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Psychological Clinical Science Accreditation System: FAQs and Facts

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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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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.