

APA
III
Division 12

CLINICAL SCIENCE

Society for the Science of Clinical Psychology
Section III of the Division of Clinical Psychology
of the American Psychological Association



developing clinical psychology as an experimental-behavioral science

Newsletter

Winter 2001 Issue

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INSTRUCTIONS FOR AUTHORS

Clinical Science is published as a service to the members of Section III of the Division of Clinical Psychology of the American Psychological Association. Three issues are published each year. The purpose is to disseminate current information relevant to the goals of our organization.

Feature Articles may be submitted to the editor via e-mail. They should be approximately 16 double-spaced pages and should include an abstract of 75- to 100- words.

Brief Articles may also be submitted, and should also include a 75- to 100-word abstract. All articles should be submitted as an attachment to an e-mail and formatted according to the *Publication Manual of the American Psychological Association, 4th edition*. We are looking forward to an exciting year.

Please submit materials to the Editor: Adele M. Hayes, Ph.D. by e-mail: ahayes@miami.edu

Comments from the President

Scientifically Rigorous Research in the Practice Setting: Practice Research Networks

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These are very exciting times, and SSCP will be in the thick of some terrific opportunities over the next year. The theme for my upcoming presidential year involves the creation of national practice research networks (PRNs) within which scientifically rigorous research can be conducted in the naturalistic setting with collaborations between clinical scientists and clinical practitioners. Internal validity and external validity can be optimized by such an approach, and there are a variety of outcome designs, methodologies, and process research approaches that can allow that to happen [cf. Borkovec, T. D., & Castonguay, L. G. (1998). What is the scientific meaning of "empirically supported therapy?" *Journal of Consulting and Clinical Psychology*, 66, 136-142]. What is foundationally necessary for this type of scientific work to be done, however, is the creation of an infrastructure that can support these kinds of efforts. Stimulating and organizing this infrastructure is what I plan to be doing for the next year. Below I describe what has been happening so far.

University Psychology Clinic PRNs

Considerable excitement has been generated recently among directors of Psychology Department clinics about the possibility of forming a University Clinic PRN. Such a PRN would involve the administration of a common core assessment battery at pretherapy, posttherapy, and follow-up to all clients entering all participating clinics. Ideally, layered below the core battery would be (a) additional measures for specific presenting problems or diagnostic groups, and (b) further measures specific to particular research questions being asked by subsequent investigations taking place within this infrastructure. Once such common assessments are being given, multiple possibilities will exist for (a) research by faculty and students at that local clinic, (b) using such research and the opportunities that it presents to build stronger scientist-practitioner training in our graduate programs, and (c) collaborative research among subsets of interested clinics or across all clinics, both from sharing data and from actually engaging in joint descriptive, correlational, process, and/or experimental investigations.

At the upcoming January meeting of the Council of University Directors of Clinical Psychology, a discussion will take place among interested directors that will be aimed at exploring the feasibility and methods of accomplishing the establishment of this very important avenue for improving our graduate training and for generating significant clinical research. Hopefully, Counseling Psychology clinics might also become involved in the network in the future. I will keep you posted as things develop here.

In the meanwhile, if you are in a clinical program that has a clinic and would like to consider having your program participate in such an endeavor, please get in touch with me to let me know of your interest. Or you may have already implemented research in your clinic, in which case I would really appreciate hearing about your methods and experiences. It is very likely that we will eventually create an e-mail listing of people who want to share information and/or organize clinic PRNs. My contact information is given at the top of this article.

State Psychological Association PRNs

Several grassroots efforts to establish PRNs within state psychological associations have been taking place throughout the country. One of the oldest was founded in 1994 in Pennsylvania. Practicing clinicians joined with clinical scientists to begin research efforts within the State. A common core battery was agreed upon and administered as part of a Phase I effort to establish a scientific infrastructure. An article describing the history, methods, and results of this pilot investigation and a discussion of conceptual and methodological issues involved is currently in press [Borkovec, T. D., Echemendia, R. J., Ragusea, S. A., & Ruiz, M. (in press). The Pennsylvania Practice Research Network and future possibilities for clinically meaningful and scientifically rigorous psychotherapy research. *Clinical Psychology: Science and Practice*]. The Pennsylvania PRN is now planning to begin Phase II investigations wherein actual experimental investigations will take place within this infrastructure. We will continue to stay in contact with other state PRNs in order to share experiences, collaborate on research, and move

toward the hopeful goal of establishing a national PRN among state psychological associations.

If your state association has been doing such work themselves or you think that you could stimulate such developments within your state association, please contact me. We can also set up e-mail connections to facilitate this effort.

National PRN Infrastructure Project

The most recent development that actually gives some promise of a rather rapid establishment of a national PRN is taking place in the context of a collaboration between clinical scientists and an outcomes assessment corporation. This corporation has a relatively brief core battery that assesses demographics, co-morbid medical conditions and medical usage, substance abuse, life stress, eight domains of symptoms, three domains of functioning, and treatment and payer satisfaction, among other variables. The battery is currently being given in over 900 service programs in 32 states and includes over 3,000 clinicians, with more than 70,000 clients in the current data base (about 4,000 new clients enrolled each month). The president of the corporation has been seeking clinical scientists to collaborate on scientifically rigorous research projects within this large and growing outcome assessment infrastructure.

Currently, an NIMH PRN Infrastructure grant proposal is being prepared to further expand the infrastructure, improve its quality and efficiency, and initiate descriptive, correlational, and experimental research projects within it. If their grant is funded, clinical scientists around the country will be notified of its existence and will be encouraged to develop NIMH RO1 proposals to pursue their own research questions within this infrastructure. I will keep you posted in the future on the progress of this endeavor.

APA's PracticeNet

Over the past year, APA's Practice Directorate has been working to build the infrastructure for PracticeNet, an Internet-based data collection system for surveying licensed psychologists regarding practice activities. Underwritten by the Federal Center for Substance Abuse Treatment, the first surveys will focus on substance abuse, with other areas of focus envisioned in the future. PracticeNet will collect information through a population-based Real Time Behavioral Sampling methodology. Participating practicing psychologists will periodically enter information on the Web about a single, recent episode of care they have given a client. A large number of practitioner participants would allow for frequent surveying without requiring any one provider to participate more than a few times a year. A variety of benefits will be offered to the participants in the system.

If you are interested in receiving more information about PracticeNet, please send an e-mail request including your name, address, e-mail, phone, and fax to practicenet@apa.org, or

contact Stefanie A. Klein, Ph.D., Director, PracticeNet at (800) 374-2723. The APA Practice Directorate has worked with the corporation involved in the National PRN Infrastructure Project described above and is interested in pursuing potential collaborative opportunities in the future. APA hopes that the methodology being developed for PracticeNet might converge with this National PRN Project at some point to take advantage of the potential strength and power of both.

A New Generation of Scientist-Practitioners

In addition to creating PRNs where clinically meaningful questions can be pursued with internally valid designs for the explicit sake of acquiring basic knowledge, the possibility of their widespread emergence at department clinic and national practice levels shows us a possible future wherein our graduate students participate in rigorous research in the very clinics where they were trained in assessment and psychotherapy. They then enter a professional world (academic or mental health service settings) where exactly the same infrastructure, philosophy, ideals, and assessment devices exist. Perhaps then a true integration of science and practice will evolve such that one's professional identity as a clinical psychologist has this integration at its very core, and the skills and experience are already established to continue contributions to that integration.

On the other hand, all of this is going to take an awful lot of work. Maybe it's just an impossible dream.

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To further stimulate growth and development of these ideas and to encourage clinicians and clinical scientists to become excited about and participate in such efforts, SSCP's program at APA next year will focus on effectiveness research and PRNs. Below is part of our tentative program, developed by our Program Chair, Louis Castonguay:

Presidential Address: Practice Research Networks: Scientifically rigorous collaborative research among practicing clinicians and clinical scientists in the naturalistic setting (Tom Borkovec).

Panel 1: Importance of, and methods, for conducting scientifically rigorous and clinically relevant research (David Barlow, Gerald Davison, Michael Lambert, and Gordon Paul)

Panel 2: Lessons from the trenches: Strategies, obstacles, pitfalls, and rewards of prevention and treatment effectiveness research (Michael Addis, Charlotte Brown, Mark Kopta, David Kraus, Michael Lambert, Ricardo Muñoz, and David Pingatore; Moderator: Louis Castonguay)

I hope that you will attend APA and come to these events. If you have any interests in any of the above PRN initiatives, I especially hope that you will contact me.

Feature Article

Training Opportunities in Empirically Supported Treatments and Their Relationship to Intern Recruitment and Post-Internship Placement: A Survey of Directors of Internship Training

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Jack J. Blanchard

University of Maryland at College Park

Abstract

Although empirically supported treatments (EST) are now available for a number of psychological disorders, the extent to which EST are being integrated into clinical training is unknown. We report the results of a survey of predoctoral clinical psychology internship programs on the availability of training in EST and on how such training is related to intern recruitment and post-internship placement. On average, internship programs offered didactic supervision training opportunities for nearly half of the 72 EST included in our survey. However, formal didactic training in EST was much less frequently available, and internship programs varied considerably in the number of EST and types of problems for which training was available. Internships that provided the greatest number of opportunities for training in EST tended to place greater emphasis on graduate training in research and objective methods of assessment than on projective methods of assessment. They were also more likely to place interns in post-doctoral fellowship or academic research positions than in clinical jobs. These results suggest guidelines for students preparing for internship training in EST and for the continued development of such programs.

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Student Corner

I just wanted to take a moment to introduce myself. My name is Erin Scott, and I am a third-year graduate student at Temple University. I will be serving as the Student Representative to SSCP for 2001. I am hoping to use this space in the SSCP newsletter and my position on the SSCP board to address issues that are important to our student members. In order to do that, I need your help. Please forward me your questions, concerns, or thoughts about life as a clinical psychology graduate student. What would you like to learn more about? Do you have questions about internships that emphasize a scientist-practitioner model? Would you like to see a discussion of career choices for scientist-practitioners? Also, please contact me if you have ideas about how SSCP can better serve our graduate students. Any suggestions are welcome, and I look forward to hearing from you.

Erin Scott, *Student Representative*

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Funding Updates

Two announcements relevant to the missions of SSCP have been developed in response to a report written by the National Advisory Mental Health Council's Behavioral Science workgroup. The Full report, "Translating Behavioral Science into Action" is available at:

(<http://www.nimh.nih.gov/tbsia/tbsiatoc.cfm>).

DEVELOPING TRANSLATIONAL RESEARCH IN BEHAVIORAL SCIENCE

Release Date: November 8, 2000

RFA: MH-01-005

National Institute of Mental Health

(<http://www.nimh.nih.gov/>)

National Institute on Drug Abuse

(<http://www.nida.nih.gov/>)

Letter of Intent Receipt Date: February 11, 2001

Application Receipt Date: April 11, 2001

THIS RFA USES "MODULAR GRANT" AND "JUST-IN-TIME" CONCEPTS. IT INCLUDES DETAILED MODIFICATIONS TO STANDARD APPLICATION INSTRUCTIONS THAT MUST BE USED WHEN PREPARING APPLICATIONS IN RESPONSE TO THIS RFA.

PURPOSE

The National Institute of Mental Health (NIMH) and the National Institute on Drug Abuse (NIDA) seek to encourage the development of collaborative partnerships between scientists who study basic behavioral processes (e.g., cognition, emotion, decision making, social networks, culture) and those who study the etiology, diagnosis, treatment, and prevention of mental and behavioral disorders (including drug abuse and addiction) and the delivery of services to those suffering from those disorders. NIMH and NIDA are issuing this Request for Applications (RFA) as a catalyst for a major, long-term commitment to (a) encourage the systematic translation of basic behavioral theory, methods, and findings

into research designed to reduce the burden of mental illness and behavioral disorders and (b) encourage basic behavioral scientists to seek a further understanding of behavioral processes through an exploration of how those processes are altered by mental and behavioral disorders.

This RFA contains three mechanisms to support varying types of translational research partnerships: (1) networking grants for the initiation of research partnerships; (2) developmental grants for the initial instantiation of translational research projects; and (3) research project grants for single and multisite translational research projects.

For more information:

<http://grants.nih.gov/grants/guide/rfa-files/RFA-MH-01-005.html>

TRANSLATIONAL RESEARCH CENTERS IN BEHAVIORAL SCIENCE (TRCBS)

Release Date: December 5, 2000

PA NUMBER: PAR-01-027

National Institute of Mental Health

(<http://www.nimh.nih.gov/>)

Letter of Intent Receipt Dates:

February 12 and September 22, 2001

September 22, 2002

September 22, 2003

Application Receipt Dates:

March 12 and October 22, 2001

October 22, 2002

October 22, 2003

PURPOSE

The National Institute of Mental Health (NIMH) invites research grant applications for Translational Research Centers in Behavioral Science (TRCBS). The purpose of these centers is to support the translation of work from basic behavioral science research,

and relevant integrative neuroscience research, to pressing issues regarding all aspects of mental disorders. Such clinical issues include an understanding of the etiology and assessment of disorders, the assessment of functioning, development of innovative and culturally appropriate preventive, treatment and rehabilitation interventions, and improvement of methods for the effective delivery of mental health services. The centers are also intended to encourage basic behavioral scientists to seek a further understanding of behavioral processes through an exploration of how those processes are altered by mental and behavioral disorders.

These Centers are intended to support integrated research teams drawn from the fields of basic behavioral and social sciences, neuroscience, epidemiology, prevention, academic mental health, and mental health services delivery. Centers are to develop hypothesis-driven approaches to an important research question, or a focused set of research questions, using innovative designs and cutting-edge approaches to methodological and statistical issues. An important goal of the centers is to transcend the barriers of disciplines, research settings, and institutions in order to harness the full range of modern behavioral science to the service of the nation's critical mental health needs.

(See the recent Institute of Medicine report, "Bridging Disciplines in the Brain, Behavioral, and Clinical Sciences," available at:

<http://books.nap.edu/catalog/9942.html>.)

This PA expires 3 years from the Release Date shown above.

For more information:

<http://grants.nih.gov/grants/guide/pa-files/PAR-01-027.html>

Membership Issues

Student Membership

Denise Sloan, Ph.D.
Membership Chair

SSCP offers several benefits to our student members. Every year we distribute several dissertation awards to help defray the expenses associated with dissertation research. We also award a cash prize for the best presentation at our annual student poster session held at the APA convention. Another example of our commitment to student members is our internship directory that contains information on Boulder model internship training programs. Finally, a new benefit to all of our members is a 20% discount on psychology books published by Oxford University Press. We are in the process of talking with other publishing companies to arrange similar discounts for our members.

In an effort to increase student representation in our organization, we are offering a discount on student memberships available when the membership is purchased by clinical psychology programs. Specifically, clinical psychology programs are able to obtain SSCP membership for their students at the price of \$7.50 per student, compared to \$10.00, if students were to join individually.

In future issues of this newsletter the SSCP, the student representative will have a section dedicated to student-related issues. Erin Scott, the current student representative, encourages you to contact her with issues that you would like addressed in future newsletters.

In sum, SSCP welcomes and strongly supports our student members as we recognize that students are the future of our organization. We encourage you to continue your membership, and we hope that you will encourage your peers to join as well.

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Professional Issues

SSCP Task Force Statement on Prescribing Privileges (RxP)

Prepared and submitted by:
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Task Force Chairman

Introduction

Advocates for prescribing authority for psychologists (RxP) have advanced the following major arguments:

- A. Psychotropic medications have become a major class of interventions that can help psychologists' clients. There is, to be sure, considerable controversy over the actual degree of their efficacy and over the biological and psychological mechanisms responsible for their apparent effects. Nevertheless, it is an undeniable fact that they seem to benefit a substantial percentage of their target populations. This includes people who lack access to psychosocial treatments, or who have refused or cannot be counted on to respond adequately to them.
- B. Prescribing authority is a natural, desirable, and attainable extension of the practice of clinical and counseling psychology. Psychological science has long recognized the role of biological factors in psychological and behavioral functioning. Graduate programs in clinical psychology already offer at least some instruction in psychophysiology, behavior genetics, and psychopharmacology. Research psychologists routinely work side-by-side with biomedical professionals in studying interactions among anatomy, physiology, psychological processes and behavior. We are no strangers to neurons and their workings.
- C. While most psychiatrists no longer offer psychotherapy or behavior therapy to their patients, they are legally permitted to do so. There is no good reason why, given appropriate training, applied psychologists cannot and should not join their psychiatric colleagues in providing the full spectrum of efficacious treatments, at least to the extent of prescribing psychotropic medications.

D. Adequate training in drug prescribing can be accomplished in a time frame and at a financial cost accessible to many, if not most psychologists. There is a precedent for such supplemental training in the field of optometry. APA's model program (at Level 3; see below) sets forth the parameters for such training as it would apply to psychologists.

E. Many people in this country lack access to psychiatrists and must look to under-trained general practitioners for psychotropic medications. RxP would go far to fill this gap. In addition, prescribing psychologists' clients would have a more complete array of treatment options available to them through a single practitioner, without the complications of interprofessional collaboration.

F. Applied psychologists as a group cannot survive in today's competitive, over-supplied, care-managed mental health field. Lacking prescribing authority, we are progressively being driven from the arena. RxP is a matter of economic survival for our profession.

We understand the above points (A-F) to represent the case for RxP, as it is commonly made. It is the consensus of the leadership of SSCP that these arguments do not hold up to careful examination.

In addition to the specific points set forth below, a further and more comprehensive objection is that RxP would dilute the existing scope of clinical psychology practice with the addition of RxP responsibilities. In an historical context, it is our belief that such a shift is short-sighted:

In the long run, it will be at the expense of the broader areas in which psychologists contribute knowledge.

In the short run, it will skew the clinical contributions made by psychologists away from those areas from which they have consistently and historically made unique contributions (i.e., assessment, behavioral programming and analysis, and psychotherapy).

While the foregoing philosophical positions underlie this statement, the resolutions below are chiefly based on the practical ways that RxP is not viable. These resolutions grow out of the following objections:

There has never been a full debate on RxP that was open to all interested members of APA. The only consideration of RxP that has taken place has been within smaller groups of individuals within APA that cannot be assumed to represent the membership at large.

Council has received pro-RxP presentations and passed enabling resolutions without the input or even the physical presence of APA members and contingents who oppose or question it.

The APA central office has been aggressively pushing RxP without adequate consideration of the broader membership of APA and without using well-established procedures such as peer review. Over \$800,000 from the APA budget has been spent advancing the RxP campaign during the past five years, despite widespread opposition in the ranks.

During the 2000 APA Annual Convention Program, APA headquarters sponsored a "mini-convention" devoted to RxP. The views presented there were strongly biased in favor of RxP, and they had not been subjected to peer review by the broader APA membership.

The RxP proposal may be the most radical proposal the APA organization has ever faced. Without a semblance of informed consent from the membership, we are gravely concerned that a fundamental change of great historical impact will be enacted in the field of psychology without fully considering the reasons and implications.

SSCP accordingly resolves:

- 1. That beginning immediately, there be a moratorium on all expenditures and advocacy by APA on behalf of RxP until the following resolutions have been carried out in full.**
- 2. That the 2001 convention feature a second mini-convention on a scale with the last one — but this time with equal planning access and "air time" for RxP opponents.**

- 3. That a complete, evenhanded report of the proceedings of the mini-convention be published in the October 2001 editions of the Monitor and American Psychologist, with full opportunity for prepublication editorial oversight by representatives of both viewpoints.**
- 4. That by January 2002, an objective and comprehensive survey of members' knowledge, experience, attitudes and intentions regarding RxP and prescribing-related issues, developed with full participation by both sides, be put into the field.**
- 5. That the results of this survey, again with bipartisan prepublication review, be published in the May 2002 editions of the Monitor and American Psychologist.**
- 6. That by July 2002, a binding membership referendum be completed on this or a closely similar proposition, "Shall APA continue or not continue to advocate for prescribing privileges within the profession and in the state legislatures?"**
- 7. That APA immediately reserve funds sufficient to put resolutions 2-6 into effect, including all out-of-pocket costs plus stipends and travel allowances for a reasonable number of members from both sides who contribute materially to carrying out these resolutions.**

The position taken herein by SSCP, including the above seven resolutions, are based on the following evidence and reasoning:

What is wrong with RxP

- 1. RxP would not fill unmet needs for service as claimed by proponents.**
 - (a) The psychiatrically underserved population is not very large. Even in the aggregate, it is smaller than RxP advocates in APA's central office wish us to believe.
 - (b) The geographic distribution of psychologists largely follows that of psychiatrists. Thus, little net gain in coverage is even possible.
 - (c) Few psychologists have chosen to practice in places like rural Montana or the South Bronx. There is no reason to think that RxP would make an appreciable difference.

- (d) Organizations of consumers of mental health services (e.g., NAMI) have not come forth to endorse RxP. At the last RxP bill hearing in the Hawaii legislature, several consumers testified against RxP but none in favor.
2. **No satisfactory precedents exist, either for designing suitable training programs or for predicting psychologists' performance as prescribers.**
- (a) The definition of what would constitute adequate training remains highly speculative and controversial. APA's model program is far from being a final or even an authoritative statement of what would be needed.
- (b) The Department of Defense program, with 10 graduates, was about twice as intensive as that envisioned by the APA model program. It cannot be reproduced on a broad scale. It is therefore not a meaningful precedent.
- (c) Guam — small, remote, and atypical in other respects — requires medical oversight of its handful of prescribing psychologists. It is not a precedent for RxP in the form espoused by APA.
- (d) APA's training model specifies three sequential levels. Current RxP training programs offer Level III (see section 3 below), but omit the prerequisite Levels I and II. They also omit the undergraduate prerequisites in biology (12-15 semester hours), chemistry (9-12 hours) and algebra (3 semester hours).
- (e) Some programs claiming to meet APA standards are conducted via distance learning — quite unlike the Defense Department program or those offered to optometrists.
- (f) In short, there is no existing program that meets even APA's scaled-down criteria.
3. **Few existing psychologists would be able to complete any acceptable training program.**
- (a) The APA Level III model, skimpy as many believe it to be, entails 28 semester hours of didactic work, plus one year of closely supervised practicum experience involving at least 100 patients. This is equal to approximately two years of full-time work.
- (b) This time requirement does not include prerequisite undergraduate-level work (see section 2[d] above), some or all of which most prospective candidates would need.
- (c) The cost of APA-model training — even when no undergraduate work is needed — is estimated at \$5,000 to \$20,000 per student if received in a university or professional school setting. This does not include up to two years' worth of job or practice income sacrificed in order to make time available for RxP training.
4. **Graduate education in basic psychological science and psychosocial treatments would be severely diminished and distorted unless most or all biomedical coursework were at the post-doctoral level.**
- (a) Many currently practicing psychologists are already under-trained in psychological science and empirically supported treatments. Displacing traditional curriculum content in graduate schools with RxP-focused coursework would render this deficiency still worse.
- (b) Making RxP training wholly post-doctoral would add two years and \$20,000 to \$30,000 — plus the cost of any undergraduate prerequisites needed and the years of earning ability forever lost — just as it would for existing psychologists.
- (c) By changing the prerequisites for doctoral programs, RxP would attract a different population of applicants and further diminish the emphasis on psychosocial/behavioral treatments.
5. **In addition to the direct costs of RxP training, there are a number of externalities — so far, not widely recognized — that argue strongly against RxP.**
- (a) Malpractice premiums would go up for those who elect to prescribe, and possibly for all licensed psychologists, whether they prescribe or not.
- (b) Should even a few malpractice suits against prescribing psychologists based on claims of inadequate medical training be successful, insurance coverage would become prohibitively expensive or disappear altogether. Legislatures that had previously authorized RxP would face an onslaught of pressures to rescind it, and those that had not yet authorized it would reject RxP bills out of hand. The

damage that would be done to psychologists and to the profession is incalculable — much worse than the damage done to physicians and medicine when they are sued.

- (c) Student loan debt would increase sharply as a result of additional borrowings and years of delay in commencing repayment.
 - (d) Adding faculty to departments of psychology to teach the RxP curriculum would cost an estimated \$800,000 to \$1,000,000 annually. Only schools wholly supported by tuition could hope to recover these outlays. Universities relying on state funds and endowments would have to absorb a large share of additional faculty costs without recourse.
 - (e) RxP would widen the existing gap between university and professional-school programs, and in effect create two divergent spinoffs of clinical psychology. It would be only mildly facetious to say that we would come to be seen, at least by outsiders, as either underpaid psychiatrists or overpriced social workers. In the process, the cross-fertilization between psychological science and practice — psychology's trump card in the mental health field — would have been severed.
 - (f) If psychologists obtain RxP, master's-level social workers and counselors will almost certainly try to follow. (Pat DeLeon has in fact written in support of social workers seeking RxP.) Should they succeed, the market will be flooded with Rx-eligible personnel, and the competitive advantage sought by psychology's RxP advocates would quickly vanish.
6. Psychologists would be exposed to patients' demands for "pill fixes" and the blandishments of the pharmaceutical industry, just as psychiatric and other medical professionals already are.
- (a) It is naïve to assume that psychologists' background in psychosocial treatments would significantly "inoculate" them against such powerful pressures.
 - (b) By de-specializing psychologists in psychosocial treatments and their scientific underpinnings, their commitment and competence in this area is likely to be further eroded.

7. Contrary to claims made by key people in APA's central office, psychology is not united behind RxP. A series of surveys over the past 10 years has shown sentiment to be about equally divided.

- (a) APA's much-cited 1995 data, which showed a majority in favor of RxP, relied upon a single, highly biased questionnaire item in the context of an omnibus survey on membership issues. More adequate studies suggest that a majority is actually opposed to RxP.
- (b) Recent survey evidence suggests that many psychologists nominally classified as "favorable" to RxP are willing to endorse RxP simply out of an altruistic desire to help colleagues — while having little or no interest in pursuing such training themselves.
- (c) There is reason to believe that few psychologists — even those who find the RxP idea attractive — are aware of and have given careful thought to the length and cost of any plausible training requirements. What their attitudes would be if they were fully informed remains unknown.

8. Organized psychiatry and medicine can be counted upon to oppose RxP in state legislatures far more vigorously and effectively than they have opposed previous expansions in our scope of practice.

- (a) They have the financial and political ability to turn the RxP campaign into a rout for psychology and are fully prepared to do so if necessary.
- (b) Faced with RxP bills in the legislatures, they are likely to seize the opportunity to roll back gains in our scope of practice that have been painstakingly eked out over decades.
- (c) There is evidence from New York that medicine's sabotage of scope-of-practice legislation sought by NYSPA was intended as a shot through our rigging to head off RxP.
- (d) Fruitful collaboration between psychologists and medical professionals would be undermined — and possibly damaged quite seriously — by the battle over RxP.

- (e) APA has spent over \$800,000 pressing its RxP agenda, and has recently escalated its efforts still further. Yet all that it will take to defeat RxP bills in state legislatures is for psychologists opposed to RxP to expose its lack of solid support among psychologists. (This has already happened in Hawaii.)
9. RxP opponents fully recognize the need for psychologists to have education and experience relevant to biomedical treatments. But this does not imply a need for prescribing authority. Good alternatives exist that have few or none of the drawbacks cited above.
- (a) For psychologists who want to prescribe drugs on their own, nurse practitioner (NP) training would prepare them far better than any RxP program that has been seriously proposed. It would provoke less opposition from the medical establishment. No new legislation — costly, time-consuming and dangerous to pursue — would be required. And it would probably be supported by the nursing profession, which as matters now stand is likely to join organized medicine in opposing RxP.
- (b) For psychologists who do not want to prescribe, or who cannot afford the time and money to obtain the requisite training, well designed CE offerings would enable them to participate collegially and knowledgeably in collaboration with medical professionals. A large percentage of psychologists are already so equipped, and they collaborate routinely and effectively with their medical colleagues.
- (c) Training is particularly needed for collaboration with primary care physicians — who write about 75% of the prescriptions for psychoactive medications in this country, yet often have skimpy knowledge of the proper use of such drugs, and are even less well acquainted with the advantages of psychological treatments. Such collaboration would also do more than RxP to meet the needs of underserved areas and populations.
- (d) APA can play a vigorous and constructive role in enhancing psychological practice via these alternatives. It can take the lead in arranging NP training at an affordable cost, and it can develop and promote CE modules to advance interprofessional collaboration. These things can be done at much less cost

and risk than pursuing the present quixotic campaign for RxP — and they would do away with the divisive atmosphere that APA's unilateral promotion of RxP has needlessly brought upon our profession.

Conference Information

2001 APS Convention:

June 14-17, 2001

Toronto, Ontario

Submission Deadline Past

<http://www.psychologicalscience.org/convention>

2001 World Congress of Behavioral and Cognitive Therapies:

July 17-21, 2001

Vancouver, British Columbia

Submission Deadline Past

For more information about the WCBCT:

AABT:(212) 647-1890, FAX (212) 647-1865

<http://www.aabt.org>

2001 APA Annual Convention:

August 24-28, 2001

San Francisco, CA

Submission Deadline Past

See the *Comments from the President (page 3)*

for more information about SSCP's program at the 2001 APA Convention.

<http://www.apa.org>

2001 AABT Annual Convention:

November 15-18, 2001

Philadelphia, PA

Submission Deadline: March 2, 2001

<http://www.aabt.org>

More Conferences:

For an extensive list of conference information, see the APA homepage or go to:

<http://aix1.uottawa.ca/~iupsys/mtg.html>

Awards and Recognition

Distinguished Scientist Award

Harm Reduction and the Politics
of Addiction Research

G. Alan Marlatt, Ph.D.

Abstract

Harm reduction provides a public health alternative to the traditional moral model of addiction (e.g., War on Drugs) or the medical model (alcoholism as a disease), both of which insist on abstinence (zero tolerance) as the only acceptable goal. Harm reduction provides a middle-way approach between total abstinence (quitting as the first step) and continued uncontrolled or hazardous drinking. As an example of this approach, results of a controlled clinical trial were presented showing the effectiveness of a brief harm reduction intervention administered to high-risk college student drinkers in the freshman year. The brief intervention, based on motivational enhancement therapy (MET), was found to be both statistically and clinically significant throughout a four-year follow-up period, compared to control group participants. Harm reduction appears to reduce the negative consequences of excessive and harmful "binge drinking" patterns in young adults.

2000 SSCP
DISSERTATION GRANT AWARDS

Dissertation grant awards were made to the following individuals in the fall of 2000. The student's name, affiliation, project title, advisor, and project aims are listed below. Congratulations to the recipients and their advisors.

Meredith E. Coles

Temple University

Implicit and Explicit Memory for Critical Faces in Individuals with Social Phobia

Advisor: Richard G. Heimberg, Ph.D.

Using an experimental paradigm, the current study will examine explicit and implicit memory biases for critical faces in individuals with social phobia (SP) and non-anxious controls (NACs). The current study will maintain strengths of previous studies (e.g., by using externally valid stimuli as in Lundh & Öst, 1996a,b), but go a step further than any previous research designs (e.g., by including distinctions between forms of memory along with visual stimuli). This combination of utilizing strengths of previous research along with remedies for past shortcomings allows for the best possible design for testing the questions at hand. There are two specific goals of the current study. First, this study will evaluate whether individuals with SP show preferential implicit memory for critical faces as compared to neutral faces and in contrast to NACs. Second, this study will evaluate whether individuals with SP show preferential explicit memory for critical faces as compared to neutral faces and in contrast to NACs.

Katrina Keil

University of Arizona

Examining Executive Function in Those With Brain Injury

Advisor: Alfred W. Kaszniak, Ph.D.

The purpose of the proposed study is to examine executive function (EF) abilities in aphasic individuals, using selected nonverbal tasks thought to tap planning and strategy. The tests selected for use in this study have been described as tests of executive function. The term executive function is broad encompassing many abilities. The specific abilities of planning, use of strategy, and rule adherence follow under the rubric of executive function and seem to be required by the selected neuropsychological (NP) tests. This study will examine whether these tests measure a common set of abilities, and whether those abilities are impaired in participants who have aphasia. In addition, a test of planning and strategy use is being developed and will be examined for its viability and validity as a nonverbal executive function test. The hypotheses to be tested are: 1) There will be a common planning factor across NP tests, 2) some aphasic individuals will have deficits in executive function compared to normal controls, and 3) there will be a relationship between deficits in executive

Continued on page 13

Continued from page 12

function and localization of damage. For aphasics with frontal damage, EF deficits will be expected in those whose middle cerebral artery (MCA) territory damage extends into the dorsolateral prefrontal cortex (seen in a comparison between anterior and posterior localization). For posterior-lesion aphasics, EF deficits may be seen in those with disruption of inner language from impaired auditory comprehension.

Michael F. Lorber

State University of New York at Stony Brook

Cognitive and Emotional Mechanisms of Harsh Parenting and Toddler Misbehavior

Advisor: Susan G. O'Leary, Ph.D.

The overarching goal of the proposed study is to expand scientific knowledge regarding the causes of overreactive parenting, with an eye toward the improvement of parenting interventions. Drawing from a biopsychosocial model, hypotheses are offered about how parents' thoughts and feelings about and physiological responses to their children relate to the harshness of their discipline. Aim 1 is to test the generalizability of the sentiment override model of the cognitive-affective correlates of dysfunctional marital relationships to the prediction of parental overreactivity and child misbehavior; integrating affective and physiological responses, expectations and appraisals of child behavior, along with parents' global sentiment about their children. Aim 2 is to replicate the relation between mothers' appraisal biases for child behavior and their overreactive discipline. These relations will be tested in a sample of 100 mother-toddler dyads in which the toddlers are exhibiting incipient externalizing problems. The results obtained with this sample should have clear implications for improving our understanding of why parents parent the way they do and how better to prevent or treat harsh, overreactive parenting. The proposed investigation represents an important step forward in the understanding of parental characteristics that maintain overreactive discipline and child behavior problems and that ultimately derail the usefulness of parenting interventions for externalizing child behavior.

Katy L. Lynch

University of Montana

Children Exposed to Domestic Violence: Resiliency and the Mother-Child Relationship

Advisor: Christine Fiore, Ph.D.

This project developed out of my own experiences working with women and children who have experienced domestic violence, witnessing the extreme range of outcomes for children exposed to violence within the home. The purpose of this is to examine parenting and the parent-child relationship in families who have experienced domestic violence and the influence of these variables on children's outcomes.

Jeneva L. Ohan

University of British Columbia

Aggression in Girls with and without ADHD

Advisor: Charlotte Johnston, Ph.D.

It is well accepted that childhood aggression plays an important role in influencing concurrent and later life adjustment (e.g., Parker & Asher, 1989). However, despite the importance of aggression on psychosocial adjustment, aggression in girls has been a neglected area of research. In particular, aggression in females with attention-deficit/hyperactivity disorder (ADHD), who we believe are at an increased risk for using aggressive interpersonal strategies, has been lacking. To address this need, this study is intended to explore differences in aggression used by girls with and without ADHD. The secondary objective of my dissertation is to investigate the usefulness of a laboratory aggression analogue task that I created to provide a behavioral measure of relationally and overtly aggressive interactions in elementary-school aged girls. I created this assessment tool to be economically and practically feasible in typical research settings and to overcome the limitations inherent in self- and other-reports of aggression.