

the Behavior Therapist

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Clinical Forum

Does Public Awareness of Secondary Traumatic Stress in Military Families Provide a Context for Intervention? A Review of Reports in the Canadian Popular News Media

Cyndi Brannen and Philip M. Grandia, *IWK Health Centre, Halifax, NS*, and *Dalhousie University*, Sherry Stewart and Marc Zahradnik, *Dalhousie University*, and Patrick J. McGrath, *IWK Health Centre, Halifax, NS*, and *Dalhousie University*

The impact on families living with someone who has PTSD has been identified as severe and requiring more investment of resources by the Canadian military (Prefontaine, 2004). Family members may experience vicarious traumatization through learning details about the traumatic event either directly from the sufferer or through secondhand reports, especially from the media (Figley & Barnes, 2005). All of these symptoms contribute to a family member's experience of secondary traumatic stress (STS; Figley, 1983) that can affect nearly all aspects of his or her life (Catherall, 2004). Empirical studies (e.g., Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Dirkzwager, Bramsen, Adèr, & van der Ploeg, 2005; Gavloski & Lyons, 2004) suggest that spouses of individuals suffering from PTSD may experience depression, anxiety, and isolation. In the case of children of PTSD suffer-

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the Behavior Therapist

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- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100-word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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ers, the negative effects of living with a traumatized parent are often significant and chronic, including the intergenerational transmission of PTSD-like symptoms, depression, and isolation (e.g., Yehuda, Halligan, & Grossman, 2001). Dekel and Solomon (2006) found that divorce and family violence are more common in families where the father is suffering from PTSD.

Canadian Military Context

Prefontaine (2004) reported that families dealing with STS deserve more support from the Canadian Forces (CF), especially in light of the current increasing climate of military service. In particular, greater numbers of Canadian soldiers are increasingly involved in combat and conflict-related activities, most notably in Afghanistan. In a special report on the prevalence of PTSD in the CF, the Canadian Department of National Defence (DND)/CF (Ombudsman, 2006) discussed the magnitude of this condition. The report quotes Major Wendy White, a psychiatrist from the Operational Traumatic Stress Support Centre (OTSSC) in Edmonton, as saying that the rate of diagnosable PTSD among CF members returning from deployments is likely to be as high as 20%, with as many as 50% developing an operational stress injury besides PTSD (2006). With over 14,000 CF personnel having been deployed to Afghanistan since 2001 (Government of Canada, 2006), the Government of Canada has committed to maintaining a presence in the country until 2009 (National Defence, 2007), with a recently granted extension to 2011 (Office of the Prime Minister, 2008).

As CF personnel become more heavily involved in combat operations, the prevalence of PTSD has the potential to increase. The prevalence of STS in family members will likely follow a similar trend. As a growing number of women choose careers in the military, are deployed on military operations, and become susceptible to the development of combat-related PTSD (Shapiro, 2005), a greater number of children, whose mothers are in many cases their primary caregivers, may also become secondary victims. Since the needs assessment conducted by the DND (Prefontaine, 2004) clearly identified the need for support of families with a member suffering from PTSD, we became interested in identifying the barriers to more resources being allocated to helping these families. Currently, the Canadian government and DND are not mandated to provide any mental health re-

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sources to families of PTSD sufferers unless a family member's condition interferes with the military member's recovery (Prefontaine, 2004). This is in contrast to the American military approach to family health care.

One possible barrier is a lack of awareness about STS in the general population and, more specifically, among politicians and influential decision makers. The principal manner in which the general public, politicians, and policy makers are made aware of the circumstances that face fami-

lies of PTSD sufferers is by being confronted with the subject through popular media sources, including newspapers and their affiliated websites, magazines, and television. The same holds true for those individuals who may be experiencing STS themselves. Such individuals may be unaware that their circumstances are common among family members of PTSD sufferers. A motivated and resourceful secondary victim will find information on secondary trauma through the various sources offered

by the CF, his or her health care provider, the Internet, books, or by other means.

Rationale and Objectives

Popular news media sources have the capacity to influence public opinion (Cook et al., 1983). This is of particular relevance in the case of elected politicians and policy makers. The more media attention that is given to a particular issue, the more politicians and policy makers perceive that the issue is, or will become, a concern to the general population. Policy-making is a political affair, and hinges on public opinion, or at least perceived public opinion. The awareness, or lack thereof, regarding STS may be due, in part, to the amount of attention given to the subject by popular news media. If the media is not reporting the issue of STS, then policy makers may believe that the general public is unconcerned with the issue, which might partially explain the shortfall in government/DND support for families of PTSD sufferers. The quality of information pertaining to STS available in the popular news media is also important. Misperceptions and inaccuracies about the circumstances that families of PTSD sufferers face could prove to be as counterproductive to the development of an effective support plan as the absence of information.

Thus, the objectives of this research were to evaluate the frequency and quality of reports on STS in widely available Canadian popular media sources. We focused on any news-media mention of the effect on the family of living with a military member who has PTSD. In order to accomplish these goals, a content analysis of popular news media articles and television transcripts was performed to evaluate both the quantity and quality of material dedicated to this subject in the media.

Methods

The content analysis was conducted using three electronic databases that search Canadian popular media: Proquest, Factiva, and Prowler. Articles and transcripts considered academic literature were not used. The search was restricted to Canadian databases, but articles and transcripts from Western English news sources that were subsequently published in Canada were also used. Articles and transcripts published between January 1, 2001, and November 21, 2006, were considered. This 5+ year window provided us the opportunity to compare the difference in coverage before the Canadian military involvement in

Afghanistan and post-Afghanistan media coverage. Convenience searches conducted through news organizations' websites were excluded as sources because general database searches were believed to be more comprehensive and time-practical than attempting to search every affiliated website of every news organization in Canada.

Search Terms

Search terms used in this study produced the most relevant returns in addition to achieving saturation. Namely, the search terms included the following: *Posttraumatic Stress Disorder, Military, Family, Operational Stress Injury, Caregiver, and Spouse*. Proquest searches were restricted to Interdisciplinary–Canadian Business and Current Affairs (CBCA) Reference, Interdisciplinary–Canadian Periodicals, and News–CBCA Current Events. Prowler searches were restricted to Quick Facts and General Information, and News and Current Events. Prowler searches were also restricted to CBCA Current Events. Factiva searches were not restricted as the search syntax did not allow further restriction. For the purpose of comparison, a search for all articles and transcripts that mentioned PTSD was conducted using the search query “Posttraumatic Stress Disorder” in Proquest

Inclusion Criteria

Results from each of the search queries were initially reviewed for relevance to PTSD and STS by reading the title and abstracts (when available). There were three classifications for articles returned using the search criteria: (a) articles that did not meet any of the inclusion criteria; (b) articles that could potentially meet the criteria, but needed to be reviewed in full before a decision could be made; and (c) articles that met the inclusion criteria based on the initial scan of the title and abstract. Articles that were determined by their title or abstract to be irrelevant to this study were not reviewed further. Articles that were deemed by their title or abstract to be potentially relevant were reviewed in full. For example, an article discussing a CF member who had been charged with a crime was reviewed in full for content. Those articles that met the inclusion criteria based on the scan of the title and abstract (when available) were reviewed for content relating to STS. Any mention of a negative impact on the family and, in particular, mention of the symptoms described earlier (violence, financial stress,

caregiving issues, sexual dysfunction, sexual abuse, relationship dysfunction, relationship breakdown, emotional numbing, stress, increased family burden, increased caregiving burden, and vicarious trauma) that stemmed directly from a family member's PTSD or combat stress injury condition was considered to be relevant content. The STS indicators are not considered mutually exclusive. Mentions of requirement for secondary victim support or vicarious trauma were also considered relevant content. Only explicit secondary trauma content was included in the content analysis. Content that was implicit or unobvious to the readers was not included.

Two researchers first agreed on what was to be considered relevant content for each of the indicators. Each researcher then independently coded the retrieved articles and transcripts in detail. Afterwards, a comparison between the two coders' results was made to provide an interrater reliability check. Finally, the two researchers discussed the results to reach consensus coding where discrepancies were present. The search was performed over 5 days: November 13–16, 2006, and November 21, 2006.

Results

Approximately 660 popular news media articles and transcripts on PTSD in general, published from January 1, 2001, to November 21, 2006, were retrieved. Using the defined search criteria, 107 articles were retrieved. Using the specified inclusion criteria, 21 of these articles (3.2% of the 660 articles on PTSD) included information pertaining to STS experienced by family members of PTSD sufferers. Saturation occurred during the search and the figure 21 represents the number of unique articles and transcripts retrieved. The Proquest News–CBCA Current Events search was the most comprehensive of all searches and returned all but 1 of the 21 articles used in the content analysis. Only 1 of the 21 documents retrieved was dedicated entirely to the discussion of STS (i.e., unspecified abuse by sufferers of PTSD towards their families). On average 6.8% (range = 1%–29%; $SD = 6\%$) of the content in the 20 other articles mentioned at least one characteristic of STS (see Table 1). Interrater reliability of STS content was 0.91. The coders discussed discrepancies and reached consensus on relevant content.

Of the articles referring to STS, 4 mentioned violence, 4 referred to emotional numbness, 1 discussed financial burdens, 1 discussed sexual violence, 7 discussed rela-

TABLE 1: Search Results of Secondary Traumatic Stress in Popular News Media Sources

Date Searched	Search Engine	Database	Date Range	First Search Line	Second Search Line	Third Search Line	Results	Mention of Family Effect	Family Effect Topic
13-Nov-06	Proquest	Interdisciplinary - Canadian Business and Current Affairs (CBCA) Reference	1 Jan 01 - 12 Nov 06	Post-traumatic stress disorder (Document feature)	Military (Document Text)	Family (Document Text)	0	0	0
			1 Jan 01 - 12 Nov 06	Post-traumatic stress disorder (Document Text)	Military (Document Text)	Family (Document Text)	56	2	0
		Interdisciplinary - Canadian Periodicals	1 Jan 01 - 12 Nov 06	Post-traumatic stress disorder (Document Text)	Military (Document Text)	Family (Document Text)	19	0	0
14-15 Nov 06		News - CBCA Current Events	1 Jan 01 - 15 Nov 06	Post-traumatic stress disorder (Document Text)	Military (Document Text)	Family (Document Text)	95	19	1
14-Nov-02				Operational Stress Injury (Document Feature)	Caregiver (Document Text)	Military (Document Text)	0	0	0
				Operational Stress Injury (Document Text)	Caregiver (Document Text)	Military (Document Text)	3	2	0
				Post-traumatic stress disorder (Document Text)	Spouse (Document Text)	Military (Document Text)	6	1	1
15-Nov-02	Factiva	All sources	1 Jan 01 - 15 Nov 06	Post-Traumatic Stress Disorder	Family		8	0	0
				Post Traumatic Stress Disorder	Family		8	0	0
21-Nov-02	Prowler	Quick Facts & General Information, News & Current Events (CBCA Current Events)	1 Jan 01 - 20 Nov 06	Post-Traumatic Stress Disorder (Keyword)	Family (Full Text)	Military (Full Text)	77	13	1
Total (no duplication)							107	20	1

Note. 660 articles on PTSD in general were retrieved, 107 articles were retrieved using the search criteria, and of the 107 retrieved, 21 contained relevant content to secondary traumatic stress.

tionship dysfunction, 3 mentioned stress in general and primary victim caregiving, 1 referred to vicarious trauma, and 7 discussed the need for secondary victim support. Seven articles mentioned that families were affected by a family member with PTSD but did not elaborate. None of the articles mentioned relationship breakdown or increased dependant caregiving responsibilities (see Table 2). Regarding STS, there was no appreciable difference in the quality or quantity of relevant content in articles published prior to the CF's involvement in Afghanistan and those published afterwards.

Discussion

Only 21 (3.2%) of nearly 660 articles pertaining to PTSD mentioned the impact on family members. On average, only 6.8% (range = 1%–29%; *SD* = 6%) of the content in the articles that did mention STS discussed the condition. Of the 660 articles retrieved, only 1 (0.15%) was dedicated entirely to the topic of STS (Brewster, 2002).

That article discussed the issue of abuse in families of PTSD victims. The results indicate a significant underrepresentation of STS in the popular news media.

While the articles that mention STS do accurately describe some of the aspects of this condition, no one article provides a comprehensive portrait of life with a military member suffering from PTSD. Furthermore, even when grouped together, the articles do not discuss all of the problems faced by families of PTSD sufferers. For example, none of the articles retrieved mentioned increased dependent caregiving responsibilities or relationship breakup. This is in contrast to research that has shown that the negative effects of STS on children are often significant and chronic, including the intergenerational transmission of PTSD-like symptoms, depression, isolation, and family discord (Yehuda, Halligan, & Grossman, 2001). This gap between scholarly evidence and popular reports exemplifies the importance of better

knowledge exchange between researchers and the media.

There are a number of limitations to this study that should be taken into consideration when interpreting the results. While the databases used were believed to be the most comprehensive available, they certainly did not incorporate every popular news media source available, or every article that was published in these publications; therefore, it is conceivable that there may be publications and articles that were relevant to STS that were not included in this content analysis. Furthermore, the manner in which the search criteria-retrieved articles were reviewed may have left some relevant content unnoticed and unaccounted for. The existing search engines make it challenging to research the type of specific information that we required for this content analysis. In addition, the various engines have different searching capabilities, adding to the difficulty in ensuring that a complete search was conducted. However, searching using Internet tools such as Google and using individual news agency websites was

TABLE 2: Content Analysis Results of Articles Mentioning Secondary Traumatic Stress as per Consensus Reached by Two Coders

Title	Publication	Physical Violence	Emotional Numbness	Financial Burden	Dependant Caregiving	Sexual Violence	Relationship Dysfunction	Stress and PV Care	Vicarious Trauma	Relationship Breakup	SV Support	Total references
Treating War's Toll on the Mind: Thousands of soldiers have post-traumatic stress disorder. Will they get the help they need?	U.S. News & World Report (USA)		X				X		X		X	4
Injured Canadian soldiers take advantage of support services for stress.	Canadian Press Newswire											0
VAC: Operational Stress Injury Clinic Opens in Calgary.*	CCNMatthews Newswire											0
Commons gives approval to new bill improving veterans' benefits.	Canadian Press Newswire											0
VAC: Operational Stress Injury Clinic at Deer Lodge Centre Officially Opens.	CCNMatthews Newswire										X	1
Ottawa will commit \$1 billion to veterans of armed forces.	CTV News - CTV Television			X							X	2
Experience teaches military to do more for returning troops and families.	Canadian Press Newswire										X	1
Battling the Effects of War.	Newsweek (USA)	X	X				X	X				4
The Homecoming, and Then the Hard Part.	Newsweek (USA)											0
Manitoba ex-soldier has PTSD, seeks to reverse guilty pleas on violent crimes.	Canadian Press Newswire	X				X						2
Combat stress: Military psychologists are sent to the front .	U.S. News & World Report (USA)											0
Ombudsman's Report: Cdn. Military a "Culture of Shame."	Canada AM - CTV Television							X				1
One in five Canadian vets of Afghan conflict have stress injuries: ombudsman.	Canadian Press Newswire											0
DND/CF Ombudsman calls for stress treatment centre outside military base.	Canadian Newswire											0
DND and VAC Announce National Peer-Support Program.	Canada Newswire										X	1
Defence Minister John McCallum, who was present for the unveiling of the stress centre Wednesday, acknowledged that the new treatment facility was set up too late for Canadian veterans who have died after returning from combat.	Canada Press Newswire						X					1
Forces ill-prepared to deal with emotional casualties in war on terror, book.	Canadian Press Newswire	X					X				X	3
Two Quebec soldiers sue Armed Forces, allege post-traumatic stress.	Canadian Press Newswire						X					1
First and only medication for patients suffering from posttraumatic stress disorder receives approval.	Canada Newswire		X				X					2
Senate committee on defence calls for \$4 billion more in military funding.	Canadian Press Newswire							X			X	2
Gone to Soldiers.	New Internationalist (UK)	X	X				X					3
Total	21	4	4	1	0	1	7	3	1	0	7	28

not appropriate either, given that news sites typically change their content frequently. Thus, we offer this as a relatively thorough analysis, while acknowledging that there may be articles that we missed in our searches.

Treatment Implications

This content analysis provides some evidence that there is a lack of awareness of STS in the general public and among policy makers based on an underrepresentation of the subject in the popular news media. The U.S. and Canada's continued involvement in the War on Terrorism will surely contribute to an increase PTSD and other combat-related stress injuries. Support for family members who are dealing with STS must also increase. It is the responsibility of the Canadian government to model other Western nations in developing appropriate

support services for these families. In particular, the use of innovative technologies, such as distance treatment (via the telephone or over the Internet) may be appropriate for Canadian military families given the geographic isolation of many military bases and the stigma associated with seeking mental health services. Programs designed to teach cognitive behavioral techniques, such as the SAFE program in the U.S. (e.g., Sherman, Faruque, & Foley, 2005), should be implemented for Canadian military families. There is a connection between the lack of media awareness and the lacklustre approach of the Canadian military to help families: the political willpower to change policy and implement programs. Increased media coverage has the potential to raise the "currency" of the issue in the current political climate, thereby creating a catalyst for change in policies and programs.

In conclusion, we hope this study can provide a context for clinicians who are working with these families. Although our analysis was focused on the Canadian media, our scan of American reports indicated similar results. The media is an important tool that may influence families' and the general public's perception of the importance of secondary traumatic stress. Specifically, the lack of media coverage on STS within the context of many reports of PTSD may provide a context to families and the general public that their own suffering is secondary to the primary victim's. As professionals involved in research and treatment for these families, we struggle with our role in facilitating the transfer of scientific knowledge of the significant and chronic impacts of STS to the general public.

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Training Forum

Balancing Science and Practice in Clinical Psychology Training Programs: A Survey of Training Directors

Sandra L. Hunt, *CUNY, College of Staten Island*, and Patricia A. Wisocki, *University of Massachusetts, Amherst*

Methods for encouraging the integration of science and practice for doctoral-level clinical psychologists have been studied since 1950 when the Boulder model was proclaimed an objective for clinical training programs (Raimy, 1950) and further confirmed at the Gainesville Conference (Belar & Perry, 1992). Although some have stated that such integration is not possible (e.g., Lorion, 1993; Peterson, 1995), many clinical training programs identify with the Boulder model (Stricker, 2000) and strive for such integration. In the

forefront of this assertion have been the clinical training programs that emphasize cognitive-behavioral principles and procedures.

In 1992 O'Sullivan and Quevillon surveyed 138 APA-approved doctoral programs in clinical psychology and 96 master's programs and found that 97.8% of the doctoral programs and 81.8% of the master's programs indicated that their programs followed the Boulder model. In 2000, Belar stated that all major organizations representing graduate education in

professional psychology explicitly endorse this model of clinical training.

In listing the core values and principles of the profession, the Committee on Accreditation has stated, "The relative emphasis a particular program places on science and practice should be consistent with its training objectives. However, all programs should enable their students to understand the value of science for the practice of psychology and the value of practice for the science of psychology, recognizing that the value of science for the practice of psychology requires attention to the empirical basis for all methods involved in psychological practice" (2007, pp. 3-4).

Although minimal data have been collected to determine how clinical training programs address integration, a survey of psychology internship and postdoctoral training programs found significant inconsistencies with regard to training models (Rodolfa et al., 2005). The authors noted that "models do not mean the same thing across internship sites and that these models

do not correspond to how sites conceptualize and implement their training” (p. 30).

In an effort to determine the current adherence of programs to the Boulder model of training, the purpose of the present study was to gather information about the ways clinical training programs in North America address the integration of science and practice in the training of doctoral students.

Method

Participants

The training directors of 165 clinical training programs, members of the Council of University Directors of Clinical Psychology (CUDCP), were invited to participate in the study by completing a 4-page questionnaire. After three mailings, 54 (33%) responded.

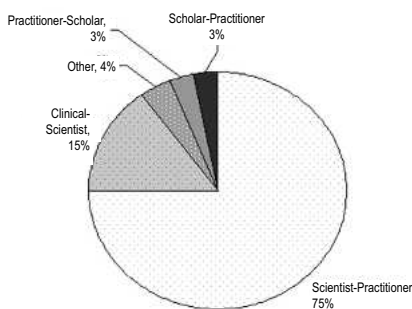


Figure 1. Identification of training model by clinical psychology training directors (N=54)

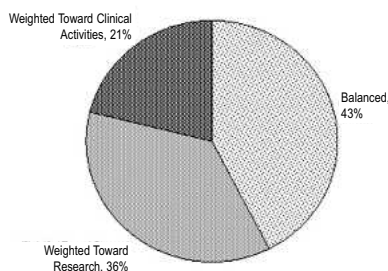


Figure 2. Clinical training directors' reports regarding the balance of research to clinical activities in clinical psychology training programs (N=54)

Materials

The integration of science and practice was measured by the following elements: (a) reading about empirically supported assessment devices and psychotherapy interventions; (b) using empirically supported assessment devices and psychotherapy interventions in clinical work; (c) determining the kind of research done by the clinical faculty and the integration of science and practice in their teaching and their own clinical practices; (d) using department training clinics for research purposes; (e) degree to which adjunct faculty from these programs use science and practice in their teaching and clinical practices; (f) presenting and publishing papers by students; and (g) identification of the training model by the program.

A questionnaire was devised with four parts. First, information was requested about the program: the number of credits given, the kinds of courses required, the courses' emphases on empirically validated treatment and assessment procedures, and whether or not the training clinic served as a research base. Second, questions pertained to the faculty and their integration of research within their clinical practices and courses, and the kind of data collection procedures they used with their clients. Third, questions were asked about the students: how many present and publish their work; how they are funded during their training period (i.e., how many research assistants exist in proportion to other sources of funding, and how many collaborate with faculty and other students in research activities). Fourth, a series of nine statements, named the Training Issues Scale, was presented about the value of integration in training programs and the importance of scientific thinking. Respondents were asked to agree or disagree in various strengths. There were two questions specifically about identifying the training program in terms of its model of training and the amount of weight given to research and practice in the program.

Results

Self-Identification of Training Model

As is evident in Figure 1, while most (75%) of the programs participating in the study identified themselves as scientist-practitioner programs, clinical-scientist was the second most frequently endorsed model, but to a much lesser extent. A small percentage of programs believed they were scholar-practitioner or practitioner-scholar programs and two programs said "other,"

but did not identify what that meant. Likewise, as Figure 2 indicates, when reporting the balance of research to clinical activities, a majority of the programs reported that they were either balanced or weighted toward research. A small portion of respondents (11 programs) reported that their programs were more heavily weighted toward clinical activities.

To further measure the programs' philosophy of training, responses to the Training Issues Scale were examined, details of which can be seen in Table 1. In responding to statements about the importance of integrating science and practice in clinical training programs, the responses were all above 90% agreement. The strength of the agreements, however, differed by question. Directors of training "agreed strongly" about the importance of imparting the central concept that science and practice must be integrated (80%), that clinical doctoral students learn and apply the various "rules" of scientific inquiry (86%), and that training in scientific thinking is essential in any clinical training program (91%). With questions about application, however, the differences in agreement became more pronounced. In particular, 50% of the training directors indicated "strong agreement" with the questions about requiring supervised students to refer to scientific literature in designing treatment programs and using clinical interventions, and with the notion that systematic assessment of a client's functioning is essential to every therapy. There was "strong agreement" among 54% of the training directors that students should demonstrate an integration of clinical intuition and empirical knowledge when making case presentations. Fifty-two percent strongly agreed that a clinical program must contain activities that promote a constant interplay of clinical hunches and intuition and hypotheses to test those hunches. Fifty-nine percent of the training directors strongly agreed that "if a clinical intervention is worth doing, it is worth evaluating in an empirical context" and 61% agreed strongly that students should be taught empirically validated clinical methods.

Courses, Practica, and the Use of the Training Clinic

We next turned to the extent to which courses and practica reflected the integration of science and practice. As presented by these training programs, 14% of clinical training was devoted to methodological concerns (statistics and research methods and design). An equal percentage of courses

Table 1: Clinical Training Directors' Responses to the Training Issues Scale (N = 48)

	<i>Strongly</i>	<i>Agree moderately</i>	<i>A little</i>	<i>Strongly</i>	<i>Disagree moderately</i>	<i>A little</i>
1. It is important for a clinical program to contain activities that promote a constant interplay between clinical hunches and intuition and hypotheses to test those hunches.	52%	30%	9%	2%	7%	2%
2. It is important for a clinical program to impart the central concept that science and practice must be integrated in order for one to be a clinical psychologist.	80%	16%	2%	0%	2%	0%
3. If a clinical intervention is worth doing, it is worth evaluating in an empirical context.	59%	32%	7%	0%	2%	0%
4. It is vital that clinical doctoral students learn and apply the various "rules" of scientific inquiry, such as representative sampling, controls, statistical significance, etc.	86%	14%	0%	0%	0%	0%
5. In supervising the clinical work of students, supervisors should require students to refer to the scientific literature in designing treatment programs and in using clinical interventions.	50%	30%	18%	2%	0%	0%
6. Training in scientific thinking is essential in any clinical training program.	91%	9%	0%	0%	0%	0%
7. When making case representations about clients, students should demonstrate the integration of clinical intuition and empirical knowledge.	54%	32%	12%	2%	0%	0%
8. Systematic assessment of a client's functioning is essential to every therapy.	50%	30%	16%	2%	2%	0%
9. Students should be taught clinical methods whose efficacy has been empirically validated.	61%	25%	9%	2%	2%	0%

Note. Alpha = .86

were taken in the broad areas of scientific psychology. Nineteen percent of the courses were devoted to clinical content in intervention and assessment and 16% and 7% of the courses, respectively, consisted of practica and internship. The remaining 30% of the courses were classified as "other" and included such topics as developmental psychology, neuropsychology, and psychopharmacology.

In indicating how teaching is distributed with regard to the scientist-practitioner balance, 27 programs (52%) reported that between 26% and 50% of the clinical faculty teach courses in empirically validated assessment and psychotherapy interventions. In 8 programs, nearly all of the faculty teach in these areas. In 12 program (23%), less

than one quarter of the faculty teach such courses.

Seventy-one percent of the programs required students to read empirical literature about assessment devices in all assessment practica. Slightly fewer programs (67%) required students to actually use empirically supported assessment devices in all assessment practica. Interestingly, three programs (6%) reported that they did not require students to use empirically supported assessment devices at all and one program (2%) reported that it did not require students to do any reading about empirically supported assessment procedures.

The numbers are diminished with respect to reading about and using empirically supported psychotherapy interven-

tions. In 53% of the programs, the students were required to read the empirical literature in all of their psychotherapy practica, while only 39% of the programs required their students to use empirically supported procedures all of the time. Fifteen and 10% of the programs, respectively, required students to read about and apply empirically supported interventions half the time in courses. One program did not require students to read anything about empirically supported psychotherapy interventions and four programs did not require students to use them at all.

The majority of the programs sampled (79%) indicated that they have training clinics. These programs reported that approximately one third of their faculty used

Table 2: Characteristics of Training Clinics (N = 42)

	<i>Yes</i>	<i>No</i>	<i>Missing</i>
1. Clients serve as research participants	64%	29%	7%
2. Client info. entered into database	64%	29%	7%
3. Ongoing research into clinical interventions	54%	39%	7%
4. Ongoing research into clinical assessment tools	46%	45%	9%
5. Ongoing research into psychotherapy outcome	64%	29%	7%
6. Other areas of psychology use clinic for research	25%	66%	9%
7. Grant-funded center of program studying clinical issues	19%	72%	9%
8. Ongoing research into process or outcome of training	31%	60%	9%

the clinic for research purposes, while approximately one quarter of their students did so. Details regarding use of the training clinic are presented in Table 2. In 64% of the programs clients typically served as research subjects, their information was often entered into a database, and there was ongoing research into psychotherapy outcomes. In considering the subject matter of these research efforts, most programs (54%) conducted research into clinical interventions; 46% reported ongoing research into clinical assessment tools; and 31% reported ongoing research into the process or outcome of clinical training.

Adjunct Faculty

In examining the use of adjunct faculty in the supervision of students' clinical work, we relied on information from 38 programs (71% of total sample). The mean number of adjunct faculty in these programs was eight. Most of the adjunct faculty in the clinical programs surveyed in this study were trained in scientist-practitioner programs. As is evident in Table 3, approximately half of the programs reported that the majority of their adjuncts do not conduct research. Nine programs, however, reported that almost all of their adjuncts conducted research into clinical or other issues. These data also indicate that it is not common for adjuncts to use empirically val-

idated assessment and therapeutic interventions in their own practices.

Faculty Information

Ninety-five percent of the clinical faculty in these training programs were themselves trained in scientist-practitioner programs and most (89%) engaged students in their own research areas. As detailed in Table 3, respondents (65%) indicated that nearly all of their faculty conducted research into clinical problems, while 38% of directors indicated that nearly all their faculty did research with clinical populations. Very few faculty in these programs were engaged in outcome research or program evaluation.

When asked to describe the clinical practices of the faculty in terms of their integration of research and practice, most program directors indicated that fewer than a quarter of their faculty presented case studies that contained systematic client evaluations, using empirically valid procedures. Only three program directors reported that nearly all of their faculty used systematic evaluations about clients when presenting case studies to students. The percentages of the faculty in clinical training programs who used self-report, behavioral measures and physiological measures to collect data from clients were small overall in each measure.

Student Information

Thirty-four programs (64% of the total sample) provided data about their students' research activities during their training programs. Most commonly, program directors reported that between one third and one half of their students engaged in some research activities other than their theses and dissertations. Only two programs indicated that all of their students engaged in research beyond the requirements of a thesis and dissertation.

In querying the programs about the kinds of research activities students were involved in, we found that the most common type of activity was collaboration with clinical faculty on publications. It was rare for students to collaborate with nonclinical faculty on publications or serve as single authors on publications. Interestingly, 23 programs reported that one third to one half of their students collaborated with other students in authoring articles; 3 programs said this happened for two thirds of their students.

When asked to indicate what percentage of the student body presented their research at conferences, we found that it was an infrequent event. Only 9 programs reported that at least half of their students presented research at professional conferences. It was more common to find that students presented their work at in-house colloquia or a similar venue, although the numbers were not high. Most respondents (17) reported that less than one quarter of their students made presentations at colloquia. Additional details regarding student research is presented in Table 4.

Discussion

Since the Boulder model was created questions have arisen about the integration of science and practice in clinical training. In this study we collected information about the frequency and extent of integration as it exists in 54 clinical doctoral training programs. In this survey, 90% of the training programs identified themselves as either scientist-practitioner or clinical-scientist models. Directors of the programs strongly endorsed the essential concepts of integration. In support of that endorsement, the majority of programs reported that a substantial number of program faculty taught courses in empirically validated assessment tools and psychotherapy procedures. Students were required to read the empirical literature about assessment and incorporate what they learn in the readings into their practica. There is active research

Table 3: Program Data on Percentage of Adjunct and Full-Time Faculty Engaged in Science-Practice Activities

	0-25%	25-50%	51-75%	76-100%	Missing
• Adjunct Faculty (N=38)					
1. Trained in scientist-practitioner programs	0 (0%)	1 (3%)	7 (20%)	27 (77%)	0 (0%)
2. Conduct research into clinical or other issues	19 (49%)	5 (13%)	3 (19%)	9 (25%)	2 (4%)
3. Use empirically validated assessment measures and therapeutic interventions in practice	8 (21%)	12 (32%)	2 (5%)	11 (29%)	5 (13%)
• Full-time Faculty (N=35)					
1. Conduct research into clinical problems	4 (11%)	5 (14%)	2 (6%)	23 (65%)	1 (4%)
2. Conduct research with clinical populations	3 (9%)	4 (11%)	12 (34%)	14 (37%)	3 (8%)
3. Engage in outcome research or program evaluation	17 (49%)	9 (26%)	4 (11%)	3 (9%)	2 (6%)
4. Present case studies that contain systematic client evaluations using empirically validated procedures.	17 (48%)	8 (23%)	5 (14%)	3 (9%)	2 (6%)
5. Use self-report measures to collect data from clients.	11 (31%)	6 (17%)	7 (20%)	9 (26%)	2 (6%)
6. Use behavioral measures to collect data from clients.	13 (37%)	13 (37%)	3 (9%)	4 (11%)	2 (6%)
7. Use physiological measures to collect data from clients.	20 (57%)	9 (26%)	3 (9%)	1 (3%)	2 (6%)

Table 4: Program Data on Percentage of Students Engaged in Research Activities During Training (N = 34)

	0-25%	25-50%	51-75%	76-100%	Missing
1. Conduct research other than dissertation	6 (18%)	21 (61%)	5 (15%)	2 (6%)	0 (0%)
2. Author publications on own	28 (82%)	6 (18%)	0 (0%)	0 (0%)	0 (0%)
3. Collaborate on publications with clinical faculty	6 (18%)	13 (38%)	8 (24%)	5 (15%)	2 (6%)
4. Collaborate on publications with nonclinical faculty	29 (85%)	3 (9%)	0 (0%)	0 (0%)	2 (6%)
5. Collaborate on publications with other students	5 (15%)	23 (67%)	4 (12%)	0 (0%)	2 (6%)
6. Present research at professional conferences	20 (59%)	3 (9%)	8 (23%)	1 (3%)	2 (6%)
7. Present at in-house colloquia or similar venue	17 (50%)	9 (26%)	4 (12%)	2 (6%)	2 (6%)

involvement of a number of faculty and students in the department's training clinics, although the numbers are small.

The majority of the faculty in the programs were trained in scientist-practitioner programs, conducted active research programs, and involved their students in their own research areas. A number of programs reported that their students were engaged in research activities beyond the required thesis and dissertations. They collaborated with their faculty on publications and worked with other students on publications as well.

There was less agreement among the directors of training about the application of the science side of the equation to clinical practice. In slightly more than half of the programs the students were required to read about empirically supported intervention procedures in their practica, but fewer programs required students actually to use empirically supported procedures with their clients.

The program faculty themselves reportedly did not frequently model the integration of science and practice by using empirically supported procedures in their own clinical practices. Nor was it common for them to present case studies that indicate a systematic assessment of the client or the use of empirically supported treatments. Likewise, adjunct faculty, whose own training was usually in the Boulder model tradition, typically did not carry out research into clinical issues or use empirically supported assessment and therapeutic interventions in their own practices.

These discrepancies between teaching and doing may signal a disconnect about one's own beliefs about clinical practice and what one believes is necessary to impart to students. It could just as well signal a relative lack of interest in clinical practice when faced with the importance of conducting research in demanding university-based clinical psychology programs. In surveying clinical psychology faculty in academic programs, Himelein and Putnam (2001) found that clinical faculty in doctoral programs spent 25% of their time conducting their own research and 5% of their time in clinical practice. When asked what their preferences were for their time allotment, the clinical faculty stated that they would like to increase their research time, but keep the clinical commitment as it was. This particular finding suggests that clinical faculty are not following an important recommendation from the Boulder model conference, namely, "those persons engaged in the teaching of clinical skills should also be con-

stantly engaged in work of this sort" (Raimy, 1950, p. 130). The bedrock concept derived from the Boulder model conference is that clinical and research work can be integrated and should be integrated for the sake of both clinical practice and clinical research. It is as important for the practicing clinician to utilize the research findings in assessment and psychotherapy as it is for the researching clinician to inform his or her research with the real-world work of the practicing clinician. Each informs and benefits the other to an equal degree.

The recent endorsement by the American Psychological Association of a policy of evidence-based practice (EBP) suggests that graduate programs will begin to incorporate more training in empirically supported treatments (EST) into their curricula in order to advance the policy of EBP. A residual effect of this may be greater integration and adherence to the Boulder model. According to Bauer (2007), a key issue in implementing the EBP model is whether graduate education should focus more heavily on training students to become competent in a number of ESTs or whether the goal is to train them in more general principles of EBP that may "enable them to easily adapt to novel demands for new competencies after attaining their Ph.D." (p. 688).

The primary limitation of this study is in the area of sample size. Despite three requests of the Directors of Clinical Training affiliated with the Council of University Directors of Clinical Psychology Programs, we were able to obtain only a 33% response rate. Thus, the percentages reported here are only suggestive of the broad picture. While the sample did contain representation from three Canadian universities and three universities with Psy.D. programs, the bulk of the responses came from major universities across the United States granting the Ph.D. for doctoral work. Compounding this problem is the fact that only partial responses were provided for several items, further limiting the value of the interpretation of the data.

Another problem is with the content of the courses that were counted. Directors of training simply listed the titles of the courses in their programs. On paper the programs appear to meet accreditation requirements of course work. We do not know what the syllabi contained. It would be useful to know whether the courses are integrated themselves along science-practice lines, or if they fall into separate groupings, so that a split is maintained (perhaps unknowingly) in that context as well.

Clearly, the application and evolution of the Boulder model is ongoing, and although it was developed nearly 60 years ago, its translation still takes many forms. As interaction among field professionals continues, including attempts to incorporate evidence-based approaches into clinical training, we may yet see a successful and complete marrying of science and practice in all training programs.

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Fighting the Good Fight by Hunting the Dodo Bird to Extinction: ABCT's Dissemination Effort

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Among the near-term goals for ABCT is the dissemination of knowledge regarding treatments with empirical support, as reflected by our past-president's recent column in *the Behavior Therapist* (DiGiuseppe, 2007). This is a monumental task, rife with challenges, some of which were highlighted within the column. DiGiuseppe offered numerous salient and thought-provoking points in his discussion of the effect of the Dodo Bird verdict (which he very glibly termed the "Doo-Doo" verdict), among them the following:

Either we rebut [the Dodo verdict] conclusions, conduct new research to show they are wrong, or we accept them and change our message. Perhaps we will learn where our evidence is weak. Perhaps we will learn to improve our interventions. (p. 119)

As noted in the column, we are not likely to change our message given the substantial empirical evidence that treatments are not equivalent, and more inclusive research will definitely be necessary to examine common factors. This work is still in its infancy, however, and any findings it brings are years away. Additionally, conclusions based on these findings are not guaranteed to be accepted by practitioners any more than the current body of academic knowledge surrounding psychological treatments. Thus, DiGiuseppe's (2007) initial suggestion of rebutting the Dodo verdict in our dissemination efforts seems critical for current efforts in infusing evidence into applied treatment settings.

One fundamental difficulty with rebutting what are essentially people's beliefs (i.e., not broadly informed, empirically supported positions) concerning the utility of evidence-based services (EBS) in practice is that those beliefs are not particularly amenable to change through traditional efforts (e.g., Anderson, Lepper, & Ross, 1980). Yet something must be done if we are to advance the role of science in practice commensurate with what has been learned about effective psychological treatments.

Taking a cue from Motivational Interviewing (Miller & Rollnick, 2002), it may not be necessary to attempt a charge through much of the field's collective roadblocks by proclaiming superiority of our approaches in an effort to disseminate decades of meaningful research. Through modification of our methods of dissemination, but not our message, it may be possible to sidestep these beliefs completely and spread the proverbial good word of evidence-based services to the front line.

Diffusion of Innovations

Research on methods of dissemination exists to guide our efforts in this process. Diffusion research, for example, is founded upon a long tradition of interdisciplinary research in communications, anthropology, public health, economics, and other social sciences, and is focused on studying the means by which people adopt innovations (e.g., technologies, ideas, health practices, etc.). This field formally began with a study of rural Iowa farmers' adoption of hybrid corn seed in the mid-1940s (Ryan & Gross, 1943), and has since been extended to numerous areas spanning diverse technologies, cultures, and socioeconomic strata (see Gladwell, 2000, and Rogers, 2003, for overviews; see Coleman, Katz, & Menzel, 1957, and Menzel & Katz, 1955, for seminal studies of diffusion in medical practitioners' prescribing practices). Diffusion research has led to construction of a general model for the dissemination process, which has several features that allow for prediction of how an innovation will be received (neatly encapsulated in Rogers, 2003, and mathematically quantified in Mahajan & Peterson, 1985). Particularly pertinent to the current position paper is the ubiquitous finding that possession and communication of empirically derived scientific data are not significant factors in convincing people to adopt innovations.

The diffusion model indicates that individual change follows a predictable pattern.

First, knowledge of an innovation (for our purposes EBS) is enhanced through some outlet (e.g., mass media, targeted marketing, professional association, contact with a friend or colleague who has already adopted the innovation, etc.). Second, an individual's attitude about an innovation can be expected to change in accord with his/her increased knowledge. Several facets of the individual and the social system in which he/she is located determine whether this change in attitude will be positive or negative, including the perceived benefit of adopting an innovation, openness of the system to change, and existing sociocultural norms. Finally, if knowledge is increased and attitudes are positively influenced, it is expected that practice will change over time until the innovation becomes a common part of daily life.

Application of Diffusion to Clinical Psychology

There are several methods of enhancing knowledge about EBS. The most typical method within scientific psychology is repeated presentation of empirical findings from well-controlled, methodologically sound outcome trials, either through publication or conference presentation. This method has been adopted by the American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures (1995), and is influential in the establishment of ABCT's own Task Force (DiGiuseppe, 2007), which will additionally focus on understanding broad principles of treatments. The difficulty with the traditional method, however, is that it is neither the most efficient way to reach practitioners (many of whom do not routinely read the literature or attend scientifically oriented conferences) nor the best way to convince them. In fact, given the heated debate over the role of EBS in influencing practice guidelines in applied settings and the siding of many practitioners against treatments developed in universities (e.g., Westen, Novotny, Thomson-Brenner, 2004), it is likely that the attitude of much of the field is negatively influenced upon contact with this information.

To the extent that EBS public dissemination efforts (such as the ones being performed by our organization) find receptive audiences, the diffusion model predicts that practitioners will change their therapeutic practices as the end product of a predictable pattern of behaviors. We are not, however, trying to reach these relative few who already appreciate evidence in selecting their

practices and value the role of science in guiding the future of psychological treatment. It is the rest of the field—those who oppose the idea of evidence-based services as being more valuable than intuitively based approaches—that we seek to influence. The diffusion model predicts that our efforts in dissemination, which largely target the former group of receptive people, actually strengthen nonreceptive practitioners' beliefs against EBS. The end result of this process is a deepening of the scientist-practitioner divide and limited (or negative) progress in the critical effort of dissemination.

What Can Be Done?

This limited progress should not be reason to throw up our hands and retreat to the confines of our ivory towers. Indeed, as pointed out by DiGiuseppe (2007), there is no more critical mission for our organization or our field than the dissemination and implementation of what has been learned through the scientific study of psychology. A shift in our approach to engaging in this process is indicated.

Diffusion research again allows insight into the directions we should take to pursue more effective methods of dissemination. Diffusion literature repeatedly indicates that influence of potential adopter's attitudes is related to many factors, not least of which is the identity and affiliation of the person delivering innovation information (Rogers, 2003). What helps convey knowledge that will positively influence attitudes is the message being delivered by someone whose opinion is valued by the message recipient (termed "opinion leaders" by Rogers, 2003). Another valuable aspect of enhancing one's likelihood of adopting an innovation is the opportunity to experiment with it before being forced to adopt. In the case of Ryan and Gross' (1943) initial work, farmers who planted a few acres of hybrid seed alongside their usual crops were much faster to adopt this innovation than farmers without such opportunity. This side-by-side comparison of the old with the new allowed them to evaluate directly, critically, and for themselves, the relative merits of each approach.

Similar strategies should be adopted for our dissemination efforts. Perhaps a goal of more insidious diffusion is appropriate. If we were able to teach strategies to practitioners without emphasis on supplanting their current efforts, we might go farther in influencing their personal implementation and evaluation of the techniques. This may

be facilitated by clinically or administratively working with practitioners in their clinics as a way of learning about the day-to-day demands of these positions without asking to conduct research projects or force the use of new techniques on therapists. The same principles apply to influencing system reorganization for EBS through careful attention to administrative and fiscal issues (for previous examinations of these topics as informed by applied dissemination research see Schoenwald & Hoagwood, 2001, and Schoenwald, Sheidow, Letourneau, & Liao, 2003). This colloquial contact will serve to augment our knowledge of the challenges facing evidence-based practice on the frontlines, which can be applied to future research in this area. Our presence in community clinics or systems will also allow scientists to answer questions or help out as situations arise. Diffusion of evidence-based practices through these channels may be more acceptable to practitioners, and as they begin to see benefit from scientific techniques (in comparison to treatment as usual) they are likely to enhance their routine practice of such. Additionally, they will influence their friends and colleagues to experiment with the same techniques, which will begin the predictable diffusion process throughout the field.

Who Can Do It?

In concert with the above recommendation, it is possible that as a field we have not dedicated enough attention to consideration of the source of messages about evidence-based services. It is possible that the zeitgeist of most academics and researchers is not currently ideally suited to effective dissemination about the scientific treatment advancements we have developed. To be fair, this is certainly not true for everyone: Look no further than public addresses by pillars of the scientific process such as David Barlow, for example, to understand that some scientists are also extremely effective opinion leaders. Diffusion research, however, suggests that the developers of treatment innovations are generally substantially different than the intended end-users, and do not necessarily have much sway in the court of public opinion. The end users themselves also express a great deal of heterogeneity in their response to innovations. As defined by Rogers (2003), any group to whom an innovation is disseminated may be thought of comprising several subgroups, each of which has distinct characteristics and patterns of innovation adoption. Early adopters are those within a given

system who value innovation, and are often aware of numerous pending social and/or technological changes. These individuals often hold special status in their social systems due to their awareness, and are valued opinion leaders concerning innovation adoption. As Rogers (2003) describes them, these are the "individual[s] to check with" (p. 283) regarding potential adoption of an innovation. Deliberate adopters, or the early majority, are those individuals who come into an innovation on the early end of the trend, but rarely lead the way. Skeptical adopters, or the late majority, are those individuals typically pushed to adopt innovations by economic or peer pressure. Finally, laggards to adopt innovations are characterized by their dogmatic adherence to traditional values in the face of change, based largely on their lack of social connectivity. The lynchpin of diffusion throughout social systems, as reiterated by numerous diffusion studies, seems to be early innovation adoption among opinion leaders, who in turn serve as authorities to the rest of the social group. If this influence of opinion leaders among end-users' social systems is not attained, an innovation is unlikely to have a broad effect.

Our job, then, must be to either seek out opinion leaders and change their minds about EBS such that they diffuse this knowledge to others in their social environment, or to become opinion leaders ourselves through partnerships with applied agencies. If we can demonstrate that we have something to offer in a quiet way that imparts benefit to practitioners, then we can become accepted in these venues and in demand as opinion leaders. Consistent with the general principles of CBT, if this process is done Socratically it will lead the frontlines to come to us for valuable suggestions on how to help their practice, rather than the other way around. In this way it will be possible to incite broad, lasting change.

What We Can Learn From the Debacle of Pseudoscience

As addressed in this very brief review of the diffusion model, people tend to value anecdotal advice of friends based on personal contact with an innovation far more than impersonal, empirical, data-based explanations. One area that has made extremely effective use of this realization in increasing the public's knowledge of various treatments is pseudoscience. Those individuals responsible for the advancement of public awareness of pseudoscientific treatments have been able to take numerous

brands of therapy without a shred of empirical evidence to support their usage (Lilienfeld, Fowler, Lohr, & Lynn, 2005; Lilienfeld, Lynn, & Lohr, 2003; Lohr, Fowler, & Lilienfeld, 2002), which are sometimes actively harmful (Lilienfeld, 2007), and disseminate them widely in both applied practice and popular culture (Olatunji, Parker, & Lohr, 2006). The strategies they use sometimes closely resemble those that would be recommended from reviewing diffusion research, and offer a naturalistic opportunity to see some of these techniques in action. Their implementation has likely been unwitting, and has certainly been applied in a way that is deleterious to the advancement of science and critical thinking (cf. Gilovich, 1991), but has been effective nonetheless.

Pratkanis (1995) offers some insights on the typical methods of the pseudoscientist in promoting belief in his/her individualized brand of snake oil, including several that resemble effective diffusion strategies. Of notable utility are the showcasing of nearly infallible “gurus” to serve as the face of marketing efforts, the use of vivid appeals or anecdotal case testimonies, self-perpetuating persuasion from potential adopter group members, and the establishment of a “granfalloon.” The latter term comes from Kurt Vonnegut’s writing, and as defined by Pratkanis (1995) can basically be translated to a “proud but meaningless association of human beings” (p. 4). This group imparts particular properties on group members and shapes the way in which they view information. The consistent use of jargon and materials to emphasize group membership is common, to the point that the group begins to ostracize outsiders who do not share their particular views.

In the promotion of pseudoscience these tactics are being used for a meritless cause commensurate with the lack of data supporting usage of the marketed strategies. Given the proliferation of all sorts of strange beliefs and concomitant industry surrounding the perpetuation of these beliefs (Gilovich, 1991; Kida, 2006; Olatunji et al., 2006; Shermer, 2002), it is difficult to dispute the effectiveness of these strategies. If the same techniques were applied to creative dissemination of EBS, real inroads could be made to reaching the core audience of clinicians resistant to adopting or even partially implementing evidence-based techniques. If we remove the infallibility and hegemonic attitude of a “guru” we have an opinion leader, which can be a force in EBS marketing attempts. The use of anecdotal information could be a powerful

tool in motivating practitioners to consider CBT and other EBS. Once our field has its foot in the door, so to speak, it would be possible to involve practitioners much more deeply in educating, applying, and diffusing EBS, which would be similar to a granfalloon, but with purpose. In much the same way as professional associations, such as ABCT, work to establish a collective identity and channels of communication about important issues, so could new organizations that are designed specifically to draw practitioners into the science of psychology. An important difference between this approach and a true granfalloon, though, would be the presence of a genuinely important purpose and the availability of evidence to support strategies associated with attaining goals related to that purpose.

Additionally, there is a notable difference between the EBS field and pseudoscience that can also inform our dissemination efforts. Pseudoscientists are out to make money through selling products based on their “findings.” This profit-oriented approach to dissemination conceivably aids substantially in their motivation for others to accept their messages. Proponents of EBS are most often associated with universities, and do not have as strong a financial interest in making their message heard. Our training and funding mechanisms are generally not related to profit-motives or complex understanding of traditional economic market forces. Perhaps more of a collective emphasis on developing effective advertisements and marketing strategies is warranted. This work could be done in collaboration with marketing researchers, who offer a nice bridge between the world of academia and business, and are likely to have expertise specific to the problems we face with dissemination.

Learning from diffusion research is an excellent place to start in designing projects of this nature. First and foremost, we need to remember that it is not necessary to tell all that we know as a method of getting people involved with EBS. Data-based explanations should be limited when initially trying to sell people on our ideas. In general, we attempt to convince people with data because data are what convince us—but this is an anachronism of thinking on our part. This strategy has demonstrated limited utility in effecting change with people who do not think like us (i.e., the very people we are trying to reach). We can instead focus on methods of targeting opinion leaders on the front lines and influencing their views such that we diffuse not only

specific EBS but also a central tenet of thought in scientific psychology: empirical epistemological methods. In our view this is also worth pursuing not only among currently practicing professionals, but at the earliest possible opportunity during graduate training education. Training (some might say indoctrinating) all members of the discipline to respect and demand scientific evidence for services would likely positively influence their subsequent behaviors, and result in a paradigm shift for the field (Kuhn, 1996).

Guided by the discussion outlined above, it may be worthwhile to establish national, private, for-profit business ventures focused on provision and dissemination of, as well as training in, EBS. Although some in the field may feel that “profit” is a four-letter word, financial gain does typically serve as a powerful reinforcer for human behavior. Should this straightforward behavioral principle be ethically integrated into dissemination strategies, it could serve to substantially advance our efforts at a faster rate than work to this point has been able to achieve. This has certainly been the case in the realm of pseudoscience (Olatunji et al., 2006), with far less to support the process. Additionally, some in our own field have adapted this model to great effect in the promotion of specific treatments (e.g., Marsha Linehan through her Behavioral Tech company, which focuses on dissemination of and training in Dialectical Behavior Therapy). Of course, it will be necessary to take great care to avoid the potential temptations and concomitant pitfalls often noted in the biomedical field (for a contemporary and widely discussed example, see Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Careful attention to structuring for-profit agencies such that scientific and ethical principles are upheld, perhaps through appointment of industry “watchdogs” or other advocates, will be paramount if such ventures are to succeed in proliferating EBS without compromising integrity.

To the extent that agencies such as ABCT or the National Institutes of Health (through their small-business grants) back such businesses, it may be possible to create an industry around this critically important area of dissemination, similar to how financially vested drug companies market themselves and their products. Once money is made through service provision and training, and tangible benefits are demonstrated to practitioners, dissemination efforts will be a logical result to sustain further economic gain. Guided by traditional market forces and diffusion research, these dissemi-

nation efforts make it more likely that a critical mass (Rogers, 2003) for EBS will be reached, and a tipping point (Gladwell, 2000) will occur wherein EBS will become the new status quo for the field. Given a high enough budget with a broad enough permeance (again, similar to drug companies), it will be possible to have far-reaching influence regarding the nature of practice on the front lines of psychological treatment. With the scope of ABCT's current 3-year plan including a component of dissemination (DiGiuseppe, 2007), we are currently in a unique position to aid this endeavor by fully pursuing the diffusion and marketing strategies outlined in this brief position piece. Numerous individual committees of our organization, including Academic Training, Professional Issues, Research Agenda, and Public Education and Media Dissemination, could also be helpful by inciting policy change directed toward dissemination as informed by the issues outlined in this paper. Perhaps through these efforts we can hunt the Dodo bird to extinction once and for all in the hearts and minds of practitioners everywhere.

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ELECTION RESULTS

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Licensure: Issues and Considerations for Individuals in Training

Sarah Sass, Gregory A. Miller, and Edelyn Verona, *University of Illinois, Urbana-Champaign*

If you are a graduate student or post-Ph.D., and you think you might want to be licensed during the course of your career, how can you plan your training accordingly, and what should you know about the licensing process? There are a number of things to consider. Most importantly, there is no single standard for licensing—each state and province has its own licensure laws and related requirements. In a given jurisdiction there may be one or more laws, implemented by a formal set of rules, leaving the licensing board much or little discretion. The Association of State and Provincial Psychology Boards (ASPPB) provides a handbook regarding states' licensure requirements (see resource list below as well as <http://www.kspope.com/licensing/index.php> for links to licensing boards and relevant laws).

It is important for students to know that each jurisdiction is free to change its requirements at any time, so what looks like a safe bet as preparation for licensing at one point in your career may not be at another point. In some respects, it seems that the general trend is for licensing requirements to become more stringent. For this reason, taking care of licensing earlier rather than later in a career might be wise, if you want to become licensed at all, because commonly people who are already licensed are grandparented in when licensing requirements change.

The American Psychological Association (APA) requires approved doctoral programs to require an internship but does not specify how doctoral programs must meet this requirement. Obviously, it has to be done in good faith. Typically, graduate programs meet this requirement by requiring a year-long internship experience (many such programs are APA-approved). For most applicants, this involves going through the Association of Psychology and Postdoctoral Internship Centers (APPIC) placement process. Doctorate programs may allow students to meet the internship requirement in other ways. For example, doctoral students at the University of Illinois at

Urbana-Champaign may create a custom internship experience in close collaboration with their academic advisor that meets the predoctoral internship requirement, although nearly all students in this program opt for a conventional, APA-approved internship.

Even for students completing a conventional APA-approved internship, the fact that each jurisdiction has its own licensure requirements that change over time may increase uncertainty regarding how readily one can meet such requirements post-internship (e.g., how many hours of what sort are needed for a given jurisdiction, over what time period, whether supervised by licensed clinical psychologists). Furthermore, state law also specifies how requirements for postdoctoral hours can be met. ASPPB reported that, for students from APA-approved programs, 2 years of full-time supervised experience (or equivalent) are typically required by most jurisdictions for licensure, with at least one of these years required to be completed as postdoc hours and the other year typically the predoctoral internship (Olvey, Hogg, & Counts, 2002). In addition, some state licensure laws require that the predoctoral internship experience span no less than 12 months and no more than 24 months, during which time 1,500 to 2,000 total hours (varies by state) are accrued, of which 500 are direct contact hours, 200 hours are supervision hours by at least two licensed psychologists, and 100 of these hours consist of individual supervision (Vaughn, 2006, pp. 11-12). In Illinois, all of the hours that count for the required 2 years must be supervised by a licensed clinical psychologist, and there must be at least 1 hour per week of one-on-one, face-to-face supervision (not group supervision) by such a person. Postdoctoral hour requirements can be more variable across states and provinces, with different portions of the required hours spent on activities such as research and teaching, in addition to direct clinical service hours (Vaughn, 2006).

Reading up on the "top 10" states in which you're most likely to want licensure

in the future can help you determine how to meet requirements. For example, as of 2000, all but four states required a doctoral degree to become a licensed psychologist (Alaska, Oregon, Vermont, and West Virginia only required a master's degree; Olvey et al., 2002). Illinois law requires 1,750 hours each for the 2 required years. Other states require a considerable amount of postdoctoral hours (e.g., in the year 2000: Delaware, 3,000 hours; Michigan and Washington, DC, 4,000; Olvey, et. al., 2002). Training experiences need to be planned accordingly.

An issue that students might wonder about is whether or how one can obtain postdoctoral licensure hours while working as a faculty member in an academic/research institution that provides opportunities for faculty to provide clinical training. It may be difficult to obtain 1,500 to 1,700 postdoc hours by providing clinical services directly to clients when most of your time is devoted to research, teaching, publishing, and perhaps grant-writing. This is one of the reasons many academic psychologists working in Research I universities do not seek licensure. However, at times it may be useful to obtain licensure as an academic clinical psychologist (e.g., it helps you build credibility with staff at agencies from which you recruit clinical participants, or it may be necessary for supervising a practicum in some conventional settings). States vary greatly in how easy it is for academics to obtain licensure. It depends on state requirements regarding how "direct service" is defined and how various activities "count." For example, Illinois allows one to count hours accrued through the clinical supervision of doctoral students as part of direct service hours. Thus, faculty who teach graduate students clinical skills (e.g., therapy, assessment) can generate most of their postdoctoral "clinical" hours through their role as a practicum supervisor. The minimum of 1 hour per week of face-to-face individual supervision of your work by a licensed clinical psychologist is still required. You may need to identify licensed faculty at your institution who would be willing and able to serve as supervisors and to meet with you weekly (it might be difficult to find someone willing to do this in a busy research institution, because typically the time the supervisor puts in is uncompensated; in a clinical setting, it's more likely to be compensated and thus easier to arrange). In fact, you could include the issue of access to such supervision in your negotiations for a job offer.

An important point of flexibility in some state licensing laws, including Illinois, is that you can acquire postdoc hours on a part-time basis. For example, Illinois requires that you obtain a total of 1,750 hours in no less than 50 weeks and no more than 36 months. Full-time work experience requires a minimum of 6 months in a given setting with at least 35 hours per week. Part-time experience requires 18 hours a week for a minimum of 9 months in a given setting. This varies by jurisdiction.

An imperative step toward obtaining licensure in 62 jurisdictions in Canada, the United States, and its territories is to pass the national Examination for the Professional Practice of Psychology (EPPP; Vaughn, 2006). The exam is the same in all jurisdictions in which it is offered (although items and their difficulty differ across administrations of the exam, regardless of what jurisdiction you are in, and jurisdictions can set different passing thresholds). The exam involves a large number of multiple choice questions that survey the whole field of psychology (including Industrial-Organizational, Biological, Sensation and Perception, Social, Cognitive, Developmental, and Personality areas, though with emphasis on Clinical). Your score is based on the number of items you answer correctly and the level of difficulty of the items in the version of the exam you take. In Illinois, you need a scale score of 500 or above to pass. How much do you need to study for the exam? If you are well versed in different literatures in psychology (you read a lot, and across areas), or you have recently taught an undergraduate class in Introductory Psychology, you may not need to study for more than a few hours. You can spend hundreds or thousands of dollars on exam-preparation courses, which may be unnecessary. Working with practice questions in advance may be useful. Given the multiple-choice format, if you are test-savvy and are immersed in academic psychology, you may often guess the correct answer for most questions. However, there is a cost for failing. Currently there is a \$500 fee for taking the exam, and if you fail you have to pay the fee again to retake it in most cases. Consider your knowledge of the field of psychology (not just clinical psychology) when preparing for the EPPP.

Some questions to keep in mind as you consider your training trajectory:

1. How likely is it that licensure will be necessary to complete your career goals? In many cases, licensure is not needed, including obtaining faculty positions, even

those that involve a traditional clinical intervention and supervision component. There is variability in what various settings require (e.g., some academic and/or medical setting job ads require candidates to be "licensure eligible" or already licensed in the local jurisdiction in order to supervise graduate students in intervention work and/or provide direct clinical services, whereas other institutions and settings do not). Settings can vary in surprising ways. For example, in Illinois, the licensure law should probably be interpreted to say that, in order to supervise a practicum, one must be licensed. However, another part of the same law contains an explicit exception for government employees. Thus, if you are a faculty member at a state university, you do not need to be licensed.

2. If licensure seems necessary or at least highly advisable given your career goals, what options are available?

3. How far or in what ways are you willing to alter or compromise your short-term career path, relationship, or family-planning options in order to expand your long-term career options?

Again, answers to these questions are made difficult by variability in what states and provinces require for licensure and the fact that those change over time. Becoming familiar with state licensure laws, consulting with program faculty and previous graduates of your program who are licensed, and contacting individuals who are licensed in states in which you wish to live who work in roles of interest to you may be important in making educational decisions in order to minimize complications in obtaining licensure. As Vaughn (2006) wrote, "It is imperative that all graduate students or prospective graduate students understand and accept that it is ultimately their personal responsibility to ensure that they meet all of the requirements for licensure as a psychologist. The primary tragic circumstance occurs when students complete their program, internship, and postdoctoral experience only to find that they are not licensable in the state or province where they had hoped or planned to practice."

Our purpose here is not to argue for or against obtaining licensure, or for or against particular licensing requirements. We hope that readers understand that licensure in clinical psychology is optional, that it can have major implications for one's career options, and that there is no single, sure-fire path to licensure. On the other hand, there are many thousands of licensed psycholo-

gists, in and outside of academia, and planning for one's future can ease the path toward licensure.

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Other Resources

- **American Psychological Association links relevant to licensure:**
<http://www.apa.org/apaps/profdev/licensure.html>
<http://www.apa.org/earlycareer/licensure.html>
- **Association of Psychology and Postdoctoral Internship Centers:**
<http://www.appic.org>
- **Association of State and Provincial Psychology Boards Handbook:**
<http://www.asppb.org/handbook/handbook.aspx>
- **Links to Psychology Laws and Licensing Boards in Canada & the U.S.:**
<http://www.kspope.com/licensing/index.php>

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Behavior Therapy and Cognitive and Behavioral Practice are available on ScienceDirect to all full members of ABCT. To activate access, go to:

<https://www.sciencedirect.com/abct/activate/members>

You will need your ABCT member ID number (if you don't know your member ID number, just call the ABCT central office).

ABCT Ambassadors: Mentorship to Help You Get the Most From Your ABCT Membership

Mitchell L. Schare, *Membership Issues Coordinator, Hofstra University*

During November of 1978 a first-year graduate student from SUNY–Binghamton boarded a train in Syracuse along with 25 other eager student travelers. When he arrived in Chicago the next day he learned that his parochial view of his graduate education, one defined by books, journals, and classes, was quite naïve. At the Association for Advancement of Behavior Therapy convention (our former name) the community of professional behavioral psychology was opened wide to him. In the elapsed 30 years I've heard many variations of this story, my story.

Often members of the Association for Behavioral and Cognitive Therapies use an endearing term when describing this organization to their colleagues, family and friends. They call it their “professional home.” As I learned those many years ago, ABCT is a place where behavioral and cognitive scientist-practitioners find like-minded individuals. Professionals share information daily on our list-serve, from our website, in our journals, and at our conventions. Paper sessions, symposia, invited addresses, panel discussions, workshops, and social gatherings provide ample opportunities to learn, exchange research ideas, and (of course) network. ABCT is a place where we feel we truly belong.

Participation in our organization is welcomed and very much encouraged. As a member-driven association our extensive website, fine journals, and activity-filled conventions are the activities we use to disseminate information. However, potential members, student members, and newer members to ABCT are often unclear or perhaps even intimidated when it comes to participating in these activities.

As people who have found their professional home here, ABCT Ambassadors are volunteers who are happy to mentor people to the association. The Ambassadors have agreed to be the “eyes and ears” locally of our organization. In this role Ambassadors will serve in a number of important ways. As information about the association needs to be spread, Ambassadors will aid in this

mission by talking to and e-mailing their colleagues, interns, and students at the institutions and practices where they work. For example, it's helpful to be notified when a call for papers is released or a submission deadline is approaching. Ambassadors will be able to answer questions about the association to potential members who are curious about us. Additionally, Ambassadors will have “hotline” e-mail access to the central office when questions arise that they need help with answering.

As many of us have experienced, a knowledgeable mentor is able to make the introduction to ABCT pleasant and easy. Getting on that train 30 years ago was not a random act. I was fortunate to have a number of faculty mentors who advocated membership and participation in this organization. They answered questions about planning a convention schedule, reserving hotel rooms, submitting articles to journals, how to write a paper abstract, etc. How is a clinical roundtable different from a panel discussion or a symposium? Our Ambassadors will be available in this critical role of mentor for those who have questions or seek help in any aspect of membership in ABCT.

As I stated earlier in this article, participation in this association is encouraged and is found by many to be central to professional growth and satisfaction. However, another level of association involvement, beyond the types of activities already mentioned, is possible. As a member-directed organization we are comprised of committees and officers, all of whom participate in the governance of this organization. There are many opportunities to have members join committees and participate in the initiatives, outreach opportunities, journal processes, and future directions of ABCT. Ambassadors will be able to provide interested people with the names of committee chairs and other governance members when looking to become involved in the leadership of ABCT.

A network of Ambassadors is actively forming. As I am writing this column, 53 members are already participating in this

program (see below). Some have been solicited based upon past service to the organization while others have self-nominated to serve as Ambassadors. Regardless, we appreciate all who wish to serve the association in this important role. The more Ambassadors we register for our network, the more local we become and the better we serve our membership. If you would like to volunteer to become an Ambassador, please write to me at ambassadors@abct.org.

* A M B A S S A D O R S *

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Find-a-Therapist

... and like-minded professionals
on the ABCT website

Meet the Inaugural “Featured Therapist”

Katherine Martinez, *Committee on Clinical Directory and Referral Issues*

The Clinical Directory and Referral Issues Committee has initiated an on-line interview series on ABCT’s website. These interviews highlight outstanding, long-time ABCT members, discussing their clinical practice, professional activities, and views on CBT. This series also features the unique ability to look up topics of interest from within the body of the interview.

In our first interview, we invite readers to learn more about **James J. Gray, Ph.D., ABPP**, who has been a member of ABCT since 1976. Dr. Gray has a private practice in Washington, D.C., and is a full-time faculty member in the Department of Psychology at American University. His clinical focus is on the treatment of OCD, trichotillomania, skin picking, and eating disorders. Dr. Gray shares his views on pro-

moting a successful practice, remaining abreast of the literature, managing burnout, and other important topics. To read the interview with Dr. Gray, go to www.abct.org, and select meet ABCT’S FEATURED THERAPIST, located under the *Special Topics* column.

Dr. Gray reminds members of the value of referral lists in promoting one’s practice. To be listed in the Find-a-Therapist directory, or to update your listing, select MEMBER LOG-IN on the ABCT home page, log in, and select FIND-A-THERAPIST DIRECTORY AND REFERRAL SERVICE “join now.”

Timely Tip

Having an up-to-date listing in the Find-a-Therapist directory can increase your patient flow.

URLs U Will Use



Dues History (including 2008 payments)

<https://abct.org/members/source/DuesHistory.cfm>

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These links require that your email address be in ABCT’s system. If you’ve never given us an email address or have changed your email you will not be able to retrieve this information.

ABCT's President, Anne Marie Albano, Ph.D., invites submissions for the 30th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. Submissions will be accepted on any topic relevant to behavior therapy, but submissions consistent with the conference theme emphasizing basic research are particularly encouraged.



Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or postresidency); and (b) have been published in the last two years or currently be in press. Submissions can consist of one's own or any eligible candidate's paper. Papers will be judged by a review committee consisting of Anne Marie Albano, Ph.D.; Raymond DiGiuseppe, Ph.D., ABCT's Immediate Past-President; and Robert Leahy, the ABCT President-Elect. Submissions must be received by August 13, 2008, and must include four copies of both the paper and the author's vita. Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

2008

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 **ABCT**

David Barlow

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For descriptions of award winners and their contributions to the field:

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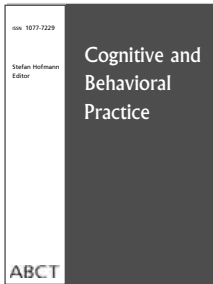
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ABCT

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to Cognitive and Behavioral Practice



The editors of *Cognitive and Behavioral Practice* invite you to contribute papers that fulfill this journal's vital mission:

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Please consider: assessment, the therapeutic alliance, diagnosis, comorbidity, treatment innovations, challenges you have confronted; *as well as aspects of treatment or populations that are underreported in the CBT literature*—for example, sociopathy; the role of social work; interventions with dysfunctional *organizations*; timing of interventions; the role of patient expectations; CBT for family work.
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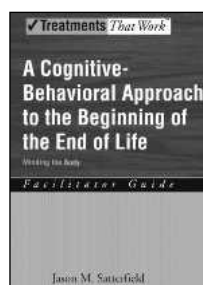
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If you need assistance or advice with formulating your thoughts and ideas into writing, please feel free to contact the editor.

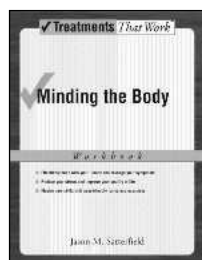
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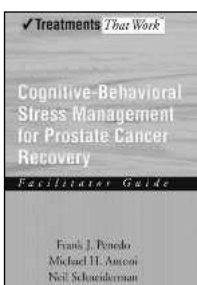
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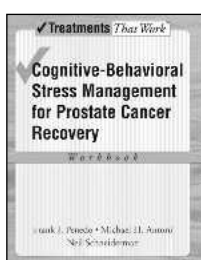
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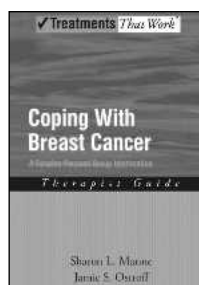
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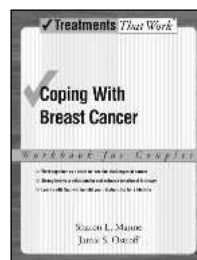
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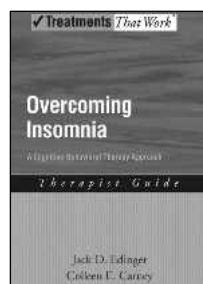
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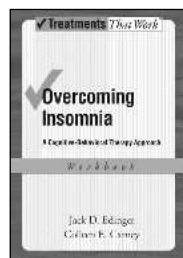
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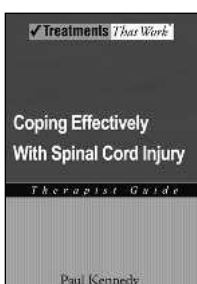
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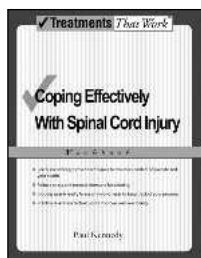
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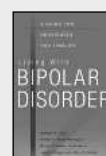


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