CONTENTS

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PRESIDENT'S COLUMN

Realizing Needs and Opportunities for Leadership: Advancing Clinical Psychologists as Leaders of Micro and Macro Level Change

Bradley E. Karlin, Ph.D., ABPP

If ever there was a need, in our profession and the nation, for strong leadership to effect change – at individual, system, and societal levels – it is now. Yet, as important and needed as it is, leadership at various levels is not something most of us receive training on or intentionally plan for. Surely, leadership does not often find its way into the syllabi of many graduate training programs in clinical psychology.

Recently, I was asked to give the commencement address at a psychology internship and postdoctoral training program. This event, the national and international events of the past several weeks, and the closing of the year has had me reflecting on the need and opportunity for strong leadership in clinical psychology, particularly within the next generation of clinical psychologists. A leadership area of particular potential and fit for clinical psychologists is serving as administrative leaders in organizations and government agencies, where the knowledge and skills of a scientist-practitioner can positively inform and be informed by administrative leadership responsibilities and help shape the delivery and quality of psychological services. This was the focus of a Division 12 sponsored symposium at the APA convention this past August that drew significant interest. In this, my last, Presidential column of TCP, I thought it timely to reflect aloud and offer some personal insights and perspective from one individual's experiences.

Bringing Macro to a Micro World

My paths to becoming and functioning as a clinical psychologist have been anything but "traditional". The decision to become a clinical psychologist

for me was rooted in a deep desire to improve mental health care and reduce unmet mental health need, particularly among older adults, by working at micro and macro levels. Prior to entering psychology, I worked in the field of law and policy (mainly focusing on mental health policy and Medicare mental health reimbursement issues) and had a strong interest in bringing my developed macro level interest and lens to professional psychology, while also bringing interests I had in helping and supporting others in my life to working to promote change at the individual level. I believed, as a clinical psychologist, that I could best advocate for and effect change in mental health care access and delivery. My interest and background in macro level change was, however, at the time met with confusion by a number of clinical psychology training programs. Fortunately, I found a perfect match in a clinical psychology training program (Texas A&M University) and mentors, such as Michael Duffy, David Gleaves, Les Morey, and Doug Snyder, who embraced the notion of effecting change at both micro and macro levels. I then had the great fortune of completing my clinical internship and postdoctoral fellowship in geropsycholgy at the Veterans Affairs (VA) Palo Alto Health Care System. VA (and especially VA Palo Alto) is a terrific place to be for someone with interests in mental health care systems, policy, and administration. Working with mentors, such as Bob Zeiss, Steve Lovett, Gary Hartz, and Keith Humphreys, I had the opportunity to be on an administrative leadership rotation (one of the very first at the time), to further research and write about Medicare mental health policy (including applying a model of policy change to a new Medicare mental health benefit), and to further develop strong clinical interests in evidence-based psychotherapy (EBP) and in psychosocial approaches to managing behavioral symptoms associated with dementia. Thanks to a combination of intentionality, a heavy dose of serendipity, and support and validation of true mentors, my decision one fateful day to leave my former professional world to enter the world of clinical psychology would be increasingly validated.

Dissemination and Implementation to Promote Mental Health Care Quality and System Change

Over the years, my interests in reducing unmet mental health need and in evidence-based psychotherapy led me to become particularly aware of and interested in the large research to practice gap related to EBP and consequent quality problem prominent in the recent mental health discourse (Karlin, 2015). In 2005, as the nation was at the height of war, I had the privilege to join Toni Zeiss, Ira Katz, and others in VA Central Office to be part of an unprecedented effort to help transform VA's mental health care system to an evidence-based and recovery-oriented system of care. In my role as National Mental Health Director for Psychotherapy and Psychogeriatrics, I and a team of incredibly dedicated mental health professionals (primarily clinical psychologists) developed an initiative nationally disseminate and implement EBPs to realize the promise of these treatments for Veterans cared for in real-world settings. This initiative, which would become the largest dissemination of EBPs in the nation, was a truly challenging and exhilarating undertaking that resulted in significant improvements among many Veterans presenting for care in real-world settings, on par with those reported in RCTs. In many ways, this was the ultimate actualization of my early hope to promote macro and micro level change to reduce unmet mental health need. This work (as the implementation science literature now increasingly emphasizes) required actions on many levels – including policy, provider, local systems, and patient levels. Along the way, I had another strong role model and the trust of a passionate and skilled clinical psychologist administrative leader in Toni.

Witnessing what is possible when implementing broad and strategic dissemination and implementation, I became passionate about realizing the promise of EBPs and promoting system change in other systems. I now work with various private and public systems to promote the dissemination and implementation of EBPs and to improve mental health and dementia care for older adults. Having the opportunity as a clinical psychologist to effect system change and bring dissemination and implementation strategies and processes to other mental health care systems is incredibly meaningful and exciting. And, as one of my SCP Presidential initiatives this year, I have worked to position SCP as a leader in dissemination and implementation within clinical psychology and professional psychology, more broadly!

I am convinced that clinical psychologists have a lot to offer as leaders of individual, systems, and societal change, and I am hopeful that an increasing number of the next generation of clinical psychologists will seek and even create such opportunities. In reflecting on my professional journey over the past several months and throughout the foregoing paragraphs, I formulated a list of tips and lessons learned. I will offer the results of this factor analysis of my reflection for aspiring leaders of tomorrow. Here goes.

1. *Do what you care about and care about what you do.*

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Victor Frankl's lessons are critical to work and life success.

2. *Identify your personal niche and frame it carefully.*

Find an area where you feel passionate, where you can make a contribution, and link this to your professional purpose and identity. In so doing, think outside the box – even if just around the borders.

3. *Use your signal to penetrate the noise.*

According to political scientists, successful policy change is impacted, in part, by the "signal-to-noise" ratio. The signal-to-noise ratio is a measure of the likelihood a constituent's concern or request (signal) is recognized by one's representative or elected official. The degree to which the message or request is perceived by the elected official is dependent upon the success of the message in penetrating the thousands of messages (noise) from many other constituents and interest groups. The importance of honing and successfully and strategically communicating one's message has relevance in many contexts beyond policy change.

4. *Seek out and volunteer for opportunities.*

An important opportunity for increasing one's signal to noise ratio and advancing thought leadership, as is publishing and presenting in strategic outlets and venues.

5. *Incorporate intentionality and embrace serendipity*.

Live and act with focus and intentionality, while at the same time welcoming and embracing the winding path. Watch for (and help to produce) open windows life presents that may lead to opportunities and adventures.

6. *Associate yourself with smart and dedicated people.*

The most successful leaders are those who are part of (and help reinforce) bright and motivated teams.

7. *Find a mentor who gets you and your passion.*

Join the new SCP Mentorship Program (as a Mentee and/or Mentor)!

8. *Share your care – inspire and motivate.*

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Ψ

As leadership expert, Simon Sinek, emphasizes, people don't care about what you do, they care about why you do it. For this reason, highly successful leaders and organizations focus on the "why" of their work and work product, not just the work itself. As Sinek notes, Martin Luther King's, "I Have a Dream Speech," was not the "I Have a Plan" speech.

As 2016 and this column draws to a close, I would like to express my gratitude for having had the experience of serving as your president at an important and challenging time for SCP and professional psychology. This was a year marked by uncertainty and transition in the field of professional psychology and the nation (and world), more broadly. This was also a year of organizational introspection, growth, and excitement. Over the past year, SCP administered its first Needs Assessment of the members and worked to establish itself as an organization of early and mid-career professionals, as well as senior-level clinical psychologists. The development of the SCP Mentorship Program this year, a new membership benefit by which members are paired with other members in specific practice or topical areas across all stages of professional development, is designed to leverage the rich resource of our broad and experienced membership and provide greater membership value to early-, mid-, and later career members (http://www.div12.org/mentor-match/). Another new program, the SCP Campus Representatives Program, focuses on outreach to and engagement of the next generation of leaders in clinical psychology. Led by members of Section 10, the Campus Reps Program works to promote awareness of the field of clinical psychology and SCP on college campuses (http://div12sec10.org/?page_id=488).

As we looked inward and to external needs and opportunities at a time when membership organizations are increasingly competing and struggling to be relevant and unique (an especial challenge in the broad field of clinical psychology), there was strong recognition and enthusiasm for positioning SCP as a home for and leader of dissemination and implementation science and practice within professional psychology. This is an opportunity that builds on SCP's rich history in identifying evidence-based psychological treatments. Increasing psychology's involvement and leadership in advancing the "how" of implementation (e.g., adoption, scaling, and sustainability), moving beyond the development and identification of "what" works, is essential to the future survival of clinical psychology and to finally realizing the potential of psychological

treatments. As the leader of an aging services system I have been working with to implement a dementia care intervention for formal care providers and family caregivers of individuals with dementia recently put it, dissemination and implementation is at the intersection of where "rigor meets reality" – a crossroads that providers and systems of many kinds and fields struggle with daily throughout the world. As part of our efforts to promote SCP's focus on dissemination and implementation, provide a foundation of information and resources for members, and place a stake in the ground of the field of D&I, we have been working to develop an SCP Dissemination and Implementation web portal (www.div12.org/implementation), which I am pleased to first announce in these pages is scheduled for launch in the weeks ahead. I hope you will take an opportunity to check out this new resource and spread the word to colleagues and students. At the same time that the SCP D&I web portal is undergoing its final phase of development, the overall SCP website is undergoing a major re-development to enhance overall design and functionality (incorporating feedback and recommendations for improvement from a number of members in the SCP Needs Assessment). So, please be on the lookout for new SCP real estate and resources on the web soon. The overall SCP website redesign is scheduled for completion in the first quarter of 2017. As this all is underway, we are also working to create a new brand, logo, and look and feel of the Society, to be completed in the months ahead.

There are too many people to thank here for their help with and support of these and other presidential initiatives and developments this past year, but I'd like acknowledge the contributions of a few: Michele Karel, Natalia Potapova, Shannon Wiltsey Stirman, Torrey Creed, Elizabeth Davis, Brandon Gaudiano, Damion Grasso, Michelle Blose, Elaine Burke, Sheehan Fisher, Derek Giannone, Kim Penberthy, Danny Wedding, Huaiyu Zhang, Tara Craighead, and the SCP Board of Directors.

Best wishes for a happy holiday season and a prosperous future for our organization. Good luck to incoming President, Michael Otto, and incoming President-Elect, Gary VandenBos.

Thanks for a great year.

Brad Ψ

Barriers to CBT Training: Is Mobile Technology The Solution?

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When thinking about the field of Clinical Psychology and where it's headed, it's almost impossible not to consider the immense possibilities (and complexities) that technology has presented for the work we do. From 2013 to 2015 alone, the number of trials examining the effectiveness of mobile health applications increased from 135 to 300 – 32% of which were specifically for mental or behavioral health applications (Anthes, 2015). In addition, there are a staggering number (4,000 and counting) of mental health applications currently available in the mobile application store (Hind & Sibbald, 2015) designed to provide a range of skills, support or education on a number of mental health issues, from an application that is marketed to "[connect] a growing community of people living with bipolar disorder" (Bipolar Disorder Connect) to others that "bring you effective tools and programs to take control of your emotional well-being" (Happify). The ease and extent to which information can be made available to the masses presents an exciting opportunity for those of us interested in reaching a wider base of the population struggling with mental health issues, while also raising some distinct concerns about the quality and accuracy of such a large volume of freely available content.

Direct patient impact aside, providers of mental health treatment are also significant users of mobile and web-based technology, and indeed, this opens up an avenue for dissemination of effective treatments that has not been possible prior to the past decade or so. The ability to reach a provider who is in the trenches of clinical work with

Anu Asnaani

a device right at their fingertips (one that is likely already integrated into a number of other functions of their practice) gives clinical scientists a chance to possibly transform the landscape of how clinical training is implemented and supported. This article reviews some of the common barriers encountered in CBT training, how technology has so far been integrated into training efforts, and what we know about current and upcoming mobile technology solutions to improving our CBT training efficacy and scope.

The Training-Practice Gap

At this point, statistics on the research-practice gap will come as no surprise to most readers: the field has succeeded in developing evidence-based psychological treatments (EBT) which successfully reduce symptoms and improve functioning for a great range of clinical problems (Nathan & Gorman, 2007; Weisz & Kazdin, 2010). Yet, self-congratulations would seem premature, as it is also well established that the vast majority of individuals seeking mental health treatment will not receive these interventions (Kazdin & Blase, 2011; Wang, Berglund, & Kessler, 2000; Wells, Klap, Koike, & Sherbourne, 2001). As one of many possible examples, cognitive behavioral therapies that include exposure techniques have a robust evidence base supporting their utilization for the treatment of anxiety disorders. And yet, data consistently shows that providers are unlikely to use exposure with their anxiety patients, even when they self-identify as CBT therapists (e.g., Becker et al., 2004). Shy of the academic departments and cognitive behavioral specialty settings that typically exist in cities, we must

collectively wonder (and often do), why aren't more therapists jumping on the EBT bandwagon?

When you ask providers directly, the answer is frequently lack of sufficient training (Becker et al., 2004; Cook et al., 2009). While not inclusive of the problem, adequate training in evidence-based treatments is a prerequisite to competent delivery of EBT that contributes to limited EBT access (Insel, 2009; Shafran et al., 2009). More providers need access to training in newer evidence-based interventions, and training needs to be effective in not only promoting competency in that intervention, but also in promoting providers' confidence and enthusiasm toward utilizing the treatment, so that he or she will elect to do so when the door is closed and the choice is left to them.

Compared to the data on evidence-based treatments, data on evidence-based training is in its relative infancy. Importantly, research to date strongly suggests that not all training is created equal. Standard training typically consists of a didactic workshop that takes place over one to four days. A growing body of research indicates that while workshop training improves knowledge, it is not adequate to produce change in provider behavior (i.e., regular use of the new treatment) or training to competence in a new intervention (see for reviews: Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). In contrast, the gold-standard training model used in most randomized controlled trials entails an expert-led workshop followed by weekly expert consultation with at least two patients. Research across disorders suggests that the addition of consultation following workshop training improves self-efficacy, proficiency, and use of evidence-based treatment (e.g., Beidas, Edmunds, Marcus, & Kendall, 2012; Sholomskas et al, 2005; Smith et al., 2007; Miller et al., 2004) compared to workshop alone. Unfortunately, while many providers are able to find the resources and time to attend training workshops, expert consultation is costly, time consuming, and limited by the finite number of experts available. Thus, the gold-standard training model, as it currently stands, is not easily scalable, and will likely prove insufficient to address the research-practice divide. In addition, there is likely a sufficient "dose" of consultation required to produce good competency outcomes. Indeed, in a study in which all community providers were offered consultation following workshop training, Beidas and colleagues (2012) found that the number of consultation hours completed predicted higher CBT adherence and skill level three months post-workshop.

Integration of Technology into Training Efforts

Technology provides an avenue through which we are better equipped as a field to deal with scalability and accessibility issues in CBT training. The bulk of the work integrating technological approaches to date has involved the use of web platforms as a replacement to the intensive in-person workshop (see for review: Khanna & Kendall, 2015). Web- based trainings offer several notable advantages compared to standard workshop trainings. For one, they increase the reach and cost effectiveness of trainings by not being geographically bound to an expert trainer's specific location or limited to a particular number of attendees. Web-basedtrainings also allow providers to customize their learning experience by signing in and out when suits their schedules, and provide the opportunity for learners to cover and review material at an individualized pace (Khanna & Kendall, 2015; Rousmaniere, 2014). To further enhance the user learning experience, some web-based trainings have been developed that allow for live interaction with expert trainers and other learners: for example, trainings in Prolonged Exposure (PE) are available through the Center for Deployment Psychology that take place via the Second Life Platform (for more information, please visit: http://deploymentpsych.org/content/attending-cdp-training-event-second-life). In this model, trainees create unique avatars that "attend" the workshop, and can directly interact with other attendees (e.g., completing role plays) remotely.

Laurie J. Zandberg

While significant work is currently in progress to empirically evaluate web-based training (e.g., the Center for Research on Eating Disorders at Oxford [CREDO] initiatives examining the effectiveness of independent versus guided web-centered training in CBT for eating disorders and depression across the United Kingdom and United States; Fairburn and Cooper, 2011; Fairburn and Patel, 2014), data from concluded studies is encouraging. For instance, one internet-based CBT training for clinicians in Russia outperformed a delayed training (waitlist) control group on providers' CBT assessment and case formulation skills, highlighting the utility of web-based trainings in breaking down

SCP's next CE webinar-Dr. Robyn Walser: Mindfulness and Mental Health: Creating Awareness, Flexibility and Freedom

Thursday, January 12 6 – 7 PM ET

Overview: The painful experiences encountered in life may not only lead to problems in functioning, including a variety of behavioral problems ranging from substance abuse to relationship problems, they may also impact our mental health and sense of well-being for long periods of time. Many of the attempts to recover from these experiences involve regaining control over thoughts, sensations, and emotions as the path to living well. While some attempt to control these experiences can be expected and useful, many attempts to control thoughts, sensations, and emotions result in a furthering of the suffering. Mindfulness can be used to reduce these often rigid and inflexible attempts to control negative internal experience by fostering a sense of conscious awareness to the same. Mindfulness work includes assisting clients to develop an awareness to the process and ongoing flow of experience and may be used to facilitate a broader perspective of life and a sense of connectedness with others. Clients engaging in mindfulness may come to see that suffering is a universal experience and this can facilitate greater acceptance of the challenges of life. Mindfulness practice may also help to improve concentration, allowing greater focus in the activities undertaken life as well as promote affect tolerance. It may help clients to cope with stress, anger, and other forms of emotional difficulty. Clients may come to see thoughts and feelings as transient experiences, helping to decrease identification with momentary affective states. Mindfulness can assist clients in experiencing internal events fully and as they are without self-judgment and the added struggle against reality. In a similar way, mindfulness can facilitate finding peace with painful memories. Finally, by fully engaging in the present, life may be experienced in a richer, fuller way. The current presentation will explore the use of mindfulness in the treatment of mental health issues.

Objectives: Participants will be able to (1) state a rationale for why mindfulness can be helpful to in the treatment of mental health issues; (2) summarize the benefits of mindfulness in mental health populations; and (3) describe the utility of mindfulness in creating psychological flexibility, a key contributor to well-being.

Presenter: Robyn D. Walser, Ph.D. is Director of TL Consultation Services, staff at the National Center for PTSD and is Associate Clinical Professor at University of California, Berkeley. As a licensed clinical psychologist, she maintains an international training, consulting and therapy practice. Dr. Walser is an expert in Acceptance and Commitment Therapy (ACT) and has co-authored 4 books on ACT including *Learning ACT, The Mindful Couple, Acceptance and Commitment Therapy for the Treatment of Posttraumatic Stress disorder and ACT for Clergy and Pastoral Counselors: Using Acceptance and Commitment Therapy to Bridge Psychological and Spiritual Care*. ACT focuses on acceptance and mindfulness as well as commitment to behavior change linked to personal values. As such, mindfulness work has been a longstanding part of her work with clients as well as a personal practice. Dr. Walser has been doing ACT workshops since 1998; training in multiple formats and for multiple client problems. Dr. Walser has been described as a "passionate, creative, and bold ACT trainer and therapist" and she is best known for her dynamic, warm and challenging ACT trainings. She is often referred to as a clinician's clinician. Her workshops feature a combination of lecture and experiential exercises designed to provide a unique learning opportunity in this state-of-the-art intervention. Dr. Walser has presented her research findings and papers at international and national conferences, universities and hospital settings; and she has been invited to international conferences to speak about ACT. She is invested in developing innovative ways to translate science-into-practice and continues to do research and education on dissemination of ACT and other therapies. She has had a number of leadership roles in international and national organizations and she served as Member At Large and President for the Association for Contextual and Behavioral Science, the main association that houses ACT.

CE Credits Available: 1

Cost: *$15 for members and $50 for Non-Members*

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Julie Petersen

barriers of language and accessibility to CBT training resources in developing countries with geographically diffuse populations (Rakovshik et al., 2013). In another study with more active training comparison groups, Dimeff et al. (2009) examined the relative efficacy of training community mental health providers in Dialectical Behavior Therapy (DBT) skills using either self-guided treatment manual review, two-day instructor-led workshops, or an interactive online training program that included audio/visual material, clinical simulations, and intermittent knowledge checks (Dimeff et al., 2009). Online training and instructor-led training were both associated with larger increases in provider satisfaction and self-efficacy compared to the manual review alone, and – of note – the online training group achieved the greatest gains in DBT knowledge. Consistent with the general reviews of the training literature, however, none of the training models evaluated resulted in high levels of competency in DBT skills, suggesting that post-training consultation may be necessary to translate knowledge to clinical competency (Dimeff et al., 2009).

The attainment of an acceptable level of competency is an essential outcome of interest for training efforts, as multiple studies have noted a positive relationship between therapist competence and patient outcomes using post-hoc analyses (see Rakovshik & McManus, 2010).

In another important training study, Larson and colleagues found that therapists trained in CBT for addictions via web training showed poorer CBT skill acquisition than those providers who received ongoing coaching or supervision following online training

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*Upcoming SCP CE webinar: Dr. Robert Reiser "Bipolar Disorder – Advances in Evidence-based Practice"

January 31, 2017 12 PM – 1 PM ET

Overview: The material in this webinar was developed based on extensive literature review prepared for our second edition Bipolar Disorder, Advances in Evidence-based Practice as part of the Division 12, Society of Clinical Psychology's Hogrefe Series. First edition sold over 4,500 copies and was translated into Chinese, Japanese, and Spanish languages. Literature review was conducted by main author, Larry Thompson and co-authors, Sheri Johnson and Trisha Suppes, well-established researches in the field of bipolar disorder. Main author conducted multi-year research study on CBT with bipolar disorder involving over 100 patients. Multiple seminars/workshops provided on Bipolar Disorder, including ABCT and University of California, Berkeley.

Objectives: (1) Summarize key evidence-based approaches to the treatment of bipolar disorder; (2) Identify 3 key strategies for assisting patients in stabilizing their mood; (3) Recognize common problems encountered in the treatment of bipolar disorder.

Presenter: Robert Reiser, Ph.D., is a cognitive behavioral therapist in private practice focusing on treatment of individuals and families with serious mental illness and a Fellow of the Academy of Cognitive Therapy. He supervises graduate clinicians in training, teaches classes in cognitive behavioral therapy, and provides workshops, consultation, and technical assistance with a goal of improving treatment of bipolar disorder and schizophrenia in community mental health settings. Dr. Reiser currently works as a consultant with the Felton Institute in San Francisco providing supervision and training for clinicians and case managers using cognitive behavioral therapy for psychosis (CBT-P), and supervises medical residents at the University of California, San Francisco in the Department of Psychiatry.

CE Credits Available: 1

Cost: $15 for members and $50 for Non-Members

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(Larson et al., 2013). Similarly, Sholomskas and colleagues (2005) compared a CBT workshop followed by traditional case consultation to a completion of a training website plus manual review. Study results revealed, again, that those receiving traditional consultation demonstrated better performance on structured role plays designed to assess competency in delivery of CBT compared to those receiving access to the training website.

Consultation has also been shown to promote positive effects for clinicians beyond clinical competency and knowledge of EBTs. For one, providers seem to like it: Lu and colleagues (2010) demonstrated that clinicians who received training in CBT for PTSD were highly satisfied with consultation feedback in the six months following the training. Further, clinicians reported that the consultation they received was helpful, specifically the written fidelity feedback from their consultants (Lu et al., 2010). In addition, clinicians who receive consultation on cases are more confident in their own abilities and memory of the treatment (Fritz et al., 2013; Hoge, Migdole, Cannata, & Powell, 2014). They report higher levels of self-perceived competency and well-being than clinicians who do not have resources for consultation (Hoge et al., 2014). Furthermore, clinicians who receive such consultation endorse less feelings of burn out, stress, and isolation (Hoge et al., 2014). Thus, there are possible benefits for both the patient and the therapist when using consultation as a tool to implement EBTs after trainings: in theory, the patient has the greatest chance of receiving more adherent and competently delivered treatment, and the therapist receives the support and guidance that keeps them motivated to use EBTs. Several studies in progress (e.g., NCT02402205, NCT02079142) will provide important data on EBT uptake and patient-level outcomes to empirically test these hypotheses in routine clinical care settings.

Technology's Role in the Use of Consultation

Few studies have looked specifically at how to take advantage of technology as a means of providing consultation. Weingardt and colleagues used a web-based platform to train therapists in CBT for the treatment of substance use disorders and designed a study where they compared rigid (i.e., set timelines for training modules and a fixed consultation schedule) versus flexible online training schedules (i.e., allowing participants to determine the sequence, pace, and emphasis of the training modules and consultation). The authors found that more flexibility both in online

training schedules and in the content of four weekly group consultation sessions following such online training was associated with equivalent CBT knowledge and self-efficacy, and less self-reported burn out by clinicians compared to the use of a more rigid training and consultation curriculum (Weingardt, Cucciare, Belloti, & Lai, 2009). These findings suggest that not only is post-workshop or post-web training likely more effective when there is follow-up consultation, but that the flexibility in how this consultation is received and the extent to which it is self-directed by the therapist could impact its utility.

Mobile technology as a unique solution. To our knowledge, there are no mobile applications that provide training or post-training CBT consultation currently in existence. There are many general applications available for diagnosis, the distribution of standardized measures, studying CBT, and teaching yourself to be your own therapist. Most applications geared towards clinicians are strictly for the logistics of running a practice. For example, Simple Practice is an application through which psychologists can make appointments, organize billing, and take notes. However, no application specifically addresses the needs of a clinician who is implementing EBTs and could benefit from the support of a real or virtual consultant.

With this in mind, the development of mobile applications designed to provide post-training support for clinicians is an uncharted and important area for exploration. Specifically, if a clinician is actually engaged in practice of the learned CBT approach and now needs to obtain a quick and accessible reminder of how to approach a given session with a patient, what's easier than pulling up an application on your smartphone or tablet? Similarly, if a clinician needs to debrief and assess how they did with a patient using a particular protocol after a session to understand what they did well and what they need to work on, a mobile application that provides such guidance (like an in-person supervisor, but with greater flexibility for feedback at an unrestricted time) could present a cost-effective and scalable method for improving our current training efforts.

How it could work: PE Consultant as an example. To capitalize on the particular strengths that mobile technology offers and are currently being under-utilized, the research team at the Center of the Treatment and Study of Anxiety (CTSA) at the University of Pennsylvania has developed a mobile application for use on multiple platforms to support individuals recently

trained in PE (Foa et al., 2007) for Post-Traumatic Stress Disorder (PTSD). This application, called PE Consultant, was created in close collaboration with PE developer Edna Foa, Ph.D., over the past year by the lead and second authors of this paper (A.A. and L.J.Z.). Briefly, PE Consultant (Asnaani, Zandberg, Ruggiero, Rheingold, & Foa, 2016) is an innovative and unique technology-based solution to the barriers faced in adequate implementation of PE, ones that are similar to those experienced in all CBTs: therapists not feeling confident enough after a training workshop to implement the treatment with their patients, a lack of access or funding to support in-person consultation, and a finite number of expert consultants to provide ongoing supervision after a workshop to the number of providers who need it.

PE Consultant addresses four important functions typically provided in post-workshop PE consultation: 1) presenting initial guidance on how to pick an appropriate case for PE and get patients prepared for this treatment, 2) providing quick refreshers for therapists about what each session will cover that can be accessed conveniently directly before sessions, 3) providing a structured way for therapists to self-assess their adherence and competency after each session, and 4) presenting tailored feedback on how they can improve adherence and competency. Self-assessment questions were developed to highlight and train providers' focus to only the most critical elements of PE. Based on a provider's response to these assessment questions, tailored educational content is then presented. Knowing that a provider's time is in short supply, every effort was made to keep assessments and feedback brief and to the point. Optional embedded videos are suggested to further illustrate a given competency. Each provider's responses to self-assessment questions are tracked by the application and could theoretically be shared with a third party to promote accountability and use of the application. For example, if the model were to be scaled up slightly, an expert supervisor could monitor a novice therapist's responses and use this as a starting point for an abbreviated consultation session.

The application is currently being pilot tested by the first wave of users, to receive information about how helpful it is to providers recently trained in PE, and to get feedback about how to improve its functionality. Acceptability of the app is a crucial element of this investigation. Initial interest appears to be high: our team surveyed 37 providers who completed an intensive 4-day PE workshop, and 36 reported that they would be "very" or "extremely" interested in using such an application. The potential to support trauma therapists in this effective but specialized therapy using such a mobile supervision tool is exciting and timely as we strive to improve dissemination of evidence-based treatments. Ultimately, the aim will be to evaluate whether mobile applications such as PE Consultant improve providers' competency and self-directed use of evidence-based treatment components (e.g., exposure) with their patients.

Where Do We Go From Here?

While we are hopeful about the potential of applications such as PE Consultant to expand the role of mobile technology in mental health training and practice, we also remain cognizant of the challenges in integrating and maximizing the impact of technology in our field. One question begs investigation: will interested and well intentioned providers – once they return to their demanding schedules – use the application as it's designed? Indeed, a Silicon Valley analyst examining a large survey of Android mobile application users (around 125 million mobile phone users) that 77% of mobile application users stop engaging with a new application only three days after the initial download (Chen, 2016). What if this remains the issue for providers of CBT, who are already stretched for time and who may forgo using the application, no matter how helpful? The sustainability of this interest over time, and utilization of the application in the months following workshop training, is an area requiring empirical investigation.

This possible obstacle has been front and center for us as we move to the next stage of our own work with PE Consultant. One solution might be to make the applications more intrinsically rewarding or reinforcing to use. For instance, would it be helpful to get points for all sessions done as close to fidelity of the protocol? Or to create an interactive game with "expert" achievements granted as one progresses through using the application over treatment with a client? Alternatively, do we need to look beyond individual therapists to the system they are embedded in, providing organizational incentives for its use in daily practice? If, as mentioned before, accountability would enhance utilization, another possibility might be a hybrid solution that triages time more effectively; that is, have providers use such an application but also add brief, intermittent check-ins with a human expert consultant who focuses their finite time on reviewing feedback already provided by the application and

addressing any supplemental questions remaining for the provider.

Whatever the eventual path, it is clear that significant innovation is still needed both on the end of designing such applications specifically for the purpose of supporting training efforts in EBTs and in our ability to ensure such applications lead to improvement in the bottom line: namely, greater access to competently delivered evidence-based treatment for a greater number of consumers. Ψ

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Section VI: Clinical Psychology of Ethnic Minorities

Submitted by Vincenzo G. Teran, Psy.D.

The Clinical Psychology of Ethnic Minorities was well represented at this year's APA Convention in Denver, CO. In addition to hosting its annual social hour, several section officers presented on range of topics pertaining to ethnic and racial issues in clinical psychology, including: "Racial Disparities in Pathways From Maltreatment to Mental Health Service Use" by Omar Gudiño, Ph.D., ABPP; "Responding to Microaggression in Therapy, the Workplace and the College Classroom" by NiCole Buchanan, Ph.D., Meng Chiang, Ph.D., and Vincenzo G. Teran, Psy.D.; and "Latino Child and Adolescent Adjustment in the Context of Exposure to Stress" by Omar Gudiño, Ph.D., ABPP. These programs covered information and perspectives in line with the mission of Section VI (see our official webpage for additional details: http://www.div12.org/section-vi/).

Section VI has also kick-started its webinar series with its first session, "What's Next? Anticipating Life and Career Trajectory as an Ethnic Minority Psychologist." This webinar was co-facilitated by Meng Chiang, Ph.D. and Viviana Padilla-Martinez, Ph.D. The webinar was well attended and a great success! The second webinar, titled "Psychologist of Color Making Their Way Through the Academy and Clinical Practice," is scheduled for December 2016 and will be facilitated by NiCole Buchanan, Ph.D., Melanie Domenech-Rodriguez, Ph.D., and Vincenzo G. Teran, Psy.D. Registration is limited, so early registration is recommended (see our social media channels for more information: http://www.div12.org/section-vi/).

Lastly, Section VI is continuing with its membership drive and welcomes new members to join this growing professional community. Membership benefits include: access to its annual newsletter, internship directory, live and archieved webinars, and APA Convention student travel awards. For more information on membership, follow this weblink: https://www.eventbrite.com/e/clinical-psychology-of-ethnic-minorities-apa-div-12-sect-vi-2016-membership-tickets-10273124191.

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 a committed and creative Board, as well as numerous volunteers who help manage the day to day needs of the organization.

APAHC recently completed an election for new board members with congratulations to the elected members who will start their 3 year terms in 2017:

   -Representative to Division 12: Donna LaPaglia, PsyD, Yale University School of Medicine

   -Member-at-Large: Andrea Bradford, PhD, Baylor College of Medicine

   -Secretary: Kristine Diaz, PsyD, Walter Reed National Military Medical Center

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 (http://www.div12.org/section8/)

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. 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.

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.

Nominations are now in progress for the 2017 APAHC Awards including the longstanding:

  -Ivan Mensh Award for Distinguished Achievement in Teaching

  -Bud Orgel Award for Distinguished Achievement in Research

  -Joseph Matarazzo Award for Distinguished Contributions to Psychology in Academic Health Centers.

In addition, APAHC is proud to issue a call for nominations for 3 New Awards:

  -Outstanding Student Contributions Award

  -Outstanding Early Career Psychologists Contributions Award

  -Outstanding Mid-Career Psychologists Contributions Award

Nomination Deadline is **January 18, 2017** with the following recommended process:

Nominations should be in the form of a 1-3 page letter. An electronic copy of the nominee's CV must also be submitted. Nominees need not be current APAHC members, but those making the nominations must be current APAHC members. Only one letter will be accepted per candidate. The nominating statement should specify the nominee's achievements and contributions and provide other information in support of the nomination. Nominators should inform nominees that their names are being submitted.

Send nominations to:

Ron Brown, PhD, ABPP (Chair of Awards Committee/ APAHC Past-President) Ronald.brown@unlv.edu

For a listing of past awardees, please visit: http://www.div12.org/section8/APAHCAward.html

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.

The busy and well respected APAHC Task Force on Health Disparities and Diversity recently sponsored a free webinar on challenges faced when using translator services: **The Human Connection: Challenges of Language Translation Services in a HealthCare Setting**. Their goal was to help health care providers enhance their skills to provide linguistically competent care in medical settings. Kudos to departing Chair, Alfiee Breland-Noble, PhD, MHSc., and other members of the Task Force on their numerous accomplishments over the past few years (http://www.div12.org/section8/diversity.html).

Members continue to benefit from valued APAHC publications, including the Grand Rounds newsletter with editor Cesar Gonzalez, PhD, ABPP, and our flagship journal: Journal of Clinical Psychology in Medical Settings, Editor Gerald Leventhal, PhD. 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. As this is my last month on the Board following a 4 year term of office as Representative to Division 12, I am grateful to APAHC members for this opportunity and thrilled to have served on the board of the Society of Clinical Psychology. Please welcome the next elected Representative, Donna LaPaglia, PsyD (2017-2019).

Ψ

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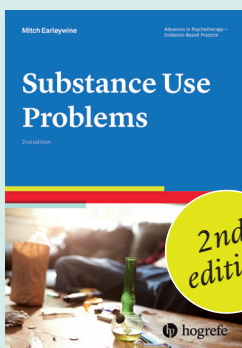
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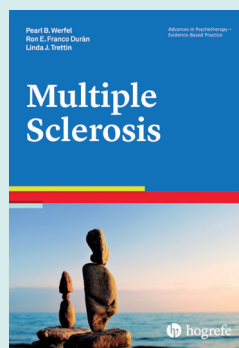
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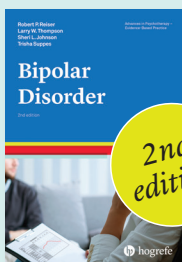
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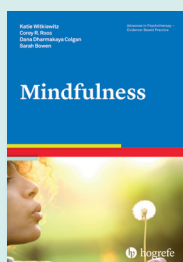ISBN 978-0-88937-504-8

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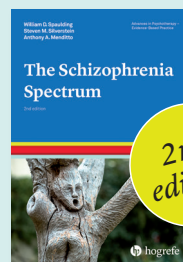
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