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PRESIDENT'S COLUMN

The Need and Opportunity for Leadership in Clinical Psychology to Bridge the Enduring Great Divide: "It's the How, Stupid!"

Bradley E. Karlin, Ph.D., ABPP

 Last week, after the last box was unloaded from the moving truck into our new home in beautiful Raleigh-Durham, North Carolina, my wife and I took a stroll around our subdivision to take in the new experience, reflect on a new chapter of our lives, and meet some neighbors. Upon rounding the corner, we were greeted by a pleasant, middle-aged couple who live down the street. After about 5 minutes in (and some nostalgic reflection on our very different home and lifestyle in Times Square, NY!), the conversation shifted to discussion of careers. My wife described her work as a foundation professional, and I noted that I am a clinical psychologist. "Tom" and "Jill" responded with several questions about what my work involves, whether I see patients in a private practice, and what "therapy" really consists of. I informed Tom and Jill that my work primarily involves working to promote the dissemination and delivery of evidence-based psychological treatments in public and private systems and to improve mental health and dementia care at systems levels. To this, Tom replied, "I didn't know that psychologists do that type of work! And, what are evidence-based psychological treatments?" This now rather familiar exchange reflects important needs and opportunities for professional psychology (and clinical psychology, in particular) to be (and be seen as) leaders in dissemination and implementation and systems change and, relatedly, in advancing public awareness and understanding of psychological treatments.

In my March 2016 President's column in *The Clinical Psychologist*, I wrote about the important, but largely exclusive, focus within clinical psychology on developing evidence-based psychological treatments (the "what") and argued for greater focus on examining and promoting processes for how to effectively implement evidence-based treatments in routine practice settings (the "how"). For decades, social scientists (including many psychologists) have written about the considerable but unrealized promise of evidence-based psychological and psychosocial treatments for addressing a wide range of psychological, behavioral, and

social problems. Despite their established efficacy in controlled research contexts, many psychological and psychosocial treatments fail to be implemented in real-world clinical settings due to barriers at multiple levels. Awareness of the now well-known research-to-practice gap among professionals and the public was intensified by the Institute of Medicine's (IOM) seminal 2001 report, "Crossing the Quality Chasm," in which the IOM Committee concluded that it takes an average of 17 years for new scientific discoveries in randomized controlled trials to be implemented in routine practice settings. This lag time, however, has shown to be considerably greater in mental health than in medical care contexts due to a number of unique factors. For example, unlike many biomedical treatments, such as medications, psychological and psychosocial treatments are considerably more complex and, consequently, require a much more complex distribution and dissemination mechanism(s). In addition, unlike medical treatments, psychosocial treatments often lack industry sponsors that have a vested interest in promoting broad dissemination and delivery of treatments. Furthermore, there is no FDA or regulatory or other process for identifying, communicating, and distilling psychosocial treatments. This has contributed to limited awareness of and difficulty distinguishing between specific therapies among insurance companies, other payors, and consumers.

A new dawn of promoting attention to and leveraging how to effectively distribute and disseminate evidence-based treatments has emerged with the developing field of dissemination and implementation science and practice – a field that has moved beyond severed factions into an established, multidisciplinary discipline with a unique identity and contribution to science and practice. In our own work, we have leveraged the knowledge and discoveries of implementation science to inform and guide broad and strategic dissemination and implementation of evidence-based psychotherapies (EBPs) and dementia care interventions. This includes the application of models and specific strategies for addressing barriers and leveraging facilitators at multiple levels, including policy, provider, systems, and patient levels and for incorporating implementation activities that span a spectrum from pre-implementation readiness assessment and enhancement through sustainability (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Karlin & Cross, 2014; Moullin, Sabater-Hernández, Fernandez-Llimos, & Benrimoj, 2015; Tabak et al., 2012).

Furthermore, the critical paradigm shift toward recognizing, understanding, and addressing implementation and contextual factors has significantly permeated and become increasingly emphasized in specific research contexts. As a grant reviewer, I have witnessed a sea change beginning to emerge over the past 5-7 years where increasing emphasis is being placed on implementation and effectiveness. Deliberations about internal validity and controlled environments have increasingly been joined or even superseded by conversations about external validity and implementation factors. Moreover, journal reviewers have

increasingly come to value and comment on the importance of effectiveness and real-world implementation and generalizability.

The growing interest in and prominence of dissemination and implementation in research is reflected in the maturation of the field of implementation research. Evolving from a scattered science of individual, one-dimensional (and often highly context-specific) factors that may impact adoption and delivery of interventions or approaches, implementation science has developed into an increasingly sophisticated field of research from which has emerged a spate of theoretically-driven, multi-level dissemination models and the identification of pre- and post-implementation processes for guiding and promoting implementation in different settings. The growing prominence and reputation of the field's flagship journal, *Implementation Science*, is a further reflection of how the field of implementation science has come in a sort time. In just five years, the impact factor of *Implementation Science* has risen to above 4. (If implementation science were a stock, now would be a buy opportunity!) In the years to come, the findings of implementation science and the incredibly impressive work of an increasing number of implementation science researchers (including many psychologists) are likely to yield important new discoveries and identify even more sophisticated approaches for bridging the great divide between psychological science and practice.

There is a significant opportunity for clinical psychologists to contribute to and help shape the field of dissemination and implementation for promoting the delivery of evidence-based psychological treatments. It is essential that clinical psychology be recognized thought leaders and actors in bridging the research-to-practice gap and helping to identify and adapt policies, systems, and other requirements for promoting the delivery of evidence-based treatments in real-world settings within community agencies and health care systems. Clinical psychologists are well poised to be agents of change at macro and systems levels, as well as individual levels. Organizationally, SCP is well poised to be a leader in dissemination and implementation within professional psychology, an opportunity embraced enthusiastically by the SCP Board of Directors.

As a first step in supporting and empowering SCP members interested in learning more about, and becoming more involved in, dissemination and implementation, we are developing a Dissemination and Implementation section of the SCP website that will include introductory information on dissemination information and resources related to specific implementation barriers and facilitators, implementation frameworks, and examples and case studies of evidence-based psychotherapy and related dissemination and implementation efforts. Shannon Wiltsey Stirman and Torrey Creed, two clinical psychologists who have been very active in the field of D&I, are helping to lead the efforts related to the development of the new section of the website. Working SCP Website Administrator, Damion Grasso, we will soon have a

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virtual D&I home within SC. I am hopeful this new information and resources will be helpful to many members, including those who are new to the field of D&I as well as those interested in learning more.

Finally, a critically important, but under-recognized, need and opportunity for promoting the dissemination and implementation of evidence-based psychotherapies involves addressing patient factors that are essential to EBP delivery (Karlin & Cross, 2014). Strategic dissemination and implementation must leverage the importance and power of patient awareness, engagement, and informed choice – beginning even prior to the initiation of treatment. If the “Toms” and “Judys” of the world are knowledgeable about EBPs, their benefits, and the treatment process, and they are engaged in an early process of shared decision making, they are more likely to initially seek out and be engaged in care. The pharmaceutical industry has well-recognized and leveraged “pull” factors for drawing interest and demand through the use of direct-to-consumer education and marketing. Promoting public awareness of and patient engagement in EBPs is an area of significant interest and focus in my current work and one I hope professional psychology (including clinical psychology, in particular) will focus greater attention to as other health care disciplines have done in recent years. I look forward to pontificating more about this in the future and to hearing your thoughts about opportunities for how clinical psychology – working at multiple levels – can contribute to and help lead efforts to close the enduring research-to-practice gap and improve mental health care delivery!

As the APA Convention approaches, I hope to see many SCP'ers who plan to be in attendance in Denver! If you will be at the Convention, I hope you will come to the new SCP Social Networking Event and Awards Ceremony on Friday August 5, 2016, in the Hyatt Regency Denver Hotel, Centennial Ballroom F – and please bring colleagues and students! The event should be lively and engaging. In addition to fun, food, and drinks with colleagues, we will be holding a Speed Mentoring Event to kickoff the SCP Mentorship Program. The SCP Mentorship Program will soon be a new member benefit available to all members and will cover a wide range of professional interest areas! I would like to thank Michele Karel and Natalia Potapova for helping to coordinate the Speed Mentoring Program and the development of the Society-wide Mentorship Program, along with a committee of dedicated SCP members and Board Members.

Please be on the lookout for the SCP Needs Assessment that we will be sending electronically to all SCP members in June. The Needs Assessment is designed to help us to identify members' needs, what they value about SCP and SCP membership, and what more we might do to promote the value proposition of SCP membership. Thank you to Elizabeth Davis and Claire Collie (Co-Chairs of the SCP Membership Committee) and the Membership Committee for their help with developing the Needs Assessment.

Warm wishes to all for a pleasant, safe, and fun Summer!

Brad 

Instructions to Authors

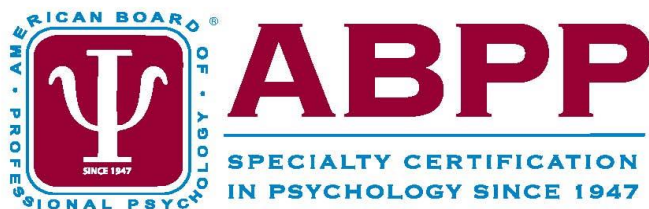


The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Division 12 of the American Psychological Association). Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Division. Topic areas 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 Jonathan S. Comer at: jocomer@fiu.edu.

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Understanding and Treating Dental Anxiety: Dentists and Psychologists Join Forces at Temple University

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Abstract

Dental anxiety is becoming increasingly recognized as a major public health concern as it is associated with underutilization of dental care and poor dental and physical health. Previous studies have demonstrated that aversive dental experiences are related to the development of dental anxiety but that cognitive-affective vulnerability factors likely moderate this association. Cognitive-behavioral therapy (CBT) has shown promise as an efficacious treatment for dental anxiety. However, because dental anxiety tends to present as a primary concern at dental clinics rather than mental health clinics, dental anxiety interventions

that can be easily delivered by dental clinic staff are needed. At Temple University, we have formed a research group that includes individuals with expertise in anxiety disorders, CBT, dentistry, and health psychology. Our group's mission is to better understand the etiology of dental anxiety and develop technology-based



Carrie M. Potter

dental anxiety interventions that can be disseminated within dental clinics. In this article, we provide a review of our existing studies and some brief comments on where we believe dental anxiety research should move in the future.

Keywords: dental anxiety, computerized therapy, cognitive behavioral therapy

Imagine you are at your dentist's office, about to have a cavity filled. What do you expect to experience? How do you feel? For many people, the answers to these questions are overwhelmingly negative. Approximately 10-20% of individuals in the United States experience significant anxiety about undergoing dental procedures, also known as dental anxiety, and 10-50% of people cancel dentist appointments due to fears of dental procedures (Sohn & Ismail, 2005). Our research group became interested in studying dental anxiety when we observed the pervasive toll it can take on oral/physical health and emotional wellbeing. Many patients of Temple University's Kornberg School of Dentistry (TUKSoD) avoid necessary dental procedures (e.g., cleanings, cavity fillings) for many years and present to our dental clinics for treatment only when their dental pain has become too great to tolerate, that is, when the pain overrides the anxiety-motivated desire to avoid. During their prolonged absence from dental care, their oral health often deteriorates, and some even withdraw from social relationships because they are embarrassed about the appearance of their teeth. As dentists, psychologists, and psychology trainees,

we have joined together to contribute to the growing body of research aimed at clarifying the psychological underpinnings of dental anxiety and informing the development of dental anxiety interventions that can be disseminated within dental clinics.

Research on adult dental anxiety began in the 1950's and has gained more momentum abroad, particularly in Scandinavia, than it has in the United States. Estimates of the prevalence of dental anxiety vary widely, ranging from 10-20% in the United States (Doerr, Lang, Nyquist, & Ronis, 1998; Locker, Liddell, & Shapiro, 1999; Milgrom, Fiset, Melnick, & Weinstein, 1988; Sohn & Ismail, 2005) and 4-30% abroad (Humphris, Dyer, & Robinson, 2009; Humphris & King, 2011; Schwarz & Birn, 1995; Vassend, 1993). The discrepancies in these estimates may be, in part, due to inconsistent measurement of dental anxiety across studies. David Locker and colleagues, who conducted much of the pivotal dental anxiety research in Canada, compared three commonly used self-report instruments



Dina G. Kinner

for the assessment of dental anxiety and found that agreement among them was only fair to moderate (κ ranged from .37 to .56; Locker, Shapiro, & Liddell, 1996). The Modified Dental Anxiety Scale (MDAS; Humphris, Morrison, & Lindsay, 1995), which is based on Corah's Dental Anxiety Scale (Corah, 1969), includes five self-report items that assess anticipatory anxiety associated with an upcoming dental appointment, fear of dental cleaning and drilling, and fear of local anesthetic injection. The MDAS is short, easily administered, and psychometrically sound, and it has become the primary dental anxiety measure used by many research groups, including our own.

Another point of confusion in the literature on dental anxiety is the difference between dental anxiety and dental phobia, which are distinct, but related, constructs. In contrast to dental anxiety, the diagnosis

of specific phobia of dental procedures, as classified in the Diagnostic and Statistical Manual of Mental Disorders – 5th edition (DSM-5; American Psychiatric Association [APA], 2013), can be distinguished by the significant degree to which the fear or avoidance of dental procedures interferes with an individual's daily routine, occupational or social functioning. In our studies on dental anxiety, we also have assessed the presence and severity of dental phobia by having trained research assistants and graduate students administer the specific phobia module of the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Brown, Di Nardo & Barlow, 1994), and we will be using the updated ADIS-5 (Brown & Barlow, 2014) in future studies. To date, we have administered the ADIS-IV to two different samples of TUKSoD patients (who were unselected on the basis of dental anxiety or other psychosocial factors), and the prevalence of dental phobia has ranged from about 10-20%.



Simona Kaplan

Much of the existing research on dental anxiety/dental phobia focuses on its development and manifestation. Armfield (2010) and Davey (1989) proposed that dental anxiety is a conditioned, or learned, fear that develops after individuals have a negative dental experience or hear dental "horror stories" from other people. However, many individuals experience an unpleasant or painful dental procedure without developing dental anxiety, suggesting that other vulnerabilities may underlie its development (Armfield, 2010; Carrillo-Diaz, Crego, Armfield, & Romero-Maroto, 2012); this area of inquiry merits further investigation. Dysfunctional thoughts about dental treatment appear to be a central feature of dental anxiety (Armfield & Heaton, 2013). Many anxious patients think that dental treatment will be extremely painful, that something catastrophic will happen during treatment, that the dentist will make a mistake, or that dental staff will be judgmental about



Dane Jensen

Gortzak, & Palmer-Bouva, 1995). A small proportion (about 13%) of individuals with dental phobia experience a vasovagal (i.e., biphasic) physiological response during dental treatment, which challenges the categorization of dental phobia as a specific phobia of the blood-injection-injury type (van Houtem et al., 2014).

the state of their oral health and/or appearance (De Jongh, Muris, Schoenmakers, & Horst, 1995; Moore, Brødsgaard, & Rosenberg, 2004). High physiological arousal is also prominent in dental anxiety, including elevations in heart rate, blood pressure, and cortisol levels during dental procedures (Brand,

A number of interventions for dental anxiety show promise, but many of the studies of these interventions have noteworthy limitations, such as small sample sizes and reliance on unvalidated measures (for a review of dental anxiety treatment studies, see Gordon, Heimberg, Tellez, & Ismail, 2013). A meta-analysis of 38 studies on cognitive-behavioral therapy (CBT) interventions for dental anxiety suggests that these interventions have a medium to large effect on dental anxiety (Kvale, Berggren, & Milgrom, 2004); however, the meta-analysis included different types of interventions (e.g., relaxation, hypnosis) under the umbrella of CBT, and it is unclear if interventions that include psychoeducation, cognitive, and exposure components are superior to those that are limited to exposure exercises. In more recent years, there have been some exciting developments in dental anxiety treatment research. One recently published randomized controlled trial (RCT) found that a computerized exposure-based therapy for dental injection fear reduced self-reported general and injection-specific dental anxiety when compared to a control group receiving a psychoeducational pamphlet (Heaton, Leroux, Ruff, & Coldwell, 2013). Furthermore, Daniel

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McNeil's research group at West Virginia University has examined ways to enhance "chairside" exposure-based therapy for dental phobia (Hayes et al., 2015; McNeil et al., 2014). These more recent studies will help inform the development of efficacious dental anxiety interventions that can be feasibly disseminated within dental clinics.

There is much we still need to understand about the development and treatment of dental anxiety. Which vulnerability factors place individuals at risk for developing dental anxiety? Can brief, technology-based CBT interventions that extend beyond injection-specific fears be feasibly delivered within dental clinics and meaningfully reduce dental anxiety? These are the types of questions we have sought to answer as we have studied the psychological correlates and treatment of dental anxiety over the past few years. In this article, we share what we have learned about dental anxiety and discuss where we think research on dental anxiety should move next.

Psychological Correlates of Dental Anxiety

One of the primary aims of our research has been to learn more about the psychological constructs associated with dental anxiety and dental phobia, with the ultimate goal of informing the development of dental anxiety interventions. Our initial project was a cross-sectional study of 120 patients scheduled for a dental appointment at TUKSoD. Participants completed self-report questionnaires assessing dental anxiety, cognitive-affective vulnerability factors (emotion regulation, distress tolerance, mindfulness, experiential avoidance), and other anxiety-related constructs (e.g., social appearance anxiety, blood-injection-injury fear). We also administered the specific phobia module of the ADIS-IV to assess dental phobia and gathered dental appointment attendance data to index avoidance of dental procedures (for more information about the method and results of this study, see Tellez et al., 2015a).

We found that patients with dental phobia ($n = 26$) scored higher than those without a diagnosis ($n = 94$) on measures of dental anxiety, social appearance anxiety, and pain experienced during their last dental appointment, but these groups did not differ on avoidance of dental treatment or our hypothesized cognitive-affective vulnerabilities. Similarly, dental

anxiety correlated with dental pain, re-experiencing symptoms related to prior traumatic dental events, social appearance anxiety, and blood-injection-injury fears; however, there was no evidence that it was related to the examined cognitive-affective vulnerability factors.

However, one of the hypothesized vulnerabilities, experiential avoidance, moderated the association between dental anxiety and avoidance of dental appointments, suggesting that targeting experiential avoidance may be a fruitful treatment strategy for helping anxious patients follow through with dental care. Further, in comparison to regular care patients ($n = 78$), emergency patients ($n = 42$) had a higher prevalence of dental phobia, a more prolonged history of avoidance of dental treatment, and reported experiencing greater pain at their last dental appointment. One of the most noteworthy implications of this study is that individuals with dental phobia may be more likely to use emergency dental services because they often avoid addressing oral health problems until reaching the point of emergency, and this may increase personal and public costs of dental healthcare (Kanegane, Penha, Borsatti, & Rocha, 2003).

As a next step toward identifying cognitive-affective vulnerabilities for dental anxiety, we designed a study examining the role of anxiety sensitivity, which is the fear of negative consequences of internal sensations (Reiss, Peterson, Gursky, & McNally, 1986), and pain expectancy in the development of dental anxiety. Much research has associated higher pain expectancy (i.e., expecting dental procedures to be painful) with greater dental anxiety; however, not all patients with high pain expectancy develop dental anxiety, and the factors that influence the impact of pain expectancy on dental anxiety remain unclear (Arntz, Van Eck, & Heijmans, 1990; Klages, Ulusoy, Kianifard, & Wehrbein, 2004). We hypothesized that anxiety sensitivity may amplify the impact of pain expectancy on the experience of dental



Elizabeth M. Waldron



Marisol Tellez

anxiety. Individuals with high anxiety sensitivity engage in more catastrophic thinking about the consequences of pain (Klages et al., 2004; Klages, Kianifard, Ulusoy, & Wehrbein, 2006); therefore, having expectations that dental treatment will be painful may be more likely to exacerbate dental anxiety for individuals with high anxiety sensitivity.

For this study, we recruited 104 adults seeking treatment at TUKSoD who exhibited a range of dental anxiety to participate in a single laboratory session. First, participants completed self-report measures of anxiety sensitivity, pain expectancy, and dental anxiety. Next, they watched a series of films of dental procedures and their psychophysiological stress reactivity to the films was measured using state anxiety ratings and physiological monitoring equipment that measured heart rate variability, respiration rate, and skin conductance levels. Participants then underwent a pain expectancy induction, which used a shock threat paradigm in conjunction with an administration of a second series of dental films. Participants were randomized to one of two pain expectancy conditions: the shock threat condition (expecting to experience electric shocks while watching the second series of dental films) or the safe condition (assured that they would not experience shocks while watching the films). Following the pain expectancy induction, participants viewed the second series of films of dental procedures another time and their psychophysiological stress reactivity was re-assessed. Data analysis is currently underway, and we expect that in comparison to individuals with low anxiety sensitivity, those with high anxiety sensitivity will exhibit strong relationships between self-reported and laboratory-induced pain expectancy and dental procedure stress reactivity/dental anxiety. The knowledge gained from this study will inform the utility of targeting anxiety sensitivity in interventions aimed at preventing or reducing dental anxiety, particularly among patients who report

expectations of experiencing pain during dental treatment.

Technology-Based CBT Interventions for Dental Anxiety

Our research group's second major goal has been to develop a brief, technology-based CBT intervention for dental anxiety and to test the feasibility and efficacy of such an intervention. We wanted the intervention to be practical, but also able to be personalized to address patients' specific dental fears. If shown to be efficacious, we envisioned this intervention as something individuals could complete in the waiting room of dental clinics before their dental appointments, or perhaps even in the comfort of their own homes as they attempt to muster the courage to schedule a long-avoided dental procedure. As a group, we have expertise in adult anxiety disorders, CBT, and dentistry, and we found that knowledge of each of these areas was needed to develop a well thought-out, comprehensive dental anxiety intervention.

The initial version of our intervention was a single, hour-long session that was primarily delivered by a computer program; however, we had a "therapy aide" with some training in CBT (i.e., a psychology research assistant or graduate student) sit with participating patients as they completed the intervention in case



Shannon Myers Virtue

any questions came up. The computer program was divided into modules that covered the following topics: psychoeducation, considering the benefits/drawbacks of addressing dental anxiety, cognitive restructuring skills, and graduated exposure to feared dental procedures. The program began with the psychoeducation module, during which the patient was provided with basic education about the nature of dental anxiety and anxiety-related topics such as: understanding the physiological, cognitive, and behavioral



Amid I. Ismail

(avoidance) components of anxiety; how anxious thoughts can be reframed into coping thoughts; rating one's subjective level of anxiety; and the rationale behind exposure to feared situations. Next, patients were guided through a decisional balance exercise that helped them consider the benefits and drawbacks of

learning to cope with their dental anxiety.

Thereafter, patients were guided through the exposure exercises via video, which were supplemented with opportunities to learn and practice cognitive restructuring skills. First, patients were asked to select their three most feared procedures from a list of six dental procedures (drilling and having a cavity filled, typical cleaning, anesthetic injection, root canal, oral X-ray, and tooth extraction) and rank the three procedures from least to most anxiety provoking. Patients then watched videos of their feared procedures, starting with the least anxiety-provoking and working up to the most anxiety-provoking. For each selected procedure, three videos, each about 4 minutes long, were presented: (1) The first video depicted a dentist and/or hygienist simulating the procedure with an actor playing the role of a patient. The voiceover explained the basics of the dental procedure, including how the dental tools were used. In addition, animated images of aspects of the procedure occurring inside the patient's mouth were presented. (2) The second video focused on the patient's face and his/her emotional experience during the procedure. The voiceover presented a dialogue between the narrator and the patient discussing the patient's negative thoughts and using cognitive restructuring to reframe these thoughts. (3) The third video was a "helmet-cam" video filmed from the perspective of a patient in the dental chair. The patient was instructed to imagine that he/she was having the procedure done and was led through the steps to develop coping thoughts to counter his/her own anxious thoughts. The intervention closed with a brief

module providing additional motivational enhancement for attending future dental appointments.

After pilot-testing the intervention and finding that it was generally well received and understood by patients (Potter et al., 2016), we conducted an RCT to test its efficacy (see Tellez et al., 2015b, for a full description of this RCT and the results). Consenting adult patients of the TUKSoD (N = 151) were randomized to one of two conditions: immediate treatment (n = 74) or wait-list control (n = 77). Participants randomized to immediate treatment completed the intervention at the dental clinic during the hour preceding an already-scheduled dental appointment, and upon completing the intervention, they attended their dental appointments and were encouraged to use the skills they learned from the intervention to cope with anxiety they experienced during the appointments. Participants randomized to wait-list control attended their dental appointments as scheduled and were offered the dental anxiety intervention following all assessments. Dental

anxiety and dental phobia were assessed using the MDAS and ADIS-IV specific phobia module at baseline (about one week before the dental appointment) and at one-month follow-up. Analyses of covariance revealed that, in comparison to the wait-list control group, the immediate treatment



Richard G. Heimberg

group exhibited greater reductions in dental anxiety and severity of dental phobia symptoms from baseline to follow-up. We concluded that our intervention showed promise, and we decided to refine it to see if we could enhance its feasibility for dissemination within dental practices while maintaining its efficacy.

One of the main limitations of our initial study on our dental anxiety intervention was that the intervention was delivered by therapy aides with backgrounds in psychology. Such individuals with expertise in CBT are rarely available at dental clinics, and if our intervention

were disseminated within dental clinics, it would most likely be administered by individuals with backgrounds in dentistry, not psychology. Although the therapy aides took a “hands off” approach during the first study and rarely had to answer questions from participants, one could argue that the intervention might be less efficacious when delivered by dental staff without much knowledge about CBT or anxiety. Therefore, we are currently planning studies aimed at demonstrating that our dental anxiety intervention is equally efficacious when delivered by dental staff and psychology personnel. Another of our current goals is to develop and test a web-based version of our intervention, which is also a step toward enhancing its feasibility for dissemination. The computerized version of our intervention can only be adopted by dental clinics that have a specific computer program, whereas a web-based version could be implemented at any facilities with Internet access.

We are currently preparing to conduct a second RCT examining a web-based version of our dental anxiety intervention, which is nearly identical to the computer-based version, but more streamlined. We are now in the process of developing a brief (about 4 hours) dental anxiety training program for dental hygienists and assistants, during which they will learn basic information about dental anxiety, CBT, and how to deliver the web-based version of our intervention. As a final step of the training, dental staff will run a dental patient through the intervention with one of the members of our research team observing, so any issues can be clarified at that point. Once we pilot test the training program and make any necessary adjustments, we will be ready to conduct the second RCT evaluating the efficacy of the web-based version of our intervention. This second RCT will have three conditions: 1) treatment with the web-based version of the intervention delivered by psychology personnel during the hour before a scheduled dental appointment, 2) treatment with the intervention delivered by dental staff who have completed our brief training program, and 3) a control condition in which the treating dentist is informed of the patient’s score on a dental anxiety scale (as simply notifying dental providers whether or not their patients have high dental anxiety has been shown to reduce patients’ dental anxiety; Dailey, Humphris, & Lennon, 2002). The control intervention of informing dental providers about their patients’ dental anxiety levels will be implemented in all three

conditions, so the two treatment conditions will involve treatment in addition to the control intervention. Finding that our web-based intervention is more efficacious than the control intervention, and equivalently so when delivered by dental and psychology personnel, will enhance our confidence in the feasibility and utility of disseminating our intervention within dental clinics.

Future Directions for Dental Anxiety Research

There are a number of important questions left to be answered about dental anxiety that we hope will inspire future studies by researchers with interest in the intersection of anxiety and physical health. First, our dental anxiety research has focused on anxious patients presenting for dental care, which has left us wondering if our findings generalize to patients with dental anxiety who avoid dental services altogether. Future studies comparing patients with varying degrees of dental avoidance are needed to clarify if high avoiders exhibit a distinct profile of dental anxiety and/or need more intensive interventions to promote engagement with dental care. Second, most of the participants in our dental anxiety research are residents of North Philadelphia, which is an urban environment, and many of them have experienced poverty and urban violence. Working with these individuals has helped us gain an appreciation of the many psychosocial factors that reduce access to dental treatment, such as lack of health insurance or child care, and we believe studies examining whether dental anxiety is associated with avoidance of dental care above and beyond other psychosocial variables are needed. Third, our focus has been on developing brief and easy-to-administer dental anxiety interventions, but we believe it is also important to learn more about who responds to brief dental anxiety treatment versus who needs more intensive or involved care. Studies aimed at answering this question might examine demographic characteristics, dental anxiety severity, and other potential mechanisms of action (e.g., anxiety sensitivity, pain expectancy, experiential avoidance) as predictors of brief treatment outcome and might follow a stepped-care approach in studying the effects of more intensive treatments on those patients who do not respond to less intensive ones. Finally, although our focus has been on anxious dental patients, we recognize that it is also important to conduct research focused on intervening with dental providers. Our experience working with faculty and students of TUKSoD has convinced us that individuals

in the field of dentistry would be open to and appreciative of programs that teach them how to help patients cope with anxiety during dental procedures. Dental providers are, after all, impacted by their patients' anxiety, and it would be a very worthwhile endeavor to consider how to support dental providers in their effort to deliver high quality dental treatment to all patients. ■■

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****Don't miss next month's SCP CE webinar!****

July 20 (12-1 PM EST) Kenneth Sher & Rachel Winograd: *Binge drinking and alcohol misuse among college students and young adults*

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Overview: This webinar is exclusively based on the content presented in the book *Binge Drinking and Alcohol Misuse Among College Students and Young Adults*, written by Rachel Winograd and Kenneth Sher. This book was published by Hogrefe Publishing and is part of an acclaimed series on evidence-based practice in psychotherapy. Hogrefe has published at least 36 volumes in this series, and each is reviewed scrupulously by multiple editors attending to scientific content, usefulness of material, and general structure and format. All the material included in this book is based on published peer-reviewed manuscripts and books on or relating to the topic of alcohol misuse and the treatment of addiction.

Objectives: (1) Discuss the epidemiology and course of young adult alcohol misuse in general terms, with particular attention to alcohol misuse on college campuses; (2) Describe the utility of three types of alcohol-related assessment measures: screening tools, consumption measures, and consequence measures and their role in treatment for young adult alcohol misuse; (3) List at least four (of eight) important components of Cognitive Behavioral Therapy for alcohol misuse.

Presenters: Kenneth J. Sher, PhD, is a Curators' Distinguished Professor of Psychological Sciences at the University of Missouri-Columbia. He has published extensively on the etiology and course of substance use disorders (particularly alcohol use disorders) in later adolescence and young adulthood, and is the principal investigator on two large longitudinal studies following student drinkers during their college years and beyond. His research is funded by the National Institute of Health, and he has received over 20 awards for his teaching, mentorship, and research activities, including the Research Society on Alcoholism's Young Investigator Award, Distinguished Researcher Award, and G. Alan Marlatt Mentoring Award, as well as the American Psychological Association's Division on Addiction's Distinguished Scientific Contributions Award.

Rachel P. Winograd is a graduate student in clinical psychology at the University of Missouri-Columbia, where she studies the acute effects of alcohol intoxication on behavior and emotion and helped establish an evidence-based intervention for heavy drinking college students. She received a National Research Service Award from the National Institute of Health to conduct her dissertation work investigating "drunk personality" and geospatial characteristics of college students' recent drinking episodes. She is currently completing her predoctoral clinical internship with the VA St Louis Health Care System, where she works with Veterans with health and substance use concerns.

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Have We Met? The Ethics of Offering Professional Opinions of People We Have Not Evaluated

Adam Fried, Ph.D.
Fordham University

 As we approach the home stretch of another presidential primary season, questions about the mental health of the candidates have again taken center stage. While psychologists can offer the public specialized knowledge and expertise to inform a number of psychological questions of societal interest, many may be asked to posit specific opinions on questions related to the mental health of a particular candidate, including diagnosis or other clinically-based conclusions. These types of statements raise important ethical questions about the implications of offering professional opinions on individuals, whether it is a political figure, celebrity or even someone outside of the public eye, that may only be drawn after conducting a proper evaluation.

Columbia University professor of psychiatry Robert Klitzman recently published an informative op-ed in the *New York Times* about the utility and ethics of public statements about political figures made by psychiatrists and psychologists (Klitzman, 2016). In his piece, Klitzman described what is commonly referred to as the “Goldwater Rule,” the American Psychiatric Association’s ethical standard enacted decades ago that prohibits psychiatrists from offering professional opinions on public figures who they have not evaluated. This rule was enacted following a survey of psychiatrists on the mental fitness of then-presidential candidate Barry Goldwater, which was published in a magazine and received considerable media attention.

In response to the op-ed, Celia Fisher, former chair of the American Psychological Association’s (APA) Ethics Code Task Force during the last major revision of the Ethics Code over a decade ago, reminded readers that psychiatrists are not the only professionals with this type of prohibition. Standard 9.01(b) of the APA Ethics Code (2010) states, “Except as noted in 9.01c, psychologists provide opinions of the psychological

characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions...”. Therefore, offering psychological evaluations of individuals the psychologist has never met may be a violation of the ethics code (record review is an exception, covered by standard 9.01c). In addition, Standard 5.04 (Media Presentations) requires psychologists who provide commentary, advice or other contributions through media (including the Internet) to ensure that their statements are consistent with established professional knowledge and other standards within the ethics code. Therefore, making public statements that may only be based upon completion of a proper assessment may also be a violation of this standard (Fisher, 2016)


Irrespective of whether the individual is publicly recognizable, providing diagnostic or other professional conclusions for individuals not evaluated by a psychologist or who have not established a professional relationship raise important ethical considerations. For example, some have written on the ethics of diagnosing friends, acquaintances or strangers who have not sought the opinion of the professional, often called “unsolicited diagnosis” or “passer-by diagnosis”. These situations force us to consider the question of when, if ever, is it appropriate for helping professionals to offer advice and opinions to those who are not clients, but who may present with conditions (physical or mental health) that may require attention. Edward Mitchell has argued that important factors in evaluating the ethics of these types of interactions include the potential benefits and harms in communicating a diagnosis (or other clinical information), urgency, and the competence and qualifications of the professional making the conclusion (Mitchell, 2008; 2011). There may also be unique stigma and confidentiality concerns among individuals receiving an unsolicited mental health diagnosis (Mitchell, 2011).

Another example that may be more common in psychotherapy settings occurs when clinicians offer or are asked to offer a diagnosis or other clinical conclusions about others in the client’s life (but who are not themselves clients). Consider the following example: A therapist is working with a client and therapeutic focus has shifted to the behaviors of the client’s mother. After only a five-minute description by his client and without having met the client’s mother, the therapist declared to the client that his mother had Borderline Personality Disorder and discussed the implications of the diagnosis at length with the client in an attempt to help him develop more effective communication and coping techniques. The client told his mother about his therapist’s diagnosis. She was upset and confused at having being diagnosed by someone she had not even met and refused her son’s requests to have joint sessions with the therapist.

Although the therapist's intervention was likely made in what he believed to be the best interest of his client, this is a troubling scenario, as there were several ethical and clinical implications that may not have been anticipated by the therapist. In addition to ethical problems of diagnosing someone he had not even met, the therapist's actions contributed to the potential alienation of the client's mother as perhaps a collateral or even source of support to the client's work in therapy. Although this was a fictional example, one wonders how often this happens in every day practice and how do we as professionals decide the best course of action (including how to respond to direct requests from clients to diagnose others in their life).

Obviously, our clinical work can focus on the people most important to our clients and they may sometimes be a major factor in the origin and/or maintenance of our clients' difficulties. Just by listening with a specially trained clinical ear, mental health professionals may formulate a hypothesis of a diagnosis for an individual they have never met without even meaning to, and these may be helpful to clinicians in conceptualizing cases or otherwise assisting the client. The ethical challenge is determining how to incorporate this information as part of a helpful psychological intervention to benefit our clients that does not violate our ethical responsibilities.

Our training and expertise provides a unique perspective that can both inform national conversations on mental health and policy as well as to improve the welfare of those with whom we work. Although many psychological conditions, such as "narcissistic", "sociopathic" and "delusional", have become embedded in our everyday

language, it's important to remember the power and implications of these diagnostic labels and the responsibility of mental health clinicians to ensure that they are assigned accurately and appropriately in all areas of our professional work, whether it be in public statements, our teaching or clinical work. 

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Section II: Society of Clinical Geropsychology

Submitted by Sherry Beaudreau (SCG president) and Victor Molinari (SCG rep to SCP)

 SCG has partnered with the other geropsychology groups, including APA's Committee on Aging, Division 20 (Aging & Human Development), Psychologists in Long Term Care, and the Council of Professional Geropsychology Training Programs to renew the APA geropsychology specialty application. The plan is to have a rough draft by mid-summer so the application will be able to be vetted well and submitted by the deadline of December 31.

As part of the presidential gerodiversity initiative, SCG is involved in a variety of gerodiversity projects:

1. SCG is instituting an annual Gerodiversity Award in collaboration with the SCG Diversity Committee. This award goes to a member and student who exemplify excellence in diversity and aging through their clinical work, research, teaching and/or other professional activities. Awardees receive \$250 and will be highlighted in the newsletter.
2. There are social media gerodiversity initiatives including: creation of a Gerodiversity Wikipedia; blogs related to gerodiversity on the APA Pubic Directorate page by members; and creation of a Diversity Resources list to post to the SCG website.
3. SCG has had discussions of section diversity based on a review of a recent membership committee survey of members.
4. The APA SCG Presidential address and conversation hour will have diversity as their main themes, and there will be a focus on gerodiversity in the Presidential column of our newsletter.
5. There have been SCG presidential efforts to bridge with other sections and Divisions that have a diversity focus in order to encourage cross-membership.

We announced our Gerodiversity Awards on other listservs as one way to coordinate this effort. The SCG president also plans to be in more formal contact with other sections and divisions to introduce what we do and open discussion on further collaboration.

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, PhD, ABPP

The Association of Psychologists in Academic Health Centers (APAHC) continues to thrive with an energetic and creative Board, as well as numerous volunteers who help manage the day to day needs of the organization.

APAHC continues a productive relationship with the AAMC (The Association of American Medical Colleges) with a variety of projects and the opportunity to impact medical training as well as the involvement of psychologists in medical school settings. The APAHC Research Committee, lead by Gerald Leventhal, PhD, conducted an online survey in collaboration with APA Center For Workforce Studies to address questions related to integrated care and interdisciplinary teams in various clinical work settings. They presented a poster at the AAMC Workforce Conference in May 2016.

APAHC continues to enhance resources available on our website at: <http://www.div12.org/section8/>, including those related to teaching, writing, conducting research, and grant writing in the Behavioral Sciences. APAHC members place high value on the resources provided as a membership benefit.

APAHC has also recently re-invigorated a Consultation Program, co-lead by Drs. Zeeshan Butt and Cheryl Brosig-Soto. Experienced consultation is available to APAHC members regarding career development, dealing with institutional or workplace opportunities, challenges, and barriers, and other professional

development issues of concern. Student Representative Teresa Pan, leads efforts to recruit Student Members and Trainees, with great opportunities for involvement and professional development. She can be reached for more information at: tpan@ku.edu

Members continue to benefit from valued APAHC publications and our website, including the Grand Rounds newsletter (lead by Cesar Gonzalez, PhD), and our flagship journal: Journal of Clinical Psychology in Medical Settings JCPMS. Editor, Dr. Gerry Leventhal, and Health Disparities Committee Chair, Alfee Breland-Noble, are collaborating on a special JCPMS issue on issues related to Health Disparities. Plans are in place to recruit an associate editor who specializes in child and adolescent psychology.

2017 Conference! The bi-annual APAHC Conference will be held in Detroit, Michigan March 7-9, 2017. Please mark your calendars and plan to attend! The Conference Co-Chairs, John Yozwiak and Amy Williams, are working to create another great line-up of speakers and events! A Mid-Career Boot camp will be hosted by Eugene D'Angelo, PhD.

APAHC is proud that a longstanding member (since the original AMSP Association of Medical School Psychologists), John "Jack" Carr, PhD, ABPP, will be honored at the APA Convention in Denver (August 2016) with the 2016 APA Award for Distinguished Professional Contributions to Institutional Practice! He is recognized for his "longstanding contributions to psychology within medical centers, serving as an early proponent and champion of integrating psychology with the practice of medicine, integrating psychology and social science into the medical school curriculum, and serving as an institutional role model for medical school psychologists and psychology faculty member." Congratulations Jack on this well deserved award!

APAHC welcomes new members, including student members, and board members reflect the diversity of those in academic health settings, including early career and student representatives. Membership dues are low and this is a great way to add 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 📧

INSTRUCTIONS FOR ADVERTISING IN THE CLINICAL PSYCHOLOGIST

Display advertising and want-ads for academic or clinical position openings will be accepted for publishing in the quarterly editions of The Clinical Psychologist.

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

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

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

Advances in Psychotherapy

Evidence-Based Practice

“Clinical psychologists understand and appreciate the need for integrating science and practice, and these short, user friendly volumes provide the most science that can be packed into 100 pages. Reading these books will make you a better practitioner.”

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Book series developed and edited with the support of the Society of Clinical Psychology (APA Division 12)

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The series *Advances in Psychotherapy–Evidence-Based Practice* provides therapists with practical evidence-based guidance on the diagnosis and treatment of the most common disorders seen in clinical practice – and does so in a uniquely reader-friendly manner. Each book is both a compact how-to reference for use by professional clinicians in their daily work, as well as an ideal educational resource for students and for practice-oriented continuing education.

In planning is a new strand dealing with methods and approaches rather than specific disorders.

Practice-Oriented

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Easy-to-Read

The most important information is summarized in tables, illustrations, displayed boxes, and marginal notes.

Compact

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We recruit genuine authorities to write for the series; many of our authors are leaders in the Society of Clinical Psychology (APA Div. 12).

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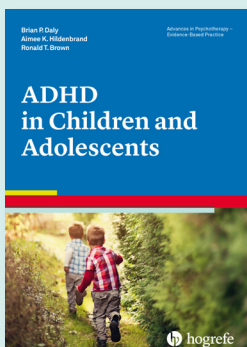
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The list price is under \$30 per volume. Discounts apply for members of APA Div. 12 and for readers who subscribe for a minimum of 4 volumes.

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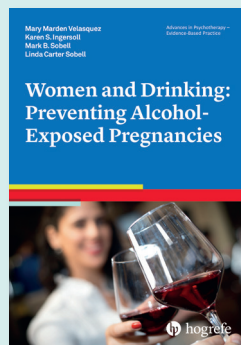


Brian P. Daly /
Aimee K. Hildenbrand /
Ronald T. Brown
**ADHD in Children
and Adolescents**

Vol. 33, 2016, x + 110 pp.,
ISBN 978-0-88937-412-6
Also available as eBook

Attention-Deficit/Hyperactivity Disorder (ADHD) is a common childhood disorder that can have serious consequences for academic, emotional, social, and occupational functioning. When properly identified and diagnosed, however, there are many interventions for the disorder that have established benefits.

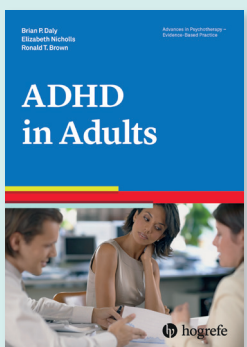
This volume is both a compact “how to” reference, for use by professional clinicians in their daily work, and an ideal educational reference for practice-oriented students. It is “reader friendly” and a compact and easy to follow guide covering all aspects of practice that are relevant in real life in the assessment and management of ADHD across the life span.



Mary Marden Velasquez /
Karen Ingersoll / Mark
B. Sobell / Linda Carter Sobell
**Women and Drink-
ing: Preventing
Alcohol-Exposed
Pregnancies**

Vol. 34, 2016, xii + 84 pp.
ISBN 978-0-88937-401-0
Also available as eBook

Drinking during pregnancy can cause a range of disabilities that have lifelong effects yet are 100% preventable. A variety of brief motivational behavioral interventions developed for nonpregnant women of childbearing age can effectively prevent alcohol-exposed pregnancies (AEP). This book outlines clinical definitions of Fetal Alcohol Spectrum Disorders (FASD), epidemiology and effects across the lifespan, evidence-based prevention practices such as CHOICES and CHOICES-like interventions. The information and resources presented will help a wide variety of practitioners in diverse settings, ranging from high-risk settings such as mental health and substance abuse treatment centers to primary care clinics and universities, deliver interventions targeting behavior change.

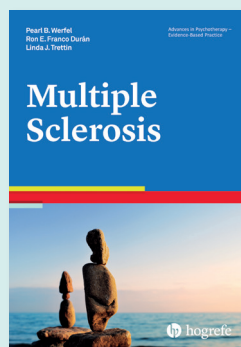


Brian P. Daly /
Elisabeth Nicholls /
Ronald T. Brown
ADHD in Adults

Vol. 35, 2016, viii + 96 pp.
ISBN 978-0-88937-413-3
Also available as eBook

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that emerges during childhood. However, it is now well recognized that ADHD frequently persists over the lifespan and well into adulthood. Without appropriate symptom management, ADHD can significantly interfere with academic, emotional, social, and work functioning. When properly identified and diagnosed, however, outcomes in adults with ADHD who receive appropriate treatment are encouraging.

This volume is a compact and easy to follow guide covering all aspects of practice that are relevant in real life in the assessment and management of ADHD in adults.



Pearl B. Werfel /
Ron E. Franco Durán /
Linda J. Trettin
Multiple Sclerosis

Vol. 36, 2016, viii + 128 pp.
ISBN 978-0-88937-409-6
Also available as eBook

This innovative book will help both mental health and medical professionals empower patients or clients to live well with multiple sclerosis (MS). It is a practical, culturally relevant guide to the most effective current medical, psychological, and neuropsychological diagnostic methods and interventions. The book describes a biopsychosocial, multidisciplinary, and integrative approach to treatment and provides information on psychological, mind-body, and complementary interventions for symptom management and to increase quality of life. Both seasoned practitioners and students will find this volume useful in helping clients cope with this complex, unpredictable, and chronic neurological disorder.

All volumes at a glance

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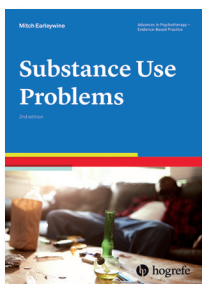
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In preparation



Mitch Earleywine **Substance Use Problems**

Vol. 15
2nd ed. coming April 2016,
approx. viii + 100 pp.,
ISBN 978-0-88937-416-4



Mitch Earleywine

The literature on diagnosis and treatment of drug and substance abuse is filled with successful, empirically based approaches, but also with controversy and hearsay. Health professionals in a range of settings are bound to meet clients with troubles related to drugs – and this text helps them separate the myths from the facts. This fully updated new edition provides trainees and professionals with a handy, concise guide for helping problem drug users build enjoyable, multifaceted lives using approaches based on decades of research.

Readers will improve their intuitions and clinical skills by adding an overarching understanding of drug use and the development of problems that translates into appropriate techniques for encouraging clients to change behavior themselves. This highly readable text explains not only what to do, but when and how to do it. Seasoned experts and those new to the field will welcome the chance to review the latest developments in guiding self-change for this intriguing, prevalent set of problems.

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Dorothy J. van Buren

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- **Panic Disorder and Agoraphobia**
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The volumes may be purchased individually, by Series Standing Order (minimum of 4 successive volumes), or as a complete package. The advantages of ordering by Series Standing Order: You will receive each volume automatically as soon as it is released, and only pay the special Series Standing Order price of US \$24.80 – saving US \$5.00 compared to the single-volume price of US \$29.80.

Special prices for members of APA Division 12: APA D12 members can purchase a single volume at US \$24.80, and only pay US \$19.80 per volume by Series Standing Order – saving US \$10 per book!

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