

THE CLINICAL PSYCHOLOGIST



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

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Nominations ballot now available for Division 12 elections

Participate in Division 12's nomination process! We will be selecting three positions: **President, Treasurer,** and one **Representative to the APA Council.**

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PRESIDENT'S COLUMN

Clinical Psychology in the Future



By Mark Sobell, Ph.D., APBB
Nova Southeastern University, FL



When you are President of this Society, the need to write columns for *The Clinical Psychologist* can sneak up on you. It seems like you need to have finished another column within a few days of your previous one being published. The hard question is what to write about. I had already written about changes going on in the field and about how the Society is a complicated organization. Then, I was having a discussion with a journal editor colleague about how the digital revolution was changing everything (including, Einstein aside, speeding up time) and was speculating about the future of journals when it struck me that the clinical psychology of the future might be a good topic. So here are a couple of the many things one might speculate could possibly come to be. I make no claim to clairvoyance or special predictive powers, and none of what is mentioned may come to pass, but it is fun to think about. I realize that parts of this discussion date me, but that should be no surprise. So here are a couple of future possibilities, one for science and one for practice.

Many years ago, when I was an associate editor for a journal, authors submitted six copies of their journal manuscript by mail. Four of the copies, along with review forms, were mailed to prospective reviewers, one was for the editor's office, and one for the associate editor assigned to handle the manuscript. Needless to say this was a lot of work, took a lot of time, and involved copying and mailing costs. There were rumors that computerization was coming to the world of journals, but at that point the intrusion was limited to authors using word processing programs to prepare their manuscripts (a miracle itself, in terms of facilitating re-writing). Later, when I was an associate editor and then became acting editor for the *Journal of Consulting and Clinical Psychology*, the APA computerized system, Journal Box Office, was getting off the ground and there was a lot of grumbling that it was more complicated and took more time than the old land mail system. Now, a decade later I am an associate editor for two journals and could not imagine returning to the old ways. No cluttered file drawers, and it is as quick (instantaneous) and easy to solicit a reviewer from The Netherlands as from New York. The systems are amazing, and it is equally amazing that I can download a pdf of almost any article of interest to me from the university library just by clicking a key. So what might be yet to come? Well, although most everything on the reviewing and publishing end

(continued on page 2)

INSIDE: Call for Award Nominations (See page 6 for details)

President's Column (*continued*)

has been computerized (authors do most of the work now), the major computer activity on the authors' end is still just the use of word processing in preparing manuscripts. In other words, with minor variations it is basically just as it was two decades ago. Using APA as an example, although there have been various changes in how manuscripts are formatted, and even in how appendix material can be considered and made accessible, if we put aside word processing the preparation of a manuscript today is very similar to how it was 40 years ago. In the information age, however, brevity and links are coming to dominate our information. This is not to say that there will ever be twitter journal arti-

cles, describing the whole study within 140 characters. But it is easy to imagine a new formatting for articles where an article looks and reads like an internet web page, complete with abundant links to the multiple areas of content, so that rather than literally reading through an article readers can "click and choose" what they read. Some so-called Open Access journal articles are already somewhat there, in that the reader can click a link for tables or figures, but the articles still read like articles. It isn't difficult to imagine publishers issuing instructions to authors, however, that would yield a manuscript format that was basically a webpage with links. This would likely be followed by a lot of com-

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plaining about the change and how difficult it is to do, followed by a begrudging acceptance that the new way is better. Personally I have no idea whether this sort of change is on publishers' wish lists, but it would seem a reasonable possibility. Of course, this also implies that hard copies of journals will become a thing of the past, and that definitely looks like something that is in the cards for many journals.

The other possibility on which I offer speculation involves what some might consider challenging a commandment. The therapeutic alliance occupies

a central place in clinical psychology, and many consider it the bedrock of psychotherapy. I believe it is important, and that is what most of my colleagues and I tell our students. The dyadic situation where we typically think about the therapeutic alliance goes back to Freud (a confidential discussion between patient and therapist) and was empirically bolstered several decades ago most notably by Carl Rogers. Rogers not only provided data, his ideas made sense. However, does the therapeutic alliance need to be limited to a dyadic relationship, and is it essential for helping people make real changes? The one to one relationship has much to recommend it, such as fewer opportunities for violations of trust and a feeling that you have "your"

therapist. But from a business standpoint, it has some drawbacks, such as that therapist's and client's schedules need to coincide. From a broader perspective, this is not the only model for how to facilitate behavior change. Considerable research has recently begun to accumulate on self-change, and on the value of brief interventions. This highlights that if we really want to understand the behavior change process, we have to look beyond the population that attends traditional treatment. In medicine this is sometimes referred to


as Berkson's Bias, the notion that if observations of a disorder are confined to cases seen in treatment they are likely to give a biased view of the problem, since it is likely the more serious cases that seek treatment. So a prediction is that as we shift more to a public health perspective on mental health, our ideas about how and why behavior changes will also broaden, as will our models for how to facilitate change. Some of this is already occurring. Telemental health is demonstrating that therapist and client do not need to be in close physical proximity, and therapy by telephone, which has a longer history, has made it clear that therapy can proceed by audio alone. Screening and brief interventions for substance use are often conducted in a short period of time by hospital emergency room staff, yet often with positive results. All of these changes and pending changes make me harken back several decades to one of our earliest research studies. Not having been indoctrinated in the importance of the therapeutic alliance, having several part time staff, and with our clients having several other demands on their time, we simply scheduled sessions to be run by whoever would be working at a time when the client would be free. Recognizing that continuity would be imperative, therapists made extensive notes about what had occurred in each session, and a requirement was that therapists carefully read the notes for the previous sessions before running their session. We had no measure of a working or therapeutic alliance because at the time (1970) that area of research was in its infancy. Anecdotally, however, it was our impression that the clients developed a strong bond with the program, and with the group of therapists. Whether that was an illusion or was real is an empirical question. But suppose it was tested and it was found that a working alliance could develop in that context. That could provide yet another venue for providing services. Mental health walk-in clinics are already available in many places, but those mostly either provide crisis services or serve as an entry point to link clients with therapists. Might a program in the future provide continuing therapy using an array of therapists? Perhaps this already occurs and I just don't know about it, but the point is that the way the world is rapidly evolving, clinical psychologists need to be prepared to work in a variety of formats. Individual psychotherapy will still be practiced, but it seems clear that horizons are expanding rapidly, and hopefully clinical psychologists will be leaders in innovation. The only sure thing is that the opportunities are waiting. ■■

Does the therapeutic alliance need to be limited to a dyadic relationship, and is it essential for helping people make real changes? The one to one relationship has much to recommend it, such as fewer opportunities for violations of trust and a feeling that you have "your" therapist. But from a business standpoint, it has some drawbacks.

Ethics, Self-Care and Infirmary I: Rituals to Develop Health-Enhancing Habits

George J. Allen, Ph.D.

University of Connecticut

 Psychologists impress me as having a love-hate relationship with personal self-care. On one hand, we appear to recognize that we need to remain healthy enough in body and fit enough in spirit to engage in the arduous tasks associated with caring for others. On the other hand, we often find it difficult to impossible to engage in self-care activities in what Norcross (2009) described as a “workaholic nation” (p. 1).

Protecting our own physical, mental, and spiritual well-being appears to have grown more difficult in the past decade as we collectively endure greater exposure to vicarious traumatization (Pearlman & Saakvitne, 1995), greater vulnerability to intrusive contact (and potential liability) via electronic media (Barnett & Scheetz, 2003), increasingly stringent requirements for clinical practice management, and greater competition for research grants and tenured teaching positions.

The stresses associated with our work filter down to our graduate students, who carry their own additional sets of stressors. Several recent surveys (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012; Myers et al., 2012) have indicated that 70%-75% of current graduate students experience levels of stress that attenuate their optimal professional functioning. In elucidating some of these concerns, Wise and Fischer (2013) raised the question “Is self-care purely personal?” (p.15) or is it a professional obligation. These authors called on graduate training programs to better integrate self-care into their curricula and for faculty “to model a balanced and compassionate approach to their own lives” (p. 15).

My work with both graduate students and faculty always has been guided by three beliefs: (a) self-care represents an ethical imperative, (b) as professionals, our word of honor (e.g., making commitments, amending them, etc.) is sacred, and (c) our professional activities represent a life-long marathon and not a sprint. I endeavored to impart these beliefs to our students by engaging in two classroom rituals that eventually

became woven into our graduate training program. I share them with you in the hope that you may be able to morph them into rituals in your own workplaces that can enhance well-being.

The first ritual was to ask students in my ethics class to write me a “Dear George” letter in which they made commitments to engage systematically in three tasks: (a) complete a specific amount of required reading each week, (b) take on a professional improvement activity (e.g., learn a new statistical or library search program, etc.) and (c) commit to a personally meaningful self-care pursuit. I emphasized that these tasks were ungraded (to reduce impression management) but were vitally important to their professional well-being.

Their initial reaction to the self-care assignment typically was to ask “what specifically do you want us to do?” I told them that they were in the best position to decide what activities would calm and restore them, but asked only that they set reasonable and achievable goals, given their current obligations. I had the students file mid- and end-of-semester reports about their success and difficulties and asked them to make alterations in their commitments as their changing circumstances dictated. During the last class, I asked them to describe what they had learned about self-care and urged them to continue using their successful activities. I also requested that they file voluntarily follow-up reports about their endeavors during the following year, emphasizing that self-care was a life-long obligation. The almost universal student reaction to this assignment was gratitude that I demonstrated a commitment to their well-being through a class assignment.

The second ritual developed serendipitously. I rushed into one graduate class immediately following an especially contentious meeting where we administrators had hassled over allocation of resources. I told the students that I had just been in a difficult meeting and needed a minute or two to center myself so I could teach effectively. I engaged in a mini-relaxation process (Ponce et al., 2008) which calmed me, then began teaching. Several weeks after that class, one student disclosed that my actions that morning comprised his most meaningful graduate school learning experience. The next semester, I began every class with a period of quiet reflection (read “mindfulness”) as a prelude to learning.

Students’ immediate response to this experience

was to grow quiet and then enter the learning process with seemingly clearer and more intense focus. When first initiating this ritual, I asked students to rate themselves on a 0 - 100 stress pulse before and after the exercise. Almost invariably, students reported a reduction in their stress following relaxation. Once again emphasizing their long-term obligation to self-care, I encouraged the students to practice this activity frequently during the day, especially during times of lower stress.

As psychologists, we know a great deal about managing human stress and possess uncommon awareness about a plethora of health-promoting interventions. Norcross (2009) provided 12 strategies for remaining healthily centered [e.g., nurture relationships, set boundaries, "return again and again to the physical fundamentals" (p 5) of adequate sleep and good nutrition, among others]. We can use the routines and rituals existing in a multitude of our professional settings to practice momentary stress-reduction strategies and to teach and encourage our younger colleagues to do the same.

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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

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Submission deadlines for advertising and announcements:

Winter issue: January 3

Spring issue: April 1

Summer Issue: July 1

Fall issue: October 1

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Guerda Nicolas, Ph.D. nguerda@miami.edu

CALL FOR AWARD NOMINATIONS

.....
*Deadline is **November 1, 2013***
.....

The Society of Clinical Psychology invites nominations for its five psychologist awards, three early career awards, and three graduate student awards. These awards recognize distinguished contributions across the broad spectrum of the discipline, including science, practice, education, diversity, service, and their integration. The Society and the American Psychological Foundation encourage applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

Nominations must include a CV and at least one letter of endorsement. Self-nominations are permitted and should include at least one external endorsement. Candidates can be simultaneously considered for multiple awards, although a psychologist may receive only one Division 12 award in any given year. No voting members of the Division 12 Board of Directors will be eligible to receive awards from the Division while serving their term. **Nominees must be current members of Division 12.**

Please submit nomination materials electronically to Awards Committee Chair at div12apa@comcast.net. The deadline is November 1st. Inquiries should be directed to the Division 12 Central Office at 303-652-3126 or div12apa@comcast.net.

SENIOR AWARDS

Award for Distinguished Scientific Contributions to Clinical Psychology

Honors psychologists who have made distinguished theoretical and/or empirical contributions to clinical psychology throughout their careers.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

Honors psychologists who have made distinguished advances in psychology leading to the understanding or amelioration of important practical problems and honors psychologists who have made outstanding contributions to the general profession of clinical psychology.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology

Honors psychologists who have made remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind.

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology

Honors psychologists who display excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows, and junior faculty. Recognizes those individuals who have been outstanding in supporting, encouraging and promoting education and training, professional and personal development, and career guidance to junior colleagues.

MID CAREER AWARD

American Psychological Foundation Theodore Millon Award

The American Psychological Foundation (APF) Theodore Millon, Ph.D. Award will be conferred annually to an outstanding mid-career psychologist engaged in advancing the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. A review panel appointed by APA Division 12 will select the recipient upon approval of the APF Trustees. The recipient will receive \$1,000 and a plaque. Nominees should be no less than 8 years and no more than 20 years post doctoral degree.

EARLY CAREER AWARDS

David Shakow Early Career Award for Distinguished Scientific Contributions to Clinical Psychology

Given for contributions to the science of clinical psychology by a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to science and to practice. Up to \$500 for travel to the APA Convention is awarded.

Theodore Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology

(given jointly with APF)

Honors a clinical psychologist for professional accomplishments in clinical psychology. Accomplishments may include promoting the practice of clinical psychology through professional service; innovation in service delivery; novel application of applied research methodologies to professional practice; positive impact on health delivery systems; development of creative educational programs for practice; or other novel or creative activities advancing the service of the profession. Nominees should be no more than seven years post doctoral degree. Amount of the award is \$4000.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology

This award will be conferred annually to an early career psychologist who has made exemplary contributions to diversity within the field. Such contributions can include research, service, practice, training, or any combination thereof. Nominees should be no more than seven years post doctoral degree.

GRADUATE STUDENT AWARDS

Recipients of the Division 12 graduate student awards must be matriculated doctoral students in clinical psychology (including predoctoral interns) who are student affiliates of Division 12. Nominations should include a copy of the nominee's curriculum vitae and at least one letter of support detailing the nominee's service contributions to the profession and community. Recipients of the awards receive a plaque, a \$200 honorarium contributed jointly by Division 12 and the *Journal of Clinical Psychology*, and a complementary two-year subscription to *JCLP*. The Division 12 Education & Training Committee will determine the award recipients.

Please submit nomination materials electronically to Education & Training Committee Chair, Dr. John Pachankis at john.pachankis@yale.edu. The deadline is November 1st.

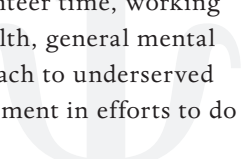
Distinguished Student Research Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made exemplary theoretical or empirical contributions to research in clinical psychology. Clinical research contributions can include quantity, quality, contribution to diversity, and/or innovations in research.

Distinguished Student Practice Award in Clinical Psychology


Honors a graduate student in clinical psychology who has made outstanding clinical practice contributions to the profession. Clinical practice contributions can include breadth and/or depth of practice activities, innovations in service delivery, contribution to diversity, and/or other meritorious contributions.

Distinguished Student Service Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made outstanding service contributions to the profession and community. Service contribution can include development of creative educational programs or other novel activities in the advancement of service, contributions to diversity, working to increase funding for agencies, volunteer time, working on legislation regarding mental health, general mental health advocacy; as initiating outreach to underserved communities or substantive involvement in efforts to do such outreach. 

Transdiagnostic Psychotherapy Training

Christopher Conway, Ph.D.

 Clinical psychology trainees often find themselves in the position of needing to master a new method of psychotherapy. Supervisors, upon hearing that a trainee is working with a certain diagnostic group for the first time, have a tendency of scanning the bookshelf, selecting a healthy-sized manual or text, and extending it to the student with the advice “you’ll probably want to use therapy X with this patient.” The student then realizes that the next few nights will be dedicated to committing this new material to memory (and not managing data and writing case notes as planned).

Part of the challenge of this style of training is the ever-growing number of treatment manuals available for different diagnostic entities. It seems that several new protocols are developed each year for most prevalent forms of illness; this is true even for conditions with high degrees of phenomenological and etiological overlap (e.g., GAD and social phobia). Additionally, each acronym (ACT, DBT, EFT, PE, etc.) is associated with its own set of procedural and “cultural” guidelines to which the therapist must adhere. Trainees must keep in mind these (sometimes subtle) differences between the systems to ensure fidelity to the respective psychotherapies.

“Manual-by-manual” learning is a rite of passage in clinical training and is not necessarily a problem. Research may ultimately reveal it to be the preferred method in most training contexts. At the same time, an alternative to the multimanual method—it could be called *transdiagnostic psychotherapy training*—might be worth some discussion in our Student Section. I will briefly describe the rationale for a transdiagnostic approach, provide some examples, and end with some issues for future investigation.

Efficiency is perhaps the main upside of a transdiagnostic approach to psychotherapy. Accumulating research suggests that commonly co-occurring diagnoses (e.g., the depressive and anxiety disorders) share a great deal of symptomatology, antecedents, and inherited biology. For instance, constructs like emo-

tion dysregulation, anxiety sensitivity, and rumination are characteristics of most internalizing disorders and are targeted by nearly all existing cognitive-behavioral therapies for internalizing distress. It would be arguably more efficient to engineer one protocol to target these overarching pathologies, rather than rely on a separate treatment for each diagnosis. In theory, only one treatment would be needed for a patient with multiple (comorbid) internalizing syndromes, saving time and effort for both patient and clinic. Similarly, a clinic could deliver the same intervention to two patients who present with different internalizing diagnoses. Because of this simplicity, transdiagnostic therapies can theoretically allow for shorter treatment periods (and thus access to services for more people) and easier dissemination, two desirable features of a clinical program (see Kazdin & Blase, 2011). In a nutshell, transdiagnostic treatments may be capable of having a major public health impact.

It should be noted that transdiagnostic psychotherapy may not be sufficient in all cases. For instance, even after completion of a transdiagnostic treatment for internalizing pathology, a patient with chronic depression may experience continued interpersonal deficits that cause social impairment. Or perhaps this same treatment remediates a panic disorder (the primary presenting problem) that is superimposed on borderline personality disorder for another patient, and additional focus on reducing self-injurious behavior is indicated. I posit that in these cases a transdiagnostic therapy for internalizing distress can serve as an initial stage—or an intermediate stage if there are other, more preliminary, phases of care—in a stepped care model for emotional disorders. If a patient does not completely respond to the transdiagnostic intervention, then treatment supplements (presumably of relatively short duration) tailored to a diagnosis or other patient characteristics can be administered to address remaining psychopathology. (In contrast with traditional stepped care models, patients would not necessarily “step up” to a more intense or resource-heavy form of treatment [see, e.g., Fava & Kellner, 1993], but rather a circumscribed intervention specific to some unresolved pathology.) This stepped approach may be most economical for organizations in which patients

Student Column continued on page 13

Advances in Psychotherapy

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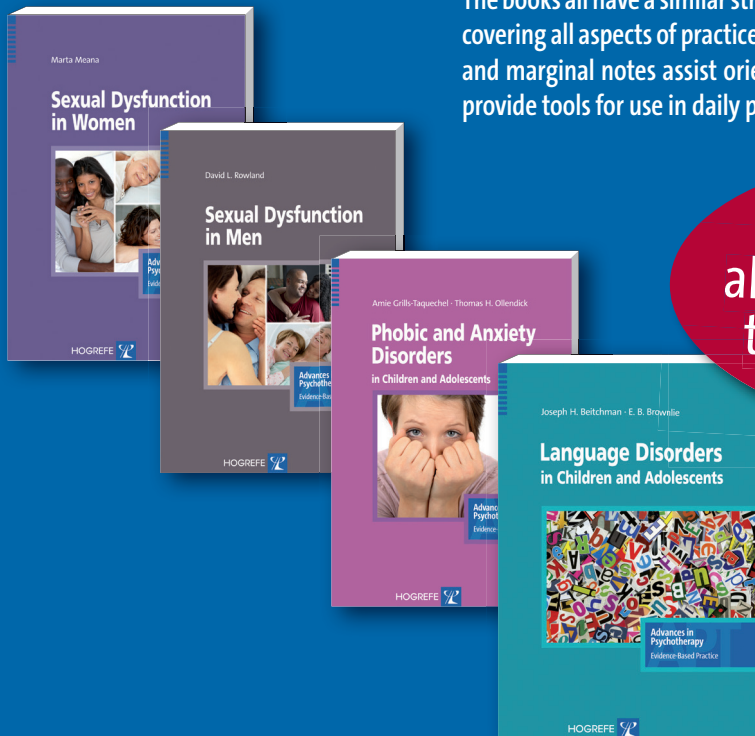
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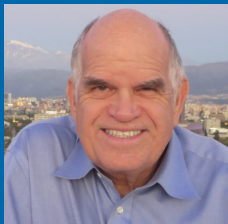
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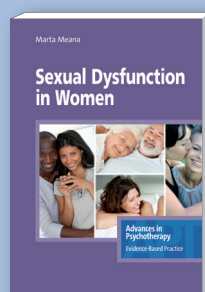
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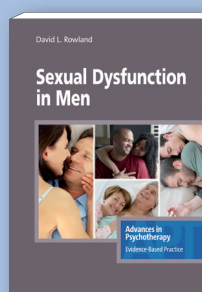
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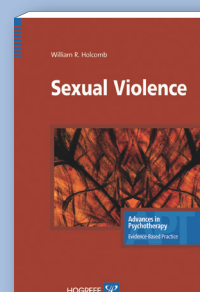
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2013, viii + 108 pp.,
ISBN 978-0-88937-402-7



William R. Holcomb
Sexual Violence
Volume 17
2010, viii + 96 pp.,
ISBN 978-0-88937-333-4

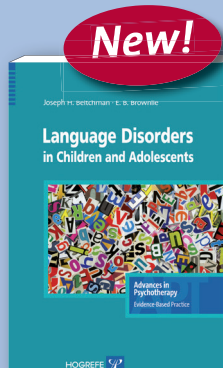
Children & Adolescents:

"Insights from research and snapshots from practice will guide clinicians, parents, and teachers to find practical ways to help children with language impairments and social-emotional problems."

Nancy Cohen, Professor of Psychiatry / Applied Psychology at the University of Toronto, Canada

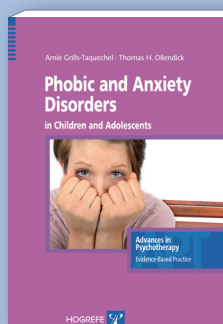
"Anxiety disorders of childhood in a perfect nutshell. If you are looking for a concise, thorough, and bang up-to-date book, then this is the one!"

Dr. Sam Cartwright-Hatton, NIHR Career Development Fellow, University of Sussex, UK



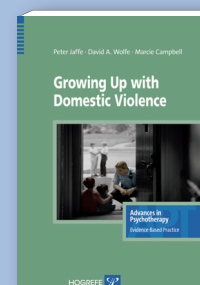
New!
Joe Beitchman & E. B. Brownlie
Language Disorders in Children and Adolescents
Volume 28
2014, vi + 130 pp.,
(Coming September 2013)
ISBN 978-0-88937-338-9

This book offers a clear and comprehensive description of language impairment emerging in childhood and its implications for clinical practice with children and youth. Unique to this book are the recommended modifications to empirically validated treatments for language impaired children with comorbid anxiety or disruptive behavior disorders.

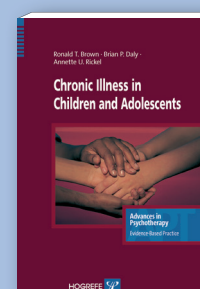


Amie E. Grills-Tauchel & Thomas H. Ollendick
Phobic and Anxiety Disorders in Children and Adolescents
Volume 27
2013, x + 130 pp.,
ISBN 978-0-88937-339-6

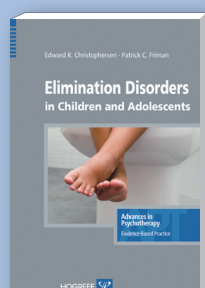
This authoritative but compact text addresses the psychopathology, assessment, and treatment of the anxiety disorders and phobias in childhood and adolescence. Effective treatments exist, but unfortunately many of these interventions are either not known to the practicing professionals or not used by them. This volume aims to address this gap and to present these interventions in a clear and straightforward manner.



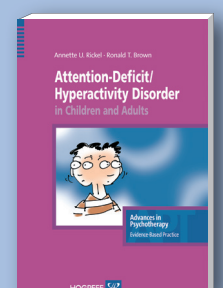
Peter Jaffe, David A. Wolfe, M. Campbell
Growing Up with Domestic Violence
Volume 23
2012, x + 78 pp.,
ISBN 978-0-88937-336-5



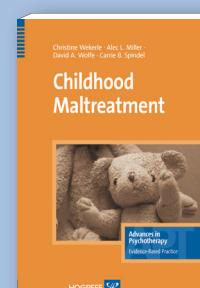
Ronald T. Brown, Brian P. Daly, Annette U. Rickel
Chronic Illness in Children and Adolescents
Volume 9
2007, viii + 86 pp.,
ISBN 978-0-88937-319-8



Edward R. Christophersen, Patrick C. Friman
Elimination Disorders in Children and Adolescents
Volume 16
2010, vi + 91 pp.,
ISBN 978-0-88937-334-1

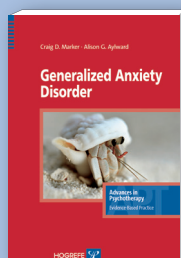


Annette U. Rickel, Ronald T. Brown
Attention-Deficit/Hyperactivity Disorder in Children and Adults
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ISBN 978-0-88937-322-8

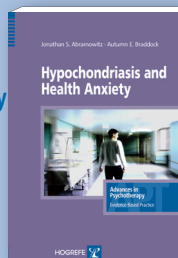


Christine Wekerle, Alec L. Miller, David A. Wolfe, Carrie H. Spindel
Childhood Maltreatment
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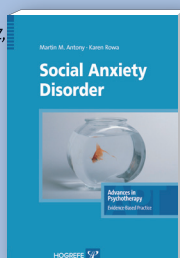
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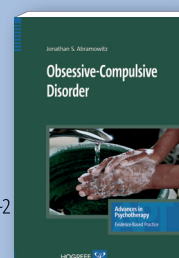
*Craig D. Marker,
Alison G. Aylward*
Generalized Anxiety Disorder
Volume 24
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*Jonathan S. Abramowitz,
Autumn E. Braddock*
Hypochondriasis and Health Anxiety
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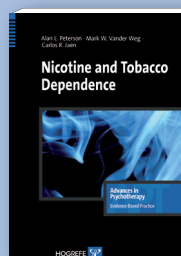


*Martin M. Antony,
Karen Rowa*
Social Anxiety Disorder
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ISBN 978-0-88937-311-2

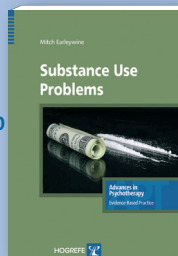


Jonathan S. Abramowitz
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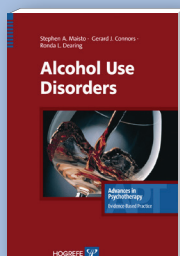
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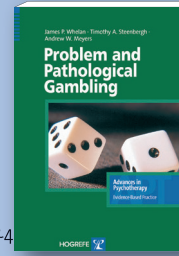
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Mark W. Vander Weg,
Carlos R. Jaén*
Nicotine and Tobacco Dependence
Volume 21
2011, x + 94 pp.,
ISBN 978-0-88937-324-2



Mitch Earleywine
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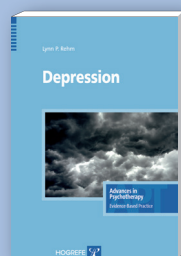


*Stephen A. Maisto,
Gerard J. Connors,
Ronda L. Dearing*
Alcohol Use Disorders
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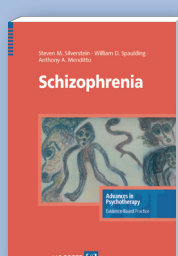


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Timothy A. Steenbergh,
Andrew W. Meyers*
Problem & Pathological Gambling
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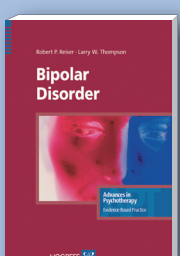
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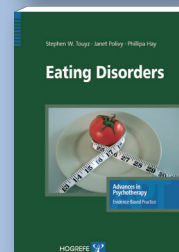
Lynn P. Rehm
Depression
Volume 18
2010, vi + 90 pp.,
ISBN 978-0-88937-326-6



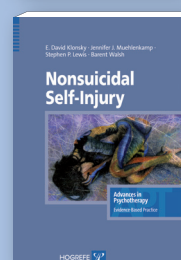
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William D. Spaulding,
Anthony A. Menditto*
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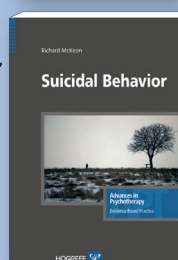
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Larry W. Thompson*
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*Stephen W. Touyz,
Janet Polivy,
Phillipa Hay*
Eating Disorders
Volume 13
2008, viii + 112 pp.,
ISBN 978-0-88937-318-1



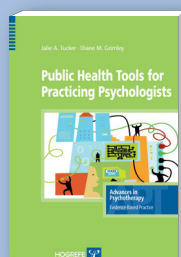
*E. David Klonsky,
Jennifer J. Muehlenkamp,
Stephen P. Lewis,
Barent Walsh*
Nonsuicidal Self-Injury
Volume 22
2012, vi + 98 pp.,
ISBN 978-0-88937-337-2



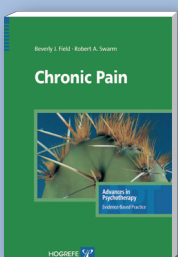
Richard McKeon
Suicidal Behavior
Volume 14
2009, viii + 104 pp.,
ISBN 978-0-88937-327-3

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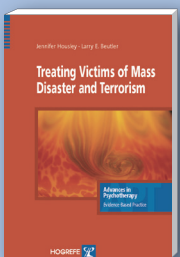
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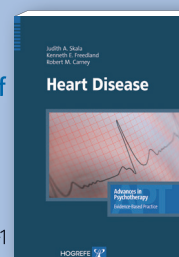
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Diane M. Grimley*
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have high rates of comorbidity and tend to “bounce around” to multiple diagnosis-specific clinics, participating in a full course of psychotherapy at each one.


Is there any evidence that transdiagnostic psychotherapies work? There have been several positive reports on the effectiveness of transdiagnostic treatments for emotional, eating, and sleep disorders, to cite only a few examples (see Nolen-Hoeksema & Watkins, 2011). Clinical researchers are in the process of examining whether these treatments can even outperform diagnosis-specific therapies (DSTs), especially for comorbid conditions that are not the advertised target of the DST (e.g., Farchione et al., 2012). Overall, there is promising evidence supporting the utility of transdiagnostic psychotherapies, but much more work remains to be done.

One could make the argument that if transdiagnostic psychotherapies work just as well as DSTs for, let's say, substance use disorders, then training in a particular transdiagnostic intervention could be the most effective use of mentorship time in a drug abuse clinic, especially in the context of a relatively short training cycle. It is certainly hard to imagine transdiagnostic therapeutic techniques or concepts not being transferrable, by and large, to other therapy situations. However, there could be many diagnoses or training settings for which a transdiagnostic approach would not be advisable. For example, Linehan (1993) developed Dialectical Behavior Therapy after observing that traditional behavioral therapies, which are based on transdiagnostic learning principles, were ineffective for women with borderline personality pathology. More investigation into the appropriate conditions for transdiagnostic training certainly seems warranted.

I am interested in hearing more about trainees' and

supervisors' experiences with transdiagnostic psychotherapies on Section 10's (Graduate Students and Early Career Psychologists) Facebook page (<https://www.facebook.com/groups/div12sec10/>). Also, feel free to contact me at div12sec10@gmail.com with any suggestions for future columns or to continue the conversation about training.

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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!



How will practice take shape in the new healthcare environment?

Donna Rasin-Waters, Ph.D.

Division 12 Federal Advocacy Coordinator



Healthcare reform is no longer an abstract concept. The Affordable Care Act (ACA) of 2010 continues to rapidly transform the healthcare system at the state level as millions of uninsured Americans will be eligible for insurance programs beginning in 2014.

As the system transforms, how might we expect to practice differently as psychologists? As many new words and terms roll off the tongues of policy makers and those who present or write about reform, what types of shifts or changes are we going to need to make with our patients on a day to day basis? Or will we need to make any changes at all?

As the much anticipated transformation begins to truly take form, I suggest that each and every psychologist consider the following changes.

Health insurance expansion under Medicaid

The government, through Medicaid expansion in the states, will become the largest insurer of the new patients on the insurance rolls. So, tuning into what your state psychological association is doing about this expansion and understanding the current Medicaid benefits in your state will be important in the coming years. Input into payment system transformation will be crucial so that we can practice in the new integrated environment that might include same day referrals for

mental and behavioral health care.

Are you a Medicaid provider? If not, you may want to find out how to become one in your state. Consider getting involved in how the new government insurance plans in your state are taking shape and have input regarding your area of expertise.

Improving outcomes

How many of us have thought about how to improve the services we deliver to our patients so the outcome of what we provide adds value to the healthcare system? Not many of us, I bet.

Well, here is a simple (though not necessarily easy) practice suggestion to begin to make a shift toward outcome measures and interventions that assist with the overall health of our patients. In making such a shift it is important for us as a profession to quantify and share our work with key providers. While maintaining great respect for privacy rules and regulations, the new system will be integrated with communication across the professions, particularly as electronic health records become commonplace. Sharing the mental and behavioral health treatment goals with other providers and collaborative intervention aimed at integrating physical and mental health will be the new norm. These efforts have been shown to reduce overall health care costs.

One thing that is on the easy side is using a form in your office to obtain permission to contact patients' primary care providers and obtain informed consent to send the diagnosis and treatment goals to the provider. Most providers appreciate communication that is brief, with bulleted points and free of psychology jargon.

Looking for back issues of The Clinical Psychologist?

Past issues of *The Clinical Psychologist* are available at:
www.div12.org/clinical-psychologist



Federal Advocacy Column (*continued*)

For example, you might obtain consent from a patient you diagnosed with major depression and non-compliance to their medical regimen as follows:

(Your letterhead with contact information: phone, fax, email)

Date

Dear _____,

My office has started treatment with (patient name, date of birth). She/he was evaluated on (date).

Diagnoses:

**Major depression, single episode, severe and
Non-compliance with treatment (insulin dependent diabetes).**

The following data were obtained:

Depression measured in the severe range (BDI score 38/63).

Suicide screen **negative**.

Patient is **not** homicidal or aggressive.

Symptoms include insomnia, weight loss, and social isolation.

Patient reported non-adherence to insulin regimen.

Treatment plan:

Major Depression

Evidence-based cognitive behavioral protocols for insomnia and depression.

Diabetes

Motivational interviewing for non-adherence.


(Expected treatment timeframe and prognosis).

Your name, degree

License

Communication with a patient's primary care provider has been a Centers for Medicare and Medicaid (CMS) regulation for years. By adopting such a form to your practice you can begin to share critical information with medical professionals. Don't necessarily expect a return contact, although in complex patient cases it might be necessary to communicate about a patient and collaborate further on their overall health care.

For information about the laws for documentation and electronic health records in your state visit APA Communities and take a look at the Documents section. To gain access to this online sharepoint contact tbarnes@apa.org.

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



SECTION UPDATES

Guerda Nicolas, Ph.D., and Roxanne Donovan, Ph.D.—Editors

Section II: Society of Clinical Geropsychology

Submitted by Michele J. Karel, Ph.D.



The Society of Clinical Geropsychology (SCG) has news in the way of elections, awards, and an update from the APA convention:

Elections: Section 2's new President-Elect is Margaret Norris, PhD. Dr. Norris is an Independent Psychologist in Longmont, Colorado. She serves as the Co-Chair of the combined SCG and Psychologists in Long Term Care (PLTC) Public Policy Committee and the SCG representative to the APA Interdivisional Healthcare Committee. She also served as past treasurer of Section 2. Dr. Norris will serve her term as President-Elect with incoming President Brian Yochim, PhD, and soon-to-be Past-President Amy Fiske, PhD.

Awards: SCG is pleased to announce the winners of our three annual awards:

- M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology: Victor Molinari, Ph.D., ABPP, Professor, School of Aging Studies, University of South Florida
- Distinguished Mentorship Award: Jennifer Moye, Ph.D., Director, Geriatric Mental Health, VA Boston Healthcare System, Associate Professor, Harvard Medical School
- Student Paper Award: Philip Sayegh, M.A., University of Southern California. Paper entitled: *Assessment and Diagnosis of Dementia in Hispanic and Non-Hispanic White Outpatients* (advisor: Bob Knight)

APA Guidelines for Psychological Practice with Older Adults: At the APA Convention, the APA Council of Representatives adopted the updated *Guidelines for Psychological Practice with Older Adults*. The updated guidelines will be posted on the APA Office on Aging website (<http://www.apa.org/pi/aging/>) and published in *American Psychologist* early next year. Thanks to the Working Group who lead the update effort: Greg Hinrichsen, PhD, Adam Brickman, PhD, Barry Edelstein, PhD, Kimberly Hiroto, PhD, Tammi Vacha-Haase, PhD, and Rick Zweig, PhD, and

to SCG and APA Division 20 for their support of the update effort.

And, reminders:

GeroCentral: The Society of Clinical Geropsychology is excited to announce that the "GeroCentral" website is on-line at <http://gerocentral.org/>. GeroCentral is a website clearinghouse of practice and training resources related to psychology practice with older adults.

Geropsychology ABPP: Applications are now being accepted for ABPP certification in Geropsychology. See the ABPP website, Applicant section, for more information, at www.abpp.org

Section VII: Emergencies and Crises

Submitted by Marc Hillbrand, Ph.D.



Section VII has, in the last two years, made contributions to the Division 12 Clinician Toolkit that summarize the state of the art in risk assessment and management. *Assessing Violence Risk in General Practice* and a collection of documents relevant to suicide risk assessment are now available to D12 members exclusively at <http://www.div12.org/member-login/toolkit/>. A Section workgroup, consisting of Phillip Kleespies and Marc Hillbrand (co-chairs), David Drummond and James Werth, is now summarizing what is known about co-occurring violence and suicidality. Their report will be added to the Clinician Toolkit later this year.

Section offerings at the 2013 APA convention in Honolulu, HI included a symposium entitled *The Challenge of Bullying & Suicide in American Youth* by Bruce Bongar and colleagues, a joint symposium with representatives from the APA Committee on Rural Health on *Rural Suicide*, and a Presidential Address by James Werth. The late James Rogers, Past Section President, posthumously received the Section VII Career Achievement Award. Jonathan Green received the Section Student Award for his work *Assessing the Perceived Normativeness and Functions of Direct and*

Indirect Self-Harm in Men.

In anticipation of new rules regarding program submissions for the 2014 APA convention in Washington, DC, Section VII is exploring collaborative program, cutting across APA divisions and across Sections within Division 12. One of the themes of the Convention will be *The Psychology of Violence*, a topic of great interest within the Section. Readers who belong to other D12 Sections or other Divisions are encouraged to contact any member of the Section VII Executive Committee (<http://www.apa.org/divisions/div12/sections/section7/contacts.html>) if they have interest in collaborating on program proposals.

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, Ph.D.



The Association of Psychologists in Academic Health Centers (APAHC) hosted a number of stimulating presentations at the recent APA Annual Convention in Honolulu, Hawaii.

Featured speakers and topics included the 2012 Winner of the IVAN MENSCH AWARD FOR DISTINGUISHED ACHIEVEMENT IN TEACHING, John Linton, PhD, ABPP: *Teaching Behavioral Science in Academic Health Centers Throughout the Ages*. Dr. Linton highlighted the perception that behavioral sciences are the default in medical education. He described this as “an inconvenient truth...that medicine prefers ‘real’ science, and that psychologists need to stay ahead of the default position if they want to stay relevant in a medical environment. He further noted the perception that behavioral science is about “caring,” whereas medicine is about “competencies.”

Former APA President, James Bray, PhD, ABPP, presented a symposium on “*Psychology Practice and Science in Academic Health Centers – Implications of Health Care Reform*.” Dr. Bray noted that health care costs comprise approximately 16% of the US GDP (gross domestic product), whereas those with mental health issues make up about 91% of the GDP; co-morbidities increase costs. Health care reform will lead to more money for primary care, which currently reflects 30% of all health care providers, in contrast to specialty care at about 70%. The goal is “faster, better, cheaper” (ala author, Ian Morrison), including increased access, improved quality, and cost containment.

The Joseph D. Matarazzo Award for Distinguished Contributions to Psychology in Academic Health Centers was presented to Barry Hong, PhD, ABPP whose presentation will be given during the 2014 APA Convention in Washington, DC. In addition, APAHC hosted an event: Navigating the Academy: A conversation hour for women of color trainees and professionals. APAHC leaders and members also created an informal “meet and greet” opportunity to address: Positioning yourself for the new era of health care – tips for early career psychologists in academic health centers.

For further information about APAHC/Division 12 Section 8, please check our website at: <http://www.div12.org/section8/index.html> or contact me directly at Sharon.Berry@ChildrensMN.org. ■

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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 consider being 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 service.


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 their work and nominating them 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 

NOMINATIONS BALLOT: DIVISION 12 ELECTIONS

Dear Division 12 Colleague:

Once again it is time to request your participation in the Division's nomination process. We will be selecting three positions: **President, Treasurer,** and one **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 29, 2013.**

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 29, 2013.**

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 *SOCIETY OF CLINICAL PSYCHOLOGY (DIVISION 12)* NOMINATIONS BALLOT

PRESIDENT: _____

TREASURER: _____

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*

Remember:
nominations are
due by **Friday,**
Nov. 29, 2013!

JOIN A DIVISION 12 SECTION

The Society of Clinical Psychology has eight sections covering specific areas of interest.

- Society of Clinical Geropsychology (Section 2)
- Society for a Science of Clinical Psychology (Section 3)
- Clinical Psychology of Women (Section 4)
- Clinical Psychology of Ethnic Minorities (Section 6)
- Section for Clinical Emergencies and Crises (Section 7)
- Association of Psychologists in Academic Health Centers (Section 8)
- Section on Assessment Psychology (Section 9)
- Graduate Students and Early Career Psychologists (Section 10)

To learn more, visit Division 12's section web page: www.div12.org/sections

To learn more about the
Society of Clinical Psychology,
visit our web page:
www.div12.org



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 is 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* includes 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 editor
Guerda Nicolas at: nguerda@miami.edu.

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.