

THE CLINICAL PSYCHOLOGIST



A publication of the Society of Clinical Psychology (Division 12, American Psychological Association)

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EDITORIAL

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By J. Gayle Beck, Ph.D.,
University of Memphis, TN

PRESIDENT'S COLUMN

Already?

As my presidential term draws to a close, I want to thank those of you who have offered me support and assistance along the way. It has been an honor to serve as the President of the Society and I am thankful for this opportunity. I have had the good fortune to work with a team of consummate professionals (Danny Wedding, Immediate Past-President, Mark Sobell, President-Elect, John Linton, Secretary, Barbara Cubic, Treasurer, and Lynn Peterson, Administrative Officer), which has made the job both more enjoyable and easier. We have traveled an interesting journey during this past year and it has been wonderful to be part of this august group during this era. For this and more, thank you!

Looking ahead – Leadership opportunities

Would you like to participate in a leadership position within the Society? Do you know someone who would fit this role but who is a bit reticent to put themselves forward? If you answer to either of these questions is 'yes', please consider nominating yourself or your shy colleague for one of the four available leadership positions:

- President
- Secretary
- Representative to APA Council (two positions)

Nominations are due by November 30th. Nominations may be submitted only by Division 12 members, who must sign the nomination. Candidates must be Members or Fellows of Division 12. No individual may run simultaneously for more than one elected Division 12 office or Board of Directors seat and no individual may simultaneously hold two elected seats on the Board of Directors. Please send your letter of nomination to Lynn Peterson, div12apa@comcast.net.

Hawaii – is it in your future?

The annual meeting of the American Psychological Association will be July 31 – August 4, 2013 in Honolulu, Hawaii. The submission deadline is November 16th (for papers, posters, and symposia). The call for submissions can be found here: <http://www.apa.org/convention/call-for-programs.pdf>. The Society's program chair for the 2013 convention is Katie Witkiewitz,

(continued on page 2)

President's Column (*continued*)

PhD, who can be reached at the Department of Psychology, University of New Mexico, Albuquerque, NM 87131; (505) 277-4121; witkiewitz@gmail.com.

By-laws revision

In an effort to keep the divisional leadership structure current and transparent, the Executive Committee agreed that the Society by-laws were in need of updating. Some of the proposed changes can best be categorized as “housekeeping” while others are more substantive in nature (e.g., providing an expanded definition of accrediting organizations). These specific changes have been emailed to you and require a vote.

As you work your way through the proposed by-laws changes, please consider the Pro/Con statements that accompany the substantive changes. We thank the By-Laws Work Group (Mark Sobell [chair], Larry Beutler, Danny Wedding, and Doug Mennin) for their tireless efforts in re-vamping our by-laws.

Fall working meeting

It is common for the Society to hold a Board of Directors meeting every winter. What is less common is for the Society to host a working meeting for committee chairs. This October, select committee chairs will be headed to Memphis, Tennessee, to brainstorm new ideas for

DIVISION 12 BOARD OF DIRECTORS

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Section 9: Assessment Psychology (2011-13)

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Section 10: Graduate Students and Early Career Psychologists

(2011-13) Brian Hall, M.A.*

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Technology Update: Zeeshan Butt, Ph.D., Northwestern University

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VII: Marc Hillbrand, Ph.D., Connecticut Valley Hospital

VIII: Rita Hauera, Ph.D.

IX. Norman Abeles, Ph.D., ABPP, Michigan State University

X. Brian Hall, M.A., Kent State University


GRAPHIC DESIGN

Jason Crowtz



enhancing our membership services, particularly ideas that will involve our new web-site. The group will include John Pachnankis (Chair, Education and Training Committee), Barbara Cubic (Treasurer), Damion Grasso (Web Editor), Deb Drabick (Chair, Committee on Science and Practice), Katie Gordon (Membership Committee), Gayle Beck (President), and Lynn Peterson (Administrative Officer). We hope to emerge with a focused plan for developing our continuing education portfolio, including integration of these offerings as a

membership benefit. Financing the cost of this working meeting is made possible by a less-expensive Board of Director's meeting this year, resulting in a win-win for the Society.

As I close my final TCP column, I am amazed at how quickly this year has flown by. This has been an interesting and multi-faceted experience, both professionally and personally. As I pass the torch to Mark, I know that the Society is in good hands. Again, thank you for this rare and remarkable opportunity!. 

BECOME A DIVISION 12 MENTOR

Section 10, *Graduate Students and Early Career Psychologists*, has developed a **Clinical Psychology Mentorship program**. This program assists doctoral student members by pairing them with full members of the Society. We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit www.div12sec10.org/mentorship.htm, and visit www.div12.org/mentorship to become a mentor today!

Bridging the Gap Between Research and Practice in VA Psychotherapeutic Care

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Mental Health Services, U.S. Department of
Veterans Affairs



As the Division 12 Special Committee on Science and Practice has duly noted (Teachman et al., 2012), the gap between clinical research and clinical practice continues to be a concern for psychologists despite good progress on the foundations of that “bridge”. The U.S. Department of Veterans Affairs (VA) has been working to address this gap by developing and implementing systems that bring psychotherapy research to bear on clinical practice (Ruzek, Karlin, & Zeiss, 2012) and that also allows the experience of clinical practitioners to inform the design and adaptation of mental health provider training and mental health care.

The VA health care system is the nation’s largest integrated health care system and focuses on the provision of evidence-based, interdisciplinary, and integrated care for the physical and mental health prob-

lems of our nation’s Veterans across the course of their lifetimes. VA employs over 20,000 full-time equivalent (FTE) mental health care professionals, which includes over 3,000 FTE psychologists, and is the largest provider of training in psychology in the nation.

In 2004, VA developed a Mental Health Strategic Plan (MHSP) in response to the report by President’s New Freedom Commission on Mental Health (2003), which called for the implementation of evidence-based approaches in mental health treatment. Recognizing that there was a low delivery rate of such approaches in most mental health settings, VA saw this as one opportunity to begin to bridge the gap between mental health research and practice. A guiding principle of the MHSP was that mental health care is an essential component of overall health care. The MHSP had many goals including reducing the stigma associated with mental illness, ensuring equitable access to mental health services, building collaborative care models in primary care, and promoting recovery through evidence-based care.

To complete the implementation of the MHSP, VA Handbook 1160.01, Uniform Mental Health Services (UMHSH) was developed which defines the minimum mental health services that must be provided to all enrolled veterans who need them, regardless of where they receive care in VA. These requirements are described at a broad level so that there are opportunities for local choice to address variations found at VA facilities, which are located in areas that range from highly rural to urban settings and include sites in all 50 states and the US territories. UMHSH, VA/Department of Defense Clinical Practice Guidelines, and other policy documents specify the evidence-based psychotherapies (EBPs) and behavioral interventions that must be available to Veterans who need them. These EBPs augment the existing offerings that are a part of VA mental health care.

To promote the availability of EBPs and ensure a well-trained clinical workforce, VA has developed national initiatives, which include competency-based training programs, to disseminate a broad array of evidence-based psychotherapies for PTSD, depression, serious mental illness, insomnia, substance use disorders, relationship distress, and motivation (Karlin et al., 2010, 2012; Ruzek, Karlin, & Zeiss, 2012. As of August 2012, VA has provided training in one or more

Bridging the Gap (continued)

EBPs to more than 6,000 staff.

The psychotherapy training literature has demonstrated that developing EBP competency requires didactic training that incorporates role-playing, skill practice, observing adept modeling of therapy skills, and expert supervision on training cases (e.g., Rakovshik & McManus, 2010; Sholomskas & Syracuse-Siewert, 2005). Accordingly, VA's psychotherapy training model for each of these initiatives involves two key components designed to promote skill mastery: attendance at an in-person, experientially-based multi-day workshop; followed by weekly expert consultation on actual therapy cases at the clinician's home facility for a period of approximately 6 months. Each VA EBP training program has defined criteria for completion of training and many involve the submission of audiotaped sessions that are rated for adherence to the protocol.

Each training program has also established detailed

evaluation systems that examine training effectiveness, therapist adherence to protocols, implementation of the therapy or intervention, and patient outcomes. Program evaluation data from several of these training programs (Acceptance and Commitment Therapy, Cognitive Behavioral Therapy, Cognitive Processing Therapy [CPT] and Prolonged Exposure Therapy [PE]) have been very promising, with positive training outcomes being demonstrated, and more importantly, Veterans showing significant treatment gains when treated by VA clinicians trained in these therapies (Chard et al., 2012; Karlin et al., 2010, 2012). Of note, these outcomes are achieved with Veterans who often have significant medical and mental health comorbidities in addition to the target complaint being addressed by the EBP. VA continues to collect program evaluation for these and the other EBPs that are being disseminated, which will allow for further review of the effects of

APA DIVISION 12 – NOMINATION BALLOT

Dear Division 12 Colleague:

Once again it is time to request your participation in the Division's nomination process. We will be selecting four positions: **President, Secretary**, and two **Representative to the APA Council**. You may enter the names on the ballot of any Division 12 members whom you believe would serve the Division well.

Thank you for your participation in the nominations and elections process. **Ballots must be postmarked on or before Friday, November 30, 2012.**

Sincerely yours,
J. Gayle Beck, 2012 President

NOMINATIONS BALLOT POLICIES

1. Nominations may be submitted only by Division 12 full members.
2. The Division 12 member must electronically sign the ballot.
3. Nominations ballots must be completed on or before **November 30, 2012.**

ELIGIBILITY REQUIREMENTS

1. Candidates must be Members or Fellows of Division 12.
2. No individual may run simultaneously for more than one elected Division 12 office or Board of Director seat.
3. No individual may simultaneously hold two elected seats on the Board of Directors.
4. No individual may hold the office of President more than once.

OFFICIAL DIVISION 12 NOMINATIONS BALLOT

PRESIDENT: _____

SECRETARY: _____

REPRESENTATIVE TO THE APA COUNCIL: _____

REPRESENTATIVE TO THE APA COUNCIL: _____

Your name (please print): _____ Your signature: _____

SEND THIS BALLOT TO:

*Society of Clinical
Psychology,
P.O. Box 1082,
Niwot, CO 80544*

YOU ALSO MAY MAKE YOUR NOMINATION **ON LINE** AT: www.div12.org/2012-call-nominations

EBP delivery across the VA system.

Evidence-based training methods must be supplemented with additional systems-level interventions if these EBPs are to be successfully implemented. To aid with facility-level EBP implementation, every VA medical center has an EBP-trained clinician who devotes a third of his or her time to serving as a Local Evidence-Based Psychotherapy Coordinator. These staff serve as local champions who educate VA staff and leadership about EBPs, encourage providers to attend and complete EBP training, and work with management on identifying and addressing system barriers in order to improve the local implementation of EBPs (Sullivan, Blevins, & Kauth, 2008). To further ensure that EBPs are available to all Veterans in need, VA recently began implementing a national initiative to promote the delivery of CPT and PE telemental health services, by funding the placement of VA staff at targeted sites to provide these EBPs via clinical

video conferencing (CVT) to Veterans located at remote VA clinics and at non-VA community sites, such as colleges and universities.

Additionally, documentation templates for these EBPs will soon be implemented that will be available for clinicians' use in VA's electronic medical record. These templates will help VA to track EBP delivery and assess aggregated patient outcomes in response to these treatments by using embedded health factors and validated assessment instruments. These templates may also serve to reinforce clinician fidelity to the therapy protocols since they ask the clinician to report on whether key components of the treatment were incorporated into particular sessions.

A particular strength of VA is its ability to develop and engage intervention-specific communities of practice within the larger system. Intranet websites have been created to support those delivering several of the

IS HAWAII IN YOUR FUTURE?

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JOIN THE SOCIETY OF CLINICAL PSYCHOLOGY IN HONOLULU, HAWAII AT THE 121ST APA ANNUAL CONVENTION

The next annual meeting of the American Psychological Association will be July 31 – August 4, 2013 in Honolulu, Hawaii. The submission deadline is November 16th (for papers, posters, and symposia). The Society's program chair for the 2013 convention is Katie Witkiewitz, Ph.D. She can be reached at the Department of Psychology, University of New Mexico, Albuquerque, NM 87131; (505) 277-4121; witkiewitz@gmail.com.

Call for submissions: www.apa.org/convention/call-for-programs.pdf

For more information on the convention and the activities of the Society of Clinical Psychology, contact Lynn Peterson, Division 12 Central Office (Tel: 303-652-3126, E-mail: div12apa@comcast.net).

disseminated EBPs, with more under development. These websites have fostered communities of practice and allow for information sharing and access to EBP materials. Some of these sites make available advanced training materials, video- and audio-taped lectures, video vignettes of therapy, examples of adapted therapy materials for special populations (such as modified therapy worksheets for Veterans with traumatic brain injury or other cognitive impairments) and more. Staff trainers and clinician trainees interact via scheduled teleconference sessions as well as in online forums, in part to discuss challenging cases and relevant new research. Field staff members are active participants in these interactions and often provide important new information that is useful to their EBP-trained peers and the EBP training program staff as the training programs mature. In addition to these EBP-specific programs, there are related clinical communities of practice such as the PTSD Mentoring Program, which fosters clinical best management practices by supporting regional experts in their mentoring of other VA PTSD program administrators (Bernardy, Hamblen, Friedman, Ruzek, & McFall, 2011). These mentors actively assist the mentee program managers in how to effectively implement delivery of CPT and PE in their clinics.

In summary, VA provides a promising example of how a large health care system can help to bridge the gap between clinical research and clinical practice in a manner that leads to better outcomes for our nation's Veterans. This approach incorporates both centrally designed and administered training and implementation components and systems for monitoring clinician feedback and expertise to inform VA leadership and training program staff about how to effectively disseminate, implement, and adapt these treatments to meet the needs of our Veterans.


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Subgroup Differences in Asian Americans

Minsun Lee, Ph.D.

Drexel University

 Asian Americans comprise 4.8% of the total U.S. population. When people who are Asian combined with at least one other race, Asian Americans make up 5.6% (United States Census Bureau, 2012). Asian Americans are viewed as a group, partly because many of their cultures share similar values such as preservation of harmony, respect for elders, a high degree of professional and academic success, high valuation of family, education and religion. These common Asian values have contributed to portraying them as a group of successful, highly educated, intelligent, and wealthy individuals, which is frequently characterized as a “model minority.” Although the concept of model minority implies positive connotation and appears to elevate Asian Americans, it overly generalizes the homogeneity of Asian Americans that involves 47 groups of Asian Americans with more than 300 languages that have a variety of histories, religions, and cultures. The model minority stereotype also tends to mask real economic, cultural and psychological problems many Asian Americans face in the process of being integrated into mainstream society. As a clinical psychologist, understanding the variation in Asian American socio-cultural backgrounds is important to provide culturally sensitive and competent psychological services (Nezu, 2010).

Studies have shown that Asian Americans suffer from various psychological problems and that there are differences in patterns of mental health status and use of mental health-related services at the subgroup level (Tummala-Narra, Alegria, and Chen, 2012; Sorkin et al., 2011). In their study that compared 496 Chinese, 255 Filipinos, 87 South Asians, 263 Japanese, 288 Koreans, and 175 Vietnamese, all of whom were aged 55 years and older, Sorkin and colleagues found that Filipino (20.3%) and Korean (18.0%) older adults were significantly more likely than other Asian groups to report symptoms of mental distress. Compared to their white counterparts (9.7%), Chinese (12.0%), Vietnamese (14.2%), and South Asian (12.7%) reported significantly more symptoms.

However, Japanese respondents (3.6%) were significantly less likely to report symptoms indicative of mental distress than other Asian groups as well as their white counterparts. According to the authors’ interpretation, Filipino Americans seem to experience greater immigration stress in spite of their relatively good English proficiency and high education. It is likely that many of them undergo under- or unemployment or decreased social status in the US considering that many of them were professionals who left Philippines due to the poor economy but their professional degrees are not recognized in the US. For Korean American older adults, high rates of poor English proficiency coupled with the lack of insurance may leave them vulnerable in spite of more than 15 years of stay in the US and high education and employment status. The finding about the significantly low rate of mental distress among Japanese older adults is somewhat inconsistent with previous studies. However, the Japanese respondents in the study were more likely to be born in the US (67.8%) compared to other older Asian Americans less than 10% of whom were born in the US. Therefore, they may not have experienced the level of migration and acculturative stress that other Asian immigrants faced. Regarding mental health service utilization, in general, East Asians such as Korean, Japanese, and Chinese were less likely to make use of mental health services compared to South Asians including Indian, Vietnamese, and Filipino.

A study comparing different Asian American subgroups with a broad range of age revealed somewhat different results although it confirmed heterogeneity of Asian Americans. Based on the data from National Latino and Asian American Study (NLAAS) collected between May 2002 and November 2003 from respondents who were 18 years of age or older, Tummala-Narra and Colleagues (2012) found that Chinese and combined group of Korean and Japanese are more likely to experience acculturative stress than South Asians, Vietnamese, and Filipinos independently from English proficiency and year in the U.S. Filipinos reported lowest level of acculturative stress among the Asian American subgroups. The combined Korean and Japanese group was at the highest risk for depression among the subgroups controlling for demographic variables and acculturative stress.

Asian American subgroup differences were also found in endorsement of somatic symptoms of depres-

sion. It is commonly known that Asian Americans tend to somatize their psychological distress. However, in their study that examined ethnic difference of somatic symptoms of depression such as changes in appetite, sleep disturbance, fatigue, and psychomotor symptoms among Asian American adolescents, Pang and colleagues (2010) found that in general, South Asians, Filipino and Vietnamese had significantly higher endorsement of somatic symptoms than Chinese and Japanese.

There is not enough research to date to establish a consistent pattern of subgroup differences in Asian Americans mental health status. However, an emerging body of research has begun recognizing the marked heterogeneity of Asian Americans and the impact of their unique culture and history on their mental health status. Identifying the subgroup differences among Asian Americans will be essential in providing culturally responsive services.

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INSTRUCTIONS FOR ADVERTISING IN THE CLINICAL PSYCHOLOGIST

Want-ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of *The Clinical Psychologist*. Ads will be charged at \$2 per line (approximately 40 characters).

Originating institutions will be billed by the APA Division 12 Central Office. Please send billing name and address, e-mail address, phone number, and advertisement to the editor. E-mail is preferred.

For display advertising rates and more details regarding the advertising policy, please contact the editor.

Please note that the editor and the Publication Committee of Division 12 reserve the right to refuse to publish any advertisement, as per the advertising policy for this publication.

Submission deadlines for advertising and announcements:


Winter issue: January 3
Spring issue: April 1
Summer issue: July 1
Fall issue: October 1

Editor: Milton Strauss milton.strauss@gmail.com



Children, Adolescents, and Clinical Psychology Organizations: Division 12's “Empty Nest”

Donald K. Routh, Ph.D.,
University of Miami

 When Lightner Witmer founded his Psychology Clinic in 1896 at the University of Pennsylvania, it was mostly for the purpose of helping children referred by the schools. While Witmer did not exclude adults from the services his clinic offered, he did not see many of them. In many respects, Witmer's work resembled the modern field of school psychology more than it did the clinical psychology of today. J. E. W. Wallin and Leta Stetter Hollingworth, the founders of the American Association of Clinical Psychologists in 1917 (the precursor of Division 12), were similarly mostly involved in work with children. In fact, the whole field focused on children, right up to World War II.

Pearl Harbor changed all this. Many clinical psychologists were needed for work with the armed services, most commonly in the assessment and treatment of military personnel. The same was true of the post-war era, when the Veterans Administration was asked to help thousands of individuals with mental problems returning from the war. Massive government funds were poured into clinical psychology training, leading to the development of an accreditation system for university training programs, internships, and postdoctoral fellowships. The demands of these times profoundly affected the nature of clinical psychology, changing it into an adult-oriented field, as it still is today. The Division of Veterans Affairs continues to be the largest employer of clinical psychologists in the United States.

It is true that even in the 1940s and 1950s some clinical psychologists continued to work primarily with children, and a few of them eventually sought recognition from colleagues for their distinctive activities. In 1959, Alan Ross, who at the

time worked for the Pittsburgh Child Guidance Clinic, wrote a book titled *The Practice of Clinical Child Psychology*. In 1962 Ross founded the Section on Clinical Child Psychology, which was the first organized special interest group within the Division of Clinical Psychology (“Section 1”). Ross eventually moved on from the child guidance center to become a professor at Stony Brook University in New York. He was subsequently a president of Division 12.

In 1968, Section 1 fostered the emergence of a group of colleagues who worked with children in medical settings, the Society of Pediatric Psychology. The leaders of the group included Logan Wright, Lee Salk, and Dorothea Ross. In 1980, it became an organized group within the Division as well (“Section 5”). Logan Wright eventually became a president of Division 12 and later of APA.

Both of these child sections grew in membership, held programs both at the APA conventions and independently, and sponsored scholarly journals. Partly as a result of these sections' advocacy, many universities now offer specialized doctoral training in clinical child and pediatric psychology.

After over 35 years of affiliation with Division 12, these child groups decided that it was time for them to seek independent Division status within the APA, and in 1999 two new organizations were formed: the Society of Clinical Child and Adolescent Psychology (Division 53) and the Society of Pediatric Psychology (Division 54). The founding president of Division 53 was John Weisz, who is now the director of the Judge Baker Guidance Center in Boston and professor of psychology at Harvard. F. Daniel Armstrong, the founding president of Division 54, is director of the Mailman Center for Child Development and professor of pediatrics and psychology at the University of Miami. Sections 1 and 5 of Division 12 disbanded themselves. The new groups have both proved themselves to be viable and seem to be permanent ones. In general, their members still identify themselves as clinical psychologists, and many of them continue to be affiliated with Division 12. ■■

Advances in Psychotherapy

Evidence-Based Practice

- ✓ Authoritative
- ✓ Evidence Based
- ✓ Practice Oriented
- ✓ Easy to Read
- ✓ Compact
- ✓ Inexpensive

Developed and edited with the support of the Society of Clinical Psychology (APA Division 12)

Series Editor:

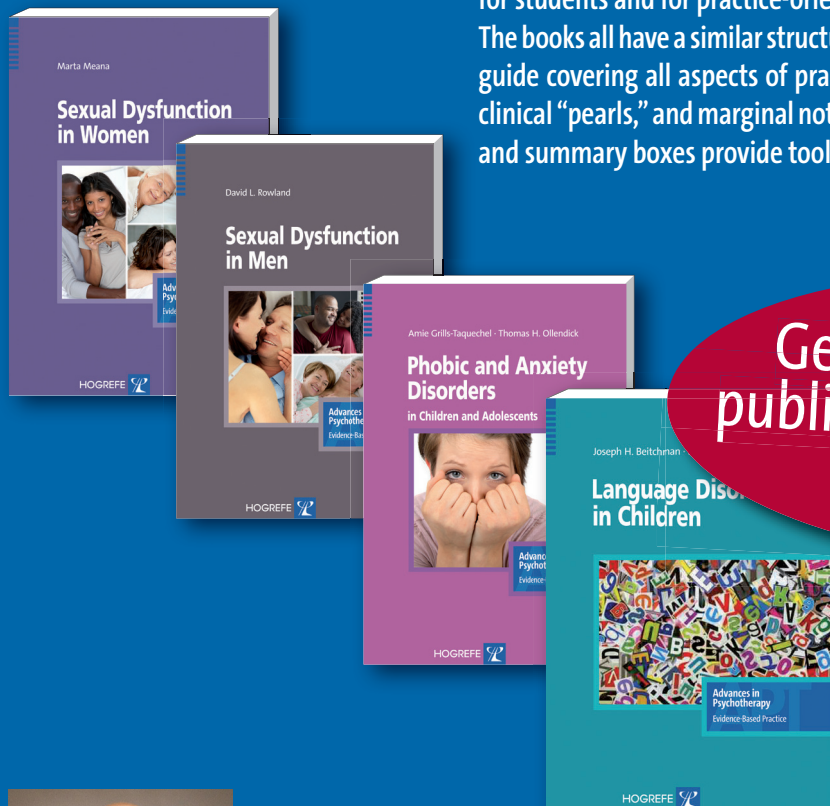
Danny Wedding

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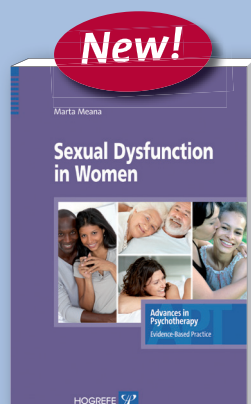
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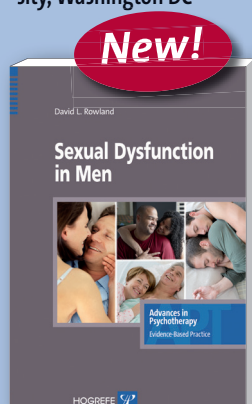
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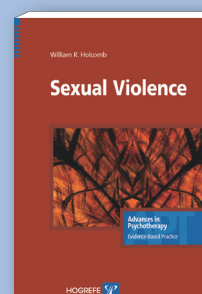
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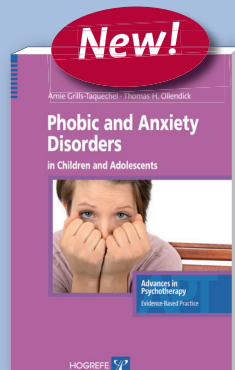


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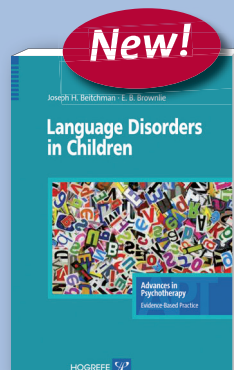


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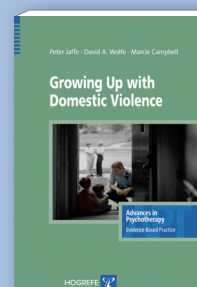
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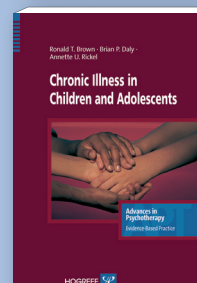
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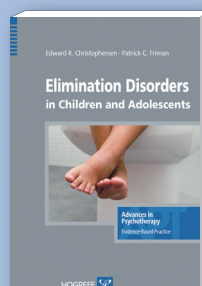
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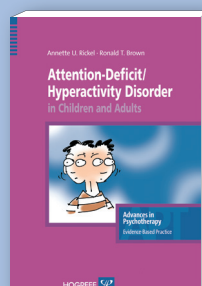
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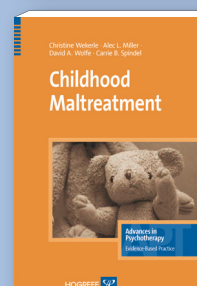
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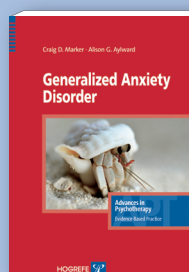


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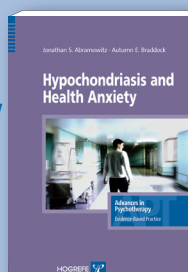


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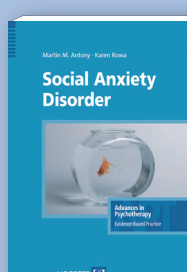
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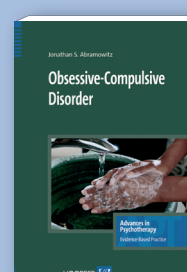
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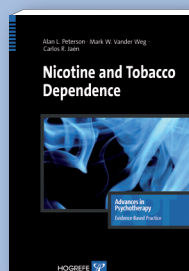


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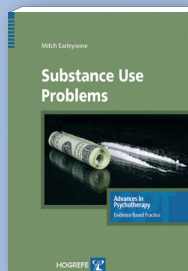


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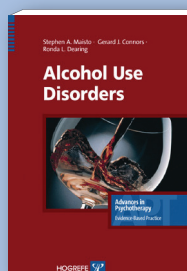
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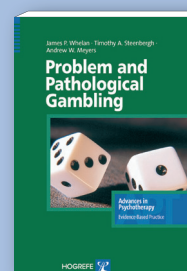
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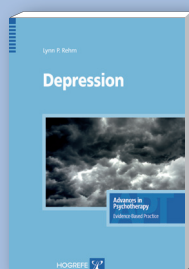


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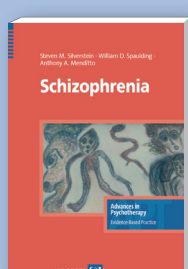


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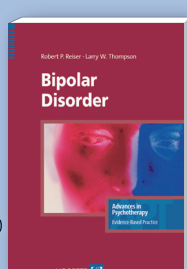
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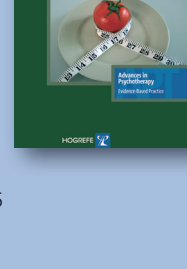
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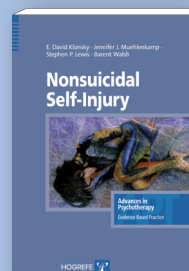
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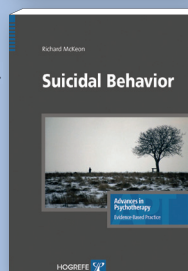
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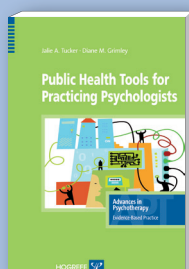
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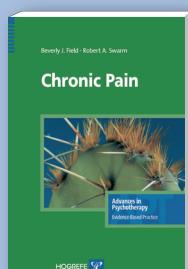
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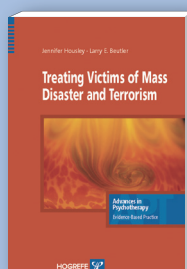
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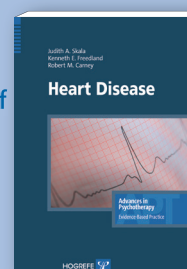
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Clinical Psychology in the Era of Electronic Health Records and “Meaningful Use”

Andrea Bradford, Ph.D.,
MD Anderson Cancer Center,
University of Texas

 The U.S. health care system is undergoing an important transformation as electronic health records (EHRs) are gradually taking the place of traditional paper-based records. One of the most important developments in this process is the enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act. This law, part of the broader economic stimulus legislation passed by President Obama in 2009, allocates billions of dollars to upgrade the nation's health information technology infrastructure. One of the key features of the HITECH Act is a mechanism to provide certain health care providers and health care organizations with financial incentives to adopt and use electronic health records (EHRs). Incentive payments, which can total tens of thousands of dollars for providers and millions for hospitals, have prompted many clinicians and health care organizations to switch from paper to electronic records or to upgrade their existing EHRs to meet the Act's requirements.

Psychologists who work in hospitals, academic medical centers, and multispecialty practices are likely to have already observed, if not participated in, responses to the HITECH Act in their local settings. However, the implications of the law for psychologists are not yet fully clear. Currently, psychologists are not able to receive incentive payments for EHR adoption under the HITECH Act. However, federal legislators have introduced bills to broaden eligibility to clinical psychologists and other mental health providers. The most recent of these, HB 6043, was introduced by U.S. Representative Tim Murphy, a psychologist, in June 2012.

The HITECH Act, in addition to offsetting the cost of transitioning to EHRs, creates incentives tied to how clinicians use EHRs to provide care. These conditions for incentives are known collectively as

“meaningful use” criteria. Examples of meaningful use include using the EHR to write electronic prescriptions, record demographics and vital signs, report certain measures of health care quality, and document preventive care screenings.

What would it mean for psychologists to be included among other eligible “meaningful users” such as physicians and dentists? Thus far there has been little discussion about how meaningful use criteria could be modified to apply to mental health care. Although a few of the current meaningful use requirements, such as recording demographics and smoking status, are already routine in many mental health practices, others are either outside the scope of most psychologists' practices (e.g., electronic prescribing) or are uncommon (e.g., providing a printed summary of each visit to the client or patient).

Because incentive payment programs are administered by Medicare and Medicaid, it is also questionable to what extent psychologists would stand to benefit from EHR incentives. Many clinical psychologists do not participate in either program. However, a possible side effect of expanding eligibility for incentive payments would be to open other billing options through Medicare and Medicaid, which may make these programs more attractive to psychologists. On the other hand, if Medicare- or Medicaid-participating psychologists become eligible for EHR incentives, they are likely to be penalized in future years for not transitioning to EHRs.

Any of these scenarios are strictly hypothetical and depend on the evolving provisions of the HITECH Act. Even so, the Act has had an undeniable effect on the world of health information technology in general. Clinical psychologists who are contemplating a transition to an EHR – whether in hope of future incentives or not – may see their choices shaped by the concept of meaningful use. Forward-looking vendors may create and market more “meaningful use ready” systems in anticipation of future regulatory changes. These systems may include features such as clinical decision support tools, secure portals for communicating with clients, and tools for sharing certain data with outside entities, all of which have implications for practice.

EHRs also raise a host of ethical issues for mental health practice, many of which have been discussed elsewhere,¹ but chief among them are concerns about

clients' privacy and confidentiality. The capability to transmit sensitive data to payers, regulatory agencies, and other providers carries the risk of unintended or inappropriate disclosures. Furthermore, an intentional breach or theft of electronic data has potential to affect many clients simultaneously. Unlike paper records, which are physically challenging to steal or photocopy in large quantities, data storage devices and "cloud based" repositories can contain thousands if not millions of records. Recent high-profile breaches of medical record systems, though often unintentional, illustrate the vulnerabilities of electronic record systems.²


In light of these risks, psychologists need to consider the rationale for and possible advantages of adopting EHRs. EHRs can benefit psychologists by mitigating the risk that records are physically lost or destroyed, facilitating certain administrative tasks, and assisting with client tracking and outcome assessment. However, whether EHRs actually improve the quality of care delivered is controversial, with some studies linking EHRs to decreased clinician productivity³ without a meaningful increase in patient health outcomes.⁴ Whether EHRs offer any benefits to recipients of psychological services is uncertain. There is a great need for research on how, and whether, EHRs can help psychologists provide services that are effective, evidence-based, and ethical.

External forces have accelerated the pace of health information technology development and implementation in a variety of health care settings, some of which include psychologists. Although clinical psychologists have had a limited role in these activities, their practices may be affected by EHR use within their organizations, and by emerging technologies

and privacy regulations for EHR users. As the status of psychologists under the HITECH Act is also subject to legislative action, clinical psychologists should attend closely to new developments and consider the ethical, clinical, and financial issues associated with electronic record adoption and use.

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The Importance of Training Students in Evidence-based Practice

Kathryn L. Humphreys, M.A., M.Ed.

 Evidence-based practice has been defined as “the conscientious, explicit, and judicious use of the current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Hayes, & Richardson, 1996). The movement towards use of evidence-based practice (EBP) has been recognized across a number of clinical practitioner fields (e.g., physicians, nurses, clinical psychologists). For various reasons, there remains a gap for clinical psychology training programs to fully embrace the importance of EBP. Yet all students, regardless of their preferred theoretical orientation, should be familiar with and able to implement treatments with empirical support. Why?

It’s good science. Practices that are implemented because it is the technique used by one’s supervisor, or it is listed as the “gold-standard” practice of an outdated textbook, or because we have a “hunch” it will work with a particular client, is simply not good science. I do not mean to suggest that traditional practices are bad; in fact, many techniques used across time have persisted exactly because they work. However, we need to be mindful about being true to the science of psychology, because research findings are continuously being produced, and our ability to provide efficacious treatments requires both knowledge of the science and good clinical judgment. Without keeping abreast of the research literature for what and how to apply empirically supported techniques [EST] we risk become obsolete practitioners, akin to physicians trained to prescribe antibiotics for the common cold. Otherwise psychology is a field in which our practices are random trial and error, rather than starting each clinical case with a template for what has been shown to work in prior similar clients.

It’s good for psychology as a discipline. Patients deserve to be delivered treatments shown to be effective. As patients become informed of EBP, they are able to be more thoughtful consumers. Division 12 recommends

that clients ask therapists about their likely diagnosis and what therapies have been shown to be beneficial for the treatment of individuals with that diagnosis. Thankfully, there are many empirically supported treatments available, and the numbers continue to grow. For the above client presenting with depression, the therapist is able to list cognitive-behavioral therapy, short-term psychodynamic psychotherapy, interpersonal therapy, antidepressant medication, acceptance and commitment therapy (and others), as well as outline the estimated length, cost, procedures, benefits, and risks of various treatments. It is therefore necessary that clinicians be informed of EBP in their training, and gain experience in the provision of these services under the supervision of knowledgeable and trained practitioners. Most empirically supported treatments have manuals available for therapists in order to closely adhere to the protocols studied and found to be effective, and trainings are often provided at institutional levels for continued training. Clinical psychologists compete for clients with therapists from other disciplines (e.g., social work, psychiatry, marriage and family therapists). One way for clinical psychologists to differentiate themselves, and this requires a significant movement on the part of those training burgeoning practitioners in clinical psychology, is to underscore the importance of EBP in the training of our professionals. We should market that practitioners from our field are not only informed of practices that have been shown to work, but they also believe that the implementation of such practices is both good science and good business, and are able to apply them in a cost-effective and timely manner. In a crowded and expensive healthcare marketplace, psychologists will benefit by demonstrating that their services are a sensible use of funding (whether public or private) via the use of EBP.

Recommendations for students:

Read journals (e.g., *Clinical Psychology: Science and Practice*; *Journal of Consulting and Clinical Psychology*; *Journal of Clinical Psychology*) **for up-to-date research on clinical practice.** Textbooks may be outdated, and journals continue to produce fresh and timely studies on the efficacy of various practices.

Choose practica that provide training in EBP. These

training experiences may be in house at department clinics or sought outside of typical practica, and I encourage students to research and seek out opportunities that may be new to them and to the other students in their programs. Spring (2007) argued that training in empirically-supported treatments may need to occur stepwise in training, such that “competencies like mindfulness, emotion modulation, and paradoxical intervention ... need to be practiced and mastered before a clinical psychologist can be considered to have expertise in a complex EST, like dialectical behavior therapy.”

Discuss with current supervisors the possible inclusion of EBPs for cases. Supervisors have the ability to see the potential limitations of following a strict manualized treatment when client’s problems or individual differences suggest a modification is warranted. Becoming flexible with the use of EBP may be the goal of becoming a competent practitioner within clinical psychology, and students can only do so with practice. Prepare for supervision by reading the latest literature of EBP for each client’s presenting problem, and discuss thoughts about how to use of

these techniques in session, and whether tailoring of such techniques may be useful for your own practice.


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Time for Negotiation

Lisle Kingery, Ph.D.,
CogState, Inc.

 Some graduate, internship, or postdoctoral programs might offer seminars on professional issues, such as negotiating terms of a new contract. There are also informal means of gaining guidance on this process, such as through academic advisors or mentors. It is likely the case though that early-career psychologists who enter into an academic position, whether in a medical or university setting, are more readily able to access guidance on negotiating a new contract, than early-career psychologists who enter private industry. This column provides insight on issues for psychologists considering careers in private sector/"industry" settings (e.g., corporations, small businesses, contract research organizations, pharmaceutical companies), who may face some unique issues in contrast to clinical and/or academic settings, when it comes to salary and benefits negotiations.

Among the many important variables to consider during negotiations is salary. Most businesses likely have defined salary ranges for specific positions within their organization, but it may be unlikely that they will inform you of this salary range. In contrast, each company's Recruitment and/or Human Resource department will likely ask you to provide your expected salary target or range. It is important for early career psychologists to not underestimate this target figure. Discussing typical salary ranges from colleagues in similar fields will be useful in determining an appropriate starting point for salary negotiations. Importantly, some companies also offer a sign-on bonus and you should inquire about this during the negotiation process. You should also inquire about moving expenses as many companies will reimburse employees for their relocation costs where indicated. Moving expenses may also be negotiable so if a costly move is expected, discuss this during the negotiation process.

If the company is publicly traded, it may be possible to be awarded stock options that are linked to performance goals. If this is the case, carefully review the conditions under which these options may be granted. For instance, it might be the case that you forfeit your

stock benefits if you leave the company within a specified amount of time. Be sure to carefully review the details surrounding this issue and if necessary, seek expert help in reviewing the terms.

Most companies understandably place special emphasis on protecting intellectual property and reducing risk from competition. Early-career psychologists entering an industry position can expect to sign standard confidentiality agreements. The specific content of the agreements will vary but generally preclude employees from sharing information on product development and testing. Many companies also include non-solicitation agreements and non-disparagement agreements. The former precludes you from soliciting/recruiting employees from your previous employer whereas the latter precludes you from publicly denigrating the company or its employees. In addition, companies may require employees to sign non-compete clauses, typically lasting from 6 months to 2 years. Although details vary depending on the nature of the agreement, essentially non-compete agreements prohibit you from working for another company that provides similar/competitive services. Overall, there are various strategies that companies use to protect intellectual property and reduce risk from competition. The agreements can be long and complicated to read. Be sure you carefully read the documents and fully understand the content. Individuals are often available in the Human Resources office to help clarify the specific terms within the agreements. You should also consider securing expert help in clarifying especially complex agreements.


Performance reviews, evaluations, and incentive plans vary widely in the private sector industry and it is important to inquire about the approach taken by each company. It might be useful to have a written document that outlines the specific expectations of the position and the particular evaluative procedures. The incentive plans may involve cash bonuses, stock opportunities, or other options for encouraging high performance. There may be opportunity for negotiating the incentive plan so you should be prepared to discuss the options.

One unique aspect of careers in many private-sector settings is the possibility of telecommuting. Some positions are entirely home-based, and expectations and requirements for working in this manner need

to be discussed and agreed upon. For example, if telecommunicating you will need to consider whether you have everything you need to efficiently work from home and while traveling. You should inquire about all anticipated needs, such as a computer when working from home, a laptop for travel if indicated, a cell phone, and any other potential necessity. In addition, travel expectations should be discussed fully so that expectations are agreed upon and feasible. For instance, you should be clear about whether you have a cap for meals while traveling, what mileage can be reimbursed, and whether your company requires you stay at particular hotel chains. Though the details may seem tedious in comparison to salary issues, explicating them early in the process will help the overall transition to the new position go more smoothly.

Insurance and retirement benefits are likely the most similar aspect to traditional academic and medical settings. Psychologists working in industry can expect some choice regarding insurance and retirement benefits. Most companies offer a few options and it is important to compare all available options.

Private companies typically offer retirement plan services (i.e., 401-K, IRA), and match some amount of pay (3-6%). You can also inquire about whether retirement planning services are available to provide guidance on investment decisions. Typically there is not much room, if any, for negotiating benefits, though by offering at least a few options companies provide employees with some choice in the process.

Lisle Kingery, Ph.D., is a licensed psychologist in NY State. After completing a PhD in clinical psychology at the University of Maine and an internship at the Ann Arbor VA Healthcare System, Dr. Kingery completed a postdoctoral fellowship in Clinical Neuropsychology at Johns Hopkins Hospital, Department of Medical Psychology. For 6 years, Dr. Kingery worked at i3 research, a contract research organization providing consulting and training services for pharmaceutical companies, particularly in clinical trials of Alzheimer's Disease and Parkinson's disease. He is currently Senior Clinical Scientist at CogState. 

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- Society for a Science of Clinical Psychology (Section 3)
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- Clinical Psychology of Ethnic Minorities (Section 6)
- Section for Clinical Emergencies and Crises (Section 7)
- Section of the Association of Medical School Psychologists (Section 8)
- Section on Assessment (Section 9)
- Graduate Students and Early Career Psychologists (Section 10)

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Donna Rasin-Waters, Ph.D.—Editor

APA Communities: State Health Care Reform Group

By Donna Rasin-Waters, Ph.D.

Division 12 Federal Advocacy Coordinator



Since the Affordable Care Act (ACA) was signed into law in 2010 many changes have taken shape with more to come. Health reform is happening now with the next critical steps occurring as state health insurance exchanges form. Beginning in 2014, millions of people without insurance will join the ranks of the insured as the ACA aims to increase access to health coverage. State health insurance exchanges will list health plans offered in a state, thus allowing consumers the opportunity to shop and compare plans. Most plans will be government run through the Medicaid program in the states.


Why is this important for psychology? Health insurance policies will need to include a list of essential health benefits signed into law under the ACA, one of which is mental health benefits. As the state exchanges form workgroups to develop the benchmark health insurance plans, it will be critical for psychologists to stay informed about developments and seek to have input.

The American Psychological Association Practice Organization (APAPO) has made a concerted effort, through Dr. Katherine Nordal's practice initiative on the state implementation of health care reform, to keep psychologists updated on health reform developments in the states. The practice initiative, facilitated

administratively by the State Advocacy Office, is made up of internal APA staff from almost every practice office, as well as an advisory group of external experts. You can access information about your state and many other resources regarding health reform via APA Communities (<http://www.apa.org/pubs/newsletters/access/2012/04-10/social-media.aspx>) by joining the State Health Care Reform Group. The State Health Care Reform Group is a document library and discussion forum that connects users to current state level work on psychology's role in health care reform. Once logged-in users will find resources categorized by a list of Priority Areas in ACA and State Implementation including such topics as accountable care organizations (ACOs), health care financing, medical homes, primary care and updates from the APA practice initiative on state implementation of health care reform.

APA Communities is an online professional network provided to all APA members and is securely accessed by users through their individual MyAPA ID. Connect to APA Communities (www.apacommunities.org) and join the important conversation happening right now about the future of our profession. Click on the APA Communities link above to read the APA Access Newsletter article that introduced APA Communities to all APA members on April 4, 2012.

For access to the State Health Care Reform Group email Tammy Barnes, State Advocacy Officer, at tbarnes@apa.org.

Donna Rasin-Waters, PhD, can be contacted at drrasinwaters@aol.com, LinkedIn or Twitter @rasinwaters. 

Looking for back issues of The Clinical Psychologist?

Past issues of *The Clinical Psychologist* are available at:

www.div12.org/clinical-psychologist



Section II: Society of Clinical Geropsychology

Brian D. Carpenter, Ph.D., Editor



Are you a student interested in gaining leadership experience? Do you know a student who would like the chance to do some professional networking while expanding their service experience? Section II is currently recruiting students for several standing committees. Student committee members provide important input on all the Section's activities, and committee involvement gives students an important professional development experience and opportunity to collaborate with enthusiastic members of the Section. Committees seeking students include Awards, Public Policy, Mentoring, Diversity, and Membership. Contact any Section officer for more information.

Close on the horizon is the introduction of GeroCentral, a Section-sponsored website clearinghouse for educational materials and training opportunities related to geropsychology. Among other features, the site will include a web-based version of the Pikes Peak geropsychology competencies assessment tool, links to geropsychology training and mentoring opportunities, a clinician's toolbox with access to evidence-based assessment and treatment resources, and geropsychology webinars. A broad collection of geropsychology organizations contributed expertise and financial support toward this effort, including the Society of Clinical Geropsychology (Section 2), APA Division 20 (Adult Development and Aging), APA's Committee on Aging (CONA), Psychologists in Long Term Care, and the Council of Professional Geropsychology Training Programs. And the project was supported by an Interdivisional Grant from APA's Committee on Division/APA Relations (CODAPAR). Stay tuned for the launch of this exciting resource in early 2013.

Recipients of several Section II awards were announced this summer. They include Sara Qualls from the University of Colorado at Colorado Springs, who was awarded the Distinguished Clinical Mentorship Award. The M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology was awarded to Bob Knight at the University of Southern California. And the Award for Excellence in Research by a Student Member was awarded to Lindsay Gerolimatos from

West Virginia University for her paper, "Predictors of Health Anxiety among Older and Young Adults."

Representatives from Section II on the Interdivisional Healthcare Committee, Cheryl Shigaki and Margie Norris, have been thick in the Committee's recent work focused on the Healthcare Reform Act. One potential practice opportunity of interest to all psychologists, including geropsychologists, is in state Medicaid programs, a large component of the new legislation. It's unclear whether mental health will be treated at parity in these programs, but APA is partnering with state psychological associations to promote psychology's presence in Medicaid.

For professional geropsychologists, one of the highlights of the summer was the release of a report by the Institute of Medicine's Committee on the Mental Health Workforce for Geriatric Populations. Notably absent from an earlier IOM report in 2008, *Retooling for an Aging America: Building the Health Care Workforce* (<http://www.iom.edu/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx>), geropsychologists had a keen interest in this new report. APA was very forceful in providing the Committee information about the important role psychologists play in geriatric mental health and substance use. And in the new report, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*, (<http://www.iom.edu/Reports/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults.aspx>), psychologists are included more prominently in the Committee's recommendations for addressing the unmet health care needs of the increasingly diverse aging population.

Finally, the Section is gearing up for another innovative and informative program at the upcoming annual meeting of the Gerontological Society of America in San Diego, which will feature symposia and posters by many Section members and students. As usual, one of the highlights will be the Student Social Hour, an opportunity for casual networking and camaraderie. Hope to see you there! 🍷



ON BECOMING A FELLOW OF THE SOCIETY OF CLINICAL PSYCHOLOGY



The Society of Clinical Psychology, APA Division 12, welcomes within its membership psychologists who are interested in and who identify with the field of clinical psychology—its practice, research, service, and/or missions. Besides being an esteemed member of Division 12, there are within our Society those who should be considered to be nominated and elected to fellow status. Many such members have not taken steps to apply for fellow status. Sometimes this is due to extreme modesty in evaluating one's own achievements, intimidation by the thought of the application process and being reviewed by peers, modesty in asking others for endorsement, or simply time constraints. Yet becoming a fellow of Division 12 holds many rewards and benefits well worth applying and focusing on successful election to fellow status.

There are two categories of fellow status: initial fellows and previous fellows. Initial fellows are those who have not yet been elected to fellow status in any APA division and need to apply for this in the division. Endorsements by three fellows are required. Current fellows are usually willing to mentor the initial applicant through the process and thus make it more user-friendly. Previous fellows are those who, having been fellowed by another division, can state how their work and experiences also qualify them to become fellows of Division 12. All members who are not yet Division 12 fellows or fellows of any other division need to consider applying for fellow status in Division 12. All who are current fellows are encouraged to give a helping hand to deserving potential fellows who might otherwise be overlooked: Nominate others who should be recognized for their outstanding and unusual clinical research, practice, or services.

What are the benefits and rewards of becoming a fellow of the Society of Clinical Psychology? The deserved recognition, appreciation, and greater visibility of one's research, practices, and service by one's peers are highly important to most of us. Research can certainly be disseminated without being a fellow, but having one's work

seen in the light of becoming a fellow within the Society of Clinical Psychology burns a far brighter and visible light on one's accomplishments and achievements. Often the more modest members within our Society feel overlooked and even isolated by the lack of colleagues recognizing and appreciating one's work and nominating him or her for fellow status.

The networking and cross-research connections may be much increased when members become fellows. Collegiality is usually increased as fellows more identify with the field and their contributions to clinical psychology. Greater opportunities to share what one has done in clinical psychology usually come with fellow status. Often more opportunities to enter divisional offices come after one is fellowed. Fellows are often more sought for mentors of peers and early career psychologists, as well as in teaching and advisor capacities. Fellows have often been cited and referenced before being fellowed but may find even more of such citations and references after their fellow status has been achieved.

Sometimes our members overlook Division 12 sectional interest groups, such as sections on children, women's issues, ethnic minority issues, and research. Special achievement within these groups may well merit fellow nomination and election. Further, opportunities for intra- and interdivisional interests may foster new opportunities and challenges for research, practice, and publication. Our Society has more abundant and untapped talents and skills than we have sufficiently appreciated and that need to be acknowledged.

The greater collegiality and sense of appreciation by peers in adding deserving fellows to the Division enhances division cohesiveness and solidarity and contributes to the strength of the field of clinical psychology itself. Look in the mirror and at your colleagues and nominate the worthy for fellows!

—Carole A. Rayburn, Ph.D. Fellows Chair, Division 12



To learn more about the
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Instructions to Authors



The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Division 12 of the American Psychological Association). Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Division. Topic areas might include issues related to research, clinical practice, training, and public policy. Also included will be material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. Examples of submissions include: position papers, conceptual papers, data-based surveys, and letters to the editor. In addition to highlighting areas of interest listed above, *The Clinical Psychologist* will include archival material and official notices from the Divisions and its Sections to the members.

Material to be submitted should conform to the format described in the sixth edition of the Publication Manual of the American Psychological Association (2010). An electronic copy of a submission in Word format should be sent as an attachment to e-mail. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries and submissions may be made to the editor at milton.strauss@gmail.com.

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