

THE CLINICAL PSYCHOLOGIST



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

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By David F. Tolin, Ph.D., APBB

PRESIDENT'S COLUMN

Empirically Supported Treatments: An Agenda for 2014



I'm delighted to write this first column during my term as President of Division 12, and hope to follow the exemplary leadership example of my predecessor, Past-President Dr. Mark Sobell. I would like to extend my thanks to this year's Program Chairs, Drs. Bunmi Olatunji and Lisa Elwood, who have worked tirelessly to put together an outstanding lineup for this year's Convention.

One of my 2014 presidential initiatives concerns empirically supported treatments (ESTs), a topic that is near and dear to the hearts of many of our members, but which has also sparked a great deal of controversy. Many scholars, even those committed to the integration of science and practice, have raised thoughtful critiques of ESTs and the EST movement. Some, for example, have suggested that the success of psychological therapy has little to do with specific therapeutic techniques, and much to do with common factors such as a strong therapeutic relationship. They argue, therefore, that our main thrust of scientific inquiry should be to investigate the principles of empirically-supported relationships, rather than empirically-supported treatments.

Other authors have argued that the overreliance on randomized controlled trials (RCTs) is fundamentally flawed. The reliance on DSM diagnostic criteria has been one common sticking point; critics have pointed out that many clinical patients either meet criteria for multiple diagnoses, or do not neatly conform to any specific diagnosis. Others have pointed out the high exclusion rates in many RCTs, which raise important questions about the degree to which the results of these studies will generalize to clinic patients who would not have been excluded. Still others have noted that the "bar" is rather low in many RCTs of psychological treatments, suggesting that it is not terribly difficult for any treatment, sufficiently studied, to prove superior to no treatment, and that the absence of double-blind placebo control makes these studies prone to inflated outcomes and researcher allegiance effects.

Many authors have objected to the association between the EST movement and manualized treatment. They point out that a practicing clinician would need to possess and master an exorbitant number of treatment manuals—a point compounded by the fact that many

(Continued on page 2)

President's Column (*continued*)

patients do not respond adequately to the first treatment provided. Manuals are perceived by many as being unnecessarily stifling and lacking in flexibility.

Finally, some critics have pointed to significant problems of interpretation under the current EST structure. Many treatments on the current EST list either overlap substantially with one another, or contain ingredients that have been demonstrated to be inert. The "box score" approach to determining effi-

cacy has also been criticized, with some authors noting that there is no means of determining relative strength of treatment effects, degree of scientific support, or cost-effectiveness. The absence of long-term outcomes and the relative inattention to outcomes such as quality of life or degree of functional impairment have also been noted.

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GRAPHIC DESIGN

Jason Crowtz



tasked with updating and revising our list of ESTs (www.psychologicaltreatments.org). As we go forward, we will have to grapple with a number of thorny issues, including:

- Should relationship and techniques be considered different domains of psychological treatment? Or is it time to lump them together under the category of “stuff the psychologist should do?”
- Should we stop applying the “empirically supported” label to multi-component treatment packages, without understanding what the active and inactive ingredients are? Or should we turn our focus to empirically supported principles of change?
- Should we continue to focus on ESTs, and manuals thereof, for discrete DSM diagnoses? Or should we instead focus on treatments for syndromes of psychopathology that cut across diagnoses?
- Should we continue to call a treatment “empirically supported” if it has not been demonstrated to be superior to placebo or an alternative treatment? Or is it time to raise the bar?
- Should we continue to rely on the “box score” methodology of counting successful trials? Or should we adopt a more sophisticated rating system, such as using pooled effect size or number needed to treat?
- Is symptom reduction a satisfactory outcome for determining whether a treatment is empirically supported? Or should the treatment also be required to have demonstrable benefit on functioning or quality of life?

Want to speak up or get involved? Email me at david.tolin@hhchealth.org or send an email to the listserv at div12apa@lists.apa.org. 📧

APA Presidential citation for Dr. Terence Keane

Dr. Terence Keane received a Presidential citation from APA President, Nadine Kaslow, Ph.D. during the Division Leadership Conference in Washington, DC January 25, 2014. The citation reads as follows:

Terence (Terry) M. Keane, Ph.D. — for his lifelong commitment to helping our nation's Veterans.

A tireless clinician, researcher, teacher, mentor, advocate, bureaucrat, psychometrician, spokesperson, administrator, board member, and leader, Dr. Keane is a gentleman and a scholar with a bottomless pit of energy, passion, and compassion. His keen clinical skills identified commonalities in returning Veterans even before posttraumatic stress disorder (PTSD) was a diagnosis. He tried to understand, define, and help them, and he hasn't given up yet. His corpus of work paved the foundation for today's standard way of conceptualizing, assessing, and treating PTSD. He serves as the “go-to” expert to the governments and decision makers of various countries, world-renowned institutions and agencies, and all branches of the United States Military and its leaders. In 1989, he became Director, Behavioral Sciences Division at the Boston VA, of one of the newly developed National Centers for PTSD, and over the next 20 years has been instrumental in its ascension as one of the world's leading research centers on all aspects of military trauma. Dr. Keane has participated in many scientific review panels and co-chaired the National Institute of Mental Health Consensus Conference that established national standards for the diagnosis and assessment of PTSD. Dr. Keane is an extraordinary person who has shaped an entire field of psychological inquiry. His manifold contributions have exerted a life-changing impact on thousands of veterans and their families, as well as on people of all socioeconomic stripes around the world who have endured the devastating repercussions of trauma.



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Darwin and Clinical Psychology

Donald K. Routh, Ph.D.

University of Miami

 In the past, my history columns have mainly concerned about the last 120 years. This column will deal with the approximately 3.5 billion years since life began, because I think all psychologists need to think about that, too. I have been working on a “Darwin project” for about a year and a half now and have read over 200 books on the history of the field of evolution and human behavior. This essay gives me a chance to try to pull some of this material together in a brief way.

In addition to the great achievements of humanity—art, music, language, technology, and science itself—which are all illuminated by Darwin’s theory of evolution, his work and that of his followers have also shed considerable light on topics closer to the hearts of clinical psychologists, such as ADHD, aging, aggression, alcoholism, anxiety, attachment, autism, depression, problems in neurodevelopment, intellectual disability, language impairment, perceptual disorders, and schizophrenia. Obviously, this paper cannot cover this whole spectrum of human misery. It does attempt to show the clear applicability of Darwin’s theory to problems such as depression and anxiety.

Charles Darwin himself grew up in an environment where clinical issues were salient. His grandfather, Erasmus Darwin, was a physician who wrote a noteworthy poem about his own concept of evolution. Charles Darwin’s father, Robert, was also a physician and encouraged his son to choose the same profession, and he did indeed attend medical school at the University of Edinburgh. As it turned out, he was too tender hearted to perform even minor surgical procedures, so he went on to Cambridge and prepared to be a clergyman (!) before he decided on the life of a naturalist. Personal health issues provoked in him an interest in clinical matters. He suffered from a mysterious gastrointestinal illness much of his life. It has been debated whether this was a form of Chagas disease acquired in South America or was psychosomatic. The illness was never cured despite considerable efforts by the “hydrotherapists” of that day.

Darwin’s famous book, *On the Origin of Species*, published in 1859, sold out immediately and set off a firestorm of both advocacy and criticism from his fellow scientists. Another influential author in this era was Herbert Spencer, the man whose psychology was the best known in Darwin’s time. Spencer’s writings concerning evolution were published in 1857, two years before Darwin’s. Spencer invented the phrase, “survival of the fittest,” which Darwin adopted. Already in the 1870s, Spencer’s work was labeled as “social Darwinism.” As a result of Richard Hofstadter’s writings in the 1930s, Spencer became widely known by this phrase. By the 1940s Hofstadter’s work had given social Darwinism a bad name in the social sciences, which has to some extent lingered on to the present. Spencer was somewhat inaccurately portrayed as having views resembling those of “robber barons” such as Rockefeller or modern libertarians and advocating a total absence of any social safety net. Actually, Spencer only opposed the use of government assistance to the poor on the grounds that it might create a dependent class. He approved of private charity. In 1871, Darwin published his own account of the evolutionary descent of humans, including his ideas about sexual selection.

The most influential modern psychologist who took Darwin seriously was William James, whose psychological writings in the 1870s already were noteworthy and arguably established him as the founder of psychology in America. His textbook, commissioned in 1878 and published in 1890, has been read by generations of psychologists and is still in print. Ever since that time his work has influenced us toward accepting the scientific theory proclaimed by Darwin. James was a graduate of Harvard Medical School, though he never practiced medicine, because he, like Darwin, was subject to considerable psychological stress and wrote about clinical matters with personal conviction as well as great authority.

The essence of Darwin’s theory is that humans, like other organisms, evolved over a period of what he underestimated as 400 million years or less. This occurred through a process of “natural selection” in which the hereditary characteristics of those organisms that survived and produced offspring were preserved in their progeny. Organisms that did not manage to reproduce obviously did not pass along hereditary characteristics (what we now call “genes”) to later

generations. Primates with larger brains were highly adaptable to a huge variety of different environments. In this way, humans have indeed acquired impressive dominion over the earth.

Another process specified by Darwin was “sexual selection” in which preferences of mates determined which hereditary characteristics survived in offspring. Peahens prefer peacocks with those beautiful tail feathers we all admire; the peacock’s tail therefore survived despite the fact that it was also attractive to potential predators. Women likewise prefer men who are physically attractive, intelligent, assertive, and high in social status; men prefer women who have “beautiful” faces (including those that are particularly symmetrical) and figures, are healthy, compassionate, and seem likely to be able to bear children. This is true despite the fact that “beauty,” like the peacock’s tail, is not necessarily of direct functional value. Obviously, there are also cultural variations in mate preferences that go beyond any inherited ones. For example, in certain third world countries, women are more likely to select men who are good hunters; men are more likely to find women attractive who in our own society might be seen as obese.

Evolutionary psychologists distinguish between “proximal” and “ultimate” causes. Psychologists, including clinical psychologists, have been mostly concerned with proximal influences, namely those resulting from the person’s current environment. These include learning, the influence of parents and peers, and, of course, psychotherapy. Darwin and his followers are more concerned with ultimate causes such as evolved adaptations, perhaps acquired in the Pleistocene era of geological time, which lasted from 2,588,000 to 11,700 years ago.

Many animals other than humans are “precocial,” requiring little or no parental care. They tend to have relatively short life spans. Humans are “altricial,” requiring a lot of parental care and indeed support from their communities. They also live a relatively long time. Humans have large brains and therefore large heads. Theory speaks of “neoteny,” the idea that birth of immature offspring allows for greater behavioral plasticity. Newborns also have skulls with bones that are not fully knitted together so that they are able to pass through the birth canal. Human infants are thus less developed than the young of most other animals, and much of their brain growth must be post-natal. Humans therefore experience a long and

complex period of dependency usually on parents or “alloparents” in communities where many others take on a parental role. The transition from dependence to independence experienced by young adults often involves so much anxiety and depression that they seek professional help. Therapists might find understanding the evolutionary context of these and other emotions to be useful. This may be the price we pay for our large brains.

One of the most ancient psychological problems is that of depression. The Hippocratic writings spoke of “melancholia.” They suggest that this was due to an excess of “black bile” in the body and advised that it be treated by purging, perhaps using enemas, and this theory persisted up to the time of 17th century French dramatist Moliere and beyond.

Clinical psychologists commonly attribute depressed mood to life events such as death of spouse, divorce, marital separation, and imprisonment. These are, of course, items on the Holmes and Rahe Social Readjustment Rating Scale and all represent good examples of proximal causes. Without in any way denigrating the importance of such influences, a Darwinian clinical psychologist would also wonder about ultimate causes. For example, it may be that ancestral primates who lost their mates and underwent a time of depressed mood and reduced activity elicited sympathy and practical help from their peers in obtaining food and raising children. If so, those who suffered such “problems” might actually adapt better than others less subject to depression, in the sense of being more likely to survive and to produce additional offspring. In addition, there has been recent talk of depression (and anxiety) as responses to social exclusion.

Third, an influential theory has emerged over the last few decades that links depression to infectious disease. When a person becomes ill, for example with influenza, the immune system reacts by producing hormones known as cytokines such as interleukin 1, interleukin 2, interleukin 6, and tumor necrosis factor (TNF). Some of these cytokines have been used to treat cancer, and it has been found that they lead patients to experience malaise, withdraw from social activities, sleep excessively, and cease to enjoy many of their usual activities (anhedonia), in other words, mild symptoms of depression. When cytokines are administered to laboratory animals, they also exhibit “sickness behavior.” In ancient times, when there were no antibiotic drugs, infectious disease took a huge toll. Thus, indi-

viduals who inherited the ability to produce cytokines in response to illness would be more likely to survive and produce offspring. It may be that clinical depression is in part a pathological variant of an evolved adaptation that is useful in combating infectious disease. All of these concepts, if confirmed, would also provide evidence depression is an evolved adaptation, in part at least. As Peter Richerson says, "Having the machinery for depression present may also lead to the machinery misfiring for various pathological reasons. Adaptations often come with costly tradeoffs. For the clinician, the distinction is important. If depression, say, upon the death of a spouse, is doing useful work, a clinician might do harm by treating the adaptation. On the other hand, if it is a case of misfiring due to excess sensitivity of the individual or novel stimulus in the modern environment the clinician would want to treat the symptoms that are doing no good."

As Darwin himself said in a letter, "Pain or suffering of any kind, if long continued, causes depression and lessens the power of action, yet it is well adapted to make a creature guard against any greater or sudden evil."

Another clinical problem of ancient vintage is anxiety, or irrational fear. Anxiety can obviously be due to the person's traumatic experiences, as in the post-traumatic stress so commonly observed in combat veterans, a proximal cause. In this case, a likely ultimate cause has been identified by Swedish psychologist Arne Ohman. He showed, by ingenious experiments,

that people were much more easily conditioned to fear snakes and spiders than buttons or other neutral objects. It seems likely that this readiness to acquire certain kinds of fears is an evolved adaptation.

In conclusion, probably the main contribution that evolutionary psychology can make to clinicians is to encourage them to think about the "ultimate" causes of behavior and not only the "proximal" ones. This can only increase their effectiveness as researchers, assessors, and therapists. As Richerson says, "The task is to understand the evolved functions of psychological states so as to separate them from non-functional symptoms. The former one will probably not want to treat, whereas the latter one would."

I very much appreciate the opportunity to share the beginning stages of my Darwin history project with readers of *The Clinical Psychologist*.

Acknowledgements: I wish to thank my wife, Margaret Gonzalez, for her excellent editorial suggestions on the first draft of this paper, and my 13-year-old grandson, Paul Martin, for letting me know that he found this same draft to be easy to read. Christopher Green, the well-known historian of psychology who teaches at York University in Toronto, made comments on the second draft that saved me from several inaccuracies and made this a more nuanced piece of writing. Evolution Peter Richerson gave the paper a very subtle reading. Nicola Foote of Florida Gulf Coast University, Lakshmi Gogate, and Michael Antoni of the University of Miami also made helpful comments. ■■

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Addressing Ethical Concerns about Colleagues via Informal Means

George J. Allen, Ph.D.,
University of Connecticut,
and Allison N. Ponce, Ph.D.,
Yale University Medical School



Much has been written about the importance of self-care for members of our profession. Our colleagues have published a substantial number of articles (e.g., Barneers, and (d) integrating self-care into our daily routines.

Making ethical judgments about the activities of our peers is a complex activity that requires balancing delicately fundamental values (i.e., beneficence, fidelity, integrity, justice, respect) embedded in the five aspirational principles of our ethics code (American Psychological Association, 2010). In addition, we weigh

power and authority differentials and ponder (sometimes obsess about) the pervasiveness, length, and seriousness of the concerning action, all while being anchored in some level of familiarity/intimacy in our relationship to the colleague(s) whose behaviors concern us.

We believe that experiencing mounting suspicions about possible ethically dubious actions of colleagues is almost always an unsettling and uncomfortable experience.

We can all too easily look the other way and keep silent. Such silence, however, can serve as a Petri dish that promotes the growth of all sorts of unsavory social bacteria; insistent negative rumors about the alleged perpetrator, an atmosphere of heightened suspicion and ill will in which we judge our colleague as guilty, without providing opportunity for justification, and self-recrimination for not taking action.

Ethical standard 1.04 enjoins us to begin rapprochement via informal means, so long as such discussion is

consistent with intersecting legal, organizational, and contextual issues. Failure to resolve the concern can then lead to reporting suspected violations to appropriate higher-level authorities. Van Horne (2004) received responses about the disciplinary activities of 37 licensing boards covering 37 jurisdictions from 1996 to 2001 and reported that complaints had been filed against approximately 2% of licensees. Greyner and Lewis (2012) found an identical 2% complaint rate leveled against registered Australian psychologists between July 2003 and July 2007.

This lower rate of reporting suspected violations may be a function of widespread efforts toward resolving them informally. Koocher and Keith-Spiegel (2010) surveyed confidentially researchers receiving NIMH funding about how they dealt with suspected acts of scientific wrongdoing. They reported that 63% of 2,193 respondents who had experienced such suspicions had intervened with their colleagues and that most interventions were informal. A majority of interveners reported either no negative consequences or having gained respect following the intervention, although a substantial minority reported being treated disrespectfully ($\approx 10\%$), experiencing negative emotional costs ($\approx 10\%$), or suffering adverse career consequences, social costs, or loss of reputation ($\approx 5\%$). Respondents were less likely to intervene with superiors or with colleagues with whom they were socially close. Analysis of respondents' comments also suggested that a higher percentage of problems appeared to be corrected when interveners took "softer, less accusatory" stances (p 439).

Such informal attempts at negotiation provide all involved parties the greatest initial privacy and also the greatest freedom of personal movement toward successful resolution. One author of this column once learned that a secretary who did billing for a clinical practice had become upset at what she thought was unethical invoicing by one of her employers. We thanked the woman for bringing the problem to our attention and mentioned that we would attempt to keep her identity anonymous, but also obtained her permission to identify her by name if the situation required it. Several of us met with the colleague, described hearing rumors about the questionable practices, and pointed out that, if true, the activities could be construed as insurance fraud. We mentioned that we were concerned that our colleague maintain a

Experiencing mounting suspicions about possible ethically dubious actions of colleagues is almost always an unsettling and uncomfortable experience.



good reputation. We also, most gently, suggested that we would also be alert to any activities that could be construed as reprisals against any individuals who the colleague might believe had reported the potential misdeed. The questionable practices quickly ended.

In this scenario, we made no accusations or threats, but simply reported what we had been hearing. Accusations severely reduce the freedom of the alleged perpetrator to remedy the problematic situation. Continuation of dubious actions often calls for more specific and thoroughly documented accusations being directed toward various sanctioning bodies. Keith-Spiegel, Sieber, and Koocher (2010) provide a free and very useful guide to dealing with suspected research wrongdoing. The suggestions contained in their guide also are applicable to many additional clinical and professional situations.

Within the page limitations of this column, we offer five broad guidelines for negotiating informally ethical concerns about colleagues directly with them.

1. Attempt to obtain enough information about potential misdeeds to provide a firm base for informal discussion. Listen carefully but avoid engaging in rumors or innuendo. Greater privacy of all participants results when converging data emerge from several sources.
2. Be respectful of the privacy rights of all participants. Seek to protect the anonymity of others who are sources of information. If intervening for other parties, be clear about your options regarding revealing their identities. Obtain if possible their consent to be identified if necessary. Honor their choice, but explain the limitations placed on you if such permission is not granted.
3. Be non-accusatory and non-adversarial in tone and content when beginning discussion. Consider what you are doing as a “teaching moment” to your colleague.
4. Expect initial negative reactions involving anger or denial. Such negativity can be defused by pointing out that you are:
 - a) Not making accusations, simply bringing news of what you have heard or experienced to your colleague;
 - b) Doing everyone a favor by raising the issue in privacy and informally. This message can be made more powerful by acknowledging that the confrontation is uncomfortable and distressing for you.
 - c) Framing the initial conversation as the opening of a dialogue which can be carried out further in the future. This framework provides all parties the opportunity to strategically retreat and defuse increased acrimony.
5. Keep written notes about your involvement; this practice can be protective for you. Such a record should provide a running chronology noting events, dates, your actions, and the reactions of others. Such notes should remain totally private. They can be destroyed subsequent to the successful resolution of the circumstances or introduced as evidence in the event that more formal action needs to be taken at a later point in time. One additional suggestion is to keep such records for the same length of time that state statutes mandate retention of clinical records.

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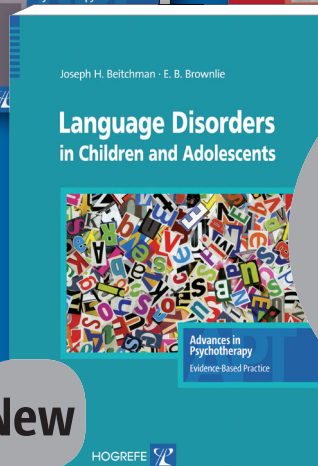
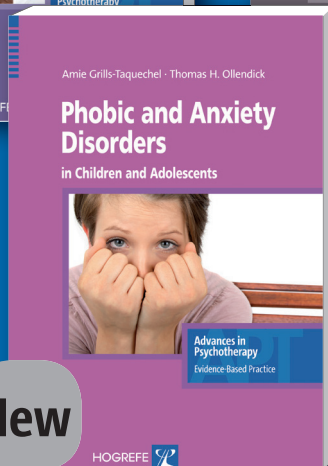
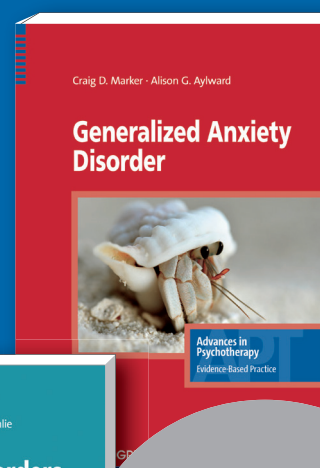
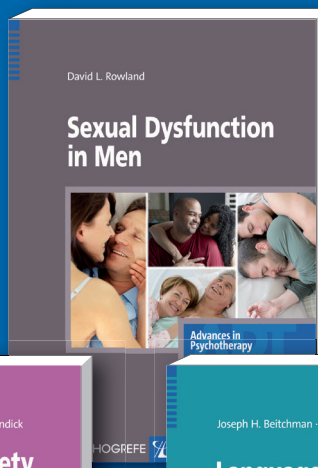
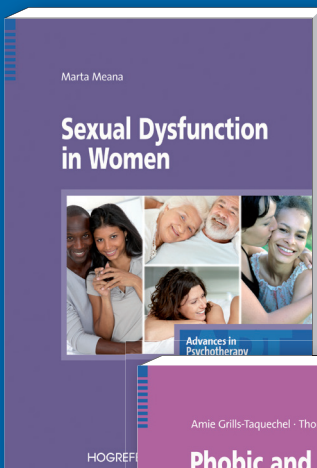
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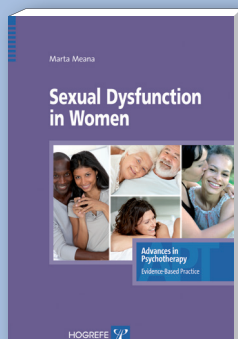
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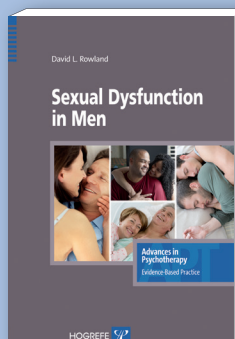
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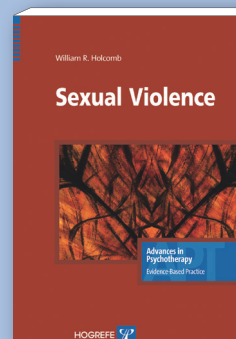
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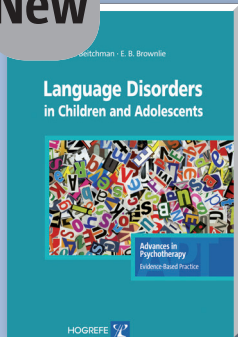
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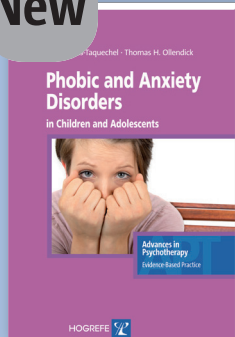


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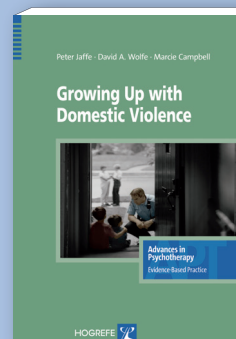
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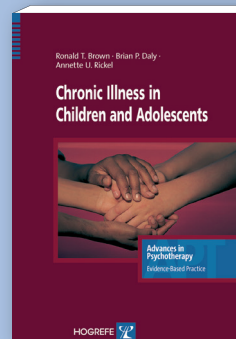
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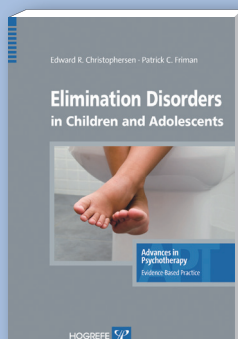


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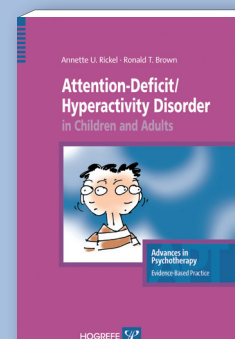
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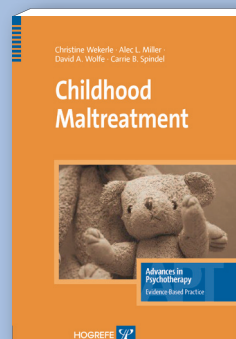
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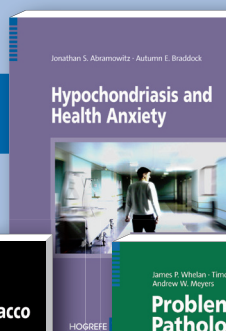
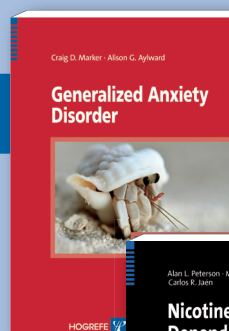
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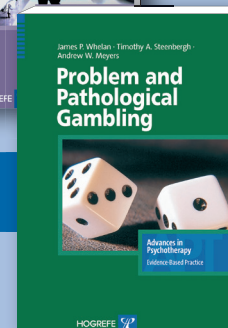
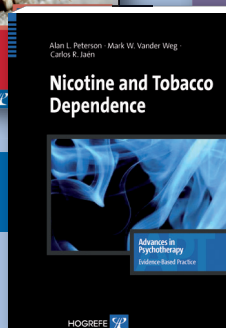
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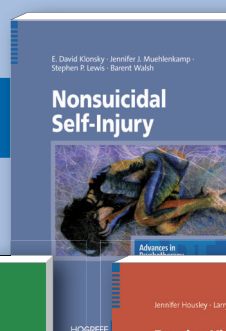
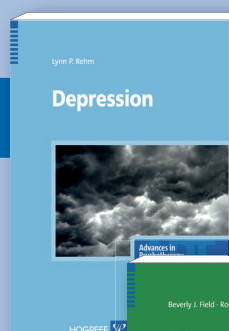
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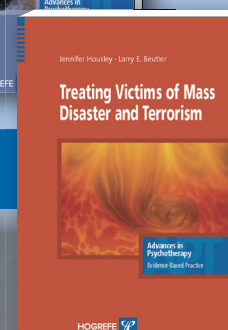
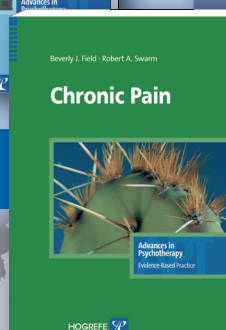
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Psychology trainees' use of disclosure in clinical psychotherapy supervision

Megan Reuter, M.A.

Megan Reuter attends the American School of Professional Psychology at Argosy University in the San Francisco Bay Area. She is working towards a Psy.D. in Clinical Psychology.

 To disclose or not to disclose? That is the question that all psychology trainees face at some point during their clinical training years. There are myriad implications of not disclosing clinical information to supervisors. Before discussing implications, I'd like to acknowledge that the supervisory relationship is a complex one that involves trust and vulnerability on the psychology trainees' end. It's no wonder that psychology trainees, knowing they are being evaluated for clinical competencies, oftentimes shy away from accurate reporting of clinical case details. The struggle of deciding to disclose certain types of clinical information to one's supervisor originates from the trainee, in his or her own worst fears, appearing incompetent as a budding therapist (Ladany, Hill, Corbett, & Nutt, 1996; Yourman & Farber, 1996). In a dated study of psychology trainees, up to 30-40% admitted to occasionally withholding or distorting important clinical information from their supervisors (Yourman & Farber, 1996). I could not find a study that provides a more recent statistic, which leaves room for researchers to reassess this phenomenon. The clinical saliency of this topic is clear in its implications not only for supervision, but also for its impact on clients.

Much of the research that informs us on clients' willingness to disclose information to their therapists can parallel the experience of the psychology trainee in supervision (Falender & Shafranske, 2004). Time and time again, research has indicated that the most salient, active ingredient in therapy is the quality of the therapeutic relationship, regardless of theoretical orientation and interventions used. Without strong rapport built, it is unlikely that therapists will contribute as an active agent of change in their clients' lives. An important process that takes place is called isomorphism, also known as parallel processes. For an example of isomorphism in

play, the psychology trainee likely feels the same way as a client in therapy. In other words, without strong rapport built between the supervisor and trainee, trainees are more likely to not disclose critical clinical information, which may lead to negative effects with client treatment (Yourman & Farber, 1996).

So, what constitutes "good" supervision in which psychology trainees feel comfortable disclosing clinical information to their supervisors? In a phenomenological study by Jacobsen and Tanggaard (2009), eight beginning therapists universally conveyed that they valued a supervisor who not only gave them advice on interventions to use with clients, but also affirmed their present skill level to combat beginning therapists' self-criticism. Beginning therapists also valued being able to "express their failures openly" (pp. 15). Once again, the fundamental ingredient of these results is the existence of a strong supervisory relationship.

In summary, below are some suggestions of what clinical supervisors can do to facilitate open discussion of clinical case details:

- a) Just like in psychotherapy, focus on building strong rapport with your psychology trainee from the beginning of training.
- b) Explicitly address your openness to hearing about clinical mistakes with the psychology trainee, without expectation of harsh judgment.
- c) Adapt various relationship outcome measures to assess the quality of the supervisory relationship. As Gunn and Pistole (2012) noted, there is "no attachment-based supervision measure" (p. 231). Various researchers have therefore adapted, for example, the Client Attachment to Therapist Scale (CATS) to the Therapist Attachment to Supervisor Scale (Marmarosh, et al., 2013).
- d) Engage in a collaborative dialogue when going over formal reviews of the psychology trainee.

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DIVISION 12 ELECTIONS

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

Division elections are coming

Each member of the division will soon have the opportunity to help select the next President-elect of Division 12, the next Treasurer of Division 12, and two Division 12 Representatives to the APA Council of Representatives. The candidates are listed below in alphabetical order.

PRESIDENT-ELECT:

Barbara Cubic, Ph.D.

Brad Karlin, Ph.D.

TREASURER:

Kalyani Gopel, Ph.D.

Jonathan Weinand, Ph.D.

DIVISION 12 REPRESENTATIVE TO APA COUNCIL:

Barry A. Hong, Ph.D., ABPP

Kenneth J. Sher, Ph.D.

David A. Smith, Ph.D.

Mark B. Sobell, Ph.D., ABPP

Statements submitted by the candidates are as follows:



Candidate statement for President-elect: Barbara Cubic, Ph.D.

The field of clinical psychology is facing challenges in this era of healthcare reform that requires a new vision. We must learn to utilize our skills to increase engagement in inter-professional education, research, and clinical practice with other healthcare disciplines. To do so the Society of Clinical Psychology (Division 12) must emphasize training, dissemination, and implementation of evidence-based practice of clinical psychology and increase its membership and active involvement of the membership. If elected as president, my primary goals will be:

1. A focused, extensive membership drive with emphasis on recruitment of student, early career, and minority psychologists to allow a more diverse voice within the division;
2. Development of task forces to identify the needs of a disparate membership, e.g., trainees, clinicians, researchers, educators, administrators;

3. Development of Special Interest Groups to meet the needs of the disparate membership based on recommendations of the task forces;
4. Strengthening the division's mentoring program for trainees, early career psychologists, and mid-career psychologists;
5. Developing forums in addition to the APA convention for our division members to present and discuss their research and models of clinical practice, especially those related to integrated care;
6. Creating alignments with associations representing other health care disciplines to meet the mission of the Society of Clinical Psychology and to align clinical psychology with other healthcare disciplines in a manner that allows us to thrive in an era of healthcare reform.

In meeting these stated goals, I bring an ability to view the needs of psychologists from a variety of perspectives and an understanding of and advocacy for integrated care and inter-professional education. I have held faculty positions in two separate, vastly different medical school settings. One of these institutions was a traditional, publicly funded medical school while the other is a privately funded, community based environment. At my current institution, Eastern Virginia Medical School, I hold faculty appointments in both the Department of Psychiatry and Behavioral Sciences and Department of Family and Community Medicine and serve as a Co-Director of a Clinical Psychology Internship Program; teach within a Clinical Psychology PhD program; and educate medical professionals. I also completed my internship training in a VA hospital and have set up training programs at Federally Qualified Health Centers providing me with familiarity with these types of environments. My clinical and research interests are varied and are in cognitive behavioral therapy, eating disorders, psychological aspects of bariatric surgery, and primary care psychology, and I have been awarded multiple state and national funding grants for the training and education of psychologists in integrated care. Therefore, I recognize that psychologists in different settings and at different stages of career development have varying needs and often join the Society of Clinical Psychology for very different reasons.

I also have a track record of commitment to the Society of Clinical Psychology. I have served as D12 Treasurer (2011-2014); President and Secretary for Section 8 [i.e., Association of Psychologists in Academic Health Centers] of the Division; and Program Chair for the Division for the



APA Convention in 2008 and again in 2012. Furthermore, my personal experiences, roles within medical settings and my CBT orientation have taught me to be clear and decisive in my thinking; remain goal directed; collaborate openly with others; and stay aware of whether attempts to make changes actually yield changes.

I look forward to dedicating my time, expertise and energy to the Society of Clinical Psychology as your president and will ponder leadership decisions carefully on your behalf if elected.



Candidate statement for President-elect: **Brad Karlin, Ph.D.**

I am honored and very happy to be nominated for President of Division 12. I have dedicated my career to improving mental health care and bridging treatment gaps at macro and micro levels. I would be honored to serve as your President and advance the Society at an unprecedented time of opportunity for clinical psychology.

For the past 7+ years, I served as National Mental Health Director for Psychotherapy and Psychogeriatrics for the Department of Veterans Affairs (VA) Central Office. In this role, I oversaw the national dissemination of 15+ evidence-based psychotherapies (EBPs) for a range of mental and behavioral health conditions, as part of the transformation of the VA mental health care system. As part of this process, I led the development, implementation, and evaluation of competency-based EBP training programs that have now trained 8,000+ VA staff. Despite some doubts about broad implementation of EBPs into real-world settings, EBP training and implementation have resulted in, overall, large increases in therapist competencies and large clinical improvements among Veterans reported in top-tier psychology journals. I am honored to have received a Commendation from the Secretary of VA for my work to disseminate EBPs.

In addition to EBP dissemination, I oversaw the expansion and innovation of geriatric mental health programs and the establishment of new models of integrated mental health practice, including national initiatives to integrate psychologists in all 130+ VA Home-Based Primary Care teams and VA nursing homes. I also led the adaptation of Linda Teri's STAR program into an interdisciplinary intervention (STAR-VA) for managing challenging dementia-related behaviors of Veterans that was implemented in 40+

VA nursing homes and shown to be effective. As a geropsychologist and a past-Secretary of the Society of Clinical Geropsychology, I am passionate about reducing enduring and profound undertreatment of mental illness among older adults. This passion and commitment is rooted in my past relationship with my grandfather, who was my closest friend and remains my role model and inspiration.

With VA having shown that broad dissemination of EBPs and transformation of geriatric mental health services are possible, I have a strong interest in promoting mental health care in other systems. I believe this is a pivotal time with mental health in the national discourse and unprecedented policy developments (e.g., ACA implementation, full mental health parity under Medicare as of January 1). With passion to promote further change, I decided in February to take on an exciting new challenge and joined the leadership team of the Education Development Center, a global nonprofit health and education organization. As Chief of Mental Health and Aging and Distinguished Scholar at EDC, I will lead initiatives to improve mental health care and aging services in public and private systems. I also remain engaged in academia and research as adjunct associate professor in the Bloomberg School of Public Health at Johns Hopkins University. I am also a Fellow of APA.

If elected President, I would expand the work of the Division to promote evidence-based practices utilizing push and pull strategies, including training and public education initiatives. This includes enhancing the Division's web site and disseminating print and technology-based resources, as we have done in VA. I would also work to promote innovative and interdisciplinary models of psychological practice, building on my past work in this area. At the same time, I would focus internally on the organization and bring fresh eyes, creativity, and vision to promote membership diversity, recruitment, and the value of the Society for a broader range of engaged members and leaders. Together, we can further realize the potential of psychological science and practice at a time of great need.



Candidate statement for Treasurer: **Kalyani Gopel, Ph.D.**

I am delighted to be nominated for the position of treasurer for Division 12 for the 2015-2017 term. Currently I am Past President of Section IV, Division 12 and have

Division 12 Elections (*continued*)

served as President of Section IV for two years between 2012-2014. I am also the owner and President of six mental health clinics in Indiana and Illinois and manage a host of day to day operations including oversight of finances and cash flow issues.

As treasurer if elected, I hope to support the mission of Division 12 membership and executive board and continue to enhance the financial and professional direction of our division.



Candidate statement for Treasurer:

Jonathan Weinand, Ph.D.

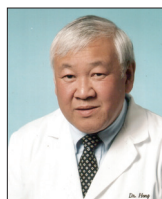
As a long-time member of the Society of Clinical Psychology, I am grateful for this opportunity to continue my activity with the division as I run for the position of SCP Treasurer. I received my undergraduate training at DePaul University, my doctoral training at Illinois Tech, and completed my residency at the University of Mississippi Medical Center/VA Consortium. I am strong adherent to empirically based assessment and treatment models, and am currently a Fellow of SCP and APA.

I have served in several leadership positions at the state (IPA- Ethics, Membership), Divisional (SCP- Education & Training) and National (ABCT- Professional Issues; APA-CESA) organizational levels.

In my professional roles as a director of a hospital based psychology department and regional director of a community mental health consortium, and current role heading up an independent practice, I have been responsible for

the development and implementation of moderate to large budgets. These experiences have assisted me in developing a strong skill set in the area of complex organizational budgeting. I am well aware of the need to understand the current and future financial needs of an organization, and the importance of continual assessment and management of an organization's financial status. I have become proficient in the area of developing positive responses to financial stressors at the organizational level.

Our membership continues to be pressed by significant funding challenges at the educational, science, and clinical levels of our profession. The Society will be well-served by continuing to lean forward while developing a financial sound, integrated plan regarding our mission of providing high quality, science-based education and training to our membership. Through quality education, research, advocacy, and practice, we can work together to assure a brighter future for clinical psychology. I welcome your consideration of my candidacy for the position of Treasurer of the Society for Clinical Psychology.



Candidate statement for Council Representative

Barry Hong, Ph.D., ABPP

Barry A. Hong is Professor of Psychiatry and Vice-Chairman for Clinical Affairs in the Department of Psychiatry at Washington University School of Medicine in St. Louis. He holds appointments in Internal Medicine and Clinical Psychology. He received his Ph.D. from St. Louis University in 1978. He is a Fellow of Divisions 12 and

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Division 12 Elections (*continued*)

38. He is an ABPP in clinical psychology and serves as the Chief Psychologist at Barnes-Jewish Hospital in St. Louis.

He is active in Division 12, having served previously as a council representative from 2005-2007 and Section VIII (Association of Psychologists in Academic Health Centers) representative to Division 12 (2010-2012). He has been an investigator and consultant to various federal agencies including the NIH, NIMH, NIDR, HRSA, CDC and Health and Welfare of Canada. His primary clinical/research areas are in solid organ transplant, hepatitis C and chronic pelvic pain.

PERSONAL STATEMENT: I am honored to be nominated as a council representative from Division 12. I have been fortunate to have served as a clinical psychologist during a historical period that witnessed the unparalleled growth and challenges of psychology in medical settings. I would like to make my experience available to the Council as APA enters a new era of change in health care settings. Clearly, there will be new opportunities to apply the science and practice of psychology to the health care of our nation, and I believe the Council of Representatives can play a lead role in helping the profession respond to these new opportunities, even as the APA has begun to restructure to improve governance and decision making. There are immense challenges confronting psychology in the academy and in health care. I would like to bring my experience to addressing these important issues.



Candidate statement
for Council
Representative
Kenneth J. Sher, Ph.D.

I'd be honored to serve as Division 12's Representative to the Council of Representatives (CoR). CoR is in the process of being restructured and repurposed with the goals of making it both more focused on strategic planning and more timely in addressing current issues. I believe I would represent a strong voice for scientific clinical psychology, evidenced-based practice, and education in psychology and bring a wealth of relevant background experiences. This includes recently serving as co-chair of APA's Board of Scientific Affairs (BSA), serving on the Commission on Accreditation (CoA), and as a member of the Good Governance Project (GGP). GGP was the group responsible for conducting a multi-year, in-depth evaluation of APA's governance

structure and making recommendations to improve its efficiency and relevance for addressing the needs of APA members, the discipline, and society. So I would bring to my position the knowledge gained from thinking about what APA does well, what it does not-so-well, and a resolve to be part of a constructive process that addresses the needs of APA's multiple constituencies. I see my greatest relevant attribute for serving on Council is my ability to "reach across the aisle" and establish good working relationships with colleagues from other groups who may have different priorities and/or perspectives. I believe an effective Council member brings both principles and pragmatism to governance and strive to be guided by both.

Although most of my service to APA has been to APA as a whole (BSA, CoA), I have served as President of Section III of Division 12 (the Society for the Science of Clinical Psychology), and served on CoR as a representative of Division 28 (Psychopharmacology) and thus understand working closely with Divisional leadership. I believe I've learned from all of these governance experiences as well as those in my "day job," at the University of Missouri where I am a professor in a doctoral program in clinical psychology and heavily involved in training and research. I've also held a number of editorial positions (e.g., Associate Editor at *Psychological Bulletin*, *Journal of Abnormal Psychology*, *Clinical Psychological Science*), been a member on NIH study sections, and served on important NIH advisory groups. These and other experiences form a foundation for appreciating the diversity of our own discipline and our relation to other disciplines, a foundation that I draw upon to inform my work in governance.



Candidate statement
for Council
Representative
David A. Smith, Ph.D.

I am honored to be nominated to serve as Division 12's APA Council Representative. I am a Full Professor and former Director of Clinical Training in the Clinical Psychology PhD program at the University of Notre Dame. I also serve as Director of the Marital Therapy and Research Clinic, where I conduct research on psychopathology and marital discord in addition to training and supervising doctoral students in evidence-based therapies. Prior to arriving at Notre Dame, I was at

Division 12 Elections (*continued*)

Ohio State University, in psychology and psychiatry, and prior to that I was at Bellevue Hospital (NYC), as a pre-doctoral intern. My PhD is in clinical psychology from SUNY Stony Brook.

I am a Fellow of Division 12 and am one of the current Division 12 Council Representatives, completing the final year of another representative's term. I am also currently a commissioner on the APA Commission on Accreditation and the former Secretary-Treasurer for Section 3 of Division 12, the Society for a Science of Clinical Psychology. In 2010 I represented Division 12 at the APA Science Leadership Conference on advancing Psychology as a STEM discipline. I am a licensed and board-certified psychologist.

My background, training, and experience have prepared me to manage the many issues associated with Council's simultaneous concern for education, research, practice, and public policy. Among the many issues needing APA attention, I am particularly eager to see progress on the internship crisis, continuing education, enhanced access to Federal research funding, and generally greater influence for the Division."



Candidate statement
for Council
Representative
Mark B. Sobell, Ph.D., ABPP

I would be honored to serve the Society of Clinical Psychology on the APA Council of Representatives (COR). This year I am completing my term as Past-President of the Society, and I feel well prepared to represent the Society during this critical period when APA is changing its governance structure. During my presidency I initiated an operational review of the Society, similar but on a smaller scale than the Good Governance initiative undertaken by the APA. The operational review was started when I was president, and it is continuing

because matters such as streamlining governance while preserving essential functions should be well reasoned and vetted before adoption. An early decision to come out of this process has been to initiate Special Interest Groups so there can be interactions between members on topics of interest without being encumbered with a formal section. We are also starting new initiatives to welcome students and early career psychologists and better integrate them into the Society. Our goal is that this operational review will result in a renewed and more unified Society of Clinical Psychology. As APA's governance structure changes it is important that our COR representative understand the impact on our division. We need to continue to lead a meaningful and realistic integration of science and practice, particularly as it relates to the recent emphasis on integrated health care and the involvement of psychologists in population level approaches to prevention and treatment of mental disorders. My recent three years on the division's Board provides me with the experience needed to represent our Society at the COR.

I am a Professor at the Center for Psychological Studies at Nova Southeastern University where I also co-direct the Guided Self-Change Clinic where we train clinical psychology doctoral students. Previously I was at the Addiction Research Foundation and University of Toronto, and prior to that I was at Vanderbilt University where I also served as the Director of Clinical Training. I have received several awards (e.g., Distinguished Scientific Contributions to Clinical Psychology, Jellinek Memorial Award), am a fellow in 6 APA divisions, am an Associate Editor for the Journal of Consulting and Clinical Psychology, American Psychologist, and Psychology of Addictive Behaviors, and have published over 300 articles, chapters, and books. My career has continuously blended science and practice, and that is the clinical psychology for which I will be an outspoken advocate on the APA Council of Representatives. ■

SOCIAL MEDIA AT THE SOCIETY OF CLINICAL PSYCHOLOGY

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SECTION UPDATES

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

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, Ph.D.




Happy New Year from Section 8: APAHC – the Association of Psychologists in Academic Health Centers!

APAHC has a unique position with membership in two professional associations, the American Psychological Association (APA) and the Association of American Medical Colleges (AAMC), through the Council of Faculty and Academic Societies (CFAS). APAHC is currently represented by Drs. Cynthia Belar and Patrick Smith. The APAHC Research Committee is working with AAMC regarding primary care and workforce studies, as well as the changing distribution of psychologists within US medical schools over the past 30-35 years. APAHC submitted a poster on Interprofessional Education for the 2014 healthcare workforce conference, and a manuscript to Academic Medicine on one of the posters presented at the 2013 Conference.

One of our APAHC members, Zeeshan Ahmad Butt, PhD, was recently presented with a Presidential Citation from APA President Nadine Kaslow (another APAHC member!)

"For his scholarly contributions related to clinical health psychology and his remarkable ability to foster professional engagement and career development among early career health psychologists. Academically productive and clinically gifted, he has made significant advances

in the development and application of patient reported outcomes in the post-surgical context, particularly for individuals following organ donation and transplantation. His scholarship is a model for other early career psychologists in his specialty. In addition to being a dedicated clinician and productive scholar, his leadership as an early career psychologist is noteworthy. In 2010, Dr. Butt was appointed the first Chair of the Division 38 (Health Psychology) Early Career Professionals' Council (ECPC). Under Dr. Butt's strong and enthusiastic leadership, the 20+ ECPC members developed a regular newsletter column, a moderated listserv, and a podcast series. His group helped expand the Division's training/teleconference series and its presence on social media. In addition, Dr. Butt served as an exceptionally effective advocate for ECP involvement in Division governance. Indeed, at the national and local levels, across his numerous professional service roles, Dr. Butt has demonstrated a clear talent for building communities where young professionals can get what they need to launch their careers and hopefully grow and develop."

APAHC welcomes new members, including student members. Membership dues are low and this is a great way to add on to the benefits offered as a Division 12 member. 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. 

Looking for back issues of The Clinical Psychologist?

Selected issues of *The Clinical Psychologist* are available from the Society of Clinical Psychology's divisional office. For more details, please contact:

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COMING THIS SUMMER

AUGUST 7-10, 2014: APA ANNUAL CONVENTION SOCIETY OF CLINICAL PSYCHOLOGY

Don't miss the American Psychological Association's annual convention in Washington, D.C. this summer! The Society of Clinical Psychology will have sessions for members, students, and Early Career psychologists, as well as eminent psychologists from around the world. Events to take place at the following facilities:

- **Walter E. Washington Convention Center**
- **Grand Hyatt Washington Hotel**
- **Renaissance Washington D.C. Hotel**
- **Washington Marriott Marquis Hotel**



PLUS—save the date for this special event:

On August 6, Dr. Steven Hollon will present a **pre-convention workshop** on the **treatment and prevention of depression**.

Noteworthy features:

.....

**EMPIRICALLY
SUPPORTED
TREATMENT UPDATES:
DR. DAVID TOLIN**

.....

**ETHNIC MINORITY
VOICES**

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To learn more about the
Society of Clinical Psychology,
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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 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.