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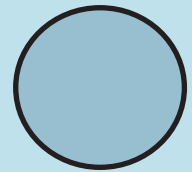


Division 12

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 sci-



Newsletter

Fall/Winter 2011: Volume 14, Issue 3

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Articles published in *Clinical Science* represent the views of the authors and not necessarily those of the Society for a Science of Clinical Psychology, the Society of Clinical Psychology, or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

Presidential Column, Part II

From Regulation to Inspiration: The Delaware Project on Clinical Science Training

Varda Shoham, Ph.D.

Univ. of Arizona Psychology Dept. and the National Institute of Mental Health on assignment from the University of Arizona

In my first presidential column I wrote about one of the major challenges facing psychosocial treatment research – controlling the elusive independent variable of psychosocial treatment research by assessing, enhancing, and maintaining treatment fidelity. My plan at the time was to focus my next column on the questions of “for whom” and “how” treatment work. While questions on how to best study moderators and mediators of treatment effects are important, I don’t have much new to say about it, especially after having engaged the topic via a commentary on Kazdin and Blase’s (2011) provocative paper, a commentary that was published last month in *Perspectives on Psychological Science* (Shoham & Insel, 2011).

Instead, I’d like to tell SSCP members about a new and exciting initiative: *The Delaware Project on Clinical Science Training*. The Project is sponsored by NIMH, NIDA, OBSSR, the Academy of Psychological Clinical Science (APCS), SAGE, and the host institution, the University of Delaware. It aims to redefine psychological clinical science training in ways that emphasize continuity across a spectrum of research activities concerned with (a) basic mechanisms of psychopathology and behavior change, (b) intervention generation and refinement, (c) intervention efficacy and effectiveness, and (d) implementation and dissemination.

As a first step, the Project brings together clinical scientists representing different sectors of this spectrum in hopes of creating productive (even visionary) dialogue leading to the articulation of new, improved models for training. To ensure breadth, two thirds of the invited participants are from APCS doctoral and internship programs and one third are intervention researchers from medical schools, VA centers, and other research institutes. A later step will involve publishing recommendations and best practices for training graduate students, interns, and post-doctoral fellows across all stages of intervention development science. The Project will also serve as a catalyst for generating web-based training resources and stimulating ideas for cross-program

demonstration projects and practice- research training networks.

Why do we need to redefine clinical science training? Despite drastic changes in the nature of clinical practice and clinical science research over the past half century, the Boulder model promulgated in 1949 (or the interpretation thereof) remains the dominant paradigm for mainstream clinical psychology training programs. At the same time, despite impressive advances in developing empirically supported interventions for specific problems and mental disorders, these treatments too often do not reach the patients in community settings who need them most. Increasingly, faculty in clinical science programs recognize that our students – the next generation of clinical scientists – do not receive optimal training for the leadership roles many of them will assume in developing and implementing new treatment and prevention interventions, testing interventions in real-world settings, or managing supervisory and training activities in an ever evolving healthcare system. Instead, we train our students for a world that no longer exists.

Given the parity law and the healthcare reform, we can expect the mental health and substance abuse workforce to grow exponentially, with quality assurance and quality enhancement methods lagging even farther behind. I fear that if we, as a field, don’t do something different, more patients will receive more mental health services from more providers (including peers) who receive less adequate training and less skillful supervision. Unless we think that other professions (e.g., public health administrators) are better suited to lead the field, an increasingly important role for well-trained clinical scientists will be to organize and oversee the delivery of mental health intervention rather than to provide these services themselves.

No less important, we have not seen sufficient innovation in psychological treatments in recent years. We have treatments that work, but they don't work for all patients, and we know too little about how and for whom they work best. We would do far more justice to the next generation of graduates as well as for the public if doctoral and internship/post-doctoral programs devote more time to training students to (a) do good science across the stages of intervention development, and (b) apply this science by developing and evaluating implementation programs, training and supervising the ever growing workforce of MA, BA, and peer-level providers, and making much needed science-based contribution to mental health policy.

Initial discussions of a possible meeting about dissemination science occurred in the May 2010 meeting of the Academy of Psychological Clinical Science (APCS), where APCS member program at the University of Delaware agreed to host such a meeting if it were ever to occur. As this "Delaware Project" gained traction, first with sponsorship from the National Institute of Mental Health (NIMH) and then from the National Institute on Drug Abuse (NIDA) and the NIH Office of Behavioral and Social Science Research (OBSSR), its scope expanded beyond APCS programs and beyond dissemination to include the entire spectrum of intervention development – from basic translational research to implementation and dissemination. A particular concern was not to marginalize dissemination science by splitting it off from other arenas of intervention development, but rather to locate and integrate implementation within the broader stage model (adapted from Rounsaville, Carroll, & Onken, 2001) that several NIH institutes use to guide the funding of research projects.

By organizing the conference according to the NIH Stage Model, we will examine training possibilities along the entire spectrum of intervention science – from basic, translational, and efficacy research to dissemination and implementation. In addition to identifying continuities, we hope to grapple with the competing priorities and inevitable tensions the stage model presents, at least as these inform training. For example, the dialectic of internal versus external validity will be central throughout. The stage model focus should help to increase correspondence between graduate training and the structure of NIH funding. We recognize, however, that the stages may be less linear than recursive, with findings and experiences at later stages feeding back to influence research

questions at earlier stages, as well as vice versa.

Finally, in contrast to the aims of the Boulder conference, the Delaware Project is not about accreditation. Its aims are aspirational and inspirational rather than regulatory and prescriptive. We aim to inspire programs to think out of the box about ways to improve clinical science training and ultimately, public health, rather than define a singular model of clinical science training; to enlarge the number of possibilities rather than restrict (e.g., via checklists, mandatory competencies, etc.) how programs should approach their training goals. We envision the Project generating state-of-the-art (and state-of-the-science) training resources and recommendations relevant to knowledge generation across all stages of intervention development. This does not obviate the need for accrediting clinical training in the context of strong clinical science programs – while allowing programs to free up curriculum hours and training resources in the service of better intervention science.

Stay tuned for more to come in my next (and last) column.

Relevant Readings

Kazdin, A.E., & Blase, S. (2011). Rebooting Psychotherapy Research and Practice to Reduce the Burden of Mental Illness. *Perspectives on Psychological Science*, 6, 21-37.

Shoham, V., & Insel, T.R. (2011). Rebooting for whom? Portfolios, technology, and personalized intervention. *Perspective in Psychological Clinical Science*, 6, 478-482.

CONGRATULATIONS TO THE NEW OFFICERS FOR 2012 !

PRESIDENT-ELECT

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AT-LARGE MEMBER

Sherryl Goodman — Emory

DIVISION 12 REPRESENTATIVE

Doug Mennin — Hunter College

STUDENT REPRESENTATIVE

Kristy Benoit — Virginia Tech

Three Years on the Tightrope: Musings of an SSCP-Division 12 Liaison

David F. Tolin, Ph.D., ABPP, Division 12 Representative
Institute of Living and Yale University School of Medicine

I don't feel that an atmosphere of debate and total disagreement and argument is such a bad thing. It makes for a vital and alive field.
— Clifford Geertz

I am delighted that our President, Varda Shoham, invited me to write a few words about my experiences as the Division 12 (D12) representative on the SSCP board. This position also entailed serving as the SSCP representative on the D12 board; thus, communications (either positive or negative) between SSCP and D12 usually ended up in my lap. I'm pleased to say that for the most part, this communication has been extraordinarily productive.

One of my first experiences of walking the tightrope between SSCP and D12 arose when the D12 Board published a statement on their web site (<http://www.div12.org/>) in support of evidence based treatments (EBTs). The SSCP board expressed some disagreement about the content of the statement, including concerns about what constitutes best scientific evidence, and which variables are paramount in establishing treatment efficacy. To reconcile the differences in opinion, I convened a working group that included Larry Beutler from D12 and Gayle Beck and Marv Goldfried of D12 and SSCP, and over the course of several teleconferences we were able to redraft a document that both parties could live with.

I came away from those discussions with the impression that I was witnessing SSCP at its finest. With input from the SSCP board and membership, we were providing important counsel to the Division, who in turn were creating a document with potential policy implications. Over the next couple of years I had the opportunity to participate in several of these dialogues, and it was clear to me that D12 found SSCP's input to be vital and helpful. These experiences got me thinking about...

Why APA Needs SSCP

In 1964 Leonard Krasner argued for the development of SSCP as:

...a section for APA members who identify themselves as both clinical psychologists and behavioral scientists. That is, they see a single role; the clinical psychologist is a behavioral scientist, whether he [sic] is doing clinical work, research, teaching or consulting. His role is the development of principles of psychology and their application in the assessment and modification of human behavior. The validation of the former depends on the latter; the utility of the latter depends on the former. They cannot be separated.

This perspective has remained relatively unchanged over the past four decades, and remains central to our identity as scientist-practitioners. As a division of APA, D12 must balance many divergent opinions, not all of which assign such a central role to empirical evidence and the scientific method. The D12 leadership, at least during my tenure, has nevertheless been unwavering in their desire for the scientist-practitioner perspective to be voiced as they develop policies and help define the identity of clinical psychology as a discipline. SSCP's input helps keep the board (who, in turn, advises the larger APA) focused on psychological science.

Why SSCP Needs APA

Just as APA needs SSCP, I suggest that SSCP also needs APA. I am aware that this suggestion is likely to be controversial among some of my colleagues (whose opinions I respect very much). Indeed, the relationship between SSCP and APA has been a perennial source of debate. In the Fall 2004 issue of *Clinical Science*, SSCP Past-President Scott Lilienfeld advocated disaffiliating from APA, noting:

The APA (1) does not brook, let alone encourage, open dissent from its divisions and sections, (2) is not firmly committed to scientific basis of clinical psychology, and (3) consistently places political considerations above science.

I would note, from the SSCP mission statement, that the stated purpose of the organization is:

...to affirm and continue to promote the integration of the scientist and the practitioner in training, research, and applied endeavors... The common bond of the membership is a commitment to empirical research and the ideal that scientific principles should play a role in training, practice, and establishing public policy for health and mental health concerns.

Assuming that we continue to strive for those ideals, what is the best way to proceed? Some of us might argue for secession: that SSCP leave APA altogether and instead focus its collaborative energy on the Association for Psychological Science (APS), an organization with which we currently enjoy a highly productive collaboration. Others might argue that we should simply become a free-standing organization with no ties to a larger organization. I would suggest that although our relationship with APS is a strength and should be nurtured, any move to disaffiliate from APA would not serve our aims well. APA, like it or not, remains the leading voice for the development of clinical training programs, mental health policy, and practice parameters for clinical psychologists. To leave APA would be to give up our seat at the table. As SSCP Past-President Kenneth Sher wrote in the Fall 2004 issue of *Clinical Science*:

...despite the constant frustration with the actions of various individuals and components of APA, I believe it is crucial that we maintain our affiliation and increase our influence and presence there if we want clinical psychology to continue to have a strong science base and enjoy the confidence of other health providers, the general public, insurers and governmental organizations. Indeed, given the rift between science and practice, which may be as large as it has ever been, the need to try to influence APA may never have been greater... If we (and other likeminded members) bail out of APA, who will be there to keep parochial guild interests (that are frequently anti-scientific) in check? Who will lobby for the highest academic and scholarly standards?

Similarly, in the Spring 2005 issue of *Clinical Science*, SSCP President Jack Blanchard wrote:

It is clear to me that SSCP's unique role within Division 12 and APA has not been diminished. Instead, our fundamental mission and purpose remains as critical as it ever was. There continue to be a range of controversies wherein SSCP provides a voice for those who are committed to clinical science. A few of these issues include: (1) the promulgation of empirically supported treatments in graduate training; (2) accreditation issues including the representation of academic psychology within the process and standards of accreditation; (3) Evidence based Practice as a policy within APA; and (4) training issues regarding prescription privileges. Thus, it appears

that controversy regarding the role of science within clinical psychology has not been resolved. The same compelling reasons that served as the foundation for the formation of this Section persist.

Does the pursuit of a stronger affiliation mean that SSCP will always agree with D12, or the larger APA? Certainly not. But if SSCP wishes to continue to make a meaningful difference in how psychology is taught, studied and applied in the U.S., they will do so most effectively from within the organization. Indeed, SSCP's relationship with APA (tenuous as it may be) is one of the few features that distinguishes it from other organizations such as the Society for Psychopathology Research or the Association for Behavioral and Cognitive Therapies (and I say this as a proud member of both organizations). Restricting our conversations to ourselves, or to only like-minded colleagues, will weaken, not strengthen, SSCP's voice.

I should note that my support of a stronger SSCP-APA relationship does not mean that I advocate a policy of appeasement. APA needs and will ultimately benefit from a strong voice from SSCP, even when that voice disagrees with the opinions and policies of APA. Indeed, some of SSCP's finest moments (in my opinion) have been when SSCP vigorously and publicly critiqued APA on topics such as prescription privileges for psychologists, anti-scientific continuing education programs, and psychologists' involvement in torture overseas. Those who have followed SSCP's recent history will recall Scott Lilienfeld's (*Clinical Science*, Fall 2004) clash with APA legal staff over published statements about prescription privileges. Although I am unable to find anything in the APA bylaws that would prohibit a section from publicly disagreeing with APA policy, I cannot guarantee that such clashes will not happen again. This is not, however, a valid reason to disaffiliate. Such conflicts are an inevitable and necessary part of a complex organization that combines legal policy, science, and, yes, politics. A strong SSCP can and should continue to stand up to APA when necessary to protect and promote clinical science. Continued affiliation need not mean that we agree to be censored.

It has been a pleasure walking this tightrope on behalf of SSCP, and I hope the organization keeps its balance over the coming years.

The author thanks Scott Lilienfeld, Bunmi Olatunji, & James Herbert for comments on an earlier draft.

APA Clinical Treatment Guidelines Advisory Steering Committee: Report of Activities

Thomas H. Ollendick, *Virginia Tech*

In September of 2010, the 9 members of the Steering Committee were appointed by the APA Board of Directors in collaboration with the Board of Professional Affairs (BEA), Board of Scientific Affairs (BSA), and the Committee for the Advancement of Professional Practice (CAPP). The Steering Committee is chaired by Steven Hollon and I am one of its 9 members. Our 3-year term of appointment began on January 1, 2011. However, our first face-to-face meeting occurred at APA Central Office, December 13-14, 2010, at which time and place our "charge" was delivered to us. The charge is as follows: "The scope of work of the Advisory Steering Committee includes: (1) establishing the process whereby APA will develop clinical treatment guidelines; (2) establishing criteria whereby clinical treatment guidelines topics will be identified for development; (3) formulating criteria whereby clinical treatment guideline development panels will be appointed; (4) determining the scope of clinical treatment guidelines; (5) determining the resources needed for the development of clinical treatment guidelines; and (6) commissioning independent systematic reviews of the relevant empirical research."

"The Advisory Steering Committee will oversee the guidelines development process, collaborate with governance and staff as appropriate, and provide consultation to the clinical treatment guideline development panels which will be appointed to write the guidelines. The Advisory Steering Committee will not write the guidelines nor will it be charged with conducting systematic reviews. But, the work of the Advisory Steering Committee is vital in shaping the Association's approach to the development of clinical treatment guidelines."

In addition to the December 2010 meeting, we met at APA Central Office February 13-14 and August 12-14. In addition to these face-to-face meetings we have monthly phone calls the third Tuesday of each month for approximately 1 hour in duration. We are also assigned to different subcommittees for work between our calls/meetings. I, for example, serve on

the "Mission, Vision and Principles" subcommittee.

To date, we have reviewed a number of papers related to the purpose and scope of treatment guidelines, as well as papers related to the selection of various topics for treatment guideline considerations and the process by which panels will be appointed to review the extant data base. At this time we are working out final details for our first three charges: "establishing the process by which APA will develop treatment guidelines," "establishing criteria whereby clinical treatment guidelines topics will be identified for development," and "formulating criteria whereby clinical treatment guideline development panels will be appointed." At this time, we have pretty much completed our first charge and the criteria are being refined for topic selection. We are tentatively pursuing the following topics: depression, obesity, oppositional defiant disorder and PTSD. We are still in the process of determining who should have input into the selection of topics. One really interesting notion is whether and to what extent clients themselves should have input into the selection of topics. As you can see, there are many facets to the work that lies ahead of us. The current plan is to put forth at least two topics for the first "trial set of guidelines." Also, in line with our charge, it can be seen that once the process by which topics are identified is completed, we then embark more fully on the criteria for selection of panels to undertake the systematic reviews. We are visiting the NICE guidelines as well as those put out by the Institute of Medicine and the Agency for Health Research Quality at this time.

All in all, the committee is making slow but steady progress in meeting its charge. It will be a long process, however. As is also painfully evident, there are a number of disorders/problems in living that deserve and will benefit from treatment guidelines. Will we ever catch up and meet those needs – the task is an enormous one! Importantly, however, SSCP is at the table and our input is being well received. It is my pleasure and distinct honor to serve the Society and our profession more broadly in this capacity.

Questions/comments/concerns may be addressed to me at tho@vt.edu or by phone (540-231 6451).

SSCP and APS Team Up to Develop New Job Mentorship Program

Bethany Teachman, *University of Virginia* -- SSCP Member-at-Large

In collaboration with the Association for Psychological Science (APS), SSCP is developing a new initiative to support job mentorship for our graduate students and post doctoral members. Specifically, this joint program is designed to connect psychological scientists working in non-traditional jobs with students looking beyond university departments of psychology for employment opportunities. The committee is planning to develop a searchable database that will connect students with psychological scientists working in a variety of roles so the students can learn from the psychological scientists directly how they attained their jobs and what the jobs involve.

The committee includes three representatives from APS (Sara Hitzig, APS Director of Membership, and Yvonne Asher and Tatyana Kholodkov, APS Student Caucus representatives) and three representatives from SSCP (Bethany Teachman, Member-at-Large on the SSCP Board, and Sara Stasik and Becca Brock, SSCP Student Board members). The goal for the initiative is to connect students wanting to learn about non-traditional psychological scientist jobs with people in those jobs. We will start with a focus on clinical science positions, and then plan to branch out to the field of psychological science more broadly.

The impetus for the new program follows from common reports of frustration by students at the lack of readily accessible information about finding non-traditional jobs following graduation, and faculty feeling unprepared to provide that mentorship. As faculty, many of us find it challenging to effectively advise our graduate students on professional development issues when they are seeking non-academic jobs, or even academic jobs in less traditional settings (i.e., not in departments of psychology or psychiatry). Not surprisingly, most of us know less about those other jobs, how to effectively find them, what's out there, how to be most competitive, etc. Often, on a case-by-case basis, faculty may try to put a student in touch with people in other positions so they can offer direct advice, or hold occasional lab meetings or departmental panels on these issues. However, this is a limited solution because it provides limited coverage of the available job options (each of us only knows so many people!), and requires a lot of repetitive effort because many individual faculty and departments are trying to do the same thing in a haphazard way on an annual basis.

By joining forces, SSCP and APS have access to a large network of members - the members share in common a commitment to psychological science but may work in very diverse roles. This closely matches the hopes many of us have for our students - we do not think our students all need to be traditional academics, but hope they will all work as psychological scientists in one capacity or another. Thus, it seems we can start to address the information access gap by working together and setting up a job mentorship network. Members who are interested, especially those who work in less traditional settings or roles, will be asked to complete a form describing their position and indicate if they feel comfortable being contacted. Students could then search the directory and contact those scientists who have jobs that they would like to learn more about.

Students, please stay tuned, and we look forward to sharing more news about the program soon, along with details about the searchable database launch.

Full members, please watch for a request soon asking you to share some information about your job, especially if you work in a non-traditional job or setting (broadly defined). The time commitment will be minimal, but we believe it can make a big difference for a student to be able to connect with someone actually working in their field of interest.

Thank you in advance for your support of early career psychological scientists and this new program!

Division 12 Highlights of 2011

David F. Tolin, Ph.D., ABPP -- Division 12 Representative
The Institute of Living and Yale University School of Medicine

1. Division 12 is pleased to welcome Mark Sobell as its new President-elect, and Robin Jarrett as its new Treasurer. Drs. Sobell and Jarrett will start in these positions on January 1, 2012.
2. With the help of SSCP, Division 12 amended its working resolution on the adoption of empirically supported treatments. The new resolution is as follows:

WHEREAS The Society of Clinical Psychology is firmly committed to identifying and promulgating interventions that work. Indeed, the Society was among the first organizations in mental health to compile a list of empirically supported treatments (ESTs) on the basis of supportive results from randomized clinical trials (RCTs). The Society is equally firm in its commitment to understanding how and under what conditions interventions work. Although RCTs address whether interventions work, it is desirable to also extend the research methods used and the constructs investigated to determine how, and under what conditions, these interventions work. Impressive developments in scientific knowledge, research designs, and researcher-practitioner collaborations now make this complementary, expanded goal feasible.

THEREFORE, to advance this broad view, the Society of Clinical Psychology advocates research into the processes of psychotherapy – those empirically supported factors, variables, and interventions that contribute to change in client/patient functioning. At this time, the randomized controlled trial (RCT) is the best available methodology for identifying efficacious treatments, and several well-supported therapeutic interventions have been identified for a wide range of psychological problems. The RCT is also the best available methodology for determining the differential efficacy of various treatments, and for dismantling multi-component treatments in order to determine which components contribute most strongly to clinical outcome.

However, RCT methodologies are limited in their ability to assess the relative contribution of other important ingredients that facilitate treatment change. There are several important questions about factors that contribute to change in psychotherapy, which can include client/patient, setting, and relationship factors, and that may mediate or moderate all psychotherapies in a similar manner, or they may exert a differential impact. We believe that such factors should not be overlooked, and should be studied using the best available methodology (including, but not limited to, correlational methods such as causal modeling or hierarchical modeling). Rigorous study of these variables, in addition to experimental efficacy research using RCT methodology, is essential for obtaining a full understanding of how interventions work, and for whom they work best. Thus, as a field, we need to value research designs that allow clear claims about the causal status of a given intervention, as well as those designs that can explain how variables other than the specific intervention affect outcomes. Greater research is needed on the specific role that social and cultural contexts play in achieving treatment outcomes and on the context in which a given intervention occurs. Research on both the efficacy and effectiveness of interventions is essential to build a comprehensive, evidence-based understanding of which interventions are most likely to help a given person, couple or family. This inclusive and evidence-based approach ensures that: 1) research on how preventive and tertiary interventions work and moderators of outcomes consider not only intervention strategies but also the participants, therapists, the therapeutic relationship, and contextual factors; 2) a wide variety of research methods are used as appropriate to the questions asked; and 3) research increases our understanding of both the common and unique principles on which effective interventions rest in order to enhance the use of participants, interactional, cultural, and technical factors in effecting change.

3. The board of Division 12 met in Ft. Lauderdale, FL on January 7-8, 2011. Some highlights:

Presidents' Reports: President Danny Wedding's primary initiative will focus on international psychology, with a goal of involving the division internationally. Past-President Marv Goldfried will continue his two way bridge initiative, and plans to continue this initiative in concert with Division 29. President-Elect Gayle Beck announced that her initiative will concern the issue of doctoral training for evidence-based practice.

Membership: The Division has a membership decline of about 5% annually, and our members' median age is 63. Several initiatives were launched following the meeting that aim to increase recognition of the Division among graduate students and early career psychologists. These include:

Facebook: The Division upgraded its Facebook page and promoted it more aggressively on the listserv and the web. As a result, we have seen an increase in viewers "liking" the page of nearly 400%. The page can be viewed at <https://www.facebook.com/#!/pages/Society-of-Clinical-Psychology-Division-12-of-APA/155569667748>.

Clinician's Toolkit: A number of paper items were generated for practicing psychologists, including an authorization to release healthcare information, client bill of rights, client registration form, clinical interview, consultation report, discharge report, group therapy progress note, intake report, mental status outline, progress note, request for release of evaluation information, and suicide risk assessment. These materials are available free of charge at <http://www.div12.org/clinicians-toolkit> and are branded with the Division 12 logo and web address.

Fact Sheets: Division 12 is in the process of developing Fact Sheets that will be available for free download on its web site. These sheets are intended to be handed out to clients, and address common questions such as: "What is a clinical psychologist?" "What is psychotherapy?" and "How do I choose between medication and therapy?"

Awards Committee: Division 12 is pleased to announce the winners of the annual awards. They are:

<i>Distinguished Scientific Award:</i>	Dr. Catherine Lord
<i>Florence Halpern Award:</i>	Dr. Steven Hollon
<i>Stanley Sue Award:</i>	Dr. Steven R. Lopez
<i>Toy Caldwell-Colbert Award:</i>	Dr. Thomas Oltmanns
<i>Millon Award:</i>	Dr. Robert Sellers
<i>Theodore Blau Award:</i>	Dr. Courtney Warren
<i>David Shakow Award:</i>	Dr. E. David Klonsky
<i>Samuel M. Turner Award:</i>	No awardee

Section Viability Memo/Responses: At the last Board meeting, questions were raised about membership size (should there be a minimum number of members for a section), proportionality (should sections' influence be proportional to membership size), and the 50% rule (should sections be required to have at least 50% of their members also be members of APA). The Sections unanimously expressed opposition to each of the proposals.

Internship Survey

We are gathering information about the internship process and possible solutions to some of the problems associated with this process.

We invite psychology graduate students, interns, post docs and faculty in psychology departments and at internship training sites to participate in this endeavor by completing an online survey.

Please also feel free to forward this email and link to anyone eligible to complete it.

The survey takes 10 to 15 minutes. It is anonymous and approved by the University of Mississippi's IRB. If you would like to participate in this study, click on the link below:

http://uofmississippi.qualtrics.com/SE/?SID=SV_7OhtZfzhlgmDWOE.

Please note that this is a revised version of the survey that was distributed last year. If you completed the previous version, we would like to invite you to respond again.

2012 APS CONVENTION

Diverse Perspectives

CALL FOR SUBMISSIONS

Including a special SSCP student Poster Session
www.psychologicalscience.org/convention

Open through
JANUARY 31, 2012

FEATURED SPEAKERS

Megan Bang, *University of Washington* • David H. Barlow, *Boston University*

Margaret Beale Spencer, *University of Chicago* • Howard Berenbaum, *University of Illinois at Urbana-Champaign*

Ellen Berscheid, *University of Minnesota* • S. Alexandra Burt, *Michigan State University*

Geraldine Dawson, *University of North Carolina at Chapel Hill*

Danielle Dick, *Virginia Institute for Psychiatric and Behavioral Genetics*

Joseph P. Gone, *University of Michigan, Ann Arbor* • Gail Goodman, *University of California, Davis*

Elaine Hatfield, *University of Hawaii, Manoa* • Elizabeth Hayden, *University of Western Ontario, Canada*

Cynthia Huang-Pollock, *Pennsylvania State University* • James S. Jackson, *University of Michigan, Ann Arbor*

Thomas Kratochwill, *Wisconsin Center for Education Research* • Helen E. Longino, *Stanford University*

Tiago V. Maia, *Columbia University* • Rick Mayes, *University of Richmond*

Richard Milich, *University of Kentucky* • Brenda Milner, *McGill University* • Matthew K. Nock, *Harvard University*

Patrick Onghena, *Katholieke Universiteit Leuven, Belgium* • Arnaud Rey, *CNRS- Université de Provence, France*

Henry L. "Roddy" Roediger, III, *Washington University in St. Louis*

Barry Schwartz, *Swarthmore College* • Richard A. Shweder, *The University of Chicago*

May 24-27, 2012

ASSOCIATION FOR
PSYCHOLOGICAL SCIENCE
24th Annual Convention

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