

the Behavior Therapist

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[*Special Issue*]

Graduate Training in Evidence-Based Approaches

From Fractionation to Integration: Problems and Possible Alternatives for Clinical Science Training

*Joanne Davila and Greg Hajcak, Stony
Brook University*

Clinical science bridges research and practice, presenting a challenge in terms of graduate training. In particular, how do we integrate training in practice within the context of a science-based graduate curriculum?

In our view, this question is generally answered with an emphasis on evidence-based training. That is, students learn about treatments, and their outcomes, and are trained to provide only evidence-based treatments. Science-based clinical training can mean nothing more than learning to deliver empirically supported treatments. In our opinion, this is not enough—and does not address a fundamental divide between the practice of science and the practice of therapy. We believe that there are a number of “splits” in the way graduate training is often conducted that can get in the way of true integration of science and practice.

One obvious split is between the structure of didactic experiences and the reality of clinical training. Students learn about the science of

[continued on p. 3]

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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.

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psychopathology and about empirically supported assessments and treatments in the classroom, often in separate courses that are conceptually (not practically) based. Then they often do completely separate practica, oftentimes off-site, and with supervisors who may or may not take a scientific approach to practice. To relate science to clinical practice, then, students not only have to integrate across multiple didactic experiences in the classroom, but also across separate classroom and practical experiences.

Another “split” that can get in the way of strong clinical science training is the division of labor. Often clinical psychology faculty members conduct research and teach courses, but do not provide training in clinical practice. That is, faculty members often do the science part of training, but not the clinical part. Clinical psychology faculty members who can provide both science and clinical training (e.g., as clinical supervisors) role model clinical scientists, and programs that utilize faculty supervisors have the potential to provide the kind of implicit and explicit integration that can best facilitate training in clinical science.

Another issue that can get in the way of strong evidence-based graduate training is the fact that clinical curricula are governed by APA guidelines. In particular, the guidelines highlight “broad and general” training, and indeed, these guidelines prioritize breadth at the expense of depth. Although we acknowledge the necessity and importance of breadth (no one benefits from narrowly trained students), we would argue that clinical science training requires depth of both subject matter and experience. Moreover, when done well, depth of training does not need to result in students who only know one thing. Rather, it can serve as a model for how to approach any clinical problem from the perspective of a clinical scientist.

Stony Brook’s clinical science program has been making strides to integrate clinical research and practice since its inception, including the fact that our faculty members provide clinical supervision to students. More recently, we have been developing a curriculum that fully integrates training in clinical research and practice through support from an NIMH R25 grant. This grant supports the development of our Anxiety Disorders Clinic, a specialty clinic within our larger clinic (the Krasner Psychological Center), as well as the development of a scientifically informed clinical training program in exposure-based therapy for anxiety disorders that integrates research and practice

at all stages of training and serves as a model for how exposure-based therapy for anxiety disorders can be disseminated both within clinical psychology graduate programs and in the larger clinical psychology community.¹ The anxiety program involves a 15-month experience that begins in a student’s second year. The program integrates didactic and clinical training in the nature and treatment of anxiety, and further addresses supervision and dissemination, which is often overlooked in clinical science programs. The program has a number of key features that we believe address the “splits” described earlier and that provide students with sufficient depth of experience.

First, the entire program is centered on bringing together experiences in the classroom, lab, and clinic. For example, students initially participate in 8 to 12 hours of intensive didactic training designed to provide them with a broad background in affective, cognitive, social, and neurobiological correlates of anxiety, with an explicit focus on how these literatures inform contemporary views on the etiology of anxiety disorders and mechanisms of successful treatment. In particular, both human and animal learning models and their direct translation to intervention are stressed. This background is then directly applied in the context of teaching students how to conduct assessments, conceptualize cases, and plan treatment. For instance, we teach students how to use fear learning and habituation models in the course of providing psychoeducation. We have students watch or listen to clients describing their symptoms and have students describe the mechanisms at work. We have students develop and present case formulations for their clients that include basic and applied/treatment research that informs the conceptualization and treatment plan, as well as features of the case that point to gaps in the literature and directions for future research.

Second, as noted earlier, clinical faculty provide all training and supervision in the program. This allows for seamless integration of information across all phases of the training, thus explicitly contributing to the integration of science and practice. It also implicitly contributes to such integration by reinforcing that it is natural for clinical scientists to combine research and practice. Once students complete their training in the anxiety clinic, we then train them to be

supervisors for anxiety cases and provide them with “super-supervision.” This allows them to begin to learn how to function in the role they had previously observed and prepares them to carry on the practice of integrated clinical science training. This is beneficial regardless of the career path students ultimately take. Those who go on to academia can then train the future generation of students in a way that no longer splits science and practice training. Those who go on to clinical careers can engage in strong evidence-based practice. This is a significant service to the field, because many clinicians do not know the science behind efficacious treatments (nor are many actually trained in the most efficacious treatments).

With regard to depth of training, our anxiety disorders training program is provided as an addition to the foundational training that is the core of our Ph.D. program and the breadth of training required by APA. The benefit of providing anxiety-related training in addition to other course work is that students learn, in an intensive and deep way, how all of the individual pieces (e.g., psychopathology, assessment, intervention, methods, cognitive-affective, biological, etc.) come together around a single clinical topic (i.e., disorders of fear and anxiety).

We believe the anxiety training program provides for students an example or prototype of science-informed, integrated, evidence-based practice that brings together all parts of their training. Moreover, we think that the program serves as an exemplar that students can then take with them and apply to whatever topic/clinical problem they want to study or work with, as well as into other aspects of their own professional roles. Furthermore, because our anxiety training program emphasizes dissemination, students learn the importance of it, as well as key skills, particularly with regard to disseminating information to the public (via educational lectures/workshops), the field (via the development of training materials), and the future generation of psychologists (via supervision and training). As such, our program produces students who have the benefit of in-depth training in anxiety disorders—they become experts in anxiety and its treatment—and the benefit of sufficient breadth to be able to apply their training as they become experts in principles of evidence-based practice and training

¹ In line with the program’s emphasis on training models and dissemination, we have developed didactic (e.g., learning processes; interpersonal processes) and clinical (e.g., differential diagnosis; designing exposures) training modules that are available from the authors upon request.

more broadly, which they can then take forward to shape the field of clinical science.

Competence in our field is based on education, training, and experience. Competent clinical science training can only happen with direct, hands-on experiences in situations that integrate the classroom, the lab, and the clinic. We believe our training program provides one model of how to do so in a way that bridges the divide between the practice of science and the practice of therapy and that can lead to the integrated practice of clinical science.

...

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Implementing a Dialectical Behavior Therapy Training Program for Graduate Students

Anita Lungu, Magda Rodriguez Gonzalez, and Marsha M. Linehan,
University of Washington

Training graduate students in the delivery of evidence-based treatments (EBTs) plays a key role in ensuring that progress in clinical research translates into state-of-the-art treatments for clients in need. However, implementing training in EBTs within graduate programs is not easy given that both a solid theoretical foundation (taught through courses) and opportunities for practice need to be in place. The challenges faced when implementing such EBTs in graduate programs increase when treatments target complex, high-risk, suicidal, multidisordered clients.

Knowing how to competently treat high-risk, suicidal, complex individuals is an important and necessary skill within the mental health field for a variety of reasons. Most mental health practitioners will encounter the suicide of a client at some point in their career (Rosenberg, 1999), and suicide remains the leading cause of legal action against mental health professionals across disciplines (American Association of Suicidology, 2002). Lacking competence to treat a suicidal client due to inappropriate training can obviously have lethal, irreversible consequences and does not provide a sufficient defense in case of a litigation (Simon & Shuman, 2006). Considering the

above, there is a great need for training therapists in EBT for suicidal individuals. However, many graduate programs do not provide such training (Dexter-Mazza & Freeman, 2003).

One treatment with a substantial body of evidence showing its effectiveness in working with complex, high-risk populations is dialectical behavior therapy (DBT; Kliem, Kroger, & Kosfelder, 2010; Lieb, Zanarini, Linehan, & Bohus, 2004). DBT, a cognitive behavioral treatment, was originally developed for suicidal individuals, then expanded to treat borderline personality disorders (BPD) with comorbid Axis I disorders, and now further expanded to a range of other Axis I disorders and problem behaviors (Evershed et al., 2003; Gratz, Tull, & Wagner, 2005; Harned et al., 2008; Keuthen et al., 2010; Lynch et al., 2006; Lynch & Bronner, 2006; Nelson-Gray et al., 2006; Rosenfeld et al., 2007; Safer, Robinson, & Jo, 2010; Safer, Telch, & Agras, 2001).

For a number of reasons, DBT is a promising candidate for inclusion in general clinical training programs. First, the treatment combines, with an equal emphasis, the two primary strategies underpinning all major treatments: acceptance (which repre-

sents the focal point of supportive therapy, client-centered therapy, mindfulness-based cognitive therapy, etc.) and change (the primary strategy for CBT, pharmacotherapy, etc.). In particular, learning DBT requires learning both supportive/validating strategies as well as a full range of core CBT interventions. Second, overarching DBT principles encourage learning and then integrating other evidence-based interventions and protocols. To stay within the treatment model, students learn how to interact flexibly with movement, speed, and flow in individual interactions as well as how to follow a specific protocol when necessary. Third, DBT teaches therapists how to provide therapy in a range of settings: individual therapy, group therapy, telephone/text/email, and within the natural environment. Fourth, treatment targets in DBT are arranged in stages. Stage 1 targets reducing behavioral dyscontrol (including life-threatening behaviors) and severe disorder, Stage 2 entails reducing quiet desperation, Stage 3 addresses problems in living, and Stage 4 focuses on resolving incompleteness and enhancing freedom. This gives a wide range of severity for graduate students' first clients, and provides a path to learning to treat more severe and complex disorders. Fifth, the efficacy of DBT for treating highly suicidal individuals and the procedures aimed at keeping therapists at a high standard for treating suicidality provide students, supervisors, and clinic directors with confidence that the therapy meets high standards of care. For example, with suicidal individuals with BPD, DBT reduces both suicide at-

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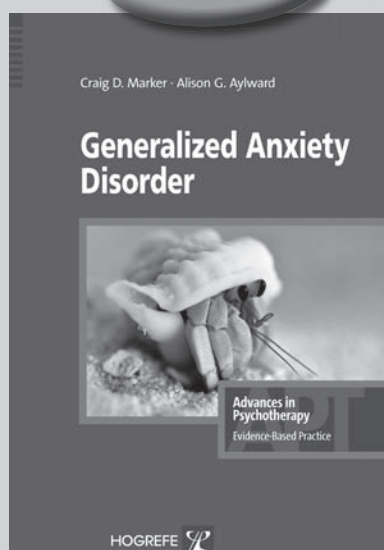
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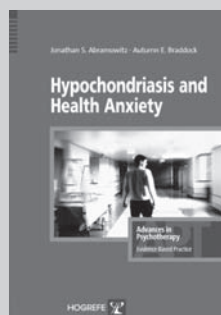
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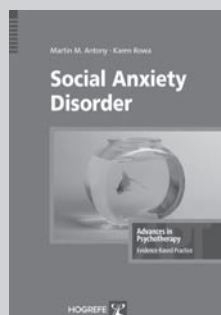


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tempts and suicide emergency room visits by 50%, and inpatient admissions for suicidality by 75% when compared to community expert treatment (Linehan et al., 2006).

Mission and Structure of the DBT Training Program

Suicidal individuals with severe and complex disorders, particularly those meeting criteria for BPD, are highly underserved (Langreth & Ruiz, 2010). One of the reasons for this is the limited opportunities for students to learn the requisite EBTs within graduate training clinics. Although DBT training opportunities are growing in academic settings, they are still extremely meager (Bongar & Harmatz, 1991; Neimeyer, 2000; Rosenberg, 2000). Difficult clients are often excluded from graduate training clinics (Dexter-Mazza & Freeman, 2003), and when not excluded it can be extraordinarily difficult to find clinicians with the willingness and expertise to supervise stu-

dents treating suicidal clients with complex and severe disorders. When such difficult clients can be seen by graduate students through practica outside clinical psychology departments, the practica often lack academic courses that lay the theoretical foundation of the treatment. The situation was similar at University of Washington, which prompted Marsha M. Linehan to start her own graduate training clinic with the goal of training graduate students to treat these complex, high-risk clients. This training program has been developed and expanded within the University of Washington over the past 15 years. Funding to more rigorously develop, evaluate, and disseminate the training program was obtained 3 years ago. At present, sites at several other universities (e.g., Rutgers University, California Lutheran University) are pilot testing the training program. This article describes the current training program as well as preliminary evaluation data on the program.

The DBT graduate training program is located in a clinic under the direction of Dr. Linehan and separate from the psychology department clinic. The clinic is named the Treatment Development Clinic (TDC) to instill in students (and remind DBT experts) that all treatments, even when evidence based, can be continuously improved and that the task of clinician-scientists is to keep working on identifying improvements. These improvements must address failures or deficiencies of the treatment as currently proposed and researched, and must be guided by clinical experience as well as translational science. The TDC clinic is established and functions as a research clinic with IRB approval. All clients and therapists are research subjects.

The DBT training program is a 2-year, 8-hour per week program that combines a practicum that runs continuously. Students apply to join the program during their second year or after, must provide two letters of clinical recommendation, and must be voted in by current DBT consultation team members. The program has three integral and mandatory parts with associated training components and requirements: requisite academic seminars, teaching DBT in the clinical community, as well as a clinical practicum.

Requisite Academic Courses and Teaching DBT in the Community

A critical component of the training is providing the foundation needed for a DBT therapist and potentially for a future DBT mentor for other students. The practicum includes a series of seminars and/or workshops that relate the theory, specific DBT methods, core behavioral methods, behavioral assessment, and suicide interventions needed for applying DBT. The six requisite courses and the teaching requirement are briefly described in Table 1. The course titled "The Piano Recital" provides students with the opportunity to teach DBT within the clinical community. In this course, the content and scope of a 2-day DBT training workshop is split into topics and taught by students to the community.

The DBT Clinical Practicum

Standard DBT is a comprehensive treatment that is intended to increase (a) behavioral capabilities, (b) motivation to behave skillfully, (c) generalization of skillful behaviors, (d) environmental support of new behavior, and (e) therapists' capability and motivation to work with such challenging clients. From the perspective of the thera-

Table 1. Requisite Academic Courses and Teaching DBT in the Community

Course name	Course scope/description
Behavioral Assessment	Fundamental history, concepts, psychometric foundations, strategies, interventions and diversity aspects of behavioral assessment.
Behavioral Methods	Introduction and history of behavior therapy; behavior analyses and case formulation; theoretical foundations, potential obstacles and clinical application of cognitive modification, contingency management, exposure, skills training procedures.
DBT Basics	Problems with other treatments in treating high-risk clinical clients with multiple problems; applications of DBT and supporting research findings; dialectical philosophy within the context of balancing acceptance and change in treatment; case conceptualization within the DBT model; structure of a DBT treatment at different levels of application; core DBT strategies and their application.
DBT Skills Training	In-depth understanding and practice of DBT skills from all modules (mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness).
Suicide Assessment and Intervention	Risk factors that lead to suicidal behavior; research findings about the mechanisms and functions of suicidal behavior; overview of suicide treatment literature; conducting suicide risk assessments; principles of crisis intervention; conducting crisis intervention with a variety of scenarios of suicidal crises; basics on treatment planning with suicidal individuals.
Advanced Topics in DBT	Depending on student interest topics can include: Secondary targets in DBT, DBT for Adolescents, Mindfulness, Therapy Interfering Behaviors, Dialectics, Chain Analyses
DBT Piano Recital	Course organized around providing students opportunities to teach parts of a DBT workshop to clinical community.

pist, the treatment includes five types of intervention in which each student must gain proficiency: enhancing each other's skills and motivation by working on a treatment team, individual interventions, skills training, out-of session coaching, and environmental intervention.

Treatment team membership. Being part of a DBT team is a mandatory, core component of the treatment. DBT students observe the team for one academic quarter before joining. Because DBT is a community of therapists treating a community of clients, joining a team is no small commitment. Student therapists join with the team members in being responsible for all client outcomes. Thus, students go through an individual commitment session with a current team member where roles, responsibilities, and pros and cons of joining the team, particularly with regard to high-risk clients, are discussed. The student joins the treatment team only after making an individual, personal, and informed commitment to what being a DBT therapist involves. While on team, a student rotates among several roles and additional responsibilities: leading the meeting, taking meeting notes, and observing and highlighting when

team-interfering behaviors occur, such as lack of mindfulness (e.g., judgmental thinking, multitasking), nondialectical stances, or helping before assessing. Fulfilling all these multiple roles teaches students the different facets of a DBT treatment team so that they are well prepared to build and lead such a team after finishing the practicum.

Individual therapy. Each student sees at least two BPD suicidal clients in individual therapy for a maximum of 1 year each. Before starting therapy with the first client, students read the DBT treatment manual (Linehan, 1993b) and watch video recordings of first sessions conducted by DBT experts. Students are expected to watch one live or recorded individual session per week of Marsha Linehan or another expert DBT therapist throughout the course of the program. Students also receive weekly supervision from a senior DBT therapist who observes their individual sessions.

Skills training. A student starts as a group coleader for approximately 6 months and then progresses to being the group leader for another 6 months. Skills training (Linehan, 1993a) covers all DBT skills modules (mindfulness, emotion regulation,

interpersonal effectiveness, and distress tolerance). Being a coleader first allows the student to learn how the skills are taught, and what the role of the leader is before having to fill it. Also, coleaders teach the entire group when the leader is unavailable, which is good practice for becoming a leader. As group leader, a student prepares for teaching the group by reviewing the teaching notes and watching the same segment being taught by a senior DBT skills leader. The group leaders receive group supervision for each session.

Out-of-session coaching. Two required DBT skills are coaching clients in using skills in their natural environment, and responding effectively to suicide crises. DBT requires that therapists balance observing their own personal limits with attending to clients' limits in their ability to function without help. A critical function of the team is helping therapists maintain this dialectical balance. Suicide risk assessment and management is taught in workshops or seminars and addressed in supervision as well as throughout DBT training. To teach students how to effectively respond to a suicidal crisis phone call, the instructor of such a workshop calls each student at random



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hours playing the role of a suicidal client in distress. According to informal feedback, this scenario often triggers anticipatory and performance anxiety during the call, not unlike the anxiety students experience treating their first highly suicidal clients. Should the student not respond in an adequate way to the phone call, the student receives feedback and a new call is placed at another time.

Environmental intervention. Although DBT teaches clients to use skills for solving their own problems (without therapist's involvement), critical situations can occur when the client does not yet have the skills or the power in that environment to solve the problem. Students learn how to act in the best interest of the client and work with elements in the client's environment to produce desired solutions or changes. Trainees learn how to fulfill this function of therapy during their theoretical training (the seminars) and from the team where the appropriateness and extent of such interventions are discussed.

Specific Challenges and Solutions in Implementing EBTs Targeting High-Risk, Complex Clients Within Graduate Training Programs

Throughout the 15 years of its evolution, the TDC practicum at University of Washington has encountered a number of challenges. Implementing training for high-risk clinical disorders in graduate programs is difficult. To start, there are not many EBTs for suicidal behavior. Furthermore, in many programs there are no faculty members with sufficient training to teach and/or supervise the treatments that do exist. Marsha Linehan was the only faculty member trained in treating high suicide risk, multidisordered and complex clients. The first challenge of getting a clinical faculty member to agree to teaching/supervising such a high-risk program was solved by starting very small with Marsha Linehan teaching DBT and suicide seminars and supervising the students who were her academic advisees. Two events prompted expanding and formalizing the training program. First, although she was teaching seminars and supervising students, it was difficult for the department to give her teaching credit since the training was viewed as part of her research lab activities. Second, other graduate students expressed interest in the practicum, particularly after Dr. Linehan's students advocated for the unique and valuable opportunity offered. To address both issues,

Linehan opened the practica to other clinical students. In general, it has been our experience at the University of Washington that the way students become interested in the practicum is by hearing testimonies from more senior students. To manage the extra work, subgroups of students took charge of various activities (e.g., client screening, writing and submitting a human subjects application, organizing readings and slide presentations for seminars).

With added students, finding enough supervisors willing to be clinically responsible for students providing treatment to suicidal individuals became difficult. It is not surprising that finding such supervisors is challenging: (a) suicide remains the leading cause of legal action against mental health professionals across disciplines (American Association of Suicidology, 2002); (b) supervisors for the case of a suicidal client bear all clinical responsibility but have little direct and immediate control over the therapy provided in a suicidal crisis; and (c) supervisors for suicidal cases work with students experiencing higher degrees of anxiety, have to resolve more crises, and have to be highly available to their students. When supervising graduate students working with suicidal clients, the risk is real and the therapists are by definition not experts. This can increase the anxiety on the part of the supervisor, faculty, and/or clinic director, which in turn can lead to rigidity in working with students or the attempt to control the student, neither of which is conducive of effective training.

This was addressed by developing a cadre of research therapists from ongoing studies and former students and postdoctoral fellows in Seattle as supervisors. As the program grew from four to nine students (who provide both group and individual therapy), we were unable to find a sufficient number of DBT supervisors in Seattle. We reached out to a large number of DBT experts all over the country. We now conduct long-distance supervision with supervisors viewing sessions mailed before supervision. All first clients are supervised by an in-town supervisor and second clients and groups can be supervised by out-of-town supervisors. To our initial surprise, ratings of out-of-town supervisors are as high or higher than those for in-town supervisors. Once supervisors were found, it was important to find ways to limit burnout among them and maintain their motivation to serve as supervisors. To motivate and reinforce supervisors, many are offered faculty appointments (with associated responsibilities and advantages) and are also invited to sit in on all

training courses and workshops offered at our clinic. Marsha Linehan, in addition, is on call at all times to provide crisis consultation to both students and supervisors. Other licensed on-site psychologists are also on-call supervisors in Seattle.

As the program and curriculum grew and client referrals skyrocketed, running the clinic without a teaching assistant became more and more difficult. Upon lobbying the graduate training director, department chair, and Dean of Arts and Sciences, the students received funding for a TA.

Once a clinic is in place, graduate students need more than just supervision; they also need training in the theoretical foundation on how to treat a suicidal and complex multidisordered client. Thus, a curriculum and faculty to teach the curriculum was necessary and was developed. This can be demanding for one faculty member. As more students joined the program the curricula not only gradually took shape but also expanded. As it did, the teaching load for Dr. Linehan expanded. The department chair was petitioned and agreed to allow clinic directorship to substitute for a required undergraduate course.

Evaluation of the University of Washington DBT Training Practicum

Two key characteristics required of DBT therapists are flexibility and willingness and competence in treating suicidal behavior. When working with a client, the therapist needs to constantly assess the highest priority therapy target and then select and apply strategies to address it. The "movement, speed, and flow" of therapy (Linehan, 1993b; referring to the capability of moving a therapy session along so that progress is made) come from a clear understanding and application of the treatment principles to the current clinical picture. Self-efficacy plays a key role in successfully performing a task; this applies to both performing therapy from a flexible, principle-based perspective as well as effectively treating high-risk individuals.

We conducted a study to evaluate students' opinions about the impact of the DBT graduate training on therapists. We evaluated how helpful the program was perceived to be in improving their ability to practice therapy from a principle-based perspective as opposed to the stance of following a manual to the letter.

Table 2: Descriptive Statistics of Survey Questions Referring to Principle-Based Practice

Component	N DBT	Mean DBT	Std. Dev. DBT	N Other trainings	Mean Other trainings	Std. Dev. other trainings
Overall training rating	30	9.30	1.21	30	7.43	2.30
Intensive trainings/workshops	28	7.54	2.12	28	6.29	2.17
Watching therapy tapes	30	8.97	1.00	24	7.13	2.77
Supervision	30	9.53	0.82	30	8.13	1.91
Principle based treatments	30	8.67	1.63	25	7.08	2.18
Senior therapist interventions at group consults	30	7.73	1.76	26	6.19	2.64
Trainee therapist interventions at group consults	30	6.83	1.93	25	5.52	2.50
Supporting therapist to lower anxiety	30	7.20	1.42	29	6.17	2.12
Assessment techniques	30	8.33	1.49	28	6.57	2.59
Computed mean	30	8.24	0.91	30	6.80	1.69

Participants and Procedure

An online survey was created and the electronic link was sent together with an email to current or past students in the DBT practicum. Of the 45 individuals invited to participate, 32 (71%) completed the survey, 7 (21.8%) were current students and 25 (78.1%) were past students. In terms of practical clinical experience, 1 participant (3%) had 1 to 2 years of practice, 9 (28%) had between 2 and 5 years, and 22 (68%) had more than 5 years experience.

Measure

A survey was sent to the participants evaluating the DBT training (0 = *did not help at all* to 10 = *helped greatly*) in terms of (a) teaching students to practice therapy from a principle-based standpoint as opposed to following a manual to the letter and (b) performing clinical work and research with suicidal individuals. One question evaluated the entire practicum while eight questions assessed helpfulness of several practicum components: (a) taking part in intensive trainings; (b) watching recordings of senior therapists; (c) receiving supervision; (d) the principle-based nature of the treatment; (e) interventions of senior therapists during

team consults; (f) interventions of student therapists during team consults; (g) support received to decrease student therapists' anxiety; and (h) teaching specific assessment techniques. To place the ratings in perspective, we asked the same set of questions about other clinical trainings participants had received. Table 2 presents descriptive information on the global training ratings (first table row) and individual components (following eight rows). Separate scales were computed for the DBT practicum and Other Clinical Trainings by averaging the global rating and the ratings of individual training components. More precisely, the computed mean value, with descriptive information presented in the last table row, was obtained by averaging nine variables (one global rating of the training and eight ratings of individual components). A valid value was considered for a participant when at most three of the nine variables were missing data. The reliability for the DBT practicum scale was good (Cronbach's $\alpha = .80$) and for the Other Clinical Trainings was excellent (Cronbach's $\alpha = .90$). The Data Analysis and Results section below compares the DBT with the Other Clinical Trainings Scale using *t* tests.

We asked six questions related to the impact of the training on performing clinical work and research with suicidal individuals: (a) perceived competence in treating suicide and (b) fear in treating suicide; along with willingness to (c) treat suicidal individuals, (d) include suicidal individuals in research, (e) consult on therapy with suicidal individuals, and (f) supervise students treating suicidal individuals. Descriptive information for all questions is presented in Table 3 (first six rows). We computed separate scales (the computed mean variable in Table 3) for the DBT practicum and for the Other Clinical Trainings by averaging ratings on all six dimensions evaluated. A valid value was considered for the scale when at most two variables were missing data of the six averaged. The reliability for both scales was excellent (Cronbach's $\alpha = .91$ for DBT practicum, Cronbach's $\alpha = .98$ for the Other Clinical Trainings). Descriptives on these scales are presented in the last table row. The Data Analysis and Results section below compares the difference between these scales (the DBT versus the Other Clinical Trainings scores) using *t* tests.

Table 3: Descriptive Statistics of Survey Questions Referring to Performing Clinical Work and Research With Suicidal Individuals

Component	N DBT	Mean DBT	Std. Dev. DBT	N Other trainings	Mean Other trainings	Std. Dev. other trainings
Competence in treating suicide	27	9.56	0.85	27	3.48	2.21
Decreasing fear in treating suicide	27	9.15	1.20	27	3.52	2.17
Increasing willingness to treat suicide	27	9.07	1.64	26	3.65	2.33
Increasing willingness to include suicide in research	27	8.78	1.69	27	3.11	2.15
Increasing willingness to consult on suicide cases	27	9.15	1.23	26	3.46	2.32
Increasing willingness to supervise suicidal cases	27	8.81	1.59	26	3.19	2.33
Computed mean	27	9.09	1.19	27	3.37	2.15

Data Analysis and Results

Paired *t* tests were conducted to compare the average effectiveness (DBT and Other Clinical Training scales, described above) of helping clinicians to perform therapy from a principle-based perspective. On average, students rated DBT training significantly higher ($M = 8.24$, $SD = .91$) on training them to practice therapy from a principle-based perspective than other clinical training they had received ($M = 6.80$, $SD = 1.69$), $t(29) = 5.04$, $p < .001$. Similarly, students rated DBT training ($M = 9.09$, $SD = 1.19$) as more effective than other clinical training ($M = 3.37$, $SD = 2.15$) in training them to conduct clinical and research work with suicidal individuals, $t(26) = 13.69$, $p < .001$.

Discussion

This article describes the different components involved in the implementation of DBT training within the University of Washington's clinical psychology graduate program. We also provide preliminary evaluation of the program in terms of assessing students' self-efficacy in (a) practicing therapy from a flexible, principle-based stance as opposed to a rigid following of the manual, and (b) working with suicidal individuals in clinical and research settings. The

evaluations concluded that the 2-year DBT training overall was effective in reaching the program's goals. These results suggest that although challenging, it is definitely possible to implement graduate training in EBTs targeting complex, high-risk populations. However, considering all components necessary to implement such a training program, commitment from a faculty member experienced in DBT is a must. We are currently considering ways to develop DBT training models that would involve faculty, supervisors, and students. We look forward to further evaluating the DBT training at the University of Washington as well as at the other two university centers that are currently pilot testing the program.

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Psychological Clinical Science Accreditation System: FAQs and Facts

Richard M. McFall, *Executive Director, PCSAS, and Indiana University*

Who?

The Psychological Clinical Science Accreditation System (PCSAS) is a new, independent, nongovernmental, nonprofit corporation founded in 2007 to provide rigorous, objective, and empirically based accreditation of Ph.D. programs in *psychological clinical science*. It was founded by the Academy of Psychological Clinical Science ("Academy"; <http://acadpsychclinicalscience.org>), an organization comprising 53 doctoral programs and 10 internship programs, all committed to science-centered training and empirically supported applications in clinical psychology. PCSAS's mission is to advance public health by using the leverage of accreditation to promote superior science-centered education and training in clinical psychology, and to achieve several interrelated subgoals: (a) to encourage science-centered education across the

spectrum of mental health institutions, levels, and programs; (b) to increase the quality and quantity of clinical scientists making significant contributions to improving public health; (c) to advance the frontiers of scientific knowledge by promoting innovative research into the origins, assessment, prevention, and amelioration of problems in mental and behavioral health; (d) to enhance the quality and availability of empirically supported, cost-effective, and safe mental and behavioral health care; and (e) to foster a thorough and reciprocally reinforcing integration of basic and applied science in clinical psychology.

What?

To achieve these lofty goals, PCSAS has set stringent accreditation standards. PCSAS accredits only Ph.D. training programs in the U.S. and Canada housed in nonprofit, research-intensive universities.

PCSAS accreditation is limited to programs with a chief mission of training *clinical scientists*. Applicants need not be members of the Academy. Programs with a chief mission of preparing graduates primarily for service delivery roles are not appropriate candidates for PCSAS accreditation. PCSAS-accredited programs must provide first-rate applied training, thereby qualifying their graduates to administer and oversee the delivery of psychological clinical services; however, science must be the central focus of all training, with a thorough integration of the research and applied components.

To be deemed eligible to apply for PCSAS accreditation, a potential applicant must be committed publicly to providing science-centered clinical training. The burden of proof as to whether the program actually delivers on this promise rests with the applicant. The sine qua non benchmark of success is whether the majority of the program's graduates build successful careers as clinical scientists. PCSAS accredits only programs with well-established records of producing graduates whose accomplishments show that they have the essential skills and knowledge to be productive psychological clinical scientists. This means that the graduates will have demonstrated

that they are competent (a) to conduct research relevant to the assessment, prevention, treatment, and understanding of mental and behavioral health problems; and (b) to use science methods and evidence to design, develop, select, evaluate, deliver, supervise, and disseminate empirically based assessments, interventions, and prevention strategies. PCSAS accreditation standards focus more on a program's "outcomes" than on "inputs" such as course requirements or number of practicum hours. There clearly are multiple ways to provide high-quality clinical science training. Instead of a one-size-fits-all checklist approach to evaluating doctoral programs, PCSAS encourages innovation in pursuit of excellence, as long as applicants can show that their methods yield the intended positive results.¹

The two hallmarks of PCSAS accreditation, then, are (a) an emphasis on proximal and distal *outcome evidence* of a program's success at providing high-quality clinical science training; and (b) *flexibility* in evaluating *how* a program produces graduates who contribute to the advancement of clinical science and who effectively integrate research and application.

Why?

Information Value

Why create a *new* accreditation system for doctoral training in clinical psychology? One of the primary benefits of accreditation is that it sharpens distinctions and highlights principles and values that can help individuals and institutions make better, more informed decisions. In the domain of clinical psychology, prospective graduate students, health-care consumers, policymakers, and the general public often must make critical choices from a diverse and confusing array of options without having access to the information they need to choose wisely—for example, choices of graduate programs, mental health services, or public policies. By awarding the distinctive PCSAS "brand" to proven, high-quality, science-centered clinical programs, PCSAS arms consumers with information about scientific clinical psychology that should help them make critical decisions.

The American Psychological Association's (APA's) accreditation system has

changed dramatically over its 63-year history, both in scale and scope. In 1948, when APA started accrediting clinical programs, it accredited only a handful of established Ph.D. programs located in psychology departments within traditional nonprofit universities. All subscribed to the Boulder model of training, preparing students for careers both as research scientists and as practitioners. Thus, research training was an essential part of APA-accredited doctoral training in clinical psychology.

Today, in contrast, APA accredits 235 doctoral programs in clinical psychology, 69 in counseling psychology, 61 in school psychology, and 8 in "combined." It also accredits 469 predoctoral internship programs and 48 postdoctoral training programs. APA accreditation no longer is limited to Ph.D. programs, to programs subscribing to the Boulder model, or to programs within traditional nonprofit universities. Most striking, APA accreditation no longer requires that programs train students to be productive researchers—as in the original Boulder model.

Whereas the APA accreditation imprimatur once stood for consistent standards and homogeneous values, providing consumers with some assurance of a reliable "product," the standards and values have become increasingly heterogeneous over time. All APA-accredited clinical programs still carry the same accreditation label, despite their significant differences in training goals, philosophies, methods, and content. This obscures the public's view of critical distinctions that PCSAS regards as important. One aim of the new PCSAS accreditation system, therefore, is to bring these important distinctions to light by using the PCSAS brand to identify a specific genre and caliber of doctoral programs in clinical psychology. Thus, APA accreditation and PCSAS accreditation serve different purposes. APA serves as the guardian of the minimum threshold for recognition as a generic doctoral program in clinical psychology. PCSAS, in contrast, has established a high threshold, granting its imprimatur exclusively to Ph.D. programs that deliver a first-rate science-centered education that integrates psychological research training with evidence-based applied training, all aimed at advancing the public's mental and behavioral health.

Advancing Public Health

Why focus exclusively on accrediting *science-centered clinical training*? Another benefit of accreditation is that it can be an effective means of promoting a core set of values and principles. The PCSAS preference for science-centered training in clinical psychology is not simply a matter of taste; it is grounded in the deep conviction that rigorously integrative clinical training in scientific research and empirically supported applications not only is the best way to assure the public of access to the most cost-effective services, but also is the best hope for advancing basic knowledge regarding the origins, assessment, prevention, and amelioration of mental and behavioral health problems. It is axiomatic that expanding scientific knowledge is essential to improving public health.

When APA first began accrediting doctoral training programs, clinical psychologists had no effective interventions to offer—no interventions backed by empirical research evidence. As a result, clinical psychology developed rapidly as an *applied profession* before it had built a solid foundation as an *empirical science*. APA's Boulder model required both research training and applied training, but did not require that the applied training be backed by scientific research—there was little to be had at the time. Today, applied training remains an APA accreditation requirement, even though training for research no longer is required. Yet, there still is no requirement that applied training be backed by scientific evidence of its validity, safety, or cost-effectiveness, even though such evidence is available now.

Psychological science has made tremendous strides since 1948. Over the last decade alone, for example, the National Institutes of Health have spent several billions of dollars annually in support of research related to problems in mental and behavioral health. With such support, scientists have accumulated a wealth of knowledge and developed a number of cost-effective procedures. PCSAS believes these scientific advances should be the required foundations for clinical practice and doctoral training (see Baker, McFall, & Shoham, 2008). Too often, they are not, unfortunately.

Work Force Issues

The number of APA-accredited clinical programs has increased dramatically over the years, more than doubling since 1980. The largest increase has been among Psy.D.

¹A helpful reviewer asked, "How much 'science' does one need to engage in to be a 'clinical scientist'?" and "How much of an alumni's 'career' is relevant to the current status of the program?" Unfortunately, space limitations do not permit the kind of detailed explication of the review process and evaluative criteria that would address such questions. However, interested readers will find detailed information relevant to these and other questions on the PCSAS website: www.pcsas.org

programs. Although Psy.D. programs make up about 24% of APA-accredited clinical programs, they award more than 50% of the doctorates. This growth of provider-focused training in clinical psychology has occurred despite work force analyses (e.g., Robiner & Crew, 2000) indicating that the supply of doctoral-level service providers in clinical psychology now exceeds the demand, and that this disparity is growing. This disparity raises questions about the wisdom of doctoral-level clinical training aimed primarily at producing practitioners, training such as that currently offered by Psy.D. programs and some Ph.D. programs.

Managed health care has been a driving force behind the growing disparity between supply and demand. Historically, doctoral-level psychologists have provided a major share of the clinical services, for example, in the nation's community mental health centers (CMHCs); today, the number of doctoral-level psychologists employed by CMHCs is declining. A case in point: Centerstone Mental Health System, one of the largest and most respected community mental health systems in the U.S., has 2,187 employees distributed across 146 centers in two states. Only 32 (1.5%) are doctoral-level psychologists, often in administrative and research roles (centerstone.org/research). Most mental health services are being provided by MSWs. At CMHCs under managed care, such as Centerstone, the reimbursement rates for services provided by doctoral-level psychologists and by nonlicensed MSWs typically are the same, but the CMHC must pay doctoral-level psychologists more. Lacking evidence that Ph.D.s or Psy.D.s are more effective than MSWs (or even BAs) at delivering specific psychotherapeutic procedures, it makes economic sense for CMHCs to hire more social workers and fewer psychologists.

In this new managed care environment, the most distinctive "value-added" contributions doctoral-level psychologists can make are tied to their scientific training and research expertise. Ph.D. graduates from *clinical science* programs have an expertise that allows them to make unique contributions to the emerging mental health system—not primarily as front-line service providers, but as *clinical scientists*. In addition to filling traditional roles as educators, basic researchers, and clinicians, they will be applied scientists who develop and evaluate new, more effective mental and behavioral health services; who train, supervise, and oversee the delivery of these services; and

who evaluate and improve the health care system.

Differentiating

The differences between Psy.D. and Ph.D. doctoral programs and their graduates are striking, going well beyond obvious differences in publicized epistemologies and training goals. In fairness, comparisons between degrees use these labels only as imperfect proxies for underlying variables of interest. Not all Psy.D. programs are alike, just as not all Ph.D. programs are alike. Some Psy.D. programs (e.g., Rutgers) *do* emphasize the importance of scientific evidence. Some Ph.D. programs *don't* provide strong training in research or in empirically supported applications. The Ph.D. degree label, in particular, can be misleading. For example, 16 of the 173 APA-accredited Ph.D. clinical programs are located in professional schools. Bearing this caveat in mind, here are some noteworthy contrasts:

Most Psy.D. programs are housed in for-profit, nontraditional institutions, whereas most Ph.D. programs are housed in non-profit, traditional universities. Compared to Ph.D. programs, Psy.D. programs, on average, have more students (178 vs. 70); have higher acceptance rates (50% vs. 11%); admit larger classes (48 vs. 9); have higher student-faculty ratios (nearly double); have fewer full-time faculty members; admit students with lower mean GPAs and GREs; offer less financial support while having higher costs, leaving students with higher debt loads; place a lower percentage of their students in accredited internships; and produce graduates who earn lower mean scores on state licensing exams (Baker et al., 2008; McFall, 2006). Psy.D. programs advertise themselves as preparing students for careers in service delivery, so it is no surprise that their students spend less time than Ph.D. students involved in research and publication activities. Ironically, however, one study found that Psy.D. students, on average, do not spend more time than Ph.D. students in clinical service training activities (Cherry, Messenger, & Jacoby, 2000).

If consumers could tell training programs apart simply by their degree labels—for example, Ph.D. vs. Psy.D.—it might help them make informed choices. But it isn't that simple. As noted previously, not all Ph.D. programs are alike. Sayette, Norcross, and Dimoff (2011) surveyed all APA-accredited clinical Ph.D. programs (excluding Canadian programs; with a 100% response rate) and found considerable diversity among Ph.D. programs in

clinical, despite the fact that they award the same degree.

To begin, the programs were sorted into three groups: (a) "APCS"—49 Academy member programs; (b) "Non-APCS"—104 non-Academy programs in traditional universities; and (c) "Specialized"—8 non-Academy programs in nontraditional institutions (e.g., free-standing professional schools). The researchers found that APCS programs emphasized research training more than Non-APCS programs, which emphasized research more than Specialized programs. APCS programs were more selective in admissions than Non-APCS programs, which were more selective than Specialized programs (acceptance rates of 4.9%, 10.4%, & 57.7%, respectively). APCS students had significantly higher GREs and GPAs than either the non-APCS or Specialized students. Specialized programs made significantly more offers and enrolled over four times as many students as either of the other program types. They also placed a lower percentage of their students in APA or APPIC internships (61.5%) than APCS (93.3%) or Non-APCS (90.6%) programs. APCS programs provided tuition waivers and stipends to nearly all students (98.7%); support rates were significantly lower in Non-APCS programs (73.2%); Specialized programs provided no support. The faculty in APCS programs had significantly more research grants (26.4) than the faculties in Non-APCS programs (11.3) or Specialized programs (4.7). APCS programs also had been accredited for significantly more years than either of the other types of programs.

The point is that there is significant diversity among clinical programs—even among Ph.D. programs—but the public currently has no ready way to see these differences. Over 40 years ago, Kiesler (1966) decried the "uniformity myth" in psychology—the myth that all psychologists are alike, that all therapies are alike, etc. This myth is alive today, reflected in the APA accreditation system's treatment of doctoral programs in clinical psychology as comparable, thereby obscuring important differences in their training goals, scientific epistemology, quality, and outcomes. This is neither in the public's interest nor in the long-term interest of psychology. PCSAS believes that publicly illuminating the differences among training programs' models and achievements serves the interests of both the public and the field.

Quality Improvement

PCSAS was not created merely for the purpose of myth busting or criticizing the status quo. Its primary mission was to serve as a constructive force for transforming clinical psychology into a more rigorous, informed, and beneficial science. Its immediate focus is on improving the quality of doctoral training; its ultimate aim is to improve mental and behavioral health care. To these ends, PCSAS accreditation system provides a structure within which clinical scientists can work together toward achieving these ideals. The PCSAS “brand” can serve as a magnet, attracting programs to the clinical science model and encouraging them to strive for continuous quality improvement. By promoting high-quality clinical science education, PCSAS can transform the field.

Ideally, PCSAS might do for psychology what the Flexner Report (Flexner, 1910) did for medicine. In 1906, there were 162 medical schools in the United States, many of them offering questionable training. A review by the Council of Medical Education of the American Medical Association (AMA) found that only 82 of these—most within established universities—offered acceptably rigorous science-based medical training. Most of the rest were in free-standing, profit-driven medical schools, with low admission standards, poor facilities, high costs, and offering questionable, nonempirical training. This led the AMA to commission an independent agency—the Carnegie Foundation for the Advancement of Teaching—to study medical education. This led to publication of the Flexner Report, which clearly distinguished between the high-quality and lower-quality medical schools. By 1915, this public exposure, combined with more stringent requirements for state licenses and a new grading system for medical schools by the AMA Council of Medical Education, had reduced the number of surviving medical schools to 95. This marked the beginning of science-centered medical education as we know it.

Improving clinical psychology must start with improving education and training. This requires a consensus among leading educators about core values and goals. Unfortunately, achieving a broad consensus among all clinical psychologists today is unlikely, given the heterogeneity of views. However, PCSAS was founded by the Academy, whose members share a commitment to a scientific epistemology, to the goal of producing clinical scientists, and to

the conviction that science should be at the core of doctoral education and training in clinical psychology. This consensus gave the Academy a solid and coherent foundation upon which to build the new accreditation system. Now that PCSAS has been launched, all who share its values and goals are welcome to join in this effort. Its success ultimately will be measured by its impact on the field.

How?

PCSAS is governed by a nine-member Board of Directors appointed by the Academy executive committee. The Board comprises representatives from psychological clinical science, nonclinical psychological science, doctoral students, department chairs, and the public. PCSAS’s day-to-day business is managed by an Executive Director. The Board holds the ultimate accreditation authority, and establishes all policies, procedures, and criteria; however, it delegates the responsibility for reviewing applications and making accreditation decisions to an independent, nine-member Review Committee (RC). The Board selects RC members based solely on their scientific qualifications; areas of expertise; and educational, professional, and administrative credentials. The committee is intended to represent the cutting edge of psychological clinical science, with the collective breadth and expertise to evaluate the quality of applicants’ doctoral education and training programs.

Essentially, accreditation is a two-step process. Interested programs begin by submitting a Letter of Intent to establish that they meet PCSAS’s eligibility criteria. If deemed eligible, they then submit a full application, describing their program and providing a record of the careers of their graduates from the past 10 years. Applicants must host a site visit by two clinical scientists selected by PCSAS prior to their review. The review process is modeled after that of grant review panels, and is safeguarded by appropriate conflict of interest and confidentiality policies. Successful applicants normally are accredited for a period of 10 years. PCSAS started accepting applications in July of 2009. By October 2011, 10 programs had been accredited, 4 were under review, and 4 more had been deemed eligible to apply. (See pcsas.org for details about the application and review process, the accreditation criteria, and a list of accredited programs.)

PCSAS is intended to be self-supporting through fees and dues. However, during its

start-up these resources are insufficient to cover its operating costs, so PCSAS is relying on funds from underwriting contributions to the Founders’ Circle, a coalition of major universities, each pledging to contribute \$15,000 per year for 5 years. To date, the Founders’ Circle has 16 contributing members. In addition, individual supporters have contributed varying amounts. (See pcsas.org for a list of Founders’ Circle members and contributors.)

Future?

Doctoral programs in psychology that produce basic scientists who never have contact with clinical populations typically would not need to worry about accreditation. The goal of *clinical science* training, however, is to produce a cadre of Ph.D.s with the qualifications and competence to play leading roles in advancing mental and behavioral health *knowledge* and *care*. This means graduates of PCSAS accredited programs must be competent to function independently across the full spectrum of relevant professional activities—from basic and applied research to the delivery of patient services. Because *clinical science* training involves preparing graduates for patient contact, it requires accreditation, and accreditation, in turn, raises other credentialing issues such as licensing. For PCSAS to succeed, it must attend to all these broader credentialing requirements.

For any accreditation system to be credible, for example, it needs to be “recognized” by an appropriate oversight agency. PCSAS is applying for recognition by the Council for Higher Education Accreditation (CHEA), one of the two major agencies in the U.S. that oversee accreditation in higher education (the other being the U.S. Department of Education). In May of 2010, PCSAS was deemed eligible to apply for CHEA recognition. It now is applying, with the goal of gaining recognition in 2012. Once recognized by CHEA, PCSAS will seek recognition from the U.S. Office of Veterans Affairs, to make students from PCSAS accredited programs eligible for VA internships and for full-time VA positions. PCSAS also will launch a state-by-state campaign to gain recognition by state licensing boards in psychology.

Unfortunately, as history has shown, the current system of accreditation and licensure, by itself, does not ensure the public that the services offered by “credentialed” doctoral-level clinical psychologists have been tested empirically, or that they are the safest, most cost-effective, and most appro-

appropriate procedures for particular problems. Under the current system, once providers have acquired the credentials for independent practice, they essentially are free to practice as they like, with few constraints, practice standards, or accountability requirements.

Improving the health care system, therefore, requires both increased accountability and a shift in the decision-making processes. We need to look beyond our current reliance on basic professional credentials—degree and license—to a system that insists on science-based decision-making about both the best choice of procedures and the best choice of delivery methods. Tactical decisions about who delivers what services to whom should be dictated by the best scientific evidence, not by guild prerogatives or traditions. Credentials, assessed in the right way, are important; providers should be *trained to a high level of competence in the procedures they deliver*. However, credentials alone are not enough; attending to the scientific backing for the procedures is essential to maximizing positive results. For each clinical problem, a science-based decision about the optimal intervention procedure logically precedes a science-based decision about the optimal method of delivery.

Doctoral-level clinical psychologists should be the preferred providers for a given procedure only if the research evidence shows that they are the most cost-effective at delivering that procedure. This means that graduates of PCSAS accredited training programs should be prepared to deliver

specific services, as dictated by the evidence, but that they also must be prepared to play other key roles, as well, including the roles of educator, trainer, supervisor; program developer, evaluator, administrator; and basic research scientist. Whatever their role, they should be a model of evidence-based decision-making, and should work toward building a more informed, responsible, and robust mental and behavioral health care system.

Although some may criticize PCSAS as “elitist,” this misconstrues its aims. Setting high standards is not “elitist.” PCSAS was not intended to be a small, exclusive “club.” On the contrary, it was intended to be *inclusive*. It was created explicitly to encourage all Ph.D. programs in clinical psychology to strive for excellence, to work together to transform the field, to promote important scientific advances, and to improve the human condition. Any program that meets the minimal eligibility requirements, shares the values and goals of PCSAS, and wishes to apply for accreditation is welcome to do so. The major constraint is that the applicant must have an established record of producing psychological clinical scientists. In the ideal future, all Ph.D. programs in clinical psychology would subscribe to the clinical science model; would deliver high-quality, science-centered clinical training; and would deserve PCSAS accreditation.

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Correspondence to Richard M. McFall, Ph.D., Executive Director, Psychological Clinical Science Accreditation System, 1101 East Tenth Street, IU Psychology Building, Bloomington, IN 47405-7007; email: rmmcfall@pcsas.org

Call for Papers President's New Researcher

ABCT's 2011–2012 President, Robert K. Klepac, Ph.D., ABPP, invites submissions for the 34th Annual President's New Researcher Award. The winner will receive a certificate and a cash prize of \$500. The award will be based upon an early program of research that reflects factors such as: consistency with the mission of ABCT; independent work published in high-impact journals; and promise of developing theoretical or practical applications that represent clear advances to the field. While nominations consistent with the conference theme are particularly encouraged, submissions will be accepted on any topic relevant to cognitive behavior therapy, including but not limited to topics such as the development and testing of models, innovative practices, technical solutions, novel venues for service delivery, and new applications of well-established

psychological principles. Submissions must include the nominee's current Curriculum Vita and one exemplary paper. Eligible papers must (a) be authored by an individual with five years or less posttraining experience (e.g., post-Ph.D. or post-residency); and (b) have been published in the last two years or currently be in press. Submissions will be judged by a review committee consisting of Robert Klepac, Ph.D., Debra A. Hope, Ph.D., and Stefan Hofmann, Ph.D. (ABCT's President, Immediate Past-President, and President-Elect). **Submissions must be received by Monday, August 6, 2012, and must include four copies of both the paper and the author's vita and supporting letters if the latter are included.** Send submissions to ABCT President's New Researcher Award, 305 Seventh Ave., 16th floor, New York, NY 10001.

Call

for Award Nominations

The ABCT Awards and Recognition Committee, chaired by Shireen L. Rizvi, Ph.D., of Rutgers University, is pleased to announce the 2012 awards program. Nominations are requested in all categories listed below. Please visit our website in December for specific submission instructions. Award nominations may not be submitted by current members of the ABCT Board of Directors.

Career/Lifetime Achievement

Eligible candidates for this award should be members of ABCT in good standing who have made significant contributions over a number of years to cognitive and/or behavior therapy. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Albert Ellis, Leonard Krasner, Steven C. Hayes, David H. Barlow, G. Alan Marlatt, and Antonette M. Zeiss. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Career/Lifetime Achievement" in the subject line. Also, mail a hard copy of your submission to ABCT, Career/Lifetime Achievement, 305 Seventh Ave., New York, NY 10001.

Outstanding Contribution by an Individual for Educational/Training Activities

Eligible candidates for this award should be members of ABCT in good standing who have provided significant contributions toward educating and training behavior therapists. Past recipients of this award include Gerald C. Davison in 1997, Leo Reyna in 2000, Harold Leitenberg in 2003, Marvin R. Goldfried in 2006, and Philip C. Kendall in 2009. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Outstanding Education/Training" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Education/Training, 305 Seventh Ave., New York, NY 10001.

Outstanding Mentor

This year we are seeking eligible candidates for the Outstanding Mentor award who are members of ABCT in good standing who have encouraged the clinical and/or academic and professional excellence of psychology graduate students, interns, postdocs, and/or residents. Outstanding mentors are considered those who have provided exceptional guidance to students through leadership, advisement, and activities aimed at providing opportunities for professional development, networking, and future growth. Appropriate nominators are current or past students of the mentor. The first recipient of this award was Richard Heimberg in 2006, followed by G. Terence Wilson in 2008, and Richard J. McNally in 2010. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Outstanding Mentor" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Mentor, 305 Seventh Ave., New York, NY 10001.

Questions? Contact: Shireen Rizvi, Ph.D., Chair, ABCT Awards & Recognition Committee; e-mail: awards.abct@gmail.com

Student Dissertation Awards:

- **Virginia A. Roswell Student Dissertation Award (\$1,000)**
- **Leonard Krasner Student Dissertation Award (\$1,000)**
- **John R. Z. Abela Student Dissertation Award (\$500)**

Each award will be given to one student based on his/her doctoral dissertation proposal. The research should be relevant to behavior therapy. Accompanying this honor will be a monetary award (see above) to be used in support of research (e.g., to pay participants, to purchase testing equipment) and/or to facilitate travel to the ABCT convention. Eligible candidates for this award should be student members who have already had their dissertation proposal approved and are investigating an area of direct relevance to behavior therapy, broadly defined. A student's dissertation mentor may complete the nomination. Self-nominations are also accepted. Nominations must be accompanied by a letter of recommendation from the dissertation advisor. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Student Dissertation Award" in the subject line. Please include an e-mail address for both the student and the dissertation advisor. Also, mail a hard copy of your submission to ABCT, Student Dissertation Award, 305 Seventh Ave., New York, NY 10001.

Distinguished Friend to Behavior Therapy

Eligible candidates for this award should NOT be members of ABCT, but are individuals who have promoted the mission of cognitive and/or behavioral work outside of our organization. Applications should include a letter of nomination, three letters of support, and a curriculum vitae of the nominee. Past recipients of this award include Jon Kabat-Zinn, Nora Volkow, John Allen, Anne Fletcher, Jack Gorman, Art Dykstra, Michael Davis, Paul Ekman, and The Honorable Erik K. Shinseki. Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Distinguished Friend to BT" in the subject line. Also, mail a hard copy of your submission to ABCT, Distinguished Friend to BT, 305 Seventh Ave., New York, NY 10001.

NOMINATIONS FOR THE FOLLOWING AWARD ARE SOLICITED FROM MEMBERS OF THE ABCT GOVERNANCE:

Outstanding Service to ABCT

Please complete the on-line nomination form at www.abct.org. Then e-mail the completed form to awards.abct@gmail.com. Include "Outstanding Service" in the subject line. Also, mail a hard copy of your submission to ABCT, Outstanding Service to ABCT, 305 Seventh Ave., New York, NY 10001.

Nominate on line: www.abct.org

Deadline for all nominations: March 1, 2012

Classifieds

THE STATE UNIVERSITY OF NEW YORK AT BUFFALO'S DEPARTMENT OF PSYCHIATRY currently has an opening for a fulltime psychiatrist to work in **Adult Inpatient Psychiatry**. Rank dependent upon qualifications. Competitive salary and attractive benefits package available to qualified candidates. The University at Buffalo is an Affirmative Action/Equal Opportunity Employer. Applicants must apply online at: www.ubjobs.buffalo.edu

THE STATE UNIVERSITY OF NEW YORK AT BUFFALO'S DEPARTMENT OF PSYCHIATRY currently has an opening for a fulltime psychiatrist to work in **Outpatient Psychiatry**. Rank dependent upon qualifications. Competitive salary and attractive benefits package available to qualified candidates. The University at Buffalo is an Affirmative Action/Equal Opportunity Employer. Applicants must apply online at: www.ubjobs.buffalo.edu

THE STATE UNIVERSITY OF NEW YORK AT BUFFALO'S DEPARTMENT OF PSYCHIATRY currently has opening for an **Emergency Psychiatrist**. Rank dependent upon qualifications. Competitive salary and attractive benefits package available to qualified candidates. The University at Buffalo is an Affirmative Action/Equal Opportunity Employer. Applicants must apply online at: www.ubjobs.buffalo.edu

THE STATE UNIVERSITY OF NEW YORK AT BUFFALO'S DEPARTMENT OF PSYCHIATRY currently has opening for a **Clinical Psychiatrist**. Rank dependent upon qualifications. Competitive salary and attractive benefits package available to qualified candidates. The University at Buffalo is an Affirmative Action/Equal Opportunity Employer. Applicants must apply online at: www.ubjobs.buffalo.edu

mativ Action/Equal Opportunity Employer. Applicants must apply online at: www.ubjobs.buffalo.edu

NRSA POST DOCTORAL FELLOWSHIP. The Aaron T. Beck Psychopathology Research Center and the Center for the Prevention of Suicide of the Department of Psychiatry at the University of Pennsylvania are seeking applicants for a Ruth L. Kirschstein National Research Service Postdoctoral Fellowship (NRSA) Award from the National Institute of Mental Health (NIMH). Under the direction of Aaron T. Beck, M.D., and Gregory K. Brown, Ph.D., research fellows would have an opportunity to be involved in ground-breaking clinical, training and research advancements of cognitive therapy for the treatment of individuals with schizophrenia, depression, and high suicide risk. Successful candidates will have the opportunity to conduct basic, effectiveness and dissemination research studies in cognitive therapy. Applicants who have earned an M.D., Ph.D., Psy.D., or equivalent in psychology or other related field and have had previous training in cognitive therapy of depression and severe mental illness are encouraged to apply. Bilingual candidates are especially encouraged to apply. Please send a curriculum vita with a cover letter and two letters of recommendation via email to Aaron T. Beck, M.D., at abeck@mail.med.upenn.edu. The University of Pennsylvania is an Equal Opportunity/Affirmative Action Employer. Applications will be accepted until February 1, 2012.

THE UNIVERSITY OF CENTRAL FLORIDA ANXIETY DISORDERS CLINIC has THREE opportunities for Postdoctoral Fellowships:

Two Post-doctoral Fellows needed to participate in a Department of Defense funded research program to treat veterans of the Iraq and Afghanistan conflicts who are suffering from post-traumatic stress disorder (PTSD). One Post-doctoral Fellow needed to participate in a National Institute of Mental Health funded clinical research program to develop and assess the feasibility, acceptability and efficacy of virtual environments as a treatment for childhood social phobia.

All post-doctoral fellows will be responsible for the assessment and treatment of study populations, including implementing individual treatment using virtual-reality exposure therapy and conducting group treatment sessions using social skills training and behavioral therapies. Additionally, the fellow may participate in data analysis and manuscript preparation, and provide supervision of graduate and undergraduate research assistants.

Applicants should have a Ph.D. in clinical psychology and completed a pre-doctoral clinical psychology internship, both from programs accredited by the American Psychological Association. Experience providing exposure therapy and other behavioral treatments to individuals with anxiety disorders is required. Application deadline for both is 3/1/12; positions begin 7/1/2012.

Interested applicants may contact Deborah C. Beidel, Ph.D., ABPP at dbeidel@mail.ucf.edu or apply on line at www.jobswithucf.com/applicants/Central?quickFind=75748. The University of Central Florida is an equal opportunity, equal access, and affirmative action employer.

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17th
annual

Awards & Recognition Ceremony

Outstanding Training Program, Massachusetts General Hospital/Harvard Medical School Predoctoral Internship in Clinical Psychology: Director, Sabine Wilhelm (right), Cognitive Behavior Therapy Program (not in attendance is Steven A. Safren, Director, Behavioral Medicine Program)



Judith Beck, Outstanding Contribution by an Individual for Clinical Activities



Elsie Ramos First Author Poster Winners: left to right, **Christopher Conway**, **Shelley Robbins** (Awards Chair), **Nathaniel Van Kirk**, **Lily McNair** (Chair, Elsie Ramos Poster Award), **Debra A. Hope** (President), and **Michelle Goldwin**



George F. Ronan, Outstanding Service to ABCT



45th Annual Convention | November 11, 2011 | Toronto

Awards Chair: Shelley Robbins



Lifetime Achievement Award: Antonette M. Zeiss (center), with Awards Chair Shelley Robbins and President Debra A. Hope



**Distinguished Friend to Behavior Therapy,
The Honorable Erik K. Shinseki**



**Andres de Los Reyes,
President's New Researcher**



Student Dissertation Award Winners: left to right, **Katherine J. W. Baucom**, Virginia Roswell Dissertation; **Christian Webb**, Leonard Krasner Dissertation; **Katie C. Hart**, John R. Z. Abela Dissertation



Self-Help Book of Merit Authors: To see a complete listing of ABCT Self-Help Book Seal of Merit recipients, go to:
http://www.abct.org/Public/?m=shBooks&fa=sh_Books&nolm=1

Call for

Continuing Education Sessions

46th Annual Convention | November 15–18, 2012

National Harbor, MD

Workshops

Workshops cover concerns of the practitioner / educator / researcher. Workshops are 3 hours long, are generally limited to 60 attendees, and are scheduled for Friday and Saturday.

Jillian Shipherd, *Workshop Committee Chair*
workshops@abct.org

Institutes

Institutes, designed for clinical practitioners, are 5 hours or 8 hours long, are generally limited to 40 attendees, and are scheduled for Thursday.

Risa Weisberg, *Institute Committee Chair*
institutes@abct.org

Master Clinician Seminars

Master Clinician Seminars are opportunities to hear the most skilled clinicians explain their methods and show taped demonstrations of client sessions. They are 2 hours long, are limited to 40 attendees, and are scheduled Friday through Sunday.

L. Kevin Chapman, *Master Clinician Seminar Committee Chair*
masterclinicianseminars@abct.org

Please send a 250-word abstract and a CV for each presenter. For submission requirements and information on the continuing education session selection process, please see the Frequently Asked Questions section of the ABCT Convention page at **www.abct.org**.

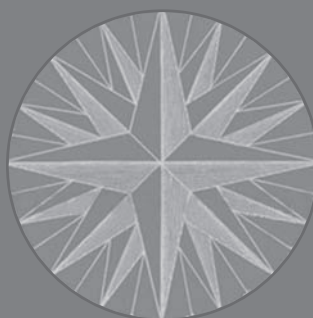
Submission deadline: February 1, 2012

call
for
papers



46th Annual Convention

November 15–18, 2012
National Harbor, MD



Principles of
Behavior Change:
The Compass
for CBT

Jeffrey L. Goodie, Ph.D., Program Chair

Over 260 years ago, less than 10 miles down the Potomac River from the National Harbor, George Washington mastered the use of the compass and other surveying instruments. Washington's use of the compass contributed to his adaptability in harsh environments and on the battlefield. When we meet in 2012, it will be 100 years since Watson coined the term "behaviorism." Watson, along with researchers before and after him, established behavior change principles that serve as a scientific foundation and a compass for our current behavioral and cognitive conceptual understandings. Given the contingencies of academic and clinical environments, researchers and clinicians often focus more exclusively on outcomes without explicit consideration of the behavior change principles that guided their efforts. However, just as Washington's use of the compass aided his success, as we adapt cognitive behavioral therapy to environments, such as traditional behavioral health clinics, primary care settings, web-based applications, or even the battlefield, it is important for our success to focus on the principles of behavior change, old and new, that guide our research and practice, wherever it occurs.

The theme for the 46th Annual Convention aims to increase the focus on the behavior change principles that will guide our future assessments, prevention strategies, and interventions. We encourage submissions for research symposia, clinical sessions, and workshops that highlight the search for, explication, and implementation of these basic principles. Special consideration will be afforded to those submissions that contribute to establishing new principles of behavior change or describe how existing principles served as a compass for development of projects and outcomes.

Submissions may take the form of symposia, clinical round tables, panel discussions, and posters:

Symposia: Presentation of data, usually investigating efficacy of treatment protocol or particular research.

Panel Discussions and Clinical Round Tables: Discussion (sometimes debate) by informed individuals on a current important topic.

Poster Sessions: One-on-one discussions between researchers, who display graphic representations of the results of their studies, and interested attendees.

Information on submitting abstracts will be on ABCT's website, www.abct.org, beginning in mid-January. The online submission portal will open in early February.

Submission deadline:
March 1, 2012



CBT Medical Educator Directory

Another indispensable resource from ABCT—an online directory of CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. In particular, the educators on this list have been involved in providing education in CBT and/or the theories underlying such interventions to medical and other allied health trainees at various levels. The listing is meant to connect teachers across institutions and allow for the sharing of resources.

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.
2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.
3. Training should take place or be affiliated with an academic training facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

Please note that this list is offered as a service to all who teach CBT to the medical community and is not exhaustive.

How to Submit Your Name

If you meet the above inclusion criteria and wish to be included, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Barbara Kamholz at barbara.kamholz2@va.gov and include *Medical Educator Directory* in the subject line.

Descriptions of training programs, teaching outlines and/or syllabi, and other supplemental teaching materials for courses specific to medical training that can be shared with others (i.e., through posting on ABCT's website or via the listserve) are also welcome. Please submit syllabi and teaching materials

Syllabi for traditional CBT graduate and postgraduate courses outside the medical community may be sent to Kristi Salters-Pedneault at saltersk@easternct.edu.

 <http://www.abct.org>

[Professionals, Educators, & Students](#) ↗

[CBT Medical Educator Directory](#) ↗



graduate Mentorship directory

"Every student deserves to be treated as a potential genius." — Anton Ehrenzweig

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ABCT WEBINAR

Patricia Resick, Ph.D.

Cognitive Processing Therapy for PTSD: Does Child Sexual or Physical Abuse Make a Difference?

Thursday, January 26, 2012

8:00–9:30 a.m. Pacific /

11:00 a.m.–12:30 p.m. Eastern

**1.5 CE credits (\$30 ABCT members/
\$45 nonmembers)**

How to Sign up on ABCT's Website

- ➔ Go to <http://www.abct.org>
- ➔ Choose Member or Visitor Login on the top left
- ➔ If you have already established an online profile with ABCT through membership renewal or convention registration, enter your current Primary Email Address (where you receive emails from ABCT Central Office) and Password. If you do not have an online profile, choose New Visitor Registration.
- ➔ Choose Join Renew & More on the left navigation pane
- ➔ Choose the webinar **Cognitive Processing Therapy for PTSD: Does Child Sexual or Physical Abuse Make a Difference?** Member or non-member pricing will be automatically displayed based on your status. Choose Next.
- ➔ Enter the appropriate information into the required fields Highest Degree, Specialty, Level and CE Certificate required. Enter all other applicable information.
- ➔ Choose Next, review and submit your registration.
- ➔ Proceed to Checkout and provide your payment information.
- ➔ Choose Next. You will receive a payment confirmation when your transaction is complete.

The purpose of this webinar is to review five studies of cognitive processing therapy (CPT) for PTSD with regard to the efficacy with clients who have a history of child sexual abuse or child physical abuse. Therapists often wonder if trauma-focused therapies are appropriate for clients with childhood trauma histories or whether they need other stabilization therapy before starting to work on their trauma. In the case of these studies, clients were recruited from the community or referred by therapists and had PTSD with or without childhood trauma histories. The webinar will describe the components of CPT and then will describe the studies chronologically including the control conditions for four randomized controlled trials and one program evaluation study conducted at a VA hospital. The webinar will end with a discussion of the implications of these studies, will provide information on resources on CPT and will allow time for audience questions.

You will learn: • The components of CPT • Whether PTSD clients with child sexual or physical abuse histories respond to CPT and whether they respond as well as those PTSD clients without such histories • Implications of trauma history in treatment planning and some resources for learning CPT.

About the presenter: Patricia A. Resick, Ph.D. is the Director of the Women's Health Sciences Division of the National Center for PTSD at the Veterans Affairs (VA) Boston Healthcare System. She is a Professor of Psychiatry and Psychology at Boston University. Dr. Resick received her Doctorate in Psychology from the University of Georgia. Over her career, she also served on the faculties of the University of South Dakota, the Medical University of South Carolina and the University of Missouri-St. Louis, where she held an endowed professorship. Dr. Resick has received grants from NIH, NII, CDC, SAMHSA, VA and DoD to provide services and conduct research on the effects of traumatic events, particularly on women, and to develop and test therapeutic interventions for PTSD. Specifically, she developed and tested Cognitive Processing Therapy, an effective short term treatment for PTSD and corollary symptoms. She has published four books and 175 journal articles and book chapters. Since 2006, Dr. Resick has been a leader in a national VA initiative to disseminate Cognitive Processing Therapy throughout the country and she is currently conducting a large clinical trial at Ft. Hood, Texas.

Continuing Education: Attendees may earn 1.5 hours of continuing education credits. **PSYCHOLOGY:** ABCT is approved by the American Psychological Association to sponsor continuing education for psychologists. ABCT maintains responsibility for this program and its content. Attendance at each continuing education session in its entirety is required to receive CE credit. No partial credit is awarded; late arrival or early departure will preclude awarding of CE credit. **SOCIAL WORK:** This program is under consideration by the National Association of Social Workers for continuing education contact hours.

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NOMINATE the Next Candidates for ABCT Office

I nominate the following individuals:

PRESIDENT-ELECT (2012–2013)

REPRESENTATIVE-AT-LARGE (2012–2015)

SECRETARY-TREASURER (2013–2016)

NAME (printed)

SIGNATURE (required)

2012 Call for Nominations

Every nomination counts! Encourage colleagues to run for office or consider running yourself. Nominate as many full members as you like for each office. The results will be tallied and the names of those individuals who receive the most nominations will appear on the election ballot next April. **Only those nomination forms bearing a signature and postmark on or before February 1, 2012, will be counted.**

Nomination acknowledges an individual's leadership abilities and dedication to behavior therapy and/or cognitive therapy, empirically supported science, and to ABCT. When completing the nomination form, please take into consideration that these individuals will be entrusted to represent the interests of ABCT members in important policy decisions in the coming years. Contact the Leadership and Elections Chair for more information about serving ABCT or to get more information on the positions.

Please complete, sign, and send this nomination form to Raymond DiGiuseppe, Ph.D., Leadership & Elections Chair, ABCT, 305 Seventh Ave., New York, NY 10001. Nomination forms can be also be send via fax (212-647-1865) or via email (membership@abct.org). If emailing, please send nomination form as a PDF attachment.