across clinicians in real-world settings. This is critical in order to improve estimation precision and enhance decision making utility (Hermann, Rollins, & Chan, 2007; Raghavan, 2010). Risk-adjustment can account for variance that would otherwise be attributed to differences in therapist skill but are actually related to the fact that some therapists treat more complicated-to-treat patients. Even with extensive risk adjustment, significant provider outcome differences were observed (Kraus et al., in press). For example, 18.72% of the variance in quality of life outcomes was explained at the between-clinician level (18.28% for Substance Abuse, 12.78% for Suicidality, and 11.82% for Depression). Furthermore, hierarchical linear modeling (HLM)-based correlations demonstrated stability in clinician performance across two separate waves of 30 patients per clinician (e.g., Substance Abuse $r = .94$, Quality of Life $r = .86$, Depression $r = .81$).

With MBC, what starts out as a relatively low-cost transdiagnostic practice behavior designed to benefit this patient ultimately yields extremely valuable comparative treatment information after a large number of a realized cases have accumulated. However, the operationalization of “large” is relative to

the intended use of this information. For example, our analyses have shown that outcome data from as few as 10-15 patients is sufficient to yield a reliable and valid estimate of clinician effectiveness in a particular outcome domain (Boswell, Constantino, Bentley, & Kraus, 2015). Furthermore, although clinicians endorse the belief that they are more effective when working with certain types of patients compared to others (clinician x patient interaction; Boswell et al., 2015), other research indicates that clinicians may not be accurate in their specific outcome predictions (Hannan et al., 2005; Walfish, McAlister, O'Donnell, & Lambert, 2012). In other words, clinicians recognize that there are certain patients whom they struggle to help, yet also have difficulty identifying individual patients who are at risk for deterioration in the absence of integrating more systematic MBC feedback as decision support.

Where Are We Going?

It has been almost 9 years since the IOM (2007) recommended that patients be granted access to provider performance data to inform treatment decisions. Theoretically, access to provider performance data would encourage patients to compare individual clinicians and preferentially choose the best performing clinician in a particular area of need or geographic location. This work is already being done in medicine. Scanlon et al. (2008) offer a systems level example; they studied the health care seeking behavior of employees at a large manufacturing company. This company offered an incentive (no co-insurance payment) to employees who sought care at a preferred hospital (tiered hospital network). A preferred hospital was determined based on several hospital-level safety and efficiency indicators established by the Leapfrog Group (<http://www.leapfroggroup.org/>). Results showed that employees who were offered the incentive did indeed seek care at preferred hospitals at a significantly higher rate than non-preferred hospitals. Similarly, Chernew, Gowrisankaran, and Scanlon (2008) found that consumers who were given health

plan report cards were willing to pay more (although only slightly) to avoid health plans with poorer ratings. Importantly, these studies did not involve direct dissemination of provider performance information to either employers or consumers.

Two systematic Cochrane Reviews (Henderson & Henderson, 2010; Ketelaar et al., 2011) examined research on the effects of publicly releasing provider performance data. Results from the few studies that were deemed methodologically suitable (i.e., randomized controlled trial [RCT], quasi-randomized controlled trial, or controlled pre-post design) were mixed. In one review, public release was correlated with increased quality improvement activity within care organizations, yet no information on patient perceptions or behavior change was provided. None of the identified studies, including those excluded from the formal review, involved behavioral health care.

We conducted a pilot survey where we asked patients about their attitudes and preferences regarding access to provider performance information (Boswell, Constantino, & Kraus, 2014). Survey results indicated that a large majority of patients experience perceived difficulty finding and selecting a mental health care provider. In addition, patients endorsed a high level of interest in the integration of provider performance information in the clinician referral (e.g., from their primary care doctor) or case assignment (e.g., within a community mental health clinic) process. However, patient attitudes were more mixed about direct-to-consumer information regarding individual provider outcome track records.

Similar to the dubiousness of choosing a provider based solely on the average number of gold stars endorsed on a consumer satisfaction website, we question the usefulness of passive public release of provider outcome data, particularly non-risk adjusted data. Nevertheless, we do believe that provider differences are meaningful and should be taken into

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consideration when making care decisions. To put this in perspective, Imel, Sheng, Baldwin, and Atkins (2015) recently conducted a simulation study to examine the impact of removing therapists with the worst outcomes, defined as performing in the bottom 5% of the sample. Extrapolated over 10 years, they found significantly higher response rates when the lowest performing therapists were replaced with a random sample of therapists from the better performing population, translating into thousands of additional treatment responders over time. It is important to emphasize that a majority of therapists are effective in several outcome domains. At the very least, we believe that strategies should be employed to steer patients toward effective providers and away from consistently ineffective and potentially harmful providers.

Our research team is working to learn more about the implications of provider differences and performance information, and to identify effective methods for harnessing provider outcome information collected through MBC. In addition to ongoing research in the area of therapist effects, we are embarking on three interrelated studies in this area, which we outline below.

Clinician Self-Knowledge and Improvement

We were fortunate to receive a Norine Johnson Psychotherapy Research Grant from Division 29 of the American Psychological Association (APA). With this grant support, we are studying therapists' predictions regarding their own effectiveness with particular types of patients, as well as the factors that contribute to their judgments regarding their effectiveness, or lack thereof, with particular patients. Specifically, therapist self-ratings of effectiveness in addressing different problem domains will be compared with their actual patients' outcomes as measured by a multidimensional ROM instrument, the Treatment Outcome Package (TOP; Kraus, Seligman, & Jordan, 2005). In addition, via survey items and semi-structured phone interviews, we are asking therapists about the basis of their self-ratings and the resources and activities that they pursue to improve their practice or increase their capacity to work productively with difficult to treat patients. Interestingly, a recent study by Chow et al. (2015) found that therapists' reported time spent engaging in deliberative practice related to their work with patients was significantly associated with their patients' outcomes. In our view, effective therapists possess a balanced view of their relative strengths and weaknesses in addressing particular problem areas and patients. This awareness should lead them to work more often with particular patients, to seek particular training experiences that address areas of relative struggling, and/or to limit their practice to specialty areas of known efficacy. A therapist's relative accuracy in making these determinations has important implications for patient care, our use of measurement tools, and better understanding the nuances of the therapist effect.

Mental Health Care Consumers' Attitudes toward Provider Performance Data

Despite demonstrated differences in performance among behavioral health care providers (Baldwin & Imel, 2013), patients rarely have direct access to this performance information. Health care systems are devoting increasing attention to provider (and system) performance measurement and the alignment of payment models and resource allocation with performance indicators (Herman & Evans, 2015). However, patient perspectives on the value of these initiatives and performance data are sorely lacking (Henderson & Henderson, 2010). Patient views are vital given the growing emphasis on performance assessment in developing new delivery and payment models. In addition to basic questions (e.g., Do patients value having access to provider performance data to inform their treatment decisions?), little is known about patient preferences regarding mechanisms of provider performance information access or dissemination, or the relative value patients place on provider outcomes compared to other provider variables (e.g., demographic match, location, Medicare/Medicaid participation).

With grant support from the Robert Wood Johnson Foundation, we are conducting a study to address these critical questions using a mixed-methods (quantitative and qualitative) approach. In community mental health settings (CMHCs), we are investigating mental health care consumers' (a) attitudes and preferences regarding the use of provider outcome/performance information, and (b) the relative values placed on providers' performance track records compared to other provider/treatment characteristics. Specifically, we are utilizing semi-structured consumer interviews and focus groups, as well as a survey methodology that integrates an adapted delay-discounting paradigm (Critchfield & Kollins, 2001; Swift & Callahan, 2010). Our research team is comprised of academic researchers, identified mental health care consumers, decision scientists from the University of Rochester and Syracuse University, and CMHC administrators and program directors at Riverside Community Care and Family Continuity in the state of Massachusetts. A more thorough understanding of patient values and preferences, and the value they place on provider performance track records compared to other provider characteristics, may help patients and other mental health care stakeholders make more personalized and informed treatment decisions, which, in turn, could lead to increased treatment engagement, retention, and better treatment outcomes.

Enhancing Mental Health Care by Scientifically Matching Patients to Providers' Strengths


Finally, we have recently been awarded funding by the Patient-Centered Outcomes Research Institute (PCORI) to conduct a large scale comparative effectiveness study examining the impact of matching patients to providers with empirically demonstrated effectiveness in that patient's primary presenting

problem domain(s). The core of this research will be a randomized controlled trial (RCT) comparing the outcomes of patients who are assigned to a well-matched clinician determined by a MBC algorithm to patients who are assigned to a clinician “as usual” within a system of care (e.g., based on availability). Similar to the Robert Wood Johnson Foundation-supported study above, we have assembled a project advisory board that is comprised of diverse mental health care stakeholders. In addition to mental health care consumers and academic researchers, our team includes clinicians (therapists, psychiatrists, and primary care), private industry, and health policy experts. We plan to assess a wide variety of treatment outcome and process variables, and predict that the scientific match group will outperform the no match group to a clinically significant degree on domain-specific symptoms and functioning, as well as global symptomatology. We also expect that the match group will be more effective in promoting working alliance quality and facilitating positive patient outcome expectations. In addition, we expect there to be less patient dropout in the match condition, and higher patient and referrer satisfaction.

Conclusion

The implications of MBC are rapidly expanding as routine process and outcome assessment becomes the norm, information technology advances, and more systems are able to talk to one another. There is solid evidence that MBC results in better outcomes for individual patients; however, critical issues have not been sufficiently addressed. These issues include, but are not limited to, what should be measured, how MBC can be effectively and sustainably implemented in routine service settings, and what can and should be done with the data collected through MBC. In this article, we have focused on the identification of provider differences, performance measurement, and provider selection.

The use of MBC data for treatment decision-making, including provider selection, would ideally involve

diverse stakeholder input on the value of different types of performance data, methods of data presentation, and how data are used. In order for any MBC-driven initiative to be successful, relevant stakeholders must be adequately represented in the design, implementation, and testing of such mental health care initiatives. Furthermore, there is a growing need to contrast clinician outcome data derived from repeated administration of standardized assessments on a large number of patients with unsystematic satisfaction ratings (Chamberlin, 2014). Although we have a lot of work ahead of us, we will be moving in the right direction, provided that we continue to put patients first. 

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The RxP Campaign Succeeds Only Within APA: A Response to Dr. DeLeon

Timothy Tumlin
Darien, IL

 In a recent issue of *The Clinical Psychologist*, DeLeon (2015) wrote a positive account of the history of the APA campaign to obtain prescribing rights for psychologists based on training standards steeply reduced from any other profession's prescribing models (RxP). Dr. DeLeon has reliably expressed such optimism since he and his employer, Sen. Daniel Inouye, initiated the campaign in 1984.

However, another view of the RxP effort shows that it has been a singular failure by almost any metric save one: continued political and financial support by the American Psychological Association despite nearly unflinching rejection, controversy, expense, and changes in the health care landscape that make it unnecessary.

Legislative bills proposing RxP laws have failed approximately 183 times in 26 states in the 20 years since APA's Board of Directors and Council of Representatives hastily tabled normal procedures and approved it as policy. Only two early legislative successes have resulted in prescriptive authority for psychologists. In 2002 New Mexico approved such a bill with tight practice restrictions and supervision requirements, which have been impervious to subsequent attempts to loosen them. Two years later Louisiana passed such a law with supervision restrictions. A revised law adopted in 2011 sparked intense controversy within the psychology community there but provided a pathway to more independent prescribing for some. However, it also moved psychologists' practice under the state's medical board, creating the first group of psychologists

to practice psychology only under medical supervision.

Some limited success in allowing psychologists to prescribe in federal positions has occurred under somewhat mysterious circumstances, possibly the result of influence of Sen. Inouye. He occupied powerful committee positions governing the military budget and overseeing Native American affairs. Spokespersons for the Army, Navy and Air Force could not explain how the 16 psychologists prescribing at military facilities were given permission to do so. In addition, 6 are known to prescribe at reservations for Native Americans. More is known about Sen. Inouye's public involvement in creating a demonstration project for RxP in the military during the 1990s. After training 10 carefully selected psychologists at a cost of \$6 million, the program was closed as unnecessary. Graduates of the experiment were found to be medically weaker than psychiatrists (American College of Neuropsychopharmacology, 2000) and the trainees opposed even less stringent proposals such as those in the RxP bills. Sen. Inouye was also publicly credited with creating an RxP-based pharmacy school in military facilities in Hawaii, although that program has so far been unable to attract enough students to remain viable.

One of the campaign's greatest setbacks occurred last year in Illinois when an RxP leader was forced to accept all conditions that medical negotiators put on the table, after which she received an APA presidential citation. It would allow psychologists to prescribe only if they meet all education and training requirements of physician assistants, amounting to six years of full-time study and practicum accredited by the agency that certifies PA programs. This would be another instance of removing authority over psychologists' practice and training from our profession and placing it under medical supervision in pursuit of RxP, whose training model is the only one for prescribers that is not accredited by a professional accrediting organization. If some psychologists do undergo that training, then they would prescribe under stricter conditions than physician assistants do, including limits based on patients' age and medical or developmental condition, and with a stringently limited formulary. Although touted as a victory by RxP advocates, few psychologists are

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expected to undergo six years of full-time education and training for a practice opportunity far more restrictive than the physician assistants their training emulates. It is also unlikely that a complete training program accredited by the PA accreditation agency, with far higher standards than what RxP proposes, would be created in light of how few persons would enroll in it.

Bleak as its record has been, RxP's prospects for success appear to be dimmer in the future. Dr. DeLeon has retired from his career in Sen. Inouye's office and the senator himself has since died, so that federal influence supporting the campaign is likely to be diminishing. The military is downsizing, and national policy on health care practices now emphasizes interprofessional collaboration, which is inconsistent with a turf war over lucrative prescribing rights. In addition, the trend for medical practice is to increase training requirements, such as among pharmacists and advanced-practice nurses, not to reduce them as RxP proposes.

Interest in RxP within APA is in steep decline. Division 55, the APA unit created in 2000 that supports the political campaign, is shrinking and is ranked second among divisions in the proportion of members leaving it (Robiner, Fossum & Hong, in press). Advocates are more likely to be individuals with personal interests in its maintenance, such as those connected to the psychology schools offering online classes. The New Mexico school offering RxP coursework has stopped accepting new students and the above-mentioned Hawaii school is at risk of closure because it has not attracted enough students. Nevertheless, APA has supported the RxP campaign generously (e.g., \$120,000 to Illinois). Overall, more than \$3 million in grants to states lobbying for RxP bills has been paid out of practice assessment funds, with many other expenses also being incurred by APA and local activists.

RxP has always been controversial within our profession. For example, 275 psychologists signed a petition opposing the RxP bill in Illinois. Nationally a volunteer-led organization, Psychologists Opposed to Prescription Privileges for Psychologists, has opposed RxP for years. A recent poll of psychologists by the Association for Behavioral and Cognitive Therapies found lopsided opposition to the RxP campaign's proposals. An earlier survey conducted by the Society for a Science of Clinical Psychology (a section of APA's Division 12) found similar opposition to RxP, but was forbidden by APA governance to publicize these findings, based solely on the fact that the findings were "not in accord with APA policy."

As a controversial campaign with a highly questionable

scientific basis, focused on expanding market share and political leverage, RxP also poses a risk to recipients of such services due to the inferiority of its proposed training (Robiner, Bearman, Berman, Grove, Colón, Armstrong, & Mareck, 2002). APA members and leaders concerned about back-room political tactics used to pursue economic and political expansion would do well to step back and take another look at whether RxP is practical and consistent with their values. ■■

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Dr. DeLeon Responds

Patrick H. DeLeon

Dr. Tim Tumlin and I fundamentally disagree on the appropriateness of RxP for the profession of psychology and we have engaged in numerous "discussions" over the years. I always appreciate hearing his elegantly expressed views. However, I am confident that time will demonstrate that properly trained colleagues with this additional expertise will be able to meet a significant societal need in a highly competent fashion.

Aloha,

Pat DeLeon

Former APA President ■■

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Jonathan S. Comer, Ph.D. - Editor

Closing the Gap Between Research and Practice: The Two-Way Bridge Initiative

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Editor's Note: This article is being simultaneously published in *The Psychotherapy Bulletin*, the official publication of APA Division 29

 Psychology researchers have long lamented that practicing therapists do not make use of research findings in their clinical work. For their part, clinicians have argued that much of what researchers have studied has not adequately addressed the issues that they confront in their practices. This gap between research and practice continues to exist, even in the face of growing external pressures for empirical accountability among policymakers and insurance companies. There undoubtedly are numerous reasons for this long-standing gap. Clinicians and researchers live in different professional worlds. Researchers seek to advance the field and are involved with publications and research grants, whereas clinicians are concerned about what works best to help specific patients and are involved with referrals and insurance reimbursement; in addition, there exist few forums where the two can

interact. Despite training models that seek to prepare psychologists in scholarship, science, and practice, the existence of these overlapping, yet separate, domains can result in a disconnect within the profession.

Another possible reason for the clinical-research disconnect is the fact that the two worlds have historically been connected by a “one-way bridge”: Researchers attempt to disseminate their findings to clinicians, but the voices of practicing clinicians typically go unheard.

Most research on the efficacy of psychotherapy has involved clinical trials carried out on interventions for treating various clinical disorders, resulting in what has been called empirically-supported treatments (ESTs). Although the findings of these clinical trials have provided important information for clinicians, they unfortunately do not offer all the information needed in using these treatments in clinical practice. Applying these findings to clinical practice often involves modification and, among other things, dealing with patients' cultural values, beliefs, and preferences.

The use of randomized controlled trials (RCTs) has been modeled on research evaluating the efficacy of new drugs. Once a drug has been shown to be effective in two clinical trials, it is approved by the FDA for clinical use. There is, however, a mechanism in medicine whereby practicing physicians can report back to the FDA about their clinical experiences—particularly the difficulties they encounter when using these empirically supported medications in practice. Up until recently, no similar mechanism has been available for psychotherapy interventions demonstrated to have efficacy based on RCTs. The clinical feedback from those in the field, in our opinion, is critical to effectively shape clinical science.

In 2010, the first author was elected President of the Society of Clinical Psychology, Division 12 of APA, and began a presidential initiative to build a Two-Way Bridge between Research and Practice. The initiative established a mechanism whereby practicing clinicians could provide researchers with feedback about their clinical use of ESTs whose efficacy was supported by RCTs. We may usefully conceptualize such clinical observations as offering what is known in the sociology of science as “the context of discovery” (Reichenbach, 1938). Specifically, these clinical observations can help to point to those mediating, moderating, and contextual variables that were missing in clinical trials, but which nonetheless are important for the effective application of these interventions in practice. In 2011, the Two-Way Bridge initiative became a collaborative effort together with Division 29 (Society for the Advancement of Psychotherapy) when the fifth author was serving as president.

In supporting this Two-Way Bridge initiative, the Society of Clinical Psychology and the Society for the Advancement of Psychotherapy appointed a diverse subcommittee to spearhead the effort. In addition to the first author as Chair, the committee consisted of:

Louis Castonguay, Jairo Fuertes, Jeffrey Magnavita, Michelle Newman, Linda Sobell, and Abraham Wolf. In our initial survey of practicing clinicians, which was internationally advertised and conducted online, therapists were asked to report on their experiences in using Cognitive-behavioral therapy (CBT) in the treatment of panic disorder (at the time, CBT was the only approved EST for this clinical problem). In addition to the questions asked of all participating clinicians, we also requested information about certain key classes of variables that they found to interfere with the clinical effectiveness of CBT in treating panic in actual practice, including:

- variables associated with patient symptoms
- patients' other problems or characteristics
- patient expectations about treatment
- patient beliefs about symptoms
- patient motivation
- social system (home, work, other)
- problems/limitations with the intervention procedure
- therapy relationship issues

The reason we wanted to know about factors that interfered with the successful treatment in clinical practice was to identify those variables that would provide important issues for therapy researchers to investigate. In addition, identifying factors that could

interfere with successful treatment could also provide valuable information to practitioners that could enhance their clinical effectiveness.

Since the initial survey of therapists on their experiences in dealing with panic disorder patients, the Two-Way Bridge initiative has looked at clinical experiences associated with the use of empirically supported treatments in dealing with social anxiety and general anxiety disorder. The findings of these three surveys, together with the supportive comments by two internationally known therapy researchers—Dianne Chambless and Tom Ollendick—have appeared in the journal *Behavior Therapy* (Chambless, 2014; Goldfried et al., 2014; Jacobson, Newman, & Goldfried, 2016; McAleavey, Castonguay, & Goldfried, 2014; Ollendick, 2014; Szkodny, Newman, & Goldfried, 2014a; Wolf & Goldfried, 2014). The published results are also posted on the Two-Way Bridge website (www.stonybrook.edu/twowaybridge).

The following survey focusing on PTSD has been conducted, analyzed, written up, and submitted for publication:

- Lauren E. Szkodny, Michelle G. Newman, and Marvin R. Goldfried (2014b): *The Use of Empirically Supported Psychological Treatments for Posttraumatic Stress Disorder in Clinical Practice*.

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When this survey is published, its availability will be announced on various listservs and the Two-Way Bridge website.

The overall objective of the Two-Way Bridge initiative is to call attention to the importance of having a mechanism whereby the dissemination of clinical observations can be sent to therapy researchers. In doing so, what gets created is a productive synergy, allowing both clinicians and researchers to have a voice in forming a consensus, and in jointly developing practice guidelines. The potential is for the advancement of psychological practice, with research in psychotherapy being informed and advanced by clinical practice, thereby leading to future research that is timely and that has greater clinical relevance. 

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Moral Stress in Mental Health Practice and Research

Adam Fried, Ph.D.


 Mental health practice, assessment and research can be highly fulfilling, but also emotionally demanding. In recent years, the field of psychology has made a concerted effort to educate psychologists about the effects of various types of caregiver stress (including secondary traumatic stress and vicarious traumatization in which the professional internalizes or is otherwise personally affected by the trauma experienced by those with whom the professional works) on their mental health and professional work (Collins & Long, 2003; Figley, 2002). Extreme cases can lead to a phenomenon known as compassion stress/fatigue (Figley, 2002), which can often be accompanied by a decrease in professional self-efficacy and a reduced willingness to help (Figley, 2002; Newell & MacNeill, 2010).

Stress can take many forms. One type that has received increased attention occurs when professional, institutional or legal rules and constraints prevent the practitioner from doing what they believe is right or most beneficial for the client/patient. Known as moral stress, these experiences describe ethical and emotional impasses experienced by professionals who may feel unable to provide the assistance they believe is truly necessary to address the client's issues while also maintaining appropriate boundaries and adhering to ethics codes and laws.

Originally developed within the nursing community (Jameton, 1984), this type of stress has been studied across many "helping" professions, including social workers, psychologists, and palliative care providers. Within psychology, it isn't difficult to imagine a variety of moral stress situations within practice, assessment and research settings, although the nature of moral stress may differ in terms of the role of the professional, the setting and the nature of the mental health condition or focus of intervention.

The psychologist who is not able to provide much-needed treatment due to client health insurance

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limitations or costs, the evaluator who hesitates about making a mandatory child abuse report because they fear the investigation may do more harm than good, the therapist who contemplates lending a destitute client money to pay for groceries, and the clinical trainee who believes that the intervention a supervisor has mandated will be ineffective or harmful have in all likelihood experienced this type of stress.

These situations are not limited to practice and assessment. Researchers are also confronted with similar and unique moral stress dilemmas. These particular moral challenges come into play when research staff want to do what they believe is right but may be prevented by their role responsibilities, job description, or organizational rules. For example, in many instances, research staff are required to follow standardized or manualized treatment protocols that are focused on a particular symptom or area of focus, but that may prevent them from addressing the a participant's more pressing clinical needs. A recent study of mental health research workers (Fried & Fisher, in press) identified several moral stress concerns within their work, including experiences where they weren't able to provide participants with the services or referrals they felt were truly needed and endorsed beliefs that participants ignored research risks in order to receive compensation.

These situations can be difficult to resolve, and may place the professional at ethical and legal risk. The psychologist's intended goal of "doing good" can lead to behaviors that conflict with ethical codes, state laws, or other rules of conduct, and can thus be dangerous to one's professional standing. As emphasized by Austin et al. (2005), psychologist awareness and recognition of a situation as morally stressful is critical. This echoes several ethical decision-making models, where the first step is often recognizing that the dilemma or question is an ethical one, likely requiring considerable deliberation, consultation with colleagues and other sources (such as laws and ethics standards) and consideration of stakeholder perspectives as well as the role and responsibilities of the professional.

The risks of not addressing chronic stress are significant, especially given the multidimensional effects of the relationship between chronic stress and burnout (which can include professional ineffectiveness). In order to provide effective services, psychologists have

an ethical obligation to ensure that their own personal problems and conditions do not negatively affect their work and possibly harm individuals with whom they work (Principle A: Beneficence & Non-maleficence; 2.06 Personal Problems and Conflicts; 3.04 Avoiding Harm; APA, 2010). Drawing on the growing self-care literature that has proliferated among psychologists to address work-related stress, the American Psychological Association's Board of Professional Affairs' Advisory Committee on Colleague Assistance has developed a number of resources and suggested interventions, including developing a peer consultation group for social support and to process dilemmas, self-assessment of stress and vulnerabilities to occupational stress, and developing and implementing personalized stress-reducing techniques.

Stress is also affected by workplace policies, climate and expectations. Perceptions of positive workplace support, policies and resources have been found to serve as protective factors against workplace distress, staff turnover and unethical behaviors in high stress professions, such as nursing (Hart, 2005; Lutzen et al., 2010; Olson, 1998; Pauley et al., 2009) and there has been recognition of the importance of working environments that are respectful and that promote discussion of work-related stress (Gelsema et al., 2005). Recent studies of community-based drug use research workers have echoed these findings, with lower levels of organizational support associated with higher levels of moral stress (Fisher et al, 2013).

Stress, including moral stress, can affect all mental health professionals regardless of experience, but there is reason to believe that those with less experience, including interns, clinical trainees and research workers may be at particularly high risk. For example, research suggests that younger, rather than older research staff, are more likely to experience moral stress and burnout (Fried & Fisher, in press). Stress in new and aspiring professionals may also be compounded by a lack of experience, professional self-doubt, and fewer opportunities to learn and use self-care strategies (Cushway, 1992; Pakeham & Stafford Brown, 2012). These factors underscore the responsibilities of supervisors to recognize and address stress among trainees. Supervisors can work to ensure that trainees, interns and assistants are afforded opportunities to process moral and other types of work-related stress, including outlets for trainees and staff to discuss

stressful work-related situations, such as debriefing sessions, supervision, or on-site counseling provided by trained outside professionals.

As psychologists and psychologists in training, it's critical to recognize that our work may place us at increased risk for workplace stress. In our attempts to "do good" and care for our clients, we may be confronted with difficult moral stress dilemmas where what we think is "right" may be constrained by professional rules, boundaries, and obligations. Although there are no easy answers to these types of moral stress dilemmas, acknowledging the tension, affirming our professional commitments, and working to process the stress through self-care strategies may be critical strategies in minimizing any negative impact on professional work. ■■

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Kaitlin P. Gallo, Ph.D. - Editor

Section II Update: Society of Clinical Geropsychology

Submitted by Michele J. Karel, PhD

The Society of Clinical Geropsychology (SCG) has several updates, regarding our 2015 award winners, outgoing presidential initiative, incoming presidential initiative, and new diversity awards for our section.

SCG Awards. At the APA convention in August, SCG recognized our three major awardees this year.

- **M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology:** Dr. Gregory Hinrichsen, Icahn School of Medicine at Mount Sinai, New York, NY. Dr. Hinrichsen has influenced the field of geropsychology through multiple leadership, clinical, training, research, and service activities. A small sampling includes: Research and professional training in Interpersonal Therapy (IPT) for late life depression; contributions to geropsychology training model, competencies, and training leadership; extensive writing on public policy and aging; past-president of SCG, past-Chair of APA Committee on Aging (CONA), past-Chair of Council of Professional Geropsychology Training Programs (CoPGTP). He will deliver the Lawton Award address at the 2016 convention.
- **Distinguished Clinical Mentorship Award:** Dr. Brian Carpenter, Washington University, St. Louis. Dr. Carpenter is an Associate Professor of Psychology and is beloved by his current and former students, who wrote many letters in support of this award. Dr. Carpenter's research focuses on family relationships in late life, with a particular emphasis on collaborative family communication and decision-making.
- **Student Paper Award:** Kellye Carver, doctoral student at the University of North Texas, Counseling Psychology program, for her paper "Influence of Grief among Parentally Bereaved Adults." Congratulations Kellye!

Presidential Initiative, Outgoing: SCG thanks Dr. Margie Norris for her phenomenal leadership as 2015 SCG President. Dr. Norris' presidential initiative this year focused on a review of the Society's history, to help inform future planning. She undertook a detailed study

of SCG newsletters since the Section's founding in 1994. Her presidential address at the APA convention, *The Aging of Society of Clinical Geropsychology: Where Have we Been and Where are we Going* (featured in the SCG Fall 2015 newsletter), summarized the results of this review and related recommendations for the Society.

Presidential Initiative, Incoming: Dr. Sherry Beaudreau, Co-Director of the VA Advanced Fellowship Program in Mental Illness Research and Treatment at the Palo Alto VA, and Clinical Associate Professor at Stanford University, will begin her terms as SCG President in January 2016. Her presidential initiative will focus on the fundamental role of diversity in ensuring the strength of geropsychology as a field, and of SCG as a society. Concurrent with this initiative is the initiation of SCG's first Gerodiversity Awards.

SCG Gerodiversity Awards and Survey. The SCG Diversity Committee recently announced two Gerodiversity awards, to acknowledge outstanding contributions to advance gerodiversity issues in clinical practice, training, research, advocacy, and/or public policy. One award is for psychologists and one for psychologists-in-training. Initial awards will be made in the spring of 2016. In addition, the Diversity committee spearheaded a membership survey regarding diversity of our membership; results are pending.

Finally, I want to express my gratitude for having the opportunity to serve as the Section 2 representative to the SCP Board. It has been a terrific experience and I have enjoyed providing updates in this forum.

Dr. Victor Molinari will take over as Section 2 representative starting in January. He is a professor at the School of Aging Studies, University of South Florida., where he studies mental health outcomes in long term care settings, among other clinical geropsychology interests. He is currently Chair of the Council of Professional Geropsychology Training Programs (CoPGTP) and President of the American Board of Geropsychology (ABGERO).

Reminders:

SCG Website: For more information about SCG, including membership application, see www.geropsychology.org.

GeroCentral: The "GeroCentral" website is on-line at <http://gerocentral.org/>. GeroCentral is a website clearinghouse of practice and training resources related to psychology practice with older adults. ☐

Section VII Update: Section for Clinical Emergencies and Crises

Submitted by Marc Hillbrand, Ph.D.

Since its inception, Section VII has promoted the enhancement of graduate education in violence and suicide risk assessment and management. In collaboration with the Palo Alto University Clinical Emergencies and Crises Research Group led by Bruce Bongar, Ph.D., Section VII has recently presented comments to the APA Committee on Accreditation in response to the call for comments issued by the COA on new Implementing Regulations in the training for graduate students in clinical and counseling psychology and other applied psychological specialties. We hope these efforts will lead to expanded opportunities for training in graduate programs and during internships and post-doctoral training programs.

Sadly, the Convention hours allotted to the Sections of the Society of Clinical Psychology for the APA 2016 Convention have yet again been cut. Section VII will use its limited Convention time to address the issue of graduate education in violence and suicide risk assessment and management. 📄

Section X Update: Graduate Students and Early Career Psychologists

Hello graduate students and early career psychologists,

We are writing to announce an upcoming change in the membership policy for Section 10. Beginning January 1, 2016, all members will need to formally register via our website and pay a small annual fee of \$10. For those who register for both Division 12 and Section 10 at the same time (<http://www.div12.org/membership/>), the Section fee will be reduced to \$5. While we wish we

could continue to operate without membership dues, this nominal fee is critical to our ability to sustain the Section going forward.

We hope that you will consider the many benefits of Section membership as you decide whether to renew:

Awards: apply for cash prize competitions for best poster and best paper presentation at the Annual Convention

Mentorship: participate as a mentor or mentee in our mentorship program

Publications: gain a publication by contributing a brief article to our blog, and enjoy reading what others have published on issues relevant to you

Internship resources: tap into our network of early career psychologists who have recently completed internships across the country, via an internship database and interview question bank that are currently in development

- Leadership: run for a position on the Board or pilot a new project
- Listserv: gain access to announcements that advertise professional opportunities

Convention programming: attend symposia that we have designed specifically for graduate students and early career psychologists

We value your participation in the Section and welcome new ideas about how to improve. Please share your suggestions with us directly in the registration form or contact President-Elect Alexandra Greenfield at apg54@drexel.edu. After January 1, 2016, our listserv announcements are only sent to paid members.

Sincerely,

The Board of Division 12 Section 10 📄

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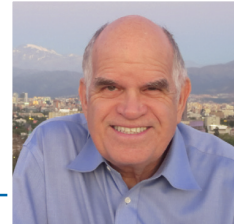
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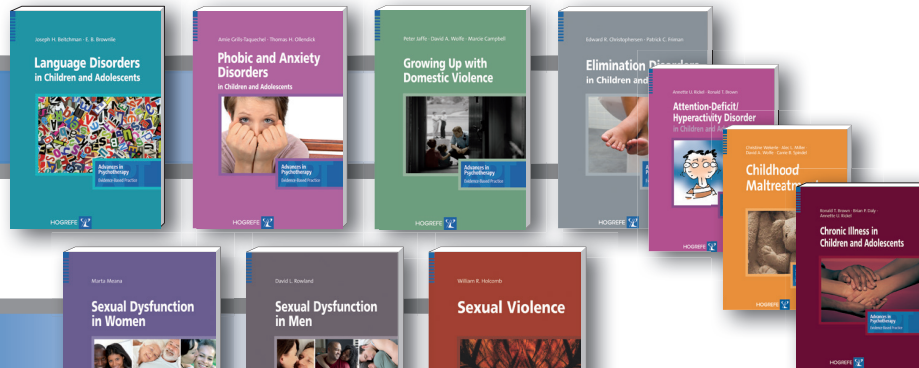
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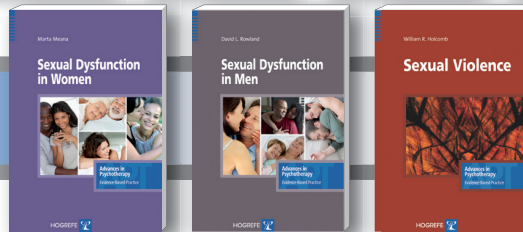


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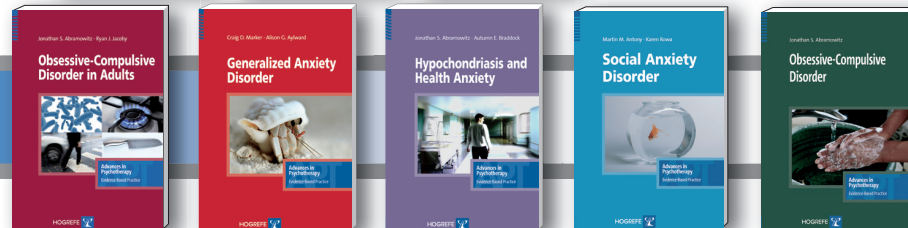
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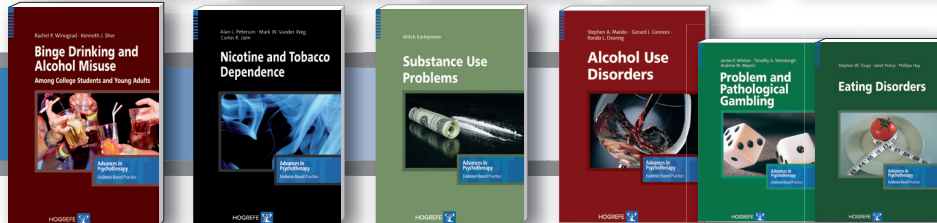
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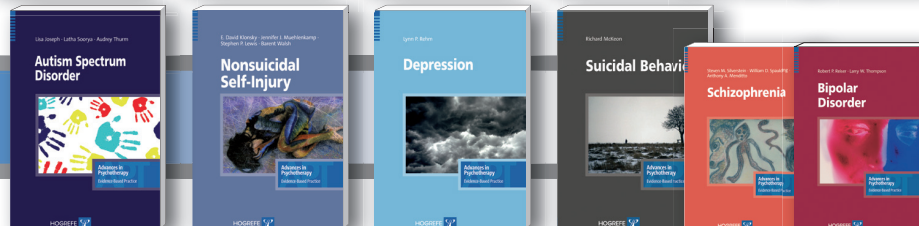
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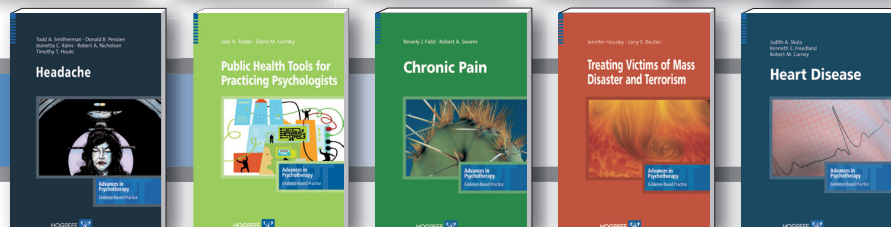
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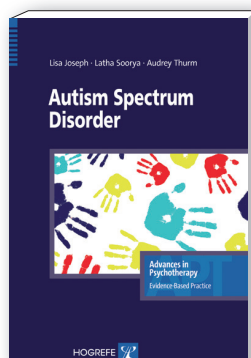


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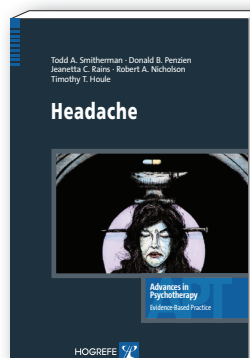
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*Todd A. Smitherman,
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Headache

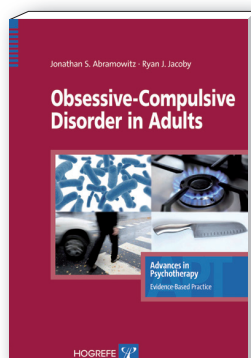
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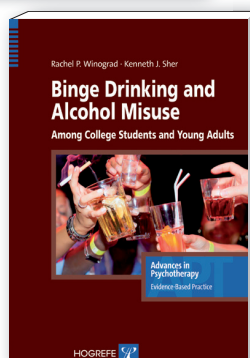
*Jonathan S. Abramowitz &
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*Rachel P. Winograd &
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