In 1994, Gerry Koocher, who had been elected President of Division 12 (Clinical Psychology) of the American Psychological Association (APA), asked me to chair the Task Force on Effective Psychosocial Interventions: A Lifespan Perspective. This was to be a task force that complemented the previously established Division 12 Task Force on Promotion and Dissemination of Psychological Procedures, chaired by Dianne Chambless. The Chambless task force had been appointed by David Barlow, who was president of Division 12 at that time; it received its initial direction primarily from members of Section III (Society for a Science of Clinical Psychology). The Lifespan Task Force was to expand the focus to populations that included children and older persons, populations that had not received much attention during the early efforts of the Chambless task force. However, the goal of both task forces was to highlight those interventions that had empirical data to support their effectiveness. Both continued to work in tandem for several years. I sat on the Chambless task force while the Lifespan Task Force used slight modifications of the Chambless criteria for determining which treatments had empirical data in support of their effectiveness with children and older populations. Three sections played central roles in the Lifespan Task Force: Section I (Clinical Child Psychology); Section II (Clinical Geropsychology); and Section V (Society of Pediatric Psychology). Each has published their work: Section I in the Journal of Clinical Child Psychology (1998, vol. 27), Section II in the Journal of Mental Health and Aging (1998, vol. 4); and Section V in the Journal of Pediatric Psychology (this issue). The efforts of both task forces were ultimately combined into a single effort that continues under the auspices of Division 12; William Sanderson is the current chair.

When I agreed to chair the Lifespan Task Force at Gerry Koocher’s request, I did so out of a certain naïve belief that psychology has effective interventions, we can document the effectiveness of those interventions, and that we have a certain obligation to let the public know “what works.” “Bragging” about what psychology can do seemed like one of the better jobs I had ever been offered. Although the work was certainly gratifying, and I am extremely proud of the accomplishments of all of the sections involved, I also learned a few things in the process. Perhaps most surprising to me was the amount of rancor these activities elicited in fellow psychologists! Division 12 was under constant attack for attempting to publish any list of any treatments that worked! The Chambless task force, being the first, was the major focus of these attacks. Some of these attacks came on the floor of APA’s Council of Representatives, others were published (see Smith, 1995; Garfield, 1996, and response by Chambless, 1996). In the 1995 and 1996 reports of the Chambless task force, the Author Note contains the usual author correspondence information. By 1998, it is a long disclaimer stating that the report is the work of individuals and does not represent “official policy” of either the division or APA.
What was this opposition really about? In the space allotted, I certainly cannot address all of the issues involved, some of which are quite complex. However, it was clear that some colleagues feared that a “list” of treatments that “worked” would somehow limit their ability to choose the best treatment approach for a particular patient. They worried that managed care organizations could use the list to dictate what would be reimbursed, further limiting their activities. At the time, I was surprised by this perspective. I had naively thought that my colleagues would applaud our efforts to inform the public, including managed care, about all that psychology could do. Looking back, I know realize that my lifetime experiences working as a pediatric psychologist in a medical setting have given me a far different perspective from that of the independent practitioner seeing mental health patients in a private office. Practice guidelines are simply part of the health care world. Physicians think nothing of writing policy statements and guidelines of all types. As an example, the American Academy of Pediatrics, one of the most respected health care organizations in the United States, lists hundreds of policies and practice parameters on their website (http://www.aap.org/policy/pprgtoc.html).

Physician training and psychologists’ training differ in a number of important respects. Physicians are taught to make decisions, given the available data, while psychologists are taught to critique the available data, always recognizing the limitations of what we know. This is no doubt an oversimplification of each profession’s training experiences and yet, time and time again, I have seen psychologists undermine their own profession. We are so good at identifying methodological weaknesses and limitations to our knowledge base that we are uncomfortable saying anything about what we do know. This may make us excellent scientists in a theoretical sense but can undermine our science and profession in a practical sense. Although practitioners may have delivered the most vocal attacks on the work of the Division 12 task forces, those of us who have worked on the task forces have faced the ire of fellow scientists, who complain that our methods are too crude and that certain treatments listed as “well-established” or “probably efficacious” do not “deserve” such a listing. Debate is a healthy thing and I would never want to imply that the task forces’ work should be accepted without question. Yet I sometimes think we spend more time criticizing each other than we do promoting our accomplishments. In the meantime, other health professions are more than willing to write practice guidelines and identify standards of care in areas where psychology has greater expertise. The scientist-practitioner model of training makes our profession unique among all health care professions; no other health profession is so well trained to both create new information and to use available information critically. Certainly, psychology should play a central role in health care. Will it? The answer depends on how psychologists choose to spend their time. Will they continue a negative, protracted internal battle or will they learn to showcase psychology’s many accomplishments to the health care industry and to the public at large?

Received February 7, 1999; accepted February 8, 1999

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