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PRESIDENT'S COLUMN



Making the Most of Clinical Science

Michael W. Otto, Ph.D.

I could not be more pleased to be starting my role as President of the Society of Clinical Psychology (SCP). As has been the focus of Presidents before me, I am particularly concerned with how SCP delivers state-of-the-art information on and training in treatment strategies for clinicians, while also offering resources for clinical-researchers trying to increase this knowledge base. These activities are at the core of the Mission Statement for the Society: to encourage and support the integration of psychological science and practice in education, research, application, advocacy and public policy, attending to the importance of diversity. So what is the next step for a society that has long focused on the creation and dissemination of treatment outcome findings, and how can this be done more usefully? Allow me to offer my perspective. I have a simple frame for how I think about the contribution of clinical science to my own practice and supervision: research reports offer me clinical experience. For the time it takes me to read a research report, I gain the experience of treating scores of patients, getting to know how treatment turned out if I treated some of them one way, and how it turned out if I treated some another way. It would take me years of direct clinical effort to get this kind of experience on my own.

I do believe I make great use of outcome feedback in my clinical practice. When something I do appears to pay off for a patient, I tend to do it again. This sort of learning is useful. It is also problematic, because ultimately it means that my successes are my ruts. I don't get to learn what would have happened if I tried an alternative intervention, and over time, the default is for my therapeutic ruts to get deeper. Outside consultation/supervision can be a helpful alternative. I can borrow from the clinical experience of another, compare that experience with my own, and decide if I want to try interventions outside my rut. But if I fall into peer supervision with people who think a lot like me, then I may not have the chance for a truly fresh perspective.

For me, clinical research offers that truly fresh perspective. I get to know the broad brushstrokes on efficacy garnered from studies with some patients like

mine (and some patients who are really not like mine, despite sharing the same diagnosis). I get to know what tends to work despite these individual differences. This is not to say that research trials are not without their biases and limitations. Training differences, allegiance issues, and rater bias are all potential issues for a well-conducted clinical trial. Nonetheless, even with these challenges, a clinical trial still offers the least-biased information to the field because of the systematic recruitment, fixed trial length, independent evaluation, and structured interventions that depart from the outcome perspectives afforded in clinical practice. In short, clinical trials are like democracy as viewed by Winston Churchill: "Democracy is the worst form of government except all those other forms that have been tried."

In addition to providing relatively unbiased perspectives on what can work with a well-defined cohort of patients, clinical trials provide an important perspective on timelines of response. This is one of overlooked values of clinical trials: showing me how fast and how well patients can respond, so I have a benchmark to know how I am doing in my practice. These response rates at 6 weeks, 12 weeks, etc., provide a crucial source of error detection, allowing me to estimate whether my patient might have gotten better faster with a different approach than one I offered. And believe me, faster makes a difference for patients: every week of less suffering for the patient, the patient's family, and the patient's role functioning is a really good week. In short, clinical trials give me a benchmark for knowing whether my own results with patients approach that for at least one well-defined alternative. Clinical trials provide me with the standard to beat.

Clinical trials also provide me with information on a set of prototypic interventions that can offer benefit. Why prototypic? Let's consider the process of treatment development and validation (e.g., Rounsaville, Carroll, & Onken, 2001). If a clinical investigator starts with a vision of the type of interventions (often reflecting a principle or principles of change) that could help a given condition, then the first step in the validation process is to complete pilot work and to turn these principle-based interventions into a particular protocol for intervention. And, even though investigators may set out to show the value of specific principles of treatment, they have to, as part of the process of progressing to a tightly-controlled study, operationalize these principles into a very specific protocol that all the study clinicians can follow. The resulting protocol then gets prime attention in the research report and published treatment manual; it is, after all, the embodiment of what worked in the trial. Yet, if we over-attend to that particular protocol of treatment, we slide forward into the complaints against manualized treatment (e.g., too stifling of innovation) that have been well documented by surveys

(Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009; Stewart, Stirman, & Chambless, 2012).

As compared to protocols, principles of treatment provide broader guidance, and presumably can be enacted by any number of specific interventions. In the early decades of the growth of empirically-supported treatments (reflected by the empirically-supported treatment list spearheaded and maintained by this Society), there were not enough studies to allow a strong perspective beyond a validated protocol of treatment to the underlying principles. However, because of the ongoing expansion of this list, the diversity of validated protocols allows us to use this treatment-outcome information differently. Rather than having a collection of interventions that work, with a corresponding pile of treatment manuals, we have enough treatments that we can now hone in on the component interventions and principles that are behind and sometimes shared by specific protocols. With enough trees, the forest is emerging. We are starting to have enough protocol validations from controlled studies that we can better return to where the researchers were before each treatment trial started—attending to underlying principles of treatment.

During the next year a number of important changes will be taking place in the way in which SCP (via the website: <https://www.div12.org/>) provides information on empirically-supported treatments. First, information on efficacious treatments will be organized around both case prototypes and dominant symptoms, allowing for a more efficient search about the sort of interventions that may be relevant for any given patient. Second, relevant treatment information will be linked with training resources, allowing for a more efficient translation of trial findings into clinical actions. Third, there will be greater emphasis on the component interventions (rather than just protocols) that are most associated with treatment results, aiding the translation between fixed protocols of treatment and component interventions for clinical change. For this lattermost innovation, SCP will rely on a new Presidential Task Force that will be providing information on the range of component interventions that have similar targets and conceptually similar interventions, and to emphasize the similarities in efficacy (where they exist) for interventions that share the same targets but may rely on diverse procedures. This information will be organized into a topographical map with information mapped according to its effect size (as indexed by vertical elevation), the number of studies on which the effect size estimation is based (as indexed by horizontal area), and the intervention's therapist/client burden (as indexed by degree of shading). Moreover, the geographical placement of intervention types on the map will reflect their relative conceptual proximity, making it possible to gauge the general conceptual "direction" in which promising

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intervention effects can be found. I am excited by the potential of these maps, and, as soon as a number of these are produced, you will see the product of this effort from this new Presidential Task Force, led by Mark Powers, and ongoing efforts of the Science and Practice Committee, led by Rachel Hershenberg and Susan Raffa.

These efforts will be part of a broader emphasis on improving the usefulness of clinical trial information and to attend to clinical decision-making. As part of a new column (to debut in the next issue of *The Clinical Psychologist*), I will be interviewing clinicians about how they know what they know for making intervention decisions for patients in their practice. These discussions will also include that clinician's wish list for the type of clinical research that would most inform their practice. My hope is to better address the research-practice divide by ensuring two-way communication about ways to enhance outcomes in clinical practice. Commensurate with these efforts, SCP will also be re-launching a clinical discussion listserv with the core mission of facilitating ongoing discussions about treatment options relevant to the choice points clinicians

face in their practices. So, stay tuned to the website, this column, and other announcements, SCP will be continuing to innovate ways to serve its membership and the field more generally. ■■

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Upcoming SCP CE webinar!

Dr. David Tolin: Blending Science and Practice

Wednesday, May 17, 2017, 12 PM – 1 PM ET

Overview: We will discuss ways for practicing psychologists, particularly those in early career, to blend scientific and clinical activities. These include consuming relevant research, making empirically-informed treatment decisions, contributing to the scientific literature, and adopting an empirical approach to treatment.

Presenter: David Tolin, Ph.D., ABPP, is the founder and director of the Anxiety Disorders Center at the Institute of Living, and an Adjunct Professor of Psychiatry at Yale University School of Medicine. He is Past-President of APA Division 12 (Society of Clinical Psychology). Dr. Tolin oversees an outpatient clinic and treats patients, while maintaining an active research program funded by the National Institute of Mental Health.

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Jonathan S. Comer, Ph.D. - Editor

Improving Daily Life Functioning of Children with ADHD; Medication, Behavioral Intervention, or Their Combination – “Just Say Yes to Drugs?” Redux

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FF Attention-Deficit/Hyperactivity Disorder (ADHD) is a chronic neurodevelopmental disorder with childhood onset characterized by core deficits in attention (e.g., distractibility, disorganization), hyperactivity/impulsivity (e.g., acting without thinking, restlessness) or both (American Psychiatric Association, 2013) that contribute to impairment across home, social, and academic settings (Pelham, Fabiano, & Massetti, 2005). ADHD is one of the most common mental health disorders among children and adolescents with an estimated prevalence rate of 8–12% (Visser et al., 2014), and the vast majority of children with ADHD continue to experience impairment in daily life functioning through adolescence and into adulthood (Barkley, Murphy, & Fischer, 2010). During childhood, children with ADHD experience a variety of impairments including, but not limited to, conflicts with parents, teachers, and other adults often leading to marked caregiver strain (Anastopoulos, Sommer, & Schatz, 2009; Johnston & Chronis, 2014), problems with peers including peer rejection (Hoza et al., 2005; Pelham & Bender, 1982), and low academic achievement

and behavior problems in school (DuPaul & Jimerson, 2014; Loe & Feldman, 2007). These problems in daily life functioning mediate of current overall functioning and long-term outcomes in children with ADHD and are therefore the key targets of intervention (Pelham & Fabiano, 2008; Pelham et al., 2005).



Fiona L. Macphee

Decades of research have identified three evidence-based treatments for ADHD: medication with central nervous system (CNS) psychostimulants (Conners, 2002; Greenhill et al., 2002), behavioral interventions (Evans, Owens, & Bunford, 2014; Fabiano et al., 2009; Pelham & Fabiano, 2008); and the combination of the two (Fabiano et al., 2007, Pelham et al., 2014). Despite numerous controlled investigations of unimodal and multimodal treatment for ADHD, current treatment recommendations are inconsistent across professional groups and individual clinicians in large part due to disagreements among leading professionals. Current psychiatric recommendations include beginning treatment with medication and increasing dosage, switching medications, or adding a second medication in cases of low response (AACAP Work Group on Quality Issues, 2007). Other groups recommend initial psychosocial intervention with modifications if needed and subsequently adding medication only if response is insufficient (APA Working Group on Psychoactive Medications for Children and Adolescents, 2006). Initiating treatment with both medication and psychosocial supports is also endorsed by the largest advocacy organization for ADHD (<http://www.chadd.org>). Most recently, the American Academy of Pediatrics guidelines recommended different treatment sequence strategies dependent on child age with combined treatment recommended across ages for most children (Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management, 2011). The puzzling differences in treatment recommendations may be in part due to mixed and limited research findings (see Fabiano, Schatz, Aloe, Chacko, & Chronis-Tuscano, 2015 for review). However, differences in professional orientation/training appear to play a major part, with psychiatric associations recommending medication

first, psychologists recommending behavioral interventions first, and pediatric groups in between. In practice, more than 80% of ADHD youth nationwide are prescribed psychostimulant medication within a given year (Visser et al., 2016) with prescription rates having risen dramatically since 2000 and continuing to rise (Dalsgaard, Nielsen, & Simonsen, 2013). Further, the vast majority of medicated children do not receive concurrent systematic behavioral interventions (Visser et al., 2016).

Psychopharmacological intervention as the first-line treatment for ADHD recommendations emerged from the widely-cited initial results of the Collaborative Multimodal Treatment Study of Children with ADHD (MTA), in which behavioral, psychostimulant medication management, the combination of the two, and usual care treatment conditions were compared (MTA Cooperative Group, 1999). The MTA was a large, multisite Randomized Controlled Trial (RCT) implemented by NIMH following several decades of smaller studies showing that behavior therapy, stimulant medication, and the combination of the two produced short-term benefits for children with ADHD. The MTA trial demonstrated that directly following treatment, medication management and the combination of medication and behavioral treatment resulted in significantly fewer ADHD symptoms than behavioral treatment alone, which was equivalent to the community comparison group. Additionally, there was no difference between combined and medication-only treatment in ADHD symptom reduction. The results were widely interpreted as showing that medication, but not behavior therapy, was an effective treatment for ADHD, and that behavioral intervention did not produce incremental benefit when added to medication (MTA Cooperative Group, 1999). The widespread publicity associated with the first MTA publication, and the independent but simultaneous FDA approval of the two long-acting stimulant drugs—Concerta XR (e.g., Pelham et al., 2001) and Adderall XR (e.g. Biederman, Lopez, Boellner, & Chandler, 2002) along with their associated widespread marketing initiatives, drove the increase in the use of stimulants.

However, there were limitations in the design and methodology of the MTA study that limit interpretation of its results (Pelham, 1999). First, 70% of the community comparison group received routine ADHD medication from their own physicians and routine behavioral classroom management from their teachers, altering the interpretation of the equivalence of the behavioral and community comparison groups.

Further, medication and behavioral treatment began simultaneously in the combined treatment arm, effectively making it impossible to determine which modality primarily contributed to outcomes. Moreover, both the medication and the behavioral components of the interventions in the MTA were provided at high doses/intensities, and it is not clear whether lower doses would have



Amy R. Altszuler

had similarly beneficial effects with lower risks (i.e., side effects) and lower costs for some or all children. It is plausible that the relatively high doses of medication in the MTA combined treatment group overpowered and therefore minimized the potential incremental benefits of the behavioral treatment. For example, medication decreased opportunities for parents and teachers to address problematic behaviors because they were largely eliminated by the acute effects of medication. Psychostimulant medication has immediate effects that wear off completely after 4 to 12 hours, depending on the formulation, while behavioral treatment (e.g., parent training, teacher consultation) takes time to establish and requires that both parents and children learn skills over time before impacts are apparent. A final but little known MTA design limitation is that medication was continued through the posttreatment assessments whereas the behavioral interventions had been dramatically reduced 4-6 months before endpoint due to NIMH funding constraints.

Perhaps not surprising given the literature regarding stimulants, 1-year and 2-year follow-ups of the MTA participants showed that the benefits of medication in both the medication alone and in the combined condition dissipated partially (at 1-year) and then completely (at 2-years; Swanson et al., 2002). Further, the 8-year follow-up found no differences between children who had received medication during and continuing after the study versus those who did not (Molina et al., 2009). The authors of the 8-year follow-up noted that “data fail to provide support for long term advantage of medication treatment...for the majority of children...decisions about medication may have to be made on an individualized basis avoiding untested assumption about continuing benefit and

using periodic trial discontinuation to check for need and benefit” (Molina et al., 2009, p. 497). Thus, the MTA results ultimately showed that medication had large acute effects but no sustained or residual benefits and is therefore not an effective treatment for ADHD when used as the sole intervention. Whether behavioral treatment or the combination of behavioral and pharmacological interventions would be more effective than medication alone in the long-term was not answered in the study because only ongoing medication treatment was tracked following the year of initial treatment. No information was gathered about whether long-term behavioral treatment or combined treatment was continued and therefore its long-term effect was not evaluated.

Dosing and Sequencing of Psychosocial and Psychostimulant Treatments

Our laboratory group has conducted a series of studies that addressed the questions raised by the results and limitations of the MTA study. These studies have investigated various aspects of sequencing, dosing, and combining behavioral and pharmacological treatment for ADHD to examine the parameters that yield the most effective treatments for children with ADHD. Our investigations have addressed the effects of (1) combining varying acute doses of each treatment (behavioral and psychostimulant) on multiple outcomes in multiple settings, (2) beginning treatment with one modality (behavioral) and adding the other (medication) for insufficient responders, and (3) comparing the effects of initial treatment modality on outcomes, as well as on the need for and the results of subsequent treatment supplementation both within and across modalities.

The first study in the set involved an analogue summer camp setting, the Summer Treatment Program (STP; Pelham et al., 2010), to evaluate the acute comparative and combined effects of (1) high and low “doses” of behavior modification—that is intensities of behavioral intervention, (2) high and low doses of stimulant medication, and (3) their combination on measures of disruptive behavior and rule violations in classroom and peer-based recreational settings (e.g. sports games)—all compared to each other and to no treatment for elementary-aged children with ADHD (Fabiano et al., 2007; Pelham et al., 2014; Pelham et al., in preparation). That study showed that intensive behavior modification produced very large treatment effects as did high doses of medication, with minimal to no incremental value from adding the other modality. In contrast, low “doses” of one treatment modality produced small to moderate

effects but left room for improvement by adding the other modality. As such, the combination of low doses/intensities across modalities resulted in positive outcomes comparable to high doses of either treatment alone with the added benefit of very low rates of medication side effects and a less complex and therefore less costly behavioral intervention. These



Brittany M. Merrill

outcomes were observed across multiple measures in both classroom and peer settings.

Further, children in this study were followed into the subsequent school year without medication and with either no additional psychosocial intervention or with a brief behavioral consultation with parents and teachers (several booster group parent training sessions and a school-home Daily Report Card; Pelham et al., in preparation). Medication was withheld during the school year until and unless a need was indicated on a predefined set of measures. Brief behavioral treatment was sufficient to eliminate or delay the need for concurrent medication for many children (only 53% needed adjunctive medication at school and 43% at home). Children who were receiving the behavioral intervention who needed medication also required substantially lower doses compared to the children who received no behavioral consultation (Pelham et al., in preparation). The beneficial impact of the brief behavioral consultation was especially large in children who had not previously been medicated at school or home. Children who had taken medication prior to the study were more than twice as likely to need it during the school year, despite not differing from previously medication naïve children on any demographic or diagnostic variables.

These studies showed that low dose treatments were sufficient for many children, and they suggested that behavioral treatment could eliminate or minimize the need for medication—especially if it was provided prior to medication. A subsequent study extended these findings in the first application of a Sequential Multiple-Assignment, Randomized Trial (SMART) in clinical psychology (Pelham et al. 2016). Children wererandomly assigned to begin treatment with a low dose of medication (.15 mg/kg methylphenidate

twice daily) or a low intensity behavioral intervention (a school-home Daily Report Card and 8 sessions of group behavioral parent training). Children who responded insufficiently at monthly assessments were re-randomized to receive either a higher dose of the original modality or to have the other modality added to their treatment regimen. Thus, the study enabled us to ask which was the best initial treatment and what was the best additional treatment modality for initial poor responders. Regarding the question of sequencing the interventions, initiating treatment with behavioral supports resulted in significantly and substantially lower levels of direct observations of negative classroom behavior—the primary outcome measure—compared to initiating treatment with medication. That is, 33% of the children who began with the low dose behavioral intervention needed no further treatment at school for the rest of the school year. Moreover, adding medication when children were insufficiently responsive to initial behavioral treatment resulted in better outcomes across multiple domains than did adding behavioral treatment secondary to medication for insufficient responders (Pelham et al., 2016). Further, the parents of children who began treatment with medication but were insufficient responders and subsequently assigned to behavioral treatment attended only 20% of parent training sessions compared to those who began with behavioral treatment, who attended nearly 80% of the assigned sessions. Finally, this study included an analysis of the relative costs of the treatment strategies. In contrast to the widely held notion that medication is the most cost-effective treatment for ADHD, in our study beginning treatment with a low intensity behavior modification consisting of large-group parent training cost \$700 less over the school year than did initiating treatment with medication (Page et al., 2016). The savings in medication costs for families beginning treatment with behavior therapy (i.e., the delay in starting or never initiating medication) completely offset the additional costs of the masters-level therapists providing the behavioral intervention.

Extension to Understudied Domains and Interventions

Our most recent studies have examined efficacy of combined treatments versus medication and behavioral interventions alone in ameliorating peripheral, functional impairments in understudied domains—(1) evening homework time, (2) sports skills development, (3) Occupational Therapy (OT) interventions in the classroom, and (4) innovative academic curricula. Each of these studies were conducted in the STP setting with 5-12 year-olds with ADHD and the psychostimulant methylphenidate was used as the

medication manipulation. We discuss each below.

The homework study evaluated the effect of unimodal and combined treatments on homework problems (n=75; Merrill et al., 2017). Specifically, the behavioral intervention, which was provided to half of the families (the other half received training after the summer), was a homework-focused behavioral group parent training, consisting of 2 hour-long evening sessions for 2 weeks, adapted from Power and colleagues' program (Power et al., 2012) with a Daily Report Card targeting homework completion and accuracy. Additionally, half of the children received psychostimulant medication for three weeks while the other half received placebo, and then these groups crossed over. This combination allowed for a between subjects examination of the effect of behavioral parent training, a within-subjects analysis of medication, and the ability to investigate the incremental benefit of combining psychosocial and medication treatments.

Children's objective homework performance (completion and accuracy) and parent-reported homework problems were evaluated. No effects were found on parent-report measures. However, behavioral parent training and a Daily Report Card produced significant improvements on objective measures of homework completion and accuracy across subject areas (math and reading). The salutary effects of the behavioral treatment were, on average, the equivalent of improving homework grades from an F to a C—an enormous effect. Medication resulted in little to no benefit on homework performance, and the addition of medication to behavioral treatment provided no incremental improvement above behavioral treatment alone. These results are somewhat surprising, given that for the past 16 years the pharmaceutical companies that market Concerta and Adderall XR have advertised to parents (and pediatricians) the benefits of their long-acting medications at homework time. In contrast, our results demonstrate that teaching parents how to structure and oversee homework should be the primary recommendation for homework problems among children with ADHD. There is no evidence that medication improves homework performance in this population.

Another study aimed to investigate the unique and combined effects of stimulant medication and skills training on one critical area of daily life functioning in children with ADHD: peer relations in the context of youth sports (O'Connor et al., 2014). The STP has been developed over more than three decades to focus on the domain of peer relations—arguably the most deficient

and most important to long term outcomes in children with ADHD (Pelham et al., 2010; Pelham & Bender, 1982). Three decades ago, our group published a study (Pelham et al., 1990) showing that medication facilitated on-task behavior in children with ADHD in the field during a baseball game. However, that study also showed that while it aided attention to task, medication did not benefit baseball skills. Nonetheless, that study was and remains widely cited among physicians as justifying medicating children with ADHD for 12 hours daily and for 7 days per week to cover the times when they engage in sports with other children. The present study was designed to investigate whether sports skills training can improve children with ADHD's functioning and whether concurrent medication facilitates that training. The study (Altszuler et al., 2017) consisted of a 2 (medication, placebo) x 2 (sports training: instruction and practice: recreational play) between-groups design and lasted for a 3-week period. Sports training was conducted with a novel sport, badminton, to limit previous sport knowledge and to differentiate it from concurrent sports training that occurred within the STP. Results indicated that, overall, brief sports training produced the largest magnitude effects on the sports-related outcomes, including observed and counselor-rated sports skills, knowledge, game awareness, effort, frustration, and enjoyment. Combined intervention—that is the incremental benefit of medication beyond the direct skills training—only demonstrated benefits on observed rule following behavior and counselor-rated sportsmanship but not on sports skills or attention during the games. These results, combined with the fact that the majority of youth recreational activities take place in the evenings and on weekends, which may be important times for children to be unmedicated in order to minimize sleep and growth-related side effects, indicate that skills training, rather than medication alone, should be used in conjunction with behavioral intervention targeting negative behaviors to teach sports to youth with ADHD.

As further evidence for the effectiveness of behavioral intervention, in this study, consider the results for attention to task during the games. In the Pelham et al. (1990) baseball study, medication had a beneficial effect on children's attention to the ongoing game. In order to measure attention during that study, we developed a procedure for asking children about their awareness of/attention to the game that we named "attention check questions." For example, the shortstop might be asked "where should you throw the ball if is hit to you?" In order to answer the question correctly, the child needs to know how many people are on base

and where they are, how many outs there are, and where the best play is—that is, he or she needs to be paying attention to the game. In the 1990 Pelham study, we were impressed that the children's ability to answer such questions improved over the 4-day study over and above the effects of medication, indicating that asking the questions prompted the children to pay better attention during the games. Since that study, "attention checks" have been incorporated in the point system that is implemented across all aspects of the recreational activities in the STP, and children are rewarded with points for correctly answering attention check questions. In the 2017 Altszuler study, in contrast to the 1990 study, there was no effect of medication on the attention check measure presumably because the behavioral point system enhanced attention beyond what medication could improve—further indication of the potency of the behavioral intervention/skills training in the current study. It is important to note that children's behavior is an essential part of performance during sports activities. In the 2017 Altszuler study, an intensive behavioral intervention was present in both the training and recreational play condition. However, as our other studies suggest (e.g., Pelham et al., 2014), if behavioral intervention is less intensive than is present in the STP, medication may be a useful adjunct for children who display very elevated rates of negative behavior during recreational activities.

Another primary setting where children with ADHD experience impairment is in the school classroom, and our latest two studies have focused on this setting. As cited above, evidence strongly supports that psychostimulant medications produce acute benefits in classroom behavior (i.e., rule following, compliance, disruptive behavior) and academic productivity (amount of assigned seatwork completed) among children with ADHD. Additionally, behavioral classroom management (BCM) is well-established treatment for children with ADHD (DuPaul, Eckert, & Vildardo, 2012). Despite the widespread availability of these well-established classroom interventions, classroom supports that are far less studied are commonly implemented with children with ADHD in elementary schools. For example, 10.8% of children with ADHD in special education receive OT as part of their 504 or IEP plans (Schnoes, Reid, Wagner, & Marder, 2006). OT is likely employed with many other children with ADHD, but unless the children have an identified accommodation, statistics on the frequency of use are not available. A recent article in the New York Times revealed that New York City public schools spent up to \$58 million per year on OT, a \$20 million increase from

just five years prior. Other major cities such as Chicago experienced a 30% increase in OT referrals over five years and Los Angeles a 20% increase over three years (Harris, 2015). Unfortunately, despite its widespread use in schools, OT lacks conclusive empirical support for improving behavior and academic functioning among children with ADHD (Bader & Adesman, 2015).

We conducted the first well-controlled evaluation of OT in a 6-week study in an STP analogue classroom ($n=64$) to address this question (Macphee et al., 2015). Children received either psychostimulant medication or placebo for three weeks with a crossover for the following 3 weeks. The study layered two common OT accommodations used with elementary-aged children with ADHD—stability balls and weighted vests—with BCM components of the STP classroom that were consistent throughout the study. OT condition was randomized and counterbalanced across days using block randomization within each medication crossover period such that each child received each OT intervention for 4 separate classroom periods with placebo and 4 with medication. Children also spent 4 periods in the control condition (sitting on regular classroom chairs) with placebo and 4 periods with medication. Dependent measures were frequency counts of classroom rule violations and completed seatwork in the general areas of math, reading, and language arts. Seatwork periods lasted for 30 minutes and the order of assignment type was randomized by day. Thus, this design allowed for a within-subject analysis. This design and dependent measures have been utilized in many studies of behavioral and pharmacological interventions in ADHD and is well-validated (e.g., Fabiano et al., 2007). Results indicated that weighted vests did not impact classroom behavior (i.e., rule violations) regardless of whether the children received medication or placebo. Conversely, children completed significantly less seatwork when wearing the weighted vests, especially when receiving placebo. The stability ball intervention negatively impacted both the children's classroom behavior and their academic productivity. The adverse effect of the stability ball intervention on behavior was more pronounced when children received placebo. The results of this study document very clearly that two of the mostly commonly employed OT interventions for ADHD in school settings—stability balls and weighted vests—have either no benefits or adverse effects for children with ADHD in classroom settings when compared to sitting in regular desks and chairs. Unfortunately, the vast majority of daily classroom 504 and Individualized Education Plans (IEP) accommodations that are

implemented for children with ADHD have either not been studied or have been shown to lack evidence for classroom behavioral or academic improvements. The same state of affairs exists with respect to other non evidence-based interventions in child mental health, e.g., homeopathic remedies (Bader & Adesman, 2015; Waschbusch & Hill, 2003) that warrant future systematic evaluations in order for the field to ensure children with ADHD are receiving the most effective treatments.

The last study we will discuss addressed the longstanding question of whether stimulant medication benefits academic achievement in children with ADHD (Morrow et al., 2014). Although stimulant medication improves classroom behavior and academic productivity, it has never been shown to have a salutary effect on academic achievement. Since achievement is one of the greatest deficits in ADHD and one of the most important mediators of outcome, it is critical to assess. The few studies that have examined achievement over the period of more than 1 school-year show that meaningful benefits of medication are not detected on such measures (Barnard-Brak & Brak, 2011; Loe & Feldman, 2007). However, there are many reasons why end-of-the-year standardized achievement scores may not be sensitive to interventions. An alternative approach that has not been attempted to date is to ask whether medication has a beneficial effect in a far more controlled setting over a shorter period of time but one in which meaningful gains in the acquisition of academic knowledge in a classroom setting can be ascertained. We set out to evaluate whether medication would facilitate the acquisition of academic content in three areas—social studies, science, and vocabulary building. Again in our STP classroom context, we systematically evaluated the effect of psychostimulants on genuine indices of classroom learning over a 6-week period and the children were randomly assigned to receive medication or a placebo for 3 consecutive weeks, with crossover for the final 3 weeks.

Two evidence-based interventions using state-of-the-art instructional approaches and curriculum that were designed to be taught in 3-week segments were employed in the classroom by certified special education teachers: Content-Area Literacy Instruction (CALI; Connor, 2013) and vocabulary instruction. CALI consisted of lesson plans and worksheets that were developed to improve students' academic knowledge as well as their ability to learn from expository text. The vocabulary lessons included explicit, i.e., teaching word definitions, and implicit instruction, i.e., teaching



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taught third grade science) unless Weschler Individual Achievement Test scores were elevated, in which case children received instruction on the grade two levels above the level they just finished. Children received two different but grade-level-equivalent units of each learning intervention within the crossover medication design such that each child received science, social studies, and vocabulary instruction for 3 consecutive weeks with medication and for 3 consecutive weeks with placebo. The BCM component of the STP classroom was constant throughout the study.

Results indicated very large gains in achievement from the evidenced-based instructional modules, with very large effect sizes between pre- and post-curriculum based tests. However, the improvements in knowledge occurred regardless of whether children received the academic instruction in conjunction with psychostimulant medication or placebo. In summary, the results strongly suggest that if teachers are implementing an evidence-based curriculum in which they have been trained, medication will not have any incremental benefits on academic achievement. The failure of medication to show gains in achievement over years may reflect these results or they could be present because teachers are not using evidence-based instructional practices, and medication also has no effect on poor instruction and curriculum. In either case, medication does not appear to be a useful intervention with children with ADHD with the often concurrent academic difficulties.

Conclusions

Our group has worked over the past three-

words in context (National Reading Panel, 2000; Nash & Snowling, 2006, Clark et al., 2010). Children received 60 minutes of instruction per day, split into 30 minutes of CALI and 30 minutes of vocabulary instruction. Children received instruction at the grade level just above the level they finished (e.g., a child who just completed second grade before the summer program was

plus decades to develop and evaluate evidence-based treatments for children with ADHD mostly in the elementary school ages. We have also completed investigations in younger and older ages of children, and the results have been similar to those reviewed. This review of our latest set of studies extends the basic work that we had previously done showing that behavioral treatments, stimulant medications, and their combination confer benefits for children with ADHD in classroom, home, and peer settings. The present results extend those studies to a new and refined set of dependent measures and show that dosing and sequencing of treatments and the nature of the psychosocial and psychoeducational interventions impact outcomes. To our knowledge, the studies presented above are the first controlled studies to examine a number of questions previously unanswered in the field: First, do the order and dose of behavioral and pharmacological treatment for ADHD influence the effectiveness of and costs of the treatments and their combination? Yes—(a) low dose treatments can be combined to yield an intervention as effective as either treatment at a high dose and with fewer side effects and lower cost, but (b) but a third of children with ADHD can be adequately treated with behavioral intervention alone in school settings and as many as two-thirds at home, and (c) starting intervention with a behavioral treatment rather than medication is far more effective than beginning with medication. Second, does long-acting psychostimulant medication improve homework completion and accuracy for children with ADHD as so widely advertised by pharmaceutical companies and believed by pediatricians? (no, it does not). And does medication increase the clear benefit of established behavioral interventions in that domain? (no, it does not). Third, do medication and behavioral treatment improve the acquisition of knowledge and skill in learning a new sport in children with ADHD? (no, medication does not, but yes, behavioral interventions do) and are there benefits to a combined intervention in this context? (no, there are not). Fourth, is OT in the form of stability balls and weighted vests an effective intervention in schools for ADHD? (no, it is not). And fifth, does stimulant medication have a beneficial effect on the learning of academic skills/content in children with ADHD? (no, it does not).

Many questions remain regarding the effectiveness of treatments for children with ADHD, and the primary one is whether the existing interventions improve adult outcomes. We know from multiple long-term outcome studies that stimulants alone confer no long-term benefit.

Unfortunately, there are not yet controlled studies of the long-term benefit of behavioral interventions or combined interventions, and those are sorely needed. Another question is what are the mechanisms that underlie the effects of behavioral, pharmacological, and combined treatments and can an understanding of the mechanisms improve the effectiveness of the interventions?

Finally, we should like to make a point regarding the outcome measures in all of our studies. We do not measure DSM symptoms of ADHD as primary outcomes of treatment in our research or clinical practice and have not for several decades. The literature is quite clear that the important variables to treat in ADHD are the problems in daily life functioning—that is the impairments—that are associated with ADHD. As we have noted above, these constitute the major problems for which children with ADHD are referred for treatment and the major mediators of long-term outcomes (Pelham & Fabiano, 2008; Pelham, Massetti, & Fabiano, 2005), and they should be the focus of treatment. Our laboratory's use of the DSM symptoms of ADHD ends with the intake from which a diagnosis is currently required for a variety of administrative functions (e.g., eligibility for special education in school settings, reimbursement from insurance for treatment in community settings). We encourage others to adopt this approach in their work with children with ADHD.

We hope that this brief review of our recent research has been useful to the readers of *The Clinical Psychologist*, and we are grateful for the opportunity to have contributed to Division 12's efforts in evidence-based practice. If this article prompts others to change the way they are treating children with ADHD, training others to do so, or if it stimulates ideas for future research in ADHD or other areas of clinical psychology, we will be pleased to have contributed to those outcomes. ■

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Ethical Practice in a Time of Post-Election Stress

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 The recent elections have brought to the fore critical societal questions about racism, prejudice, misogyny and homophobia and for many Americans, have led to an overall sense of uncertainty about the future. Indeed, several major news outlets have described increasing numbers of people seeking psychological services in response to elevated “election stress” and “post-election anxiety”. For example, a recent New York Magazine article (“8 Therapists on Postelection Anxiety — Their Clients’ and Their Own”; December 16, 2016) asked mental health clinicians to share their experiences treating clients with election-related stress and how the clinicians themselves were addressing any related stress they may be personally experiencing. The responses supported media reports of increased election-related anxiety (as the author of the article noted, “the response was so overwhelming we had to stop taking calls”) and but also sparked interesting ethical questions with regard to the best way to respond to client queries about a clinician’s personal political views, self-disclosures, working with clients with intolerant beliefs, and, finally and how these experiences may be affecting professional practice.

While we can only hope that election-related stress will diminish with time, psychologists may continue to be confronted with difficult situations in which their clients express views or beliefs that may be considered divisive, offensive and/or harmful to themselves or others. Clinicians may experience conflict between what they perceive as an ethical responsibility to respect individual differences (including beliefs) with their perceived obligations to promote social justice and prevent harms. For example, therapists may be sure about how to respond to clients who endorse certain religiously based beliefs (such as condemnations of same-sex relationships) that may be at odds with those of the practitioner beliefs or that may be harmful to the client’s well being (Knapp, Lemoncelli, & VandeCreek, 2010).

Below I briefly describe some central questions and considerations that may be particularly relevant in this post-election period.

To Share or Not To Share

Many therapists may struggle with boundary questions in terms of how to respond to client questions about personal beliefs, such as political leanings and voting behavior. For example, some therapists may believe that sharing one’s own beliefs can be a source of critical support for clients, especially those who may doubt the validity of their feelings or beliefs. Other therapists may believe that sharing personal opinions and information is unnecessarily distracting and shifts the focus away from the care, serving the needs of the clinician rather than the client.

It may be helpful for clinicians to try to anticipate, if possible, what types of questions clients may pose related to political beliefs (for example, “Who did you vote for?” “Are you a Democrat or Republican?”) and how to most effectively respond. As with most personal disclosure decisions, they should be critically evaluated in terms of their motivations and possible consequences; ensure that the decision to discuss personal beliefs is based on what is clinically indicated for the client (in terms of meeting the client’s therapeutic goals), rather than simply in reaction to a client’s beliefs or for reasons that serve the clinician more than the client (Bartoli & Pyati, 2009).

Addressing Intolerant Beliefs

Some client may express prejudiced and/or intolerant viewpoints, leading to difficult dilemmas as to how clinicians such best address these views within a therapeutic context (Bartoli & Pyati, 2009). Does confronting clients about their beliefs serve the needs of the clinician more than the client? Does the refusal to acknowledge or address these types of comments signify acceptance or even agreement with these beliefs? How do I establish a safe space where client beliefs can be explored respectfully?


Perhaps not surprisingly, little empirical research exists on these topics. In focus groups conducted with mental health clinicians about challenging prejudiced comments made by clients, views varied with respect to whether clinicians should respond, ignore, or even withdraw from the therapeutic relationship (Spong, 2012). Major considerations centered around (1) the challenge of remaining neutral and non-judgmental while maintaining a productive therapeutic relationship (2) self-care and maintaining the emotional well being of the therapist and (3) social responsibilities the clinician is perceived to have in terms of challenging these beliefs and whether these may conflict or compete with the clinician’s responsibilities to the client.

Professional Competence

Many of these aforementioned interactions can be extremely stressful, potentially impairing one's ability to competently discharge professional duties. For example, clients expressing intolerant views can create stress (whether realized or unrealized) for the psychologist that may unintentionally negatively affect the therapeutic relationship, impede therapeutic progress, and/or result in a diminished ability to experience empathy (Bartoli & Pyati, 2009). Ethics Code Standard 2.06a Personal Problems and Conflicts (APA, 2010) states that "Psychologist refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner." Although we may often think of this standard as primarily applying to ongoing medical, psychological or other major stressful events, it also encompasses work-related and other stressors that may affect the psychologist's ability to competently provide services (Fisher, 2017). Consider this example: you begin to treat a client who suffers from anxiety. As therapy progresses, your client becomes more comfortable and begins to express political beliefs that are offensive and to which you are completely opposed. As the child of immigrant parents, you are particularly troubled by your client's strong xenophobic views. Although you believe you have the requisite training and competence to treat this client's presenting psychological complaint, you are finding it difficult to concentrate on providing competent treatment because you are increasingly distressed by your client's views.

The second component of Standard 2.06 (Personal Problems and Conflicts) states that "When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures such as obtaining professional consultation or assistance, and determine whether they should limit, suspend or terminate their work-related duties." Clinicians, especially those working with at-risk and vulnerable populations, must consistently monitor their own emotional well-being and consider ways in which personal reactions, beliefs and possible prejudices may affect their ability to discharge their professional responsibilities. Many times, we may not even be aware of our negative reactions and how it may be affecting our work. Colleagues can offer helpful insights and suggestions that can improve our professional interactions and decision-making. There may also be times when seeking personal therapy or referring clients is indicated.

Concluding Comments

Election-related stress remains a major concern for many clients and highlights enduring ethical questions that psychologists must grapple with as they attempt to provide effective care in ways that best fulfill our professional and ethical obligations. Many clinicians, who themselves may be troubled by the current political realities, may struggle with decisions about whether to disclose personal information to clients, challenge clients who express what they believe to be prejudiced or intolerant views, and how to address personal stress and associated professional vulnerabilities. Although it can be difficult, identifying and addressing our own anxieties, reactions, and beliefs may help to prevent personal feelings and reactions from determining professional behaviors, and affirm the nature and responsibilities of our professional role. 

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Kaitlin P. Gallo, Ph.D. - Editor

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Donna LaPaglia, Psy.D.




The Association of Psychologists in Academic Health Centers (APAHC) has just completed an election cycle and has begun the new year with three new officers in place - Secretary: Kristine Diaz, PsyD, Walter Reed National Military Medical Center; Member-at-Large: Andrea Bradford, PhD, Baylor College of Medicine; Representative to Division 12: Donna LaPaglia, PsyD, Yale University School of Medicine.

With a strong new board and an energized conference planning committee, headed by conference co-chairs John Yozwiak, PhD and Amy Williams, PhD, APAHC continues planning for its 8th biannual conference to be held in Detroit, Michigan, at the Westin Book Cadillac March 9-11, 2017! The Theme is "Promoting Psychology in the Evolving Healthcare Landscape: Enhancing the Well-Being of Patients, Providers, and Populations." Conference registration can be found on the Conference website: <https://apahc.wildapricot.org/event-2263500>. Hotel information and reservations can be found on the APAHC webpage with Westin Book Cadillac Detroit: www.starwoodmeeting.com/book/apahc.

Conference highlights include a brand new Mid-Career Boot Camp for those over 10 years post-degree, as well as the popular Early-Career Boot Camp for those with fewer than 10 years post degree. Representatives from the APA Commission on Accreditation will be on hand to provide internship site visitor training and self-study

workshops. For additional conference information: https://apahc.wildapricot.org/resources/Pictures/APAHC%202017%20Brochure_12.19.16_without%20CE.pdf.

Other changes within the organization include new leadership of APAHC's Health Disparities Committee (HDC). Dr. RoseAnne Illes, Director of Behavioral Medicine and Assistant Clinical Professor of the FSU Family Medicine Residency @ Lee Memorial Hospital, and a Second-Chair: Mr. Michael Mejia, an advanced doctoral candidate and active HDC committee member have agreed to co-chair this committee and continue the amazing work begun by the former leader, Dr. Alfiee Breland Noble.

Strong leadership is a thread that runs throughout APAHC. Members work across institutions to further psychology's impact on health care systems; patient care and community health; psychology training and medical education; research and scholarship. One way that APAHC participates on the national leadership front is through our relationship with the AAMC (the Association of American Medical Colleges). APAHC is committed to having a voice in the Council of Faculty and Academic Societies (CFAS) of the AAMC, and has two designated representatives Dr. Barbara Cubic and Dr. Laura Shaffer. The 2016 AAMC Annual Meeting Learn, Serve, Lead was attended by Dr. Shaffer who educated the organization on current themes in academic medicine. Other APAHC leaders from the Research Committee (APAHC-RC) co-chaired by Dr. Gerald Leventhal and Dr. John Yozwiak have for the past several years attended the annual AAMC Workforce conference. Participating in these types of events members may find that they are the only psychologists present, however that is precisely the reason we do it—it's important to be at the "table" sharing psychology's perspective and having a voice in shaping the healthcare systems in which we work. 

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.div12.org/mentorship to become a mentor today.

THE CLINICAL PSYCHOLOGIST



A publication of the Society of Clinical Psychology (Division 12, APA)

The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Div 12 of the APA). Its purpose is to communicate timely and thought provoking information in the domain of clinical psychology to the Division members. Also included is material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. In addition, The Clinical Psychologist includes archival material and official notices from the Divisions and its Sections to the members.

Inquiries and submissions should be sent
to the Editor, Jonathan S. Comer, Ph.D. at: jocomer@fiu.edu

To subscribe, contact Tara Craighead
404.254.5062 | division12apa@gmail.com

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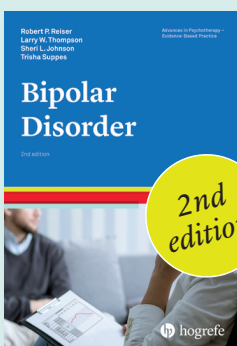
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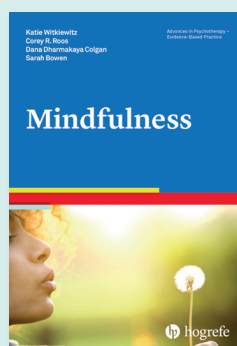
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Bipolar Disorder

Vol. 1, 2nd ed. 2017. viii + 120 pp.
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This extensively updated new edition integrates empirical research from the last 10 years to provide clear and up-to-date guidance on the assessment and effective treatment of bipolar disorder.

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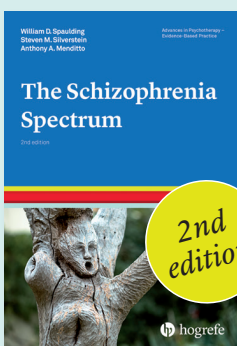


Katie Witkiewitz /
Corey R. Roos /
Dana Dharmakaya Colgan /
Sarah Bowen
Mindfulness

Vol. 37, 2017. viii + 80 pp.
ISBN 978-0-88937-414-0
Also available as eBook

This clear and concise book provides practical, evidence-based guidance on the use of mindfulness in treatment: its mechanism of action, the disorders for which there is empirical evidence of efficacy, mindfulness practices and techniques, and how to integrate them into clinical practice.

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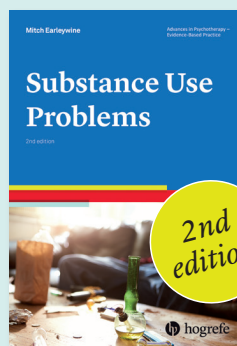


William D. Spaulding /
Steven M. Silverstein /
Anthony A. Menditto
The Schizophrenia Spectrum

Vol. 5, 2nd ed. 2017. viii + 94 pp.
ISBN 978-0-88937-504-8
Also available as eBook

The new edition of this highly acclaimed volume provides a fully updated and comprehensive account of the psychopathology, clinical assessment, and treatment of schizophrenia spectrum disorders.

The compact and easy-to-read text provides both experienced practitioners and students with an evidence-based guide incorporating the major developments of the last decade: the new diagnostic criteria of the DSM-5, introducing the schizophrenia spectrum and neurodevelopmental disorders, the further evolution of recovery as central to treatment and rehabilitation, advances in understanding the psychopathology of schizophrenia, and the proliferation of psychological and psychosocial modalities for treatment and rehabilitation.



Mitch Earleywine
Substance Use Problems

Vol. 15, 2nd ed. 2016,
viii + 104 pp.
ISBN 978-0-88937-416-4
Also available as eBook

The literature on diagnosis and treatment of drug and substance abuse is filled with successful, empirically based approaches, but also with controversy and hearsay. Health professionals in a range of settings are bound to meet clients with troubles related to drugs – and this text helps them separate the myths from the facts. It provides trainees and professionals with a handy, concise guide for helping problem drug users build enjoyable, multifaceted lives using approaches based on decades of research. Readers will improve their intuitions and clinical skills by adding an overarching understanding of drug use and the development of problems that translates into appropriate techniques for encouraging clients to change behavior themselves. This highly readable text explains not only what to do, but when and how to do it.

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