



Editorial: Connecting Clinical Practice to Scientific Progress

Author(s): Walter Mischel

Source: *Psychological Science in the Public Interest*, Vol. 9, No. 2 (November 2008), pp. i-ii

Published by: Sage Publications, Inc. on behalf of the Association for Psychological Science

Stable URL: <http://www.jstor.org/stable/20697319>

Accessed: 07-02-2017 15:41 UTC

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at

<http://about.jstor.org/terms>



Sage Publications, Inc., Association for Psychological Science are collaborating with JSTOR to digitize, preserve and extend access to *Psychological Science in the Public Interest*

Editorial

Connecting Clinical Practice to Scientific Progress

Walter Mischel*Columbia University*

Paul Meehl, in one of his last public speeches, memorably noted that most clinical psychologists select their methods like kids make choices in a candy store: They look around, maybe sample a bit, and choose what they like, whatever feels good to them. For many of us who initially became clinical psychologists because we were inspired by the scientist-practitioner ideal, Meehl's comment was as heartbreaking as it was accurate. It makes particularly compelling the article that follows, "Current Status and Future Prospects of Clinical Psychology: Toward a Scientifically Principled Approach to Mental and Behavioral Health Care" by Baker, McFall, and Shoham. This urgently needed and long overdue analysis and proposal will be welcomed by those who grieve the widening gulf between clinical practice and scientific progress in psychology. And it offers giant but feasible steps toward reforms that can advance both clinical practice and relevant psychological science, to at last reverse the disconnect that has been unfortunate for each.

The authors' proposal for a "scientifically principled approach to mental and behavioral health care" is an incisive and scholarly analysis of where clinical psychology is (and is not) today, how it got there, and how it will increasingly discredit and marginalize itself if it continues the trajectory it has pursued for far too many years. But it is also much more. The article makes clear the heavy costs and consequences to the profession, and more important to the people who have a right to expect much more from their health care providers. Most exciting, it charts a route toward a scientifically principled and thus responsible approach to the mental and behavioral health care that our science can offer and that those who suffer from mental and behavioral problems deserve to get.

The disconnect between much of clinical practice and the advances in psychological science is an unconscionable embarrassment for many reasons, and a case of professional cognitive dissonance with heavy costs. The Boulder Model of the scientist-practitioner, now mostly a historical footnote and a cue for depression, came half a century ago when psychological science was still somewhere between its infancy and its turbulent adolescence. Evidence for most assessment and treatment methods for clinical psychology was still far from solid, and

usually highly dubious, making the choices of practitioners "like kids in a candy store" more understandable. The distressing cognitive dissonance now is that the science has advanced dramatically over the last 50 years, and there are now numerous state-of-the-science-based and empirically supported choices for assessment and for treatment, yet practitioners too often still choose to do whatever they feel like, as Meehl described, regardless of evidence.

In my own career, I struggled with these issues beginning in the 1960s. During many of my 20 years at Stanford University, Albert Bandura and I tried to hold on to a science-based clinical training program. The bizarre situation we faced there is of more than personal and historical interest: I suspect that many of the same conflicts still exist and motivate the efforts described by Baker and colleagues. Bandura and I, and our students and other colleagues, were discovering the remarkable discrepancies between what the scientific work was revealing and the requirements imposed by the pressures for maintaining accreditation. The professional accreditation requirements insisted on continuing practices whose value was contradicted by the empirical findings. Those requirements not only flew in the face of the data but also made enormous demands on faculty and student time in the clinical program. At one point, Bandura made a table of faculty arrivals and departures in our clinical program. It showed rapid, continuous turnover among the junior faculty in clinical, because those who devoted their time to clinical work and were good at it generally did not meet the academic standards, and vice versa, so accepting a clinical position at Stanford almost guaranteed no future in the university. For a temporary solution, we turned the clinical program into one on experimental psychopathology. It included more experimental work and research, most of it within clinical settings and directly relevant to clinical applications. In it we also could move away from techniques that neither of us believed in, given the data, and that both of us were trying to change—from costly tests with little or no validity to therapies without evidence of efficacy but on which the American Psychological Association insisted for clinical programs and for acceptable internship experiences. It became a program that helped train many of the people who

became leaders in the development of cognitive behavior modification and assessment. And as the pressures grew, it became impossible to maintain.

Baker, McFall, and Shoham make a compelling case for what many of us have long believed: A realistic route for change requires a new accreditation system that demands high-quality science training and insists on it as part of the core for doctoral training in clinical psychology. The good news—the first in a very long time on this topic—is that such a system is here in the new Psychological Clinical Science Accreditation System (PCSAS). Its mission is to “accredit clinical psychology training

programs that offer high quality science-centered education and training, producing graduates who are successful in generating and applying scientific knowledge” (p. ii). It is a mission that deserves the strongest support.

Support for the movement toward a scientifically principled clinical psychology has self-evident potential benefits to the public, to the profession, and to our science. It’s also worth remembering that many of our best students still enter psychology to become clinical psychologists. They deserve the opportunity to do such work informed and guided by evidence, trained to evaluate it properly, and able to add to it themselves.