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PRESIDENT'S COLUMN

Looking Inward and to the Future: Advancing Needs, Opportunities, and New Directions for the Society of Clinical Psychology

Bradley E. Karlin, Ph.D., ABPP

Change is the law of life and those who look only to the past or present are certain to miss the future.

– John F. Kennedy

What an incredible – and seminal – 124th American Psychological Association Convention for the Society of Clinical Psychology (SCP)! SCP sponsored an amazing program of many well-attended sessions, several of which were followed by media coverage, interviews, or other follow-up requests. My deep appreciation to our Convention Co-Chairs, Claire Collie and Kristine Day, for their tireless efforts in coordinating the development of the program. SCP also held two successful APA-sponsored pre-convention workshops (Cognitive Therapy for Suicide Prevention by Dr. Greg Brown and Contemporary Problem-Solving Therapy: A Transdiagnostic Approach to Enhance Resilience by Dr. Art Nezu).

Especially exciting – and shall I say momentous – on the evening of the second day of Convention was the SCP Social Networking Event and Awards Ceremony, which was standing room only! A wonderful time of socializing, connecting, and inspiring was had by many who filled the room. Particularly momentous was the first-ever SCP Speed Mentoring Event held at the event, during which "mentees" were paired with three "mentors" (experts or leaders in various clinical psychology sub-fields or roles). The Speed Mentoring Event (carefully planned by our Dr. Michele Karel, Natalia Potapova, and our SCP Mentorship Program Task Force) was designed as the hoped-for kickoff of a robust SCP Mentorship Program. In this column and on the SCP listserv, I have discussed significant opportunities

and developing plans for a Mentorship Program that could be a member benefit for potentially all SCP members, leveraging the considerable expertise, wisdom, and experience of our broad membership – and serve as a vehicle to bring our membership and many Sections together. The intent is that the program would be available for general mentorship in clinical psychology, as well as be organized by more specific interest areas (e.g., integrated care, evidence-based psychotherapies, working in academic medical settings, working with older adults, working in administrative, executive, or other "non-traditional" roles, establishing a practice, evidence-based assessment, working with specific minority populations, etc.).

It has been our plan to use the experience of the Speed Mentoring Event at the APA Convention and more general response of membership to inform the final decision and planning for the full Mentorship Program. I am delighted to report that the SCP Speed Mentoring Event appeared to be a terrific success and created a lot of buzz and energy in the room during the SCP Social Networking Event. While we are conducting surveys and reaching out to participants to more fully evaluate the event and receive feedback, the reports of several mentees and mentors immediately after the event was extremely positive. In fact, the enthusiasm was a highlight of the Convention for me, personally. In addition to the experience of the Speed Mentoring Event at the APA Convention, we have also planned to assess the interest of SCP members in participating in such a program (as a mentee and/or mentor) and to identify specific areas of mentorship interest and expertise in the SCP Needs Assessment, the results from which are the focus of the remaining ink in this column! So as not to leave you in too much suspense, you will see from the results below that there was overwhelming response of interest in the program. Based on this, I am very pleased to announce the plans for the SCP Mentorship Program are official, and development of what I hope will be a very strong, value-added, and enduring program are underway, with plans to launch the program in the coming months! I hope you will consider being a part of this exciting program.

In my last two TCP columns, I reflected on the important need and opportunity for internal and external change in SCP, which has informed several new presidential initiatives and activities this year. In my last column, I argued for critical attention within clinical psychology, and SCP, specifically, to implementation science and practice – the contextual "how" factors that impact the delivery and uptake of evidence-based treatments (or lack thereof). This is a critical area of external

leadership ripe for professional psychology, and clinical psychology, specifically, to impact and help shape. In the prior column, I emphasized the need to look internally and promote membership value and engagement within SCP, particularly following declines in membership within SCP in recent years, declines also experienced by many other membership organizations. In the current column, I would like to share some updates and developments related to organizational-level activities designed to promote membership value and engagement. In particular, I am pleased to share with you key findings from the first SCP Needs Assessment recently administered to the membership. Before doing so, I would like to share some important and timely information.

Last week, information was sent to Division leaders providing analysis and graphical presentation of membership data over time for each of the APA Divisions conducted by Shane Martin using membership data maintained by the APA Divisional Services Office. These data revealed some particularly interesting themes, in my mind. In particular, the trend data revealed that the steepest membership declines over the past couple of decades were experienced by General Psychology (Division 1), Clinical Psychology (Division 12), Psychotherapy (Division 29), and Psychologists in Independent Practice (Division 42). Although the reason for membership declines in organizations is generally multifactorial, what all of these divisions have in common is that their focus and membership are among the broadest of all divisions, presenting challenges to membership identity, strategic priorities, differentiation, and, potentially, membership value. This, of course, is also true of APA as a whole – more so than most other guild organizations. As one colleague recently put it, the level of breadth and diversity found within professional psychology is not something you would experience among chemists! Most of the other organizations on Martin's graph have a much more specific identity. Significantly, one Division – Clinical Neuropsychology (Division 40) – is an especially interesting and conspicuous outlier in that it has shown dramatic membership growth that has been sustained in recent years. Qualitative researchers take note, as this would make for very interesting case study! When you have a moment, I invite you to examine the graph, which can be accessed at: https://psyborgs.github.io/projects/apa-division-memberships/

As Martin's analysis reveals, Division 12 remains among the largest of APA divisions, but this is by no means destined to be our future. In fact, looking at just demographics, Division 12 may find itself a

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considerably smaller division over the next decade and beyond because of age factors alone. With the average age of Division 12 membership approaching the age of Medicare eligibility, we may see a precipitous drop-off in Division membership in the years ahead (of course, as a gerontologist, I am hoping that is many years into the future for many of our senior members!). Martin's analyses, the breadth of SCP, the membership composition of SCP, and the spate of seemingly similar membership organizations in SCP urges that we work in earnest to promote membership value and engagement among a broad range of members, including by placing important and increasing focus on students and early career psychologists (ECPs). Of note, there is some cause for optimism as it relates to SCP membership and our efforts to promote important focus on students and ECPs: Relative to the same timeframe last year, SCP experienced a 30 percent increase in new student and ECP members year to date this year. Maybe there is hope!

To gain a better understanding of our membership, how SCP is meeting the needs of members, and how SCP could better do so, we developed and administered an SCP Membership Needs Assessment, the first such assessment of the membership that we are aware of. I would like to acknowledge, in particular, the SCP Membership Committee (and, especially, Committee Co-chairs, Drs. Elizabeth Davis and Claire Collie), as well as SCP Administrative Officer, Tara Craighead, who helped with developing and pilot testing the survey. I would like to take the opportunity here to provide a highlight of key results, as well provide as some initial reactions to the results and their implications. We also plan to conduct a webinar open to all SCP members within the next couple of months to review the needs assessment results and invite member reactions and comments. Many of the results and implications of the findings are very consistent with and validate current and planned areas of emphasis and initiatives, as well as provide valuable information for additional opportunities and for informing future directions.

The SCP Needs Assessment was administered June 15-July 14, 2016. Surveys were sent to 3,155 SCP members, with multiple reminders. Submitted surveys were received from 760 submitted surveys. I would like to extend my thanks to all of those who took the time to respond to the needs assessment. While we received a robust response, I should note that the results, of course, do not necessarily generalize to all members. Below is a summary of key results:

• In terms of SCP membership satisfaction, 91% reported being Very of Somewhat Satisfied.

• In terms of value of SCP membership, 83% reported being Very of Somewhat Satisfied.

• In terms of likelihood of renewing SCP membership, 73% reported being Extremely Likely and 22% reported being Somewhat Likely to do so.

• In terms of likelihood of recommending SCP membership to others, 51% reported being Extremely Likely and 35% reported being Somewhat Likely to do so.

• The most common reason respondents reported for first joining SCP was "Professional Identity".

• By far, the most common way in which respondents reported first learning about SCP was through a mentor.

• SCP resources identified to be of greatest interest to respondents (in descending order of frequency) are: (1) Clinical Psychology: Science and Practice (Division journal); (2) The Clinician's Toolkit/treatment manuals and resources (Division website); (3) The Clinical Psychologist (Division newsletter); (4) SCP Continuing Education Webinar Series.

• Many respondents reported infrequently visiting or being unaware of the Division website (www.div12.org), and a number of respondents provided recommendations for improvements to content and functionality.

• Several themes emerged in response to open-ended questions eliciting recommendations for promoting membership value, adding new programs or activities, or other suggestions, including: Increased communication to members/more active listserv; more communication regarding available resources; more networking/social events; more applied tools and resources (like the Clinician's Toolkit); additional advocacy; increasing focus on diversity.

On the topic of an SCP Mentorship Program, an astonishing 237 members reported that they would be Very Interested in serving as a mentor in the SCP Mentorship Program, and 160 members said that they would be Very Interested in being a mentee.

Both mentors and mentees identified a range of content areas for mentorship, including specific topic areas (e.g., Evidence-Based Practices, Mental Health/Primary Care Integration, Dissemination and Implementation, Assessment) and more general professional development or role transitions (e.g., Building a Practice, Working in Academic or Administrative Leadership, Growing a Career, Clinical Supervision).

In sum, respondents reported generally high levels of satisfaction and perceived value of membership, yet there are key opportunities for improvement. First, it is clear that there is significant interest in and opportunity for promoting member connectedness and sense of community, including in-person and virtual connectedness. Related to this finding is the reported strong interest the planned SCP Mentorship Program! Second, it is important that we increase communication with and among membership, including encouraging more active listserv communication. This fits well with an important focus this year on promoting inclusivity within the Society.

Third, there is clear interest in promoting awareness of existing resources and in expanding practical tools. I am pleased to announce that this aligns well with the current focus of the newly-appointed SCP Science and Practice Committee, which I have requested focus specifically on expanding the Clinician's Toolkit and related practical clinical resources for members, incorporating additional therapies and conditions. Fourth, there is clearly an opportunity to enhance the SCP website and increase its use by both expanding content and improving functionality. This corresponds well with plans underway to significantly overhaul the SCP website. Specifically, the SCP Executive Committee has been working with SCP Web Editor, Dr. Damion Grasso, and our external web developer on plans to significantly update and modernize the look and feel of the website, enhance organization and layout of content, and improve overall functionality and technological capabilities. We are excited about this development, which will be completed over the coming months.

Fifth, a number of responses either directly or indirectly highlighted the importance of clarifying and communicating leadership focus and identity in a field as broad and diverse as clinical psychology. Along these lines, several respondents expressed significant enthusiasm for SCP's new focus on Dissemination and Implementation and specific emphasis on attracting and engaging students and ECPs. As we move forward, careful additional reflection and focus on SCP's identity and strategic planning will be important.

Lastly, from a recruitment perspective, the finding that most respondents, by far, became connected to SCP through a mentor suggests important opportunities for engaging in targeted recruitment-related outreach to mentors and supervisors. This is a tangible and very feasible action that is likely to yield additional increases in student and ECP members. Included in this specific outreach and messaging may be information about the SCP Mentorship Program, Clinician Toolkit and related resources, and other benefits likely to be of particular interest to developing psychologists. In discussing this at the SCP Board Meeting in August, there was strong agreement for moving forward with this action and even establishing an incentive referral program that would reward mentors who refer students and ECPs with free SCP membership or other benefit. Those of you reading this who advise or work with students or ECPs, we would be very interested in your thoughts and suggestions about this. Also relevant to this – and recruitment more broadly – we have solicited proposals from communications and branding experts to work with us in to develop messaging, marketing, and strategic communications materials.

As the Summer chapter comes to a close and so does my second to last Presidential column in TCP, I feel invigorated by the process of looking inward and working to make SCP an even stronger organization – and by the validation and response to recent developments and new initiatives. Standing several feet from the SCP Speed Mentoring Event at the APA Convention, eagerly watching the session draw to a close, one of the mentors approached me to say that one of the mentee participants reported that this single session brought motivation and clarity in his career directions that he had not experienced in his 3 years of graduate training or other life experiences. The energy and enthusiasm from this experience and the overall SCP Social Networking Event was infectious and left me and several others leaving the room reflecting on the good we can achieve when we come together!

I hope that together we can bring continued growth and positive change to SCP and clinical psychology in the months and years ahead. Ψ

Brad
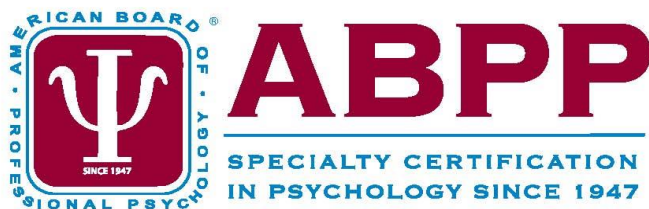
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Exams are conducted around the country by mutual convenience and are typically done at the APA and ABCT annual conferences. Exams can also be conducted at the yearly ABPP conference.

Applying Basic Affective Science to Clinical Practice: A Focus on Social Contexts and Sexual Minority Clients

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Abstract

Emotion regulation (ER) has gained attention in the clinical literature in recent years, as research has revealed that it may underlie psychopathology (e.g., Aldao et al., 2010). As a result, treatment researchers have quickly incorporated an ER framework into innovative emotion-focused forms of cognitive behavioral therapy (e.g., Barlow et al., 2004; Roemer et al., 2008). However, due to the slow nature of treatment development and implementation (including long randomized control trials; Chambless & Hollon, 2008), much basic ER work has seen little application to the clinical realm. In this paper, we demonstrate ways to glean valuable clinical insights from basic affective science research. We focus on two areas of critical clinical importance: 1) helping clients' regulate their emotions within social contexts, and 2) understanding and treating the unique emotional challenges experienced by marginalized groups, in particular, sexual minorities.

Keywords: emotion regulation, affective science, clinical science, clinical practice, sexual minorities

Emotion regulation (ER) refers to the processes by which people can alter their emotions in order to respond to environmental demands (Gross, 1998). Crucially, difficulties with ER have been conceptualized as a transdiagnostic factor cutting across psychopathology (e.g., Aldao, Nolen-Hoeksema, & Schweizer, 2010; Gratz & Roemer, 2004; Gross & Jazaieri, 2014; Insel et al., 2010; Nolen-Hoeksema & Watkins, 2011). Further, developmental psychopathologists have found evidence that ER might also constitute a risk factor for a wide range of mental disorders (e.g., Beauchaine & McNulty, 2013; Cicchetti, Ackerman, & Izard, 1995; Halligan et al., 2013; Kim & Cicchetti, 2010; McLaughlin, Aldao, Wisco, & Hilt, 2014). As a result of this work, ER has gained popularity within clinical practice, so much so, that a new wave of efficacious evidence-based emotion-focused cognitive behavioral treatments has been developed to explicitly teach clients how to disengage from maladaptive patterns of ER and replace them with more adaptive ones (e.g., Barlow, Allen, & Choate, 2004; Ehrenreich-May & Chu, 2013; Fresco, Mennin, Heimberg, & Ritter, 2013; Harvey, Watkins, Mansell, & Shafran, 2004; Roemer, Orsillo, & Salters-Pedneault, 2008).

Ilana Seager

In spite of the quick adoption of the ER framework into treatments, much remains to be understood about how it can be best leveraged to more effectively target dysfunction and therefore improve efficacy. Although the basic research literature on ER has seen a rapid expansion in recent years (Gross, 2013), treatment researchers are just beginning to incorporate much of this work into clinical practice. A key reason for this is that there is often a lag of years or even decades between findings in the lab and the dissemination of an evidence-based treatment that uses those lab findings. Such treatments require the completion of a randomized control trial, a process that involves developing a treatment manual, training therapists, administering the treatment over 12-20 weeks, and administering follow-up assessments (e.g., six months, one year), among other steps (Chambless & Hollon, 1998). Given this lag, it can thus be difficult to quickly incorporate this expansive basic ER knowledge into clinical practice.
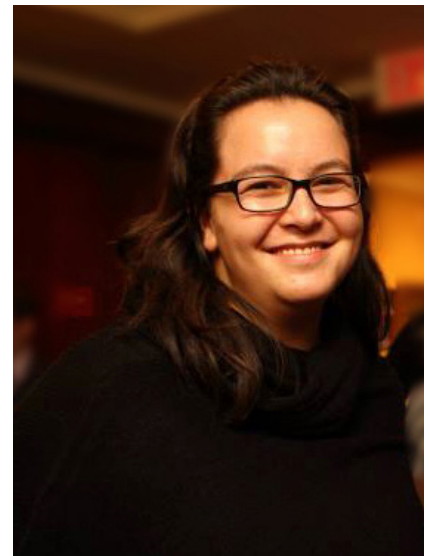
Therein lies the goal of this paper: to demonstrate how we can quickly leverage exciting new findings from basic affective science research in the provision of effective clinical work. We will focus on two specific areas of the basic ER literature that have particular relevance to popular areas of clinical practice. First, we will consider the social contexts in which clients regulate their emotions (e.g., Eisenberg, Cumberland, & Spinrad, 1998; Richards, Butler, & Gross, 2003; Rose, Carlson, & Waller, 2007; Zimmermann & Iwanski, 2014). As a highly social species, humans center their lives around relationships, from the formation of the parent-child bond early in life, to the development of romantic relationships in adulthood. Psychosocial treatments have focused on these relationships for a long time — for decades, loved ones have been involved in family-based treatments (e.g., Klerman & Weissman, 1994; Russell, Szmukler, Dare, & Eisler, 1987), in exposures for disorders like social anxiety and separation anxiety (e.g., Lyneham, Abbott, Wignall, & Rapee, 2003), and in therapies for romantic couples (e.g., Epstein & Baucom, 2002). We will propose that the basic ER literature offers some important additional insights into the mechanisms by which these social interactions may be influencing symptoms. Further, we will examine how we can harness other individuals in our clients' lives to facilitate behavioral change.

Second, we will consider how we can use basic affective science to improve our clinical understanding and treatment of the unique needs of minority groups, specifically sexual minorities. In spite of recent rises in public indices of support (e.g., federal legalization of marriage equality), sexual minorities continue to experience high rates of sexual orientation-related discrimination at both the personal (e.g., parental rejection) and institutional levels (e.g., legal inequalities) (e.g., Bostwick, Boyd, Hughes, West, & McCabe, 2014; Hatzenbuehler, 2014). This discrimination has several harmful effects: it hinders critical processes like sexual orientation self-disclosure (e.g., Day & Schoenrade, 1997; Pachankis, 2007), and it has been linked to the disproportionately high rates of mental illness sexual minorities experience compared to their heterosexual peers (e.g., Bostwick et al., 2014; Gilman et al., 2001; Meyer, 2003). In light of this heightened mental health burden, it is not surprising that lesbian, gay, and bisexual (LGB) individuals utilize mental health services more frequently than heterosexuals (Cochran, Sullivan, & Mays, 2003). To address this, we will examine the role of ER in both the development and buffering of our LGB clients' sexual orientation-related distress (e.g., Hatzenbuehler, Nolen-Hoeksema, & Dovidio, 2009;

McDavitt et al., 2008; Pachankis, 2007). Additionally, we will offer suggestions based on these basic research findings to help clinicians address minority stressors and reduce the mental health gap in this population.

Amelia Aldao

Social Contexts

At the crossroads between social psychology and affective science, a burgeoning literature is beginning to explore the ways in which ER occurs in interpersonal contexts (Dixon-Gordon, Bernecker, & Christensen, 2015; Hofmann, 2014; Zaki & Williams, 2013). The importance of understanding interpersonal affective processes has grown in recent years, as empirical studies have revealed that emotions are elicited more frequently (Gross, Richards, & John, 2006) and more strongly in social contexts (Eisenberger, Jarcho, Lieberman, & Naliboff, 2006). This work is deeply grounded in developmental research showing that ER skills are learned by observing and modeling family members early in life (Morris, Silk, Steinberg, Myers, & Robinson, 2007).

Interpersonal ER includes purposefully regulating the emotions of others (e.g., helping a friend reappraise a difficult work situation; dubbed extrinsic regulation), as well as seeking out others to regulate one's own emotions (e.g., calling a friend to discuss a work problem; dubbed intrinsic regulation) (Zaki & Williams, 2013). Extrinsic regulation plays a particularly important role in childhood. Indeed, during infancy children are completely reliant on their parents for regulating a temper tantrum (e.g., via physical or verbal soothing), but as they develop and observe how their parents regulate their own emotions, children learn to regulate their emotions more independently (e.g., by distracting themselves with toys) (Calkins & Hill, 2007; Morris et al., 2007). Adults, by contrast, frequently use intrinsic regulation when they reach out for social support.

Hofmann (2014) outlined the numerous ways in which these interpersonal processes have relevance to the treatment of anxiety and depression. For example, he

highlighted how a loved one providing reassurance about a feared outcome (e.g., unpaid bills) to an anxious client serves not only as a safety behavior, but potentially also as a maladaptive interpersonal ER mechanism. By reassuring the anxious client, the loved one is extrinsically regulating the client's fear while simultaneously reinforcing their reassurance-seeking behavior. In terms of depression, Hofmann discussed the importance of understanding the function of a romantic partner's extrinsic regulation (e.g., providing reassurance). For instance, is the partner contributing to the client's maladaptive ER by regulating them in this way? Hofmann argues that elucidating the link between the partner's behaviors and the client's emotions is critical before any effective change can be facilitated.

Thus, if a female client is having a conflict with her partner, the clinician and client could collaboratively examine the partner's behaviors to determine how the client's emotions are being affected. The clinician could set as homework a number of behavioral experiments (e.g., controversial conversations with her partner) that would assess the degree to which the partner is extrinsically regulating her emotions. The clinician could also encourage the client to record her own emotional reactions using a monitoring form. This form

could be a useful tool in identifying whether the type of regulation that the client is receiving from her partner is a) what they want, and b) what might be useful for them in the long-term. For example, the client might want her partner to regulate her emotions by providing her with reassurance, but if this client suffers from an anxiety disorder, reassurance seeking may actually be quite maladaptive long-term.

Importantly, interpersonal ER can be bidirectional — that is, a client can influence the regulation patterns of others (i.e., extrinsic regulation) while having her regulation patterns altered by others (i.e., intrinsic regulation). Research looking at this phenomenon has primarily focused on co-rumination, the process by which two individuals perseverate together on short-comings and past mistakes (Haeffel & Hames, 2014; Rose, 2002; Stone & Gibb, 2015). The landmark study in this domain examined depression, anxiety, and friendship quality in 813 students across three timepoints (5th, 7th, and 9th grades) (Rose, 2002; Rose et al., 2007). Co-rumination predicted increases in friendship quality, despite its simultaneous associations with increased symptoms of psychopathology. One of our studies expanded this work by considering how one person's use of worry or acceptance influences

another person's use of these strategies (Christensen, Plate, & Aldao, in preparation). Participants who interacted with a confederate who was worrying reported significantly higher worry and negative affect than those who interacted with a confederate who was engaging in acceptance. These findings suggest that maladaptive ER strategies may be more susceptible to being shared interpersonally than adaptive strategies.

Given the strong ties between maladaptive strategies and mental illness (e.g., Aldao et al., 2010), this work has immense relevance to clinicians. For example, if a client is engaging in co-rumination with a friend, the clinician should talk with the client about the deleterious effects of co-rumination and, since many individuals who co-ruminate may think that they are adaptively problem-solving, highlight the difference between rumination (e.g., "That was the worst presentation I've ever given") and problem-solving (e.g., "I could do a better presentation next time by preparing note cards"). The clinician could also model more adaptive ER strategies (e.g., acceptance, reappraisal) for the client, and role-play ways of interrupting co-ruminative cycles (e.g., saying to the friend, "That may not have been your best presentation, but you tried your best and ultimately, what's done is done").

Moreover, it may be advantageous to bring the friend into session so that the client can practice using more adaptive ER strategies with them. In so doing, the clinician will also be able to determine the degree to which the friend is utilizing maladaptive ER strategies. This could be an excellent opportunity to determine whether the friend a) needs a short training on more adaptive ER strategies that can occur that session (if the friend has mild ER difficulties), or b) needs a referral for a more involved course of treatment (if the friend has moderate or severe ER difficulties). By providing the friend with these skills, the clinician may simultaneously help break the co-ruminative cycle and provide the client with a stronger source of social support.

Sexual Orientation

As sexual minorities in the United States continue to experience high rates of discrimination in their daily lives (e.g., being called names, employment discrimination; Bostwick et al., 2014), an emerging line of basic affective science research is beginning to examine these emotionally-laden experiences and how sexual minorities cope with them (e.g., Eldahan et al., 2016; Hatzenbuehler, Nolen-Hoeksema, et al., 2009; McDavitt et al., 2008). For instance, in one

study we examined LGB participants' responses to both discriminatory and affirming videos (Seager & Aldao, under review). In particular, we examined their ability to experience emotions that match contextual demands (i.e., emotional context sensitivity). We found that emotional context sensitivity was associated with two known indices of adaptive functioning in sexual minorities (i.e., minority identity integration, LGB community connectedness), suggesting that flexible, contextually sensitive responses to LGB-relevant stimuli might be adaptive. Emotional context sensitivity has been conceptualized as a building block of ER flexibility, a process that is associated with good mental health (e.g., Bonanno & Burton, 2013; Kashdan & Rottenberg, 2010). This study highlights that feeling negative emotions in response to discrimination does not necessarily reflect a maladaptive response — rather, the ability to feel negative emotions in negative contexts (e.g., discrimination), and feel positive emotions in positive contexts (e.g., pride parade) may be most adaptive. Unfortunately, no work to date has examined emotional context sensitivity in relation to psychopathology in sexual minorities.

Clinicians may be able to harness these emotional context sensitivity findings in working with LGB individuals by using it as a guide to identify maladaptive responses to discriminatory events that could then be targets in treatment. So, a lesbian client may report feeling numb when hearing someone on the street call her an anti-gay slur, and continue to feel numb when she is spending time with her girlfriend later that week, an experience that usually elicits positive emotions. Her clinician may be able to infer based on this contextually insensitive responding that she is having difficulty processing emotional information, and make this the new treatment target. Alternatively, the clinician could conduct a series of exposure exercises by showing the client several film clips LGB-relevant scenes, some positively-valenced (e.g., pride parades, affirming disclosure scenes, YouTube's #ProudToLove series) and some negatively-valenced (e.g., homophobic preachers, anti-gay political commentators). While the client is watching these clips, the clinician could collect standard Subjective Units of Distress (SUDS) ratings. If the client reports similar SUDS levels during both positive and negative clips, it is likely that she is indeed experiencing context insensitivity.

Critically, new research specifically looking at regulation processes has found that the use of certain ER strategies might play a causal role in the distress sexual minorities feel after experiencing discrimination (Hatzenbuehler, Nolen-Hoeksema, et al., 2009). Specifically, a daily

diary study found that on days during which participants experienced discrimination, they endorsed using more maladaptive regulation strategies compared to days without discrimination (Hatzenbuehler, Nolen-Hoeksema, et al., 2009), highlighting the critical need for clinicians to help sexual minorities tolerate stigma-related distress (e.g., via exposures) in order to access adaptive regulation strategies. A second experimental study found that participants who ruminated about a prior instance of discrimination showed higher implicit and explicit distress than participants instructed to distract themselves (Hatzenbuehler, Nolen-Hoeksema, et al., 2009), demonstrating the particularly deleterious effects of rumination in response to discrimination.

To determine what strategies sexual minorities use naturalistically in the face of discrimination, McDavitt and colleagues (2008) conducted interviews with young gay and bisexual men about their ER strategies and mapped their responses onto Gross' (1998) process model of ER. Participants reported surrounding themselves with other sexual minorities (situation selection), concealing their sexual orientation (situation modification), selectively attending to discrimination (attentional deployment), reframing discriminatory experiences to change their meaning (cognitive change), and venting or suppressing their emotions, or using substances as a way to cope. This study provides a rich starting point for clinical work, demonstrating both adaptive (e.g., reframing) strategies that can be reinforced and maladaptive (e.g., substance use) coping mechanisms that can be replaced. By understanding how LGB individuals respond in these situations, we can provide more targeted interventions in the clinic.

An important moderator to consider with this population is internalized homophobia, which has been positively associated with rumination and psychological distress (Hatzenbuehler, Dovidio, Nolen-Hoeksema, & Phills, 2009; Szymanski, Dunn, & Ikizler, 2014). Similarly, sexual orientation uncertainty has been associated with greater rumination and distress (Borders, Guillén, & Meyer, 2014). More generally, a longitudinal study found sexual minority adolescents exhibited greater use of rumination and poorer emotional awareness than their heterosexual peers and these ER deficits mediated the relationship between sexual minority status and psychopathology symptoms (i.e., depression, anxiety) (Hatzenbuehler, McLaughlin, & Nolen-Hoeksema, 2008).

These findings demonstrate how important it is for clinicians to a) carefully assess LGB clients' use of ER strategies during discriminatory events, and b) consider how contextual factors like LGB community and family support might be harnessed in order to maximize the client's emotional wellbeing. For example, a gay male client who says he is using substances to cope with sexual orientation-related discrimination may benefit from first undergoing a thorough assessment. The clinician could encourage the client to monitor how often he is experiencing sexuality-related discrimination during a one-week period and note down a) his emotional reaction (including intensity, duration), and b) his use of ER strategies (e.g., drinking, rumination) during that discrimination experience. Additionally, the client could record how much he is drinking on days he does not experience discrimination. By doing this the clinician can determine how closely linked his drinking is to the discriminatory event, and also the intensity of his emotional reaction. Moreover, this exercise will provide the clinician with an opportunity to determine if the client has a broader ER repertoire that includes more adaptive strategies (e.g., reappraisal).

This client may also benefit from being connected to LGB social support networks (in-person, if available, or online via websites like TrevorSpace.org). The clinician can then encourage this client to use some of the situation selection (e.g., spending more time with LGB friends) and cognitive change strategies (e.g., thinking "No matter what this person says, I know there are people who love me and think I am valuable") described above to replace his maladaptive use of substances. Moreover, the clinician could use cognitive restructuring techniques to address any internalized homophobia that may be associated with their use of maladaptive strategies like rumination. Specifically, the clinician could use the downward arrow technique to determine the exact belief the client has about being gay (e.g., "Being gay means that I am less of a man than if I was straight"), and then use thought records to examine the evidence for that belief. Indeed, a recent randomized control trial of a transdiagnostic treatment for emotional disorders that was adapted for gay and bisexual men found that devoting time in treatment to minority stressors may afford key clinical benefits (Pachankis, Hatzenbuehler, Jonathon, Safren, & Parsons, 2015). Specifically, participants showed reduced symptoms of psychopathology, reduced risky sexual behaviors, and small improvements in minority stresses.

Summary

In this paper, we have reviewed a small subsection of the rich and diverse basic affective science literature examining the role of ER in daily life, and highlighted

its applications to clinical practice. While the extensive applied work investigating ER in the context of psychopathology elucidates many regulatory concerns presented to us by our clients, this basic literature fills in critical gaps related to the important role of social contexts in the development of and broader use of ER strategies. Further, work in basic affective science can help us understand why ER may play a particularly important role in the lives of sexual minorities, and why it may be important for clinicians to adapt our expectations and coverage of ER use according to each client's individual context. As clinical scientists, we need not wait years for cutting-edge research to make its way into our clinical practice via published treatment manuals. Instead, we can take advantage of the flexibility of the cognitive behavioral treatment approach and develop new exercises based on the latest research. Ψ

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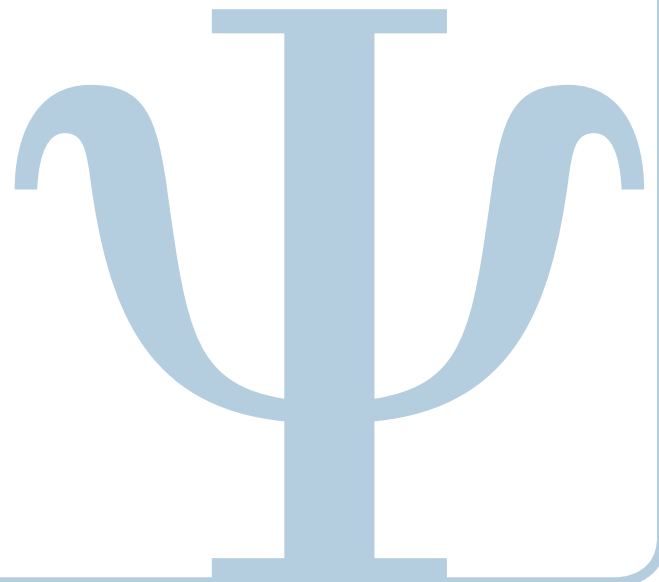
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They Never Taught Me *This* in School: Navigating Ethical Dilemmas in College and Graduate Teaching

Adam Fried, Ph.D.
Fordham University

A new school year likely brings novel (and perhaps some familiar) ethical dilemmas for psychology instructors. Some of the most challenging ones have to do with questions about appropriate boundaries and multiple relationships.

Consider some examples:

• A student comes to office hours regularly to discuss personal problems not related to class or their academic performance

• A student sends you a Facebook friend request

• Students who you know to be underage are being served alcohol at a bar you enter and invite you to share a drink

• A student requests personal, non-academic related advice

• A former client from the counseling center you worked in last year is currently enrolled in your class

• Asking students to also serve as participants in your research for course credit.

While these situations require thoughtful deliberation by even the most seasoned professors, they likely pose significant challenges for those with limited teaching experience, including new faculty, postdoctoral teaching fellows, adjunct instructors and graduate teaching assistants. First, many new instructors may have never encountered or considered the types of dilemmas they will encounter (and, therefore, don't have the benefit of experience to guide them), have not received training that addresses them, and/or may be unaware of related college policies and resources. Second, many, especially graduate assistants, non-tenured faculty and adjunct instructors, may be uncertain about their roles and expectations, or may experience a pressure to satisfy student requests, even those that may place the instructor in a difficult position or result in unethical

behaviors. Finally, instructors may feel uncomfortable or even embarrassed to ask senior and supervisory faculty for advice on how to handle difficult situations and, instead, attempt to resolve situations that likely require the expertise or assistance of others on their own.

Boundary Crossing and Multiple Relationships

Boundary crossings are frequently discussed in psychotherapy contexts, where therapists may suddenly be confronted with situations (both in and out of the office) that have the potential to confuse clients/patients about the nature of the professional relationship. The balancing act of maintaining appropriate boundaries while also serving the needs of the clients/patients is not always easy to manage. Instructors also face similar difficult decisions about how to how to best care for students in distress, address student requests, or connect with students in ways that maintains the nature of the professor-student relationship while also serving student needs.

What factors might influence a professor's decision to cross boundaries with students? As Chory and Offstein (2016) eloquently argue in their recent article, "Too Close for Comfort? Faculty–Student Multiple Relationships and Their Impact on Student Classroom Conduct," market and other forces have lead to a "changing university landscape" (p. 4) where students are seen as consumers or customers of higher education, leading to a perceived shift in expectations of faculty in terms of their expected accessibility, willingness to socialize, and tolerance for in and out-of-classroom behaviors that may be considered inappropriate. In addition, they argue, concerns about tenure, promotion and performance are often based, at least in part, on student evaluations (which can include questions about faculty accessibility and even their sense of humor!) and these concerns may influence instructors to behave in ways that may be considered inappropriate (perhaps in an attempt to solicit higher evaluation scores). Instructors may also be tempted to cross boundaries in the hopes of creating stronger relationships with students and improving student dedication and performance in the class.

Results from Chory and Offstein's research (2016) suggest that student beliefs about faculty out-of-classroom behavior does have an effect on student in-classroom behavior, but not in ways we might expect. A survey of 145 undergraduate business students revealed that when faculty were perceived as "breaking the rules" (e.g., violating boundaries), students believed they would be more likely to behave in inappropriate

ways, including coming to class intoxicated, violating rules and behaving rudely in class (Chory & Offstein, 2016). According to the authors, "…students still expect certain social boundaries and social distance with their professors" (p. 16).

Multiple Relationships:

Faculty at times may also be in or have been in an additional non-teaching relationship with students. In psychology, the term "multiple relationships" describes situations when while assuming a professional role, the psychologist takes on another role with that person, either professional or personal. Some teaching-related examples include teaching students while also being or have been a research supervisor, personal friend, sexual partner, therapist, or in some other university-based authoritative or disciplinary role. The ethicality of multiple relationships depends on a number of factors. Some multiple relationships can be unavoidable, unexpected or unintentional and of course, not all are harmful.

Several helpful ethical decision-making guidelines focusing on multiple relationships have been offered, including those by Youngreen & Gottleib (2004) and Oberlander and Barnett (2005), whose recommendations were specific to graduate assistants. Important considerations include whether the multiple relationship results in an increased incompatibility in role functions and objectives, impairs one's ability to perform professional duties competently, or risks exploiting the other person. Other important questions include whether the multiple relationship serves more the needs of the student or the instructor, whether it results in increased intimacy and blurred boundaries and whether it is avoidable.

Personal Disclosures

Instructors (especially those teaching psychology) may also experience situations in which students disclose personal information concerning the well-being of themselves or others. These may be spontaneous classroom discussion contributions or solicited by instructors through class assignments meant to illustrate a specific concept. For example, students may write in a reaction paper that they are clinically depressed and that while they are not actively suicidal, they have had passive thoughts in the recent past. These situations may place instructors in a difficult position. Should one intervene and speak with the student? Will that be viewed as an invasion of privacy or be embarrassing to the student? On the other hand, does the instructor have an obligation to

intervene or notify someone? If one does intervene, how can the instructor avoid creating the appearance of a therapeutic relationship with the student, but still provide him or her with the services and care needed? How does one best fulfill one's responsibilities as a teacher (including the limitations that accompany this role) while also ensuring that students are receiving appropriate care and services? [1]

It's important to remember that students are not the only ones who may disclose personal information. Faculty, too, may believe that disclosing deeply personal information about themselves to students may help illustrate a particular point or strengthen the student-teacher relationships. While certain anecdotes and minor disclosures may hold pedagogical value and can be used illustrate class concepts, highly personal disclosures can also have unanticipated negative consequences for students, the instructor and on classroom climate.

Like many ethical dilemmas, we want to do what's best for the person we're working with, whether it is a patient/client, research participant, or student. For example, we may believe that encouraging a student who is in distress to come each week to office hours to discuss his or her problems may be helping the student, but this may also be a violation of our ethical responsibilities, both as an educator and a psychologist, and may lead to harm, especially if the student requires specialized or more intense care or makes requests for special treatment with regard to class assignments or grading that may place the instructor in a difficult position. The challenge, in the case and in many ethical dilemmas, lies in discerning the best course of action that provides necessary assistance or resources to those in need while fulfilling professional responsibilities that reflect our ethical principles and standards. Ψ

[1] To prepare for some of these situations, it may be helpful to become familiar with university resources and policies regarding students at risk as well as any rules and policies related to threats of violence or past sexual assault. For recommendations and resources about faculty responses to students in distress, please visit: http://www.fordham.edu/StudentDistressResources

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Kaitlin P. Gallo, Ph.D. - Editor

Section II: Society of Clinical Geropsychology

Submitted by Victor Molinari, SCG representative to SCP

The Society of Clinical Geropsychology had a successful APA convention. It hosted a student social event as well as a joint dinner with Division 20 (Aging & Human Development). Both events were well attended and a good time was had by all.

The SCG presidential address (delivered by Sherry Beaudreau) and conversation hour (hosted by Sherry Beaudreau) had diversity as their main themes. Dr. Beaudreau advocated for a broad definition of diversity that includes the variety of ethnic-cultural, socio-economic, sexual orientation, and spiritual dimensions that make each individual unique. Of course, aging is also included as a diverse characteristic, and indeed even within the definition of older adults there are differences between the young-old and old-old.

SCG is making a strong membership push. One strategy that was debated is to affiliate with Division 20 to offer a joint membership package. Division 20 has spearheaded this initiative and we are hoping that this will increase membership and make for closer contacts between SCG and Division 20.

SCG has been a strong partner with the other geropsychology groups (Psychologists in Long Term Care; Division 20; Council of Professional Geropsychology Training Programs; Committee on Aging) in assisting with the APA specialty renewal process by updating some of the sections of the original application. A rough draft is now completed and both an internal and external reviewer have agreed to provide feedback by mid –September.

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 congratulates long-time member, John "Jack" Carr, PhD, ABPP who has been awarded the 2016 APA award for Distinguished Professional Contributions to Institutional Practice, recognizing his long-standing contributions to psychology within medical centers. Early on, he championed the integration of psychology within the practice of medicine, integrating psychology in social science into the medical school curriculum, and serving as an institutional role model for medical school psychologists and psychology faculty members. He has spent his professional life at the University of Washington School of Medicine where he is now Emeritus Professor of Psychiatry. This award will be presented during the 2016 APA Convention in Denver, Colorado.

APAHC is planning the 8th National Conference for March 9-11, 2017, in Detroit, Michigan, at the Westin Book Cadillac! Thanks to Co-Chairs, John Yozwiak, PhD and Amy Williams, PhD. The Theme will be "Promoting Psychology in the Evolving Healthcare Landscape: Enhancing the Well-Being of Patients, Providers, and Populations." New this year will be the Mid-Career Boot Camp for those over 10 years post-degree, as well as the ever popular and engaging Early-Career Boot Camp for those with fewer than 10 years post degree. Representatives from the APA Commission on Accreditation will be on hand to provide internship site visitor training and self-study workshops. Check the APAHC website for further details over time!

APAHC is a proud member of the Clinical Health Psychology Specialty Council, with a 2016 priority to assure that the Specialty Council represents all major stakeholders of the specialty of clinical health psychology, and facilitate communication with the Council of Specialties in Professional Psychology (CoS), the APA Commission on Accreditation, other professional organizations, and the general public. Likewise, the Council has prioritized facilitating shared understanding among stakeholders about how integrated primary care is defined and fostered as a focused area within clinical health psychology, as well as when primary care psychology is not considered clinical health psychology practice. The Council also has promulgated the Taxonomy for Education and Training in Clinical Health Psychology and all member programs are encouraged to utilize this taxonomy in their public materials. (See the Council of Clinical Health Psychology Training Programs website at http://www.cchptp.org/).

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.

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.

Under the leadership of the APAHC Diversity and Disparities Task Force Chair, Dr. Alfiee M. Breland-Noble, the Task Force contributed to the 2015 APAHC conference by nominating Drs. David Satcher and Arlene Noriega as keynote speakers. Dr. Satcher's talk was very well received by all attendees and focused on the topic of integrated care as a mechanism for health equity. Dr. Noriega's timely talk focused on issues relevant for the mental health needs of LGBTQ populations. The TF also supported special outreach to the local HBCU (Historically Black Colleges and Universities) in the area to encourage their participation in the conference including Drs. Satcher and Noriega's primary academic home, Morehouse School of Medicine. The TF is also planning to incorporate cultural relevance in evidence based and other forms of care through a planned special issue of the section's flagship journal Clinical Psychology in Medical Settings.

Members continue to benefit from valued APAHC publications, including the Grand Rounds newsletter, and our flagship journal: Journal of Clinical Psychology in Medical Settings. A recent newsletter featuring the creative talents of Editor Cesar Gonzalez, PhD, ABPP, focused on Rural Health. The March 2016 Journal will highlight articles based on presentations at the 2015 APAHC Conference: Academic Health Centers in the Era of Interprofessionalism: Multifacited Contributions to Psychology.

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. Ψ

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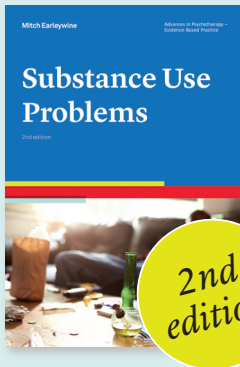
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Mitch Earleywine

Substance Use Problems

Vol. 15, 2nd ed. 2016,
viii + 104 pp.
ISBN 978-0-88937-416-4
Also available as eBook

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. It 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.

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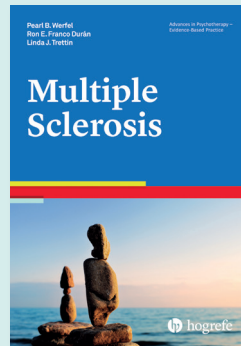
Pearl B. Werfel /
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Multiple Sclerosis

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.

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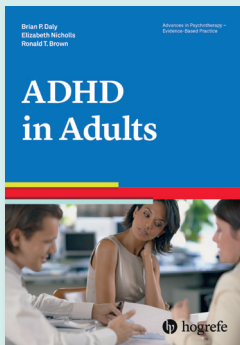
ADHD in Adults

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.

ADHD in Children and Adolescents
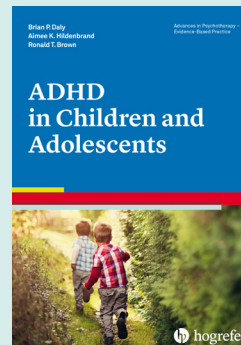
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ADHD in Children and Adolescents

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.

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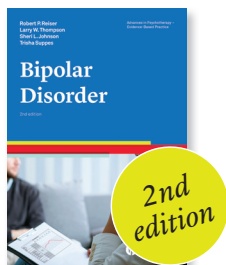
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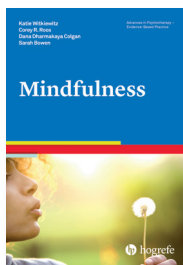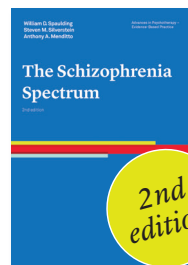
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