

CONTENTS

- 1 **President's Column:** The News Makes Me Hurt
- 5 **Upcoming Society of Clinical Psychology Webinars**
- 6 **Lead Article:** Epistemic Humility: An Overarching Educational Philosophy for Clinical Psychology Programs (Lilienfeld et al.)
- 15 **Ethics Column:** Stress and Self Care Among Graduate Psychology Students
- 17 **Letter to the Editor:** What the Trump?
- 21 **Division 12 Award Winners**
- 22 **Division Nominations**
- 29 **Previously Aired Society of Clinical Psychology Webinars**

EDITORIAL STAFF

Editor: Jonathan S. Comer, Ph.D.
jocomer@fiu.edu

Assoc Editor: Kaitlin P. Gallo, Ph.D.
kgallo@mclean.harvard.edu

Editorial Asst: Natalie Hong, B.S.
nhong@fiu.edu

Join a Division
12 Section

The Society of Clinical Psychology (Division 12) has eight sections covering specific areas of interest.

To learn more, visit Division 12's section web page:

www.div12.org/sections/

PRESIDENT'S COLUMN



The News Makes Me Hurt: Clinical Considerations for Our Public/Political Climate of Stigmatization

Michael W. Otto, Ph.D.

In every National political election there are winners and losers, and those who do not win are faced with having to cope with the repudiation (by the majority of voters, or at least by the Electoral College) of some of their political values. This always happens, and depending on the vitriol of the election and associated policy issues, there are palpable and prolonged groans of dismay in either Red States or Blue States depending on the election result. But this year is different. In the weeks following the Presidential Election in November, 2016, multiple media outlets reported a dramatic increase in hate-related incidents directed at a broad swath of our community: people of color, immigrants, Muslims, LGBTQ individuals, and women. One source of this information was an assessment of over 10,000 teachers, administrators, and school counselors conducted by the Southern Poverty Law Center's Teaching Tolerance project (Southern Poverty Law Center, 2016). Respondents to this survey were clear – 90% reported that their school climate had been negatively affected, and 80% reported heightened anxiety and concerns about the impact of the election on themselves and their families. Specific examples include the following:

- “I have seen open racism, spoken, for the first time in 23 years of teaching.” (response from a Middle School Teacher in Michigan)
- “I have never directly encountered race-related harassment in our school until after the election this year.” (response from a Middle School Teacher in Wisconsin)
- “There have been more fights in the first 10 weeks of this year than in the first 10 years of my career (this is my 11th year teaching).” (response from a Secondary Teacher in New York)

These incidents appear to be an aggravation of a general trend occurring prior to the election, with the FBI reporting a 6% increase in hate crimes in the latest (2015) yearly report available (<https://ucr.fbi.gov/hate-crime/2015>). In addition, the present time is marked by a charged environment of oppressive and dismissive behavior. Consider the following: across the first weeks of April, media outlets reported new sexual harassment claims against Bill O'Reilly at Fox News. Just one day after reports that advertisers were fleeing the show in response to the allegations, President Trump provided a twitter defense of O'Reilly: “I don't think Bill did anything wrong.” The facts

of the O'Reilly case are not publicly known, but what is known is that reporting sexual harassment is a fraught process, and organizational minimization contributes to negative outcomes (Bergman et al., 2002).

It is no surprise that leaders have an outsized influence on norm perception and subsequent behavior (e.g., Dijkstra, Lindenberg, & Veensra, 2008), and correspondingly, it is no surprise that public and repeated challenges to core values of tolerance and respect have a societal effect. Stigma, prejudice, and discrimination create a stressful and hostile social environment. The result is chronic stress, with associated mental health problems, negative health behaviors, lower participation in positive health behaviors, and physical health problems (Pascoe & Richman, 2009). For example, greater teacher-based discrimination was found to predict increased substance use across high school years for African American students (Fuller et al., 2012), following the notion that discrimination motivates attempts at threat reductions, potentially through maladaptive coping strategies (Major & Obrien, 2005).

In an especially noteworthy article, Hatzenbuehler and colleagues (2009) addressed the titular question, "How does stigma get under the skin?" They examined self-reported discrimination events (Study 1) or experimentally-manipulated discrimination recall (Study 2) and found that rumination mediated the link between perceived discrimination and psychological distress. Rumination—the passive and repetitive focus on the causes and consequences of distress without engagement in active coping/problem solving—is bad for you. Rumination is an established risk factor for the onset of major depression and anxiety, a predictor of the severity and duration of depressive episodes, and a predictor of suicidal ideation (Michl et al., 2013; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Accordingly, in understanding the influence of discrimination on mental and physical health, rumination may be an important mechanistic target for intervention.

Rumination, and its dyadic equivalent, co-rumination, may also help explain why social support does not always buffer the effects of perceived discrimination (Meyer, 2003). Co-rumination involves excessively discussing problems and negative thoughts within a dyadic relationship (Rose, Carlson & Waller, 2007). Although rumination is associated with positive friendship quality, it is also linked to higher levels of anxiety and depression (as is intra-personal rumination). As such, the richly-empathic, "I know, right?" response may have the potential downside of encouraging a further attentional focus on negative events, without necessarily encouraging adaptive coping.

So what is the right response for those in distress in relation to the current political environment and the stigmatizing events on news feeds? On the practical side, limiting the dose, duration, or timing of this input holds potential benefit. For example, couples' rules of no

news feeds after 10:00 PM or no late night political talk shows may help attenuate emotional disruptions that occur when adaptive emotional regulation has waned for the day. Monitoring and intervening with adaptive behaviors such as adequate sleep and exercise also can enhance resilience (Asmundson et al., 2013; Walker & van der Helm, 2009). For example, in addition to improving mood, regular exercise also aids cognitive control (Olson et al., 2017). Enhancing cognitive control is also an element of Rumination-Focused Cognitive Behavior Therapy (RFCBT), which includes training in identifying triggers for rumination and applying adaptive alternatives such as mindfulness, behavioral activation, or active problem-solving. Initial clinical trials support the efficacy of RFCBT as a preventive intervention for depression (Jacobs et al., 2016) and as a treatment for residual symptoms (Watkins et al., 2011), and elements of this treatment may have similar value for the ruminations and negative affect induced by the climate of stigmatization we now face.

One issue with daily news feeds being a source of distress is that there may be no one-to-one target for assertive or problem-solving action. Aside from opportunities to vote, town-hall events, occasional protests, or check-book activism, there may be no clear local target for responding to publically-displayed stigmatization. This is where values clarification and subsequent smaller local action may have benefit: finding opportunities to underscore and act in accordance with core values in community settings as a bulwark against larger cultural issues. And, there is always the open-a-bar strategy: in an April 12, 2017, article in *The New York Times*, Robert Simonson reported on an individual who complained, "for the few weeks after the election, I couldn't get out of bed...It was all I could do to read the news." That individual subsequently opened a bar, named "Coup" (as in d'état), where 100% of the profits are going to "organizations that are either being defunded by the current administration or need money to fight the current administration." This is active coping writ large.

Let me be clear: in this article I am not advocating for political action in favor of either Red State or Blue State perspectives, but I am advocating for helping those in distress due to the documented climate of stigma and oppression. In my comments I have emphasized perspectives based on a particular accounting of the role of rumination in influencing distress in response to stigmatization, and the role of adaptive action as an antidote to these effects. I am very pleased to say that a work-group consisting of the members of the Division 12 leadership in Section 4, Section 6, and the Committee on Diversity are collaborating on a broader statement on potential beneficial responses for intervening with distress linked to a public/political climate of stigmatization/oppression. When finished, this work will be posted on your Division 12 webpage. Look for it. 🍷

References

- Asmundson, G. J. J., Fetzner, M. G., De Boer, L. B., Posers, M. B., Otto, M. W., Smits J. A. J. (2013). Let's get physical: A contemporary review of the anxiolytic effects of exercise for anxiety and its disorders. *Depression and Anxiety*, 30, 362-373.
- Bergman, M. E., Langhout, R. D., Palmieri, P. A., Cortina, L. M., & Fitzgerald, L. F. (2002). The (un) reasonableness of reporting: Antecedents and consequences of reporting sexual harassment. *Journal of Applied Psychology*, 87(2), 230-242.
- Dijkstra, J. K., Lindenberg, S., & Veensra, R. (2008). Beyond the class norm: bullying behavior of popular adolescents and its relation to peer acceptance and rejection. *Journal of Abnormal Child Psychology*, 36, 1289-1299.
- Fuller-Rowell, T.E., Cogburn, C.D., Brodish, A.B., Peck, S. C., Malanchuk, O., Eccles, J. S. (2012). Racial discrimination and substance use: Longitudinal associations and identity moderators. *Journal of Behavioral Medicine*, 35, 581-590.
- Jacobs, R. H., Watkins, E. R., Peters, A. T., Feldhaus, C. G., Barba, A., Carbray, J. & Langenecker, S. A. (2016). Targeting ruminative thinking in adolescents at risk for depressive relapse: Rumination-Focused Cognitive Behavior Therapy in a randomized controlled trial with resting state fMRI. *PLoS ONE* 11(11).
- Major, B., & O'Brien, L. T. The social psychology of stigma. *Annual Review of Psychology*, 56, 393-421.
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674-697.
- Michl, L. C., McLaughlin, K. A., Shepherd, K., Nolen-Hoeksema, S. (2013). Rumination as a mechanism linking stressful life events to symptoms of depression and anxiety: longitudinal evidence in early adolescents and adults. *Journal of Abnormal Psychology*, 122(2), 339-352.
- Nolen-Hoeksema, S., Wisco, B. E., & Lyubomirsky, S. (2008). Rethinking Rumination. *Perspectives in Psychological Science*, 3(5), 400-424.
- Olson, R. L., Brush, C. J., Ehmann, P. J., & Alderman, B. L. (2017). A randomized trial of aerobic exercise on cognitive control in major depression. *Clinical Neurophysiology*, 128(6), 903-913.
- Pascoe, E. A., & Richman, L. S. (2009). Perceived Discrimination and Health: A Meta-Analytic Review. *Psychological Bulletin*, 135(4), 531-554.
- Rose, A. J., Carlson, W., & Waller, E. M. (2007). Prospective associations of co-rumination with friendship and emotional adjustment: considering the socioemotional trade-offs of co-rumination. *Developmental Psychology*, 43(4), 1019-1031.
- Southern Poverty Law Center (2016). The Trump Effect: The impact of the 2016 presidential election on our nation's schools. Available at <https://www.splcenter.org/20161128/trump-effect-impact-2016-presidential-election-our-nations-schools#the%20ugliness%20is%20new>
- Walker, M. P., & van der Helm, E. (2009). Overnight therapy? The role of sleep in emotional brain processing. *Psychological Bulletin*, 135(5), 731-748.
- Watkins, E. R., Mullan, E., Wingrove, J., Rimes, K., Steiner, H., Bathurst, N., Eastman, R., & Scott J. (2011). Rumination-focused cognitive-behavioural therapy for residual depression: phase II randomised controlled trial. *British Journal of Psychiatry*, 199(4), 317-322.

To learn more about the
Society of Clinical Psychology,
visit our web page:

www.div12.org



DIVISION 12 BOARD OF DIRECTORS

OFFICERS (Executive Committee)

President (2017) Michael Otto, Ph.D.*
President-Elect (2018) Gary Vandenbos, Ph.D.*
Past President (2016) Bradley E. Karlin, Ph.D., ABPP*
Secretary (2017 - 2019) Deborah Drabick, Ph.D.*
Treasurer (2015 - 2017) Jonathan Weinand, Ph.D.*

COUNCIL OF REPRESENTATIVES

Representative (2015 - 2017) Kenneth J. Sher, Ph.D.*
Representative (2015 - 2017) Mark B. Sobell, Ph.D., ABPP*
Representative (2016 - 2018) Danny Wedding, Ph.D.*
Representative (2017 - 2019) Guillermo Bernal, Ph.D.*

MEMBER AT LARGE

J. Kim Penberthy, Ph.D., ABPP* (2016-2018)

EDITORS (Members of the Board without vote)

The Clinical Psychologist
Editor (2015 - 2018) Jonathan S. Comer, Ph.D.
Associate Editor (2015 - 2018) Kaitlin P. Gallo, Ph.D.
Clinical Psychology - Science and Practice
(2014 - 2018) Gayle Beck, Ph.D.
Web Editor: (2016-2018) Damion J. Grasso, Ph.D.

DIVISION 12 CENTRAL OFFICE

Tara Craighead, Administrative Officer
(not a Board Member)
P.O. Box 98045
Tel: 404-254-5062, Fax:
Email: division12apa@gmail.com

* = Voting Members of Board

SECTION REPRESENTATIVES TO THE DIVISION 12 BOARD

Section 2: Society of Clinical Geropsychology
(2016-2018) Victor Molinari, Ph.D., ABPP*
Section 3: Society for a Science of Clinical Psychology
(2015 - 2017) David Smith, Ph.D.*
Section 4: Clinical Psychology of Women
(2017 - 2019) Kalyani Gopal, Ph.D.*
Section 6: Clinical Psychology of Ethnic Minorities
(2017 - 2018) Vincenzo G. Teran, Psy.D.*

Section 7: Emergencies and Crises
(2016-2018) Anders Goranson, Psy.D.
Section 8: Association of Psychologists in Academic
Health Centers
(2017 - 2019) Donna LaPaglia, Psy.D.*
Section 9: Assessment Psychology
(2016-2018) Paul Arbisi, Ph.D.*
Section 10: Graduate Students and Early Career
Psychologists
(2014 - 2017) Natalia Potapova*

* = Voting Members of Board

EDITORIAL STAFF

EDITORS:

Editor: Jonathan S. Comer, Ph.D.
jocomer@fiu.edu

Associate Editor: Kaitlin P. Gallo, Ph.D.
kgallo@mclean.harvard.edu

Editorial Assistant: Natalie Hong, B.S.
nhong@fiu.edu

COLUMN EDITORS:

Ethics Column: Adam Fried, Ph.D.
History Column: Donald Routh, Ph.D.
Student Column: Jennifer Sweeton, Psy.D.

SECTION UPDATES:

2: Victor Molinari, Ph.D., ABPP | vmolinari@usf.edu
3: David Smith, Ph.D. | dsmith11@nd.edu
4: Kalyani Gopal, Ph.D. | kgopalphd@gmail.com
6: Vincenzo G. Teran, Psy.D. | vincenzo.teran@gmail.com
7: Anders Goranson, Psy.D. | Anders.Goranson@va.gov
8: Donna LaPaglia, Ph.D. | donna.lapaglia@yale.edu
9: Paul Arbisi, Ph.D. | arbisi001@umn.edu
10: Natalia Potapova | natalia.potapova@email.wsu.edu

Upcoming SCP CE webinars!

Dr. David Tolin: Blending Science and Practice

Wednesday May 17, 2017 12p – 1p ET

CE Credits Available: 1

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

Overview: We will discuss ways for practicing psychologists, particularly those in early career, to blend scientific and clinical activities. These include consuming relevant research, making empirically-informed treatment decisions, contributing to the scientific literature, and adopting an empirical approach to treatment.

Presenter: David Tolin, Ph.D., ABPP, is the founder and director of the Anxiety Disorders Center at the Institute of Living, and an Adjunct Professor of Psychiatry at Yale University School of Medicine. He is Past-President of APA Division 12 (Society of Clinical Psychology). Dr. Tolin oversees an outpatient clinic and treats patients, while maintaining an active research program funded by the National Institute of Mental Health.

Dr. Sheri L. Johnson: Teaching Clients with Bipolar Disorder to Self-Monitor for Symptoms and Triggers

Thursday October 26, 2017 6p – 7p ET

CE Credits Available: 1

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

Overview: This program will cover basic psychoeducational techniques that are core to many different empirically supported approaches to bipolar disorder. A growing body of research indicates that psychosocial treatments, including CBT, can reduce the rate of relapse, lower symptoms, decrease hospitalizations, and improve quality of life among those diagnosed with bipolar disorder when offered as an adjunct to medication. Techniques described here are commonly employed in CBT. The triggers will be summarized based on a large literature focused on psychosocial predictors of symptom change within bipolar disorder.

Presenter: Sheri L. Johnson, Ph.D., Dr. Johnson is a professor at the University of California Berkeley, where she runs the Cal Mania (CALM) Program. She has conducted research on bipolar disorder over the past 20 years, with funding from the National Alliance from Schizophrenia and Depression and the National Institute of Mental Health. She is the current president of the Society for Research in Psychopathology. She has published over 200 manuscripts, and is a co-author of a leading textbook on abnormal psychology as well as several books on bipolar disorder.

To register for a webinar, go to: <http://www.div12.org/dashboard/webinar-series/>

Epistemic Humility: An Overarching Educational Philosophy for Clinical Psychology Programs

Scott O. Lilienfeld

Emory University
University of Melbourne

Steven Jay Lynn

Binghamton University

William T. O'Donohue

University of Nevada at Reno

Robert D. Lutzman

Georgia State University



Abstract: Doctoral programs in clinical psychology and allied fields have long struggled with the task of developing a coherent teaching and training philosophy. We propose that epistemic humility (humility regarding one's knowledge) – a rubric premised on the notion that we are all susceptible to biases and that science is the best means of compensating for them – provides a core unifying framework for educating both clinical researchers and practitioners. This framework is compatible with all three major historically defined training models in psychology (scientist-practitioner, scholar-professional, clinical science). An emphasis on epistemic humility may help to provide greater thematic coherence to graduate training, bridge the sizeable gap between science and practice, diminish resistance toward evidence-based practice, and enhance the quality of graduate coursework and training from bench to bedside.

The real purpose of the scientific method is to make sure nature hasn't misled you into thinking you know something you actually don't know. Robert Pirsig (1928-2017), 1974, p. 108.

The field of clinical psychology continues to struggle to find its voice: What are our unique competencies, and what exactly makes us distinctive? Our longstanding identity crisis is mirrored in perennial confusion regarding our optimal model of graduate education. Despite innumerable articles, discussions, conferences, and the founding of an entire American Psychological Association journal dedicated to the topic (Training and Education in Professional Psychology), the field of clinical psychology has had an exceedingly difficult time settling on a coherent model of how to teach and train its students (Benjamin & Baker, 2009; Eby, Chin, Rollock, Schwartz, & Worrell, 2011).

At the risk of painting with an overly broad brush, clinical psychology's modal model of graduate education has

been something of a grab-bag, featuring required core courses (e.g., assessment, psychopathology, psychotherapy, research methods, professional ethics, diversity), supplemented by several courses in relevant disciplines abutting clinical psychology, such as social psychology, developmental psychology, neuroscience, and cognition. The specific content and even delivery method (e.g., lecture versus student presentations) of both the core and "broad and general" courses are left largely or entirely to instructors' discretion. As a consequence, there is minimal assurance that graduate students receive exposure to shared overarching conceptual or methodological themes that have animated our discipline (Lilienfeld & O'Donohue, 2009). O'Donohue and Boland (2012) likened the typical graduate curriculum in clinical psychology to a Rube Goldberg contraption, named after the American inventor famous for designing bewilderingly convoluted, multipart devices that output a simple action (such as dropping a ball into a hole). They may have been charitable, as at least Goldberg's gadgets were carefully planned and consistently yielded the desired outputs.

In this article, we endeavor to find clinical psychology's fundamental voice. In doing so, we propose an overarching model of education for graduate students in clinical psychology and allied mental health fields (e.g., counseling psychology, mental health counseling, social work, psychiatry, psychiatric nursing), which we term epistemic humility, meaning modesty regarding one's own knowledge. The notion of epistemic humility is a key intellectual virtue (de Sousa, 1999) that helps students with the task of forming rational beliefs. More broadly, it is an epistemic duty – that is, an ethical duty to know (O'Donohue & Henderson, 1999). One such duty, we contend, is the ethical responsibility to know what one does not know. Consistent with this duty, the epistemic humility model strives to inculcate a thoroughgoing "scientific attitude" (Gauld, 1982) toward research and clinical evidence in all students.

As we later delineate in more detail, the epistemic humility framework is premised on two assumptions that are robustly supported by research: (a) clinical psychologists, be they researchers, clinicians, or both, are prone to certain biases merely by virtue of being human, and (b) science is the best set of safeguards developed by the human species for minimizing or overcoming such biases. As a consequence, a keen awareness of our vulnerability to error is ultimately our best hope for achieving high-quality patient care and high-quality psychopathology research, which in conjunction ostensibly comprise the *raison d'être* of clinical psychology.

Before proceeding further, two caveats are in order. First, epistemic humility is a pedagogical philosophy and orientation, not a pre-specified didactic rubric. Hence, we do not present specific courses, nor specific competency benchmarks (Fouad et al., 2009) for graduate education. Instead, we lay out a unifying ethos that slices across core clinical coursework as well as therapeutic and assessment training. Second, the epistemic humility framework is intended to supplement rather than supplant the three major training models for clinical psychology graduate programs, namely (a) the scientist-practitioner (Boulder) model, (b) the scholar-professional (Vail) model, or (c) the clinical science



Scott O. Lilienfeld

model. This framework is in principle compatible with all three models, at least as these models were initially envisioned. Indeed, one might even contend that the epistemic humility framework merely makes explicit what all three models in their original incarnations have largely (but not entirely; see McFall, 1991) left implicit.

The Science-Practice Gap

We trust that we need not persuade most readers of the challenges posed by the science-practice gap, the substantial discrepancy between the research support for clinical procedures and modal clinical practices in “real-world” settings (Lilienfeld, Lynn, & Lohr, 2014; Reese et al., in press; Tavis, 2014). Largely as a consequence of this gap – which is perhaps better described as a canyon – many individuals with mental disorders receive grossly suboptimal treatment, or no treatment at all (see Layard & Clark, 2014, for a review that should be required reading for all clinical psychologists). At the same time, because some scholars (e.g., Breckler, 2010; Shedler, 2015) have raised questions regarding the magnitude and perhaps even existence of this gap, a few sobering reminders may be in order.

Survey evidence reveals that large proportions of practitioners are not implementing the best supported interventions for specific psychological conditions, are using empirically unsupported interventions, or both (Baker, McFall, & Shoham, 2008; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013). To take just a few examples, in surveys of U.S. psychotherapists, 26% reported never or rarely administering exposure therapy for obsessive compulsive disorder (OCD: Freiheit, Vye, Swan, & Cady, 2004), 73% reported not using therapist-guided exposure for OCD (Hipol & Deacon, 2013), and 83% reported never or rarely administering prolonged exposure therapy for posttraumatic stress disorder (Becker, Zayfert, & Anderson, 2004), even though exposure treatments are the scientifically-based interventions of choice for these conditions (Abramowitz, Taylor, & McKay, 2009). Even among cognitive-behavioral therapists in the Netherlands, who do frequently use exposure therapy for anxiety disorders; many of the therapeutic practices appear to be suboptimal; for example, only 39% of therapists use interoceptive exposure for patients with panic disorder (Sars & van Minnen, 2015). Among Canadian community practitioners who treat eating disorders, 21% and 44%, respectively, reported administering cognitive-behavioral therapy (CBT) and interpersonal therapy either sometimes or never, even though these are the two best established interventions for these conditions. Moreover, even among practitioners purporting to practice CBT, majorities or large minorities reported not using standard CBT techniques, such as cognitive restructuring, homework assignments, self-

monitoring, or stimulus control techniques, raising questions regarding treatment fidelity (von Ransom, Wallace, & Stephenson, 2013). Perhaps even more worrisome, nontrivial proportions of mental health professionals continue to practice techniques that may place clients at risk for psychological harm. In a survey of licensed clinical social workers in the United States, Pignotti and Thyer (2012) found that 24% used critical incident stress debriefing (CISD) during the past year. This figure is troubling given that CISD has been found in controlled studies to be at best ineffective and perhaps iatrogenic for victims of trauma (Wei, Szumilas, & Kutcher, 2010).

The yawning divide between science and practice is not limited to the discrepancy between research evidence and routine clinical practice. Instead, this schism manifests itself in myriad ways in many and perhaps most clinical psychology graduate programs. In such programs, students routinely report receiving one set of messages in their coursework and research – namely, to prioritize the scientific evidence base concerning therapy outcome and process – but a competing set of messages in their clinical training – namely, to prioritize their clinical experience, intuitions, and informal observations above scientific evidence (McFall, 1991). This bifurcation is perhaps most pronounced in clinical programs that emphasize psychotherapy, such as Psy.D. programs, but it is evident in many research-oriented Ph.D. programs as well. Furthermore, over time, research-oriented and clinically-oriented graduate students frequently pursue different intellectual paths, and eventually find themselves traveling in largely distinct circles. More often than not, the former students spend much of their time in laboratories, whereas the latter students spend much of their time in clinical training sites, accruing hours for clinical internships. Indeed, Donald Peterson (2004), one of the doyens of modern clinical psychology, referred to our deeply divided profession as “hermaphroditic” (p. 206), and this science-practice schism surely extends to graduate education as well.

Clinical Psychology's Dirty Little Secret

Anyone who has taught in a clinical psychology graduate program for any extended period of time is well aware of a dirty little secret. In reality, this “secret” is a secret only because it is rarely discussed publicly. The secret is that, despite our best efforts as clinical psychology faculty instructors and mentors, many and perhaps most of our graduate students are not especially interested in becoming researchers. A few of these students were never especially interested in becoming researchers in the first place but portrayed themselves as such to gain admission to graduate programs; many were ambivalent about becoming researchers at the outset of graduate school (Gelso, 1993); and still others – although typically a minority (Perl & Kahn, 1983) – were initially interested in research, but found this interest dissipating as they progressed through graduate school. To be certain, many graduating students remain keenly interested in both research and clinical practice, but even research-oriented students with active interests in clinical work often report feeling an implicit – and at times explicit – pressure to keep their clinical interests to themselves, lest they risk being maligned by their research

supervisors.

Psychological Sources of the Dirty Little Secret

In retrospect, this dirty little secret should not have been especially surprising. Research using the Science-Practice Inventory (Leung & Zachar, 1991; see also Holmes & Beins, 2009) demonstrates that although interest in conducting research and interest in engaging in practice tend to be moderately positively correlated among undergraduates, they tend to be moderately negatively correlated among graduate students in general. That is, the more graduate students report being interested in conducting research, the less they tend to report being interested in clinical work, and vice-versa. The reasons for the apparent reversal in correlation from undergraduate to graduate years is unclear, but it may reflect the gradual self-selection of students into separable interest tracks. Furthermore, many or most graduates of clinical and counseling psychology doctoral programs express a low level of interest in statistics and research design (Zachar & Leong, 2000).

Research on the relations between interests and attitudes, although necessarily correlational and not affording conclusive inferences regarding causality, may shed light on the sources of the dirty little secret. Data indicate that whereas research-oriented graduate students tend to receive high scores on the investigative sector (reflecting interests in discovering things about the world) and low scores on the social sector (reflecting interests in helping others) of Holland's (1985) hexagon of interests, practice-oriented graduate students tend to display the opposite pattern of interests (Zachar & Leong, 1992). This interest pattern is not limited to graduate students in clinical psychology; Mallinckrodt, Gelso, and Royalty (1990) found that only 16% of students in counseling psychology doctoral programs scored highly on a measure of investigative interests.

The often unappreciated association between interests and intellectual aptitudes may further foster the split between students with primarily practice interests and those with primarily research interests. For example, individuals with social interests tend to perform somewhat more poorly in mathematics than do those with non-social interests (Ackerman & Heggstad, 1997), perhaps contributing to the "statistics phobia" familiar to virtually all psychology instructors (Chew & Dillon, 2014). Over time, weaker performance in mathematics and statistics courses seems likely to spill over into greater dislike of scientific research, further amplifying the divide between practice-oriented and research-oriented students.

The two groupings of individuals probably also differ in their cognitive styles. Mental health professionals who specialize in practice tend to report a higher reliance on intuition than do those who specialize in research, whereas those who specialize in research tend to report a higher need for cognition (a drive to engage in effortful thinking) than do those who specialize in practice. Furthermore, whereas need for cognition tends to be modestly associated with positive attitudes toward the use of empirically supported therapies (ESTs), a preference for intuition tends to be modestly associated with negative attitudes toward ESTs (Seligman et al., 2016). Leong, Zachar, Conant, and Toliver (2007) similarly found that need for cognition is associated with psychology majors' interests in

pursuing research, but not practice, careers. The implications of these findings have received insufficient attention in discussions of graduate education. To the extent that some students in clinical psychology programs prefer to rely on intuitive thinking in their decision-making, they may be reluctant to jettison their gut hunches and clinical observations when confronted with scientific research that runs counter to these more informal evidentiary sources (Lilienfeld et al., 2013).



Steven Jay Lynn

As a field, we have done little to address the dirty little secret. This neglect is unwise, as this secret makes it more challenging to find common ground between research-oriented and practice-oriented students. Most often, as instructors, we simply ignore this problem and pretend that it does not exist. Alternatively, we may try to persuade students with strong practice interests to embrace research. This approach is rarely successful, largely because research and practice interests appear to stem largely from differing personality and interest-related dispositions that are temporally stable (Zachar & Leong, 1992). In still other cases, we strive to inculcate a scientific attitude among our practice-oriented students. Although laudable, this effort may meet with limited success given that as a field, we have rarely articulated the epistemic essence of such an attitude. In particular, we have rarely attempted to identify a core theme that can unite both research-oriented and practice-oriented students in their goal of enhancing mental health. Fortunately, there may be a way of cutting the Gordian knot.

Science as a Prescription for Humility

Philosophers of science have long debated the boundaries and essential characteristics of science (see Pigliucci & Boudry, 2013; O'Donohue, 2013, for a range of perspectives), and we do not intend to resolve this exceedingly complex issue here. These intriguing discussions notwithstanding, a compelling argument can be advanced that the essence of science is the tireless effort to combat confirmation bias (Nickerson, 1998), the ubiquitous propensity to seek out and selectively interpret evidence that is consistent with our preconceptions, and to deny, dismiss, and distort evidence that is not (Lilienfeld, Ammirati, & Landfield, 2009). Philosopher of science Sir Karl Popper (1957) similarly suggested that science is a critical method in which researchers should strive to find error in their theories by constructing risky tests to falsify these theories. Put somewhat differently, we can conceptualize science as a prescription for epistemic humility (Lilienfeld, 2010; McFall, 1991).

Science reminds us that our intuitive beliefs about the world are often erroneous (Schulman, 2017), and that we require finely honed research methods to distinguish well tested from poorly supported assertions. As social psychologists Carol Tavris and Elliott Aronson (2007) noted, science is a method of "arrogance control," as it helps to keep us honest. Or, in the words of Nobel-prize winning physicist Richard Feynman (1985), science is – or at least ought to be – a bending over backwards to try to prove ourselves wrong. As Carl Sagan and

Anne Druyan (see Sagan, 1995) observed, all good scientists hear a voice in their heads that insistently intones, “you might be wrong.”

Of course, as the replicability crisis of the past decade has taught us, science is far from infallible, largely because it is practiced by fallible creatures (Ioannidis, 2005; Lilienfeld & Waldman, 2017). At the same time, the beauty of science, when practiced well, is its capacity for perpetual self-renewal and self-correction. Much as the replication crisis has been a sobering wake-up call for psychology and other disciplines, it is has forced us to develop better procedures, such as preregistration of hypotheses and analyses, to defend against p-hacking, HARKing (hypothesizing after results are known), and other questionable research practices (QRPs) that can lead to mistaken scientific conclusions.

In the domain of clinical practice, research methods are invaluable, albeit imperfect, bulwarks against a host of causes of spurious therapeutic effectiveness (CSTEs), which are reasons why we can be fooled into believing that ineffective treatments are effective. CSTEs include regression to the mean, placebo effects, spontaneous remission, effort justification, multiple treatment interference, demand characteristics, and maturation (see Beyerstein, 1997; Lilienfeld, Ritschel, Cautin, & Latzman, 2014). A key point, which is insufficiently emphasized in graduate education, is that psychotherapy research methods, such as randomization of participants to conditions, pre-test measures, blinding of observations, and attention-placebo conditions, help to control for one or more CSTEs. Furthermore, an understanding of these methods is essential if we hope to make sense of psychotherapy outcome studies.

A scientific approach to clinical psychology does not imply that our intuitions are invariably in error; it implies that science is needed to sort out which of our intuitions are more versus less accurate. More controversially and perhaps counterintuitively to some readers, a scientific approach also implies that a primary reliance on intuition in clinical decision-making runs counter to epistemic humility. The practitioner who proclaims with scarce qualification that his or her clinical expertise should be valued above systematic research evidence is in essence saying “Trust me.” Such a clinician is also neglecting to acknowledge his or her inherent propensity toward fallibility in clinical inference (see Croskerry, 2003; Dawes, 1994, for discussions). The same holds for researchers who advance highly confident claims that are not backed by sufficient evidence, a propensity that has become far too common in many psychological domains (Lilienfeld, 2017; O’Donohue, Snipes, & Soto, 2016).

Some readers may be puzzled by our contention that science is a prescription for humility. After all, many scientists are notorious for being pigheaded and arrogant. To some degree, research bears out this cultural stereotype. Data suggest that, at least among researchers in the “hard” sciences, the most eminent scholars tend to be rated by others as competitive, vain, and hostile (Feist, 1983). Furthermore, scientists, including those in psychology, have often been less than commendable role models of humility in their communications with both laypersons and academic colleagues. Even a casual perusal of blogs, listserv discussions, and manuscript reviews will reveal that

some psychological scholars routinely display what William James (1902) termed “overbeliefs” – views held with considerably stronger conviction than is objectively warranted.

Still, the contradiction here is more apparent than real. We must be careful not to confuse scientists with science. Although prominent scientists may at times be arrogant, the scientific community pushes back against them relentlessly and often mercilessly, insisting that they put up or shut up. If these scientists cannot back up their forceful claims with compelling evidence, their colleagues are likely to call them out sooner or later (Albert et al., 2012). That said, the wheels of scientific correction often grind more slowly and inefficiently than most of us would desire (Ioannidis, 2012).

When asked in a recent interview which cognitive bias he would most like to eliminate were he given a magic wand, Nobel-prize winning psychologist Daniel Kahneman responded, “overconfidence” (Shariatmadari, 2015). Indeed, scholars have long observed that overconfidence is one of the foremost obstacles to accurate clinical judgment in the domains of psychological assessment and psychotherapy (Smith & Dumont, 2002). It is also almost certainly among the wellsprings of disastrous reasoning errors among scientists and pseudoscientists alike (see Gardner, 1957, for classic and at times hilarious examples).

Epistemic Humility: Core Tenets

The Shakow report (Hilgard et al., 1947), which gave birth to the Boulder (scientist-practitioner) model of clinical training, argued that clinical psychology graduate students should be trained as psychologists first, well versed in psychological theory, research, and methods, and clinical psychologists second (see also Shakow, 1969). The epistemic humility framework offers a friendly amendment to the Shakow ranking in one significant way. According to this model, graduate students in clinical psychology should be scientists first, psychologists second, clinical psychologists third. That is, training in a scientific mindset should be the foremost goal of graduate education in clinical psychology, regardless of students’ career aspirations (see also McFall, 1991). Furthermore, the epistemic humility model makes explicit that the distinguishing feature of the scientist is not conducting research, but holding a scientific attitude. The heart of this attitude, in turn, is the awareness that we are all susceptible to information-processing biases and that scientific methods are the best means of compensating for them.

In proposing the epistemic humility framework, we begin with a straightforward assumption that should be noncontroversial: Essentially all clinical graduate students, regardless of their interests in research versus practice, sincerely want to help others,



William T. O'Donohue

whether it be directly via clinical care or indirectly via discovering knowledge that will ultimately aid in the design of effective clinical interventions. In this respect, all clinical students are more alike than different in their core aspirations. The epistemic humility framework builds on this common ground by highlighting the crucial point that a scientific approach – one that underscores the need for rigorous research as a finely honed set of safeguards against error – is our best hope for achieving accurate knowledge in both the idiographic context of individual clients and the nomothetic context of individuals with psychopathology more broadly. Hence, both clinically-oriented and research-oriented students, whatever their differences in interests and cognitive styles, should in principle feel fully comfortable embracing the tenets of the epistemic humility framework. This framework therefore offers the promise of narrowing the wide science-practice gap in graduate education.

In many respects, Shakow (1965) anticipated this model when he wrote that “psychology is immodest” (p. 353). By that, he was referring largely to the all-too-frequent propensity of psychologists to overstate the evidentiary certainty of their assertions. By emphasizing an attitude of ruthlessly rooting out errors in one’s web of beliefs, or what has been termed “wrongology” (Schultz, 2011), the epistemic humility framework may help to combat our field’s propensity toward overconfidence in clinical practice and research. By better preparing clinical practitioners and researchers to spot their own inferential errors and by equipping them with research methods and thinking skills to compensate for them, this framework aspires to make them better calibrated in their confidence. Forewarned is forearmed.

In addition, this framework may aid in diminishing some of the resistance toward evidence-based practice (EBP) expressed by a sizeable subset of practitioners (see Lilienfeld et al., 2013, for a review). We suspect that at least some of this resistance stems from the fact that scientifically supported interventions are commonly transmitted to graduate students by means of authority-driven, ex cathedra pronouncements (a didactic approach humorously termed “eminence-based practice”; Isaacs & Fitzgerald, 1999) regarding which therapeutic techniques work best for which conditions. By helping students to better understand how psychotherapy research designs help to (a) minimize confirmation bias and allied biases and (b) protect against various CSTE, the epistemic humility framework can also help them to appreciate the need for EBP as a valuable corrective against errors in clinical-decision making. More broadly, this framework may help students to grasp the need for “forcing functions” (Croskerry, 2003) in clinical practice as safeguards against mistakes in clinical practice.

Another central tenet of the epistemic humility framework is that scientific and humanistic approaches to client care, which are often misleadingly framed as antipodes, are fully compatible, the framework reminds us that a scientifically-grounded approach, which reduces the risk of mistakes in clinical judgment, is ultimately the most humane approach to helping others. In this way, this framework provides a bridge from science to practice that should be readily understandable to students regardless of their interests and cognitive propensities.

Epistemic Humility: Implementation

The epistemic humility framework affords clinical psychology programs considerable flexibility for implementation at the curricular level. Nevertheless,

this framework does impose certain general constraints with respect to curricular coverage and clinical training, as it requires instructors and clinical supervisors to consistently inculcate an attitude of modesty in their students across all phases of student education. In Table 1, we delineate some provisional recommendations for how to accomplish this goal in the context of required clinical coursework. Needless to say, these initial recommendations are hardly exhaustive, and we encourage readers to elaborate on these suggestions in discussions with their colleagues and in future writings. In anticipation of the criticism that “Well, most clinical psychology programs do these things already,” we would be remiss not to observe that this appears not to be the case. For example, only a minority of clinical psychology graduate programs provide formal coverage of research literature concerning biases and heuristics, problems in clinical judgment and prediction, or methods of enhancing clinical decision-making (Harding, 2007).

Table 1 underscores a broader recommendation that may not be self-evident: A deep understanding of the history of clinical psychology and allied disciplines is valuable, and perhaps essential, to communicating the importance of epistemic humility. This history imparts the lesson that scientific psychology can be viewed in part as a bumpy road of corrected mistakes (Wood & Nezworski, 2005). By exposing graduate students to the errors of the past, such as disastrous treatment mistakes (see Scull, 2007 and Offit, 2017, for disturbing examples), they can better appreciate (a) well-intentioned psychological (and psychiatric) scholars’ propensities toward error, (b) the perils of overreliance on unguided intuition in clinical-decision making (e.g., Grove & Meehl, 1996), (c) the need for sophisticated research methods as safeguards against error, and (d) the self-correcting engine of science. Regrettably, the history of psychology appears to have been deemphasized in graduate psychology education over the past few decades (Benjamin & Baker, 2009). Even in clinical psychology programs, in which some coverage of history of psychology is mandated, this coursework is often spotty and unsystematic. We hope that this article plays a modest role in reversing that trend.

Epistemic Humility: Relation to the Clinical Science Model

Of all prominent models of clinical psychological graduate training, the clinical science model (McFall, 1991, 2000) is perhaps the most compatible with the epistemic humility framework. At least in its initial formulation, the clinical science model wisely conceptualizes clinical doctoral education along two



Robert D. Latzman

Table 1

Provisional Suggestions for Incorporating the Epistemic Humility Framework into Core Clinical Psychology Graduate Coursework

| Core Clinical Course | Sampling of Recommended Content |
|--|---|
| <i>Statistics</i> | How we can be fooled by spurious statistical claims; the “new statistics” (e.g., confidence intervals, effect sizes, meta-analysis) as safeguards against error; the significance testing controversy |
| <i>Research Methods</i> | The replication (reproducibility) crisis; the dangers of p-hacking, HARKING, and other questionable research practices (QRPs); preregistration, adversarial collaboration, open data, and open materials as partial safeguards against QRPs; logical fallacies in interpreting research; research methods as safeguards against biases (e.g., confirmation bias, hindsight bias, illusory correlation); ways of incentivizing higher-quality and more replicable research |
| <i>Psychopathology</i> | Differing levels of explanation in the etiology of mental illness; the dangers of focusing excessively only one level of explanation; erroneous theories of the etiology of mental disorders and what we have learned from them; debates regarding the boundaries of mental disorder; controversies regarding models of the classification and diagnosis of mental illness; cultural differences in the manifestation of mental disorders |
| <i>Assessment</i> | The clinical-statistical debate; heuristics and biases; errors in clinical judgment and prediction, and safeguards against them; base rates and Bayes theorem; reasons why even invalid psychological tests may appear to be useful; response biases in psychological testing; structured interviews as partial safeguards against halo and confirmation biases; potential gender and ethnic biases in psychological tests; past and present misuses of intelligence tests; role of potentially corrective collateral information and ecological momentary assessment; evaluating and selecting appropriate assessment measures |
| <i>Psychotherapy</i> | The history of unsupported interventions and what we have learned from them; the dangers of iatrogenic interventions; causes of spurious therapeutic effectiveness and how research methods help to compensate for them; errors in evaluating therapeutic process and outcome; controversies regarding the roles of specific versus nonspecific factors in therapy outcome; the role of EBP as a safeguard against errors in decision-making; the use of forcing functions and decision-making aids in clinical practice |
| <i>Diversity</i> | The ways in ethnic and cultural variables set boundary conditions on psychological conclusions; the difficulties in disentangling cultural from genetic influences; the importance of becoming aware of one’s own biases; debates regarding the role of implicit bias in influencing behavior; the need for intellectual and ideological diversity in psychological science; finding a balance between recognizing ethnic diversity and engaging in ethnic stereotyping |
| <i>Professional and Ethical Issues</i> | The importance of informed consent in psychotherapy; the extent to which science can, and cannot, inform ethical decisions; ethical dangers of clinician underconfidence and overconfidence; the fallibility of suicide and violence risk prediction; the ethics of clinical research |
| <i>Clinical Supervision</i> | Using the research literature to inform clinical decisions; using therapeutic feedback to improve client outcomes; obtaining sources of information to rule out CSTEs; using ESTs to enhance client care; disconfirming hypotheses, considering alternative explanations; sharing rewards/costs and evidence base of alternative treatments with clients |

conceptually orthogonal dimensions: (a) science versus nonscience and (b) research versus practice. From this perspective, the goal of clinical psychology teaching and training is to produce scientifically-minded scholars. Furthermore, the two-dimensional scheme of the clinical science model reminds us of the necessity of distinguishing science from research, as one can perform research in either a scientific or nonscientific fashion. Just as important, one can practice clinically in either a scientific or a nonscientific fashion. Being a scientist is not a matter of whether one works in a laboratory and publishes articles; it is a matter of how one thinks about evidence. The epistemic humility framework wholeheartedly embraces these crucial

distinctions, and it complements the clinical science model by further articulating the internal logic of a scientific approach to evidence.

The Psychological Clinical Science Accreditation System (PCSAS), which has been proposed as an additional and perhaps alternative accreditation system to that adopted by the American Psychological Association (Bootzin & Treat, 2015), was inspired by the clinical science model but departs from it in several ways that have received insufficient discussion. Most notably, PCSAS is at present intended to accredit only programs whose primary goal is the production of clinical researchers; as a consequence, programs

whose primary function is to train practitioners are excluded from accreditation. This stipulation appears to run counter to the spirit of the clinical science model, which rightly emphasized that one can operate simultaneously as a clinician and as a scientist. In contrast, the epistemic humility framework is explicitly designed to encompass both research-oriented and practice-oriented clinical programs, including both Ph.D. and Psy.D. programs, and to recognize programs that train students to think scientifically regardless of their eventual career placements (see also McFall, 1991). As noted earlier, this framework is also in principle applicable to students in other mental health disciplines, such as psychiatry, mental health counseling, psychiatric nursing, and social work.

In addition, PCSAS strongly prioritizes student outcomes, with lesser emphasis on the content of graduate education. Specifically, PCSAS's criteria for accreditation focus primarily on whether programs are producing researchers who are active contributors to the clinical science literature. Although perhaps defensible, this criterion strikes us as potentially problematic on two grounds. First, it may imply that active contributors to the published psychological literature are necessarily conducting high-quality science. If recent debates regarding difficulties with the replicability of psychological findings and the overuse of QRPs has taught us anything, it is that this assumption is doubtful (Ioannidis et al., 2014; Tackett et al., in press). Moreover, even students who generate a large volume of peer reviewed publications may possess an insufficient perspective on the field at large to appreciate the boundary conditions and other limitations of their conclusions. Second, this criterion may overweight criterion validity at the expense of content validity. In contrast to PCSAS, the epistemic humility framework places substantial emphasis on the content of coursework, as well as of clinical and research training. In particular, it imposes a heavy onus on programs to provide students with adequate breadth and depth of knowledge regarding the fallibility of human inference and the indispensable role of science in compensating for this fallibility, and more broadly, the essential epistemological attitude of science (see also O'Donohue, 1989, for a discussion of the "even Bolder model").

Concluding Thoughts and Future Directions

Space constraints preclude us from a fuller elaboration of the epistemic humility framework and pragmatic details of its implementation. Such constraints also preclude us from providing specific resources, including recommended readings and websites, which may be helpful to instructors and clinical supervisors by bringing this framework to fruition. Needless to say, such resources will evolve and expand over time.

Up to this point, we have conspicuously neglected to address a key question: How would we know whether our proposed model is working? We would hypothesize that the epistemic humility framework, if successful, should contribute to certain measureable outcomes. On the clinical front, this framework should eventuate in, higher levels of openness to EBP and a greater willingness to monitor client outcomes using standardized measures (e.g., Lambert, 2013), as well as other quality improvement procedures. Ultimately, these clinician behaviors should hopefully translate into greater client improvement. In addition, this framework

should result in an enhanced reliance on assessment instruments with well-supported psychometric properties, as well as a better understanding of how to evaluate and select such measures for clinical use. On the research front, this framework should contribute to decreased engagement in QRPs, a greater endorsement and use of data and hypothesis preregistration along with other open science reforms, and the generation of research with higher levels of quality and replicability (see Schimmack, 2014, for an introduction to the R index, a quantitative metric of replicability).

In the spirit of modeling our own epistemic humility, we should acknowledge that this framework at present remains a promissory note. If this framework, when adequately implemented, fails to yield the anticipated outcomes we have outlined, we would be forced to reconsider it or at least entertain significant modifications to it. Whether it can deliver on its ambitious promises remains to be seen. But in view of compelling evidence that we are all prone to biases in decision-making (Kahneman, 2011) and that science is our best hope for overcoming them, it would seem to be well worth a concerted effort. ■■

References

- Abramowitz, J. S., Taylor, S., & McKay, D. (2009). Obsessive-compulsive disorder. *Lancet*, 374, 491-499.
- Ackerman, P. L., & Heggestad, E. D. (1997). Intelligence, personality, and interests: evidence for overlapping traits. *Psychological Bulletin*, 121, 219-245.
- Albert, M., Laberge, S., & McGuire, W. (2012). Criteria for assessing quality in academic research: the views of biomedical scientists, clinical scientists and social scientists. *Higher Education*, 64, 661-676.
- Baker, T. B., McFall, R. M., & Shoham, V. (2008). The current status and future of clinical psychology: Towards a scientifically principled approach. *Psychological Science in the Public Interest*, 9, 67-103.
- Becker, C. B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, 42, 277-292.
- Benjamin Jr, L. T., & Baker, D. B. (2009). Recapturing a context for psychology: The role of history. *Perspectives on Psychological Science*, 4, 97-98.
- Beyerstein, B. L. (1997). Why bogus therapies seem to work. *Skeptical Inquirer*, 21(5), 29-34.
- Bootzin, R. R., & Treat, T. A. (2015). Psychological Clinical Science Accreditation System (PCSAS). In R.L. Cautin & S.O. Lilienfeld (Eds.), *The Encyclopedia of Clinical Psychology*. DOI: 10.1002/9781118625392.wbecp571
- Breckler, S. (2010). They saw a study: Clinicians do rely on science. *Psychological Science Agenda*. Retrieved from <http://www.apa.org/science/about/psa/2010/01/study.aspx>.
- Chew, P. K., & Dillon, D. B. (2014). Statistics anxiety update: Refining the construct and recommendations for a new research agenda. *Perspectives on Psychological Science*, 9, 196-208.
- Croskerry, P. (2003). The importance of cognitive errors in diagnosis and strategies to minimize them. *Academic Medicine*, 78, 775-780.

- Dawes, R. M. (1994). *House of cards: Psychology and psychotherapy built on myth*. New York: The Free Press.
- Eby, M. D., Chin, J. L., Rollock, D., Schwartz, J. P., & Worrell, F. C. (2011). Professional psychology training in the era of a thousand flowers: Dilemmas and challenges for the future. *Training and Education in Professional Psychology*, 5, 57-68.
- Feynman, R. (1985). *Surely you're Joking, Mr. Feynman!* New York: Norton and Company.
- Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J., Hutchings, P. S., Madson, M.B., ... & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, 3(4S), S5-S26.
- Freiheit, S. R., Vye, C., Swan, R., & Cady, M. (2004). Cognitive-behavioral therapy for anxiety: Is dissemination working? *The Behavior Therapist*, 27, 25-32.
- Gardner, M. (1957). *Fads and fallacies in the name of science*. Toronto: General Publishing.
- Gauld, C. (1982). The scientific attitude and science education: A critical reappraisal. *Science Education*, 66, 109-121.
- Gelso, C. J. (1993). On the making of a scientist-practitioner: A theory of research training in professional psychology. *Professional Psychology: Research and Practice*, 24, 468-476.
- Grove, W. M., & Meehl, P. E. (1996). Comparative efficiency of informal (subjective, impressionistic) and formal (mechanical, algorithmic) prediction procedures: The clinical-statistical controversy. *Psychology, Public Policy, and Law*, 2, 293-323.
- Harding, T. P. (2007). Clinical decision-making: How prepared are we? *Training and Education in Professional Psychology*, 1, 95-104.
- Hilgard, E. R., Kelly, E. L., Luckey, B., Sanford, R. N., Shaffer, L. F., & Shakow, D. (1947). Recommended graduate training program in clinical psychology. *American Psychologist*, 2, 539-558.
- Hipol, L. J., & Deacon, B. J. (2013). Dissemination of evidence-based practices for anxiety disorders in Wyoming: A survey of practicing psychotherapists. *Behavior Modification*, 37, 170-188.
- Holland, J. L. (1985). *Vocational preference inventory*. Sunnyvale, CA: Consulting Psychologists Press.
- Holmes, J. D., & Beins, B. C. (2009). Psychology is a science: At least some students think so. *Teaching of Psychology*, 36, 5-11.
- Ioannidis, J. P. (2005). Why most published research findings are false. *PLoS Med*, 2(8), e124.
- Ioannidis, J. P. (2012). Why science is not necessarily self-correcting. *Perspectives on Psychological Science*, 7(6), 645-654.
- Ioannidis, J. P. (2014). How to make more published research true. *PLoS Med*, 11(10), e1001747.
- Isaacs, D., & Fitzgerald, D. (1999). Seven alternatives to evidence-based medicine. *British Medical Journal*, 319, 1618.
- James, W. (1902). *The varieties of religious experience: A study in human nature*. New York: The Modern Library.
- Kahneman, D. (2011). *Thinking, fast and slow*. New York, NY: Farrar, Straus and Giroux.
- Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy*, 50, 42-51.
- Layard, R., & Clark, D. M. (2014). *Thrive: The power of evidence-based psychological therapies*. London, UK: Penguin.
- Leong, F. T., & Zachar, P. (1991). Development and validation of the Scientist-Practitioner Inventory for psychology. *Journal of Counseling Psychology*, 38, 331-341.
- Leong, F. T., Zachar, P., Conant, L., & Tolliver, D. (2007). Career specialty preferences among psychology majors: Cognitive processing styles associated with scientist and practitioner interests. *The Career Development Quarterly*, 55, 328-338.
- Lilienfeld, S. O. (2010). Can psychology become a science? *Personality and Individual Differences*, 49, 281-288.
- Lilienfeld, S. O. (2017). Microaggressions: Strong claims, inadequate evidence. *Perspectives on Psychological Science*, 12, 138-169.
- Lilienfeld, S. O., Ammirati, R., & Landfield, K. (2009). Giving debiasing away: Can psychological research on correcting cognitive errors promote human welfare? *Perspectives on Psychological Science*, 4, 390-398.
- Lilienfeld, S. O., Lynn, S. J., & Lohr, J. M. (2014). *Science and pseudoscience in clinical psychology*. New York, NY: Guilford Press.
- Lilienfeld, S.O., & O'Donohue, W. (2007). *Great readings in clinical science: Essential selections for mental health professionals*. NY, NY: Pearson.
- Lilienfeld, S.O., Ritschel, L.A., Lynn, S.J., Cautin, R.L., & Latzman, R.D. (2013). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review*, 33, 883-890.
- Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2014). Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness. *Perspectives on Psychological Science*, 9, 355-387.
- Lilienfeld, S.O., Waldman, I.D. (2017). *Psychological science under scrutiny: Recent challenges and proposed solutions*. New York: Wiley.
- Mallinckrodt, B., Gelso, C. J., & Royalty, G. M. (1990). Impact of the research training environment and counseling psychology students' Holland personality type on interest in research. *Professional Psychology: Research and Practice*, 21, 26-32.
- McFall, R. M. (1991). Manifesto for a science of clinical psychology. *Clinical Psychologist*, 44, 75-88.
- McFall, R. M. (2000). Elaborate reflections on a simple manifesto. *Applied and Preventive Psychology*, 9, 5-21.
- Nickerson, R. S. (1998). Confirmation bias: A ubiquitous phenomenon in many guises. *Review of General Psychology*, 2, 175-220.
- O'Donohue, W. T. (1989). The (even) bolder model: The clinical psychologist as metaphysician-scientist-practitioner. *American Psychologist*, 44, 1460-1468.
- O'Donohue, W. T. (2013). *Clinical psychology and the*

philosophy of science. New York, NY: Springer.

O'Donohue, W., & Henderson, D. (1999). Epistemic and ethical duties in clinical decision-making. *Behaviour Change*, 16, 10-19.

O'Donohue, W. T., & Boland, M. (2012). Beyond the Rube Goldberg model of clinical training: Toward more efficient training of core competencies. *Training and Education in Professional Psychology*, 6, 174-186.

O'Donohue, W.T., Snipes, C., & Soto, C. (2016). The design, manufacture, and reporting of weak and pseudo-tests: The case of ACT. *Journal of Contemporary Psychotherapy*, 46, 37-40.

Offit, P.A. (2017). Pandora's lab: Seven stories of science gone wrong. National Geographic: Washington, D.C.

Perl, K. G., & Kahn, M. W. (1983). Psychology graduate students' attitudes toward research: A national survey. *Teaching of Psychology*, 10, 139-143.

Peterson, D. R. (2004). Science, scientism, and professional responsibility. *Clinical Psychology: Science and Practice*, 11, 196-210.

Pigliucci, M., & Boudry, M. (Eds.). (2013). *Philosophy of pseudoscience: Reconsidering the demarcation problem*. Chicago, IL: University of Chicago Press.

Pignotti, M., & Thyer, B. A. (2012). Novel unsupported and empirically supported therapies: Patterns of usage among licensed clinical social workers. *Behavioural and Cognitive Psychotherapy*, 40, 331-349.

Pirsig, R. M. (1974). *Zen and the art of motorcycle maintenance: An inquiry into values*. New York: Random House.

Popper, K. R. (1957). The aim of science. *Ratio*, 1, 24-35.

Reese, R. J., Gismero González, E., Clements-Hickman, A. L., Clemons, J. M., Farook, M. W., & Conoley, C. W. (in press). The psychotherapy researcher-practice relationship: Through a clinical supervision lens. *Counselling Psychology Quarterly*.

Sagan, C. (1995). *The demon-haunted world: Science as a candle in the dark*. New York: Random House.

Sars, D., & van Minnen, A. (2015). On the use of exposure therapy in the treatment of anxiety disorders: a survey among cognitive behavioural therapists in the Netherlands. *BMC Psychology*, 3(1), 26. DOI: 10.1186/s40359-015-0083-2

Schimmack, U. (2014). Quantifying statistical research integrity: The Replicability Index. <https://replicationindex.wordpress.com/2014/12/01/quantifying-statistical-research-integrity-r-index/>

Schultz, K. (2011). *Being wrong: Adventures in the margin of error*. New York: HarperCollins.

Schulman, A. (2017). *Scienceblind: Why our intuitive theories about the world are so often wrong*. New York: Basic Books.

Scull, A. (2007). *Madhouse: A tragic tale of megalomania and modern medicine*. New Haven, CT: Yale University Press.

Seligman, L. D., Hovey, J. D., Hurtado, G., Swedish, E. F., Roley, M. E., Geers, A. L., ... & Ollendick, T. H. (2016). Social cognitive correlates of attitudes toward empirically supported treatments. *Professional Psychology: Research and Practice*, 47, 215-223.

Shakow, D. (1965). Seventeen years later: Clinical psychology in light of the 1947 Committee on Training in Clinical Psychology Report. *American Psychologist*, 20, 353-362.

Shakow, D. (1969). *Clinical psychology as science and profession: A forty-year odyssey*. Chicago, IL: Aldine.

Shariatmadari, D. (2015, July 18). Daniel Kahneman: "What would I eliminate if I had a magic wand? 'Overconfidence.'" *The Guardian*.

Smith, J. D., & Dumont, F. (2002). Confidence in psychodiagnosis: What makes us so sure? *Clinical Psychology & Psychotherapy*, 9, 292-298.

Shedler, J. (2015). Where is the evidence for "evidence-based therapy"? *The Journal of Psychological Therapies in Primary Care*, 4, 47-59.

Tackett, J. L., Lilienfeld, S. O., Patrick, C. J., Johnson, S. L., Krueger, R. F., Miller, J. D., ... & Shrout, P. E. (in press). It's time to broaden the replicability conversation: Thoughts for and from clinical psychological science. *Perspectives on Psychological Science*.

Tavris, C. (2014). Foreword: The widening scientist-practitioner gap. In S. O. Lilienfeld, S. J. Lynn, & J. M. Lohr (Eds.). *Science and pseudoscience in clinical psychology* (pp. ix-xviii). NY, NY: Guilford Press.

Tavris, C., & Aronson, E. (2007). *Mistakes were made (But not by me): Why we justify foolish beliefs, bad decisions, and hurtful acts*. Orlando, FL: Harcourt.

Von Ranson, K. M., Wallace, L. M., & Stevenson, A. (2013). Psychotherapies provided for eating disorders by community clinicians: infrequent use of evidence-based treatment. *Psychotherapy Research*, 23, 333-343.

Wei, Y., Szumilas, M., & Kutcher, S. (2010). Effectiveness on mental health of psychological debriefing for crisis intervention in schools. *Educational Psychology Review*, 22, 339-347.

Wood, J. M., & Nezworski, M. T. (2005). Science as a history of corrected mistakes: comment. *American Psychologist*, 60, 657-658.

Zachar, P., & Leong, F. T. (1992). A problem of personality: Scientist and practitioner differences in psychology. *Journal of Personality*, 60, 665-667.

Zachar, P., & Leong, F. T. (2000). A 10-year longitudinal study of scientists and practitioner interests in psychology: Assessing the Boulder model. *Professional Psychology: Research and Practice*, 31, 575-580.



Stress and Self Care Among Graduate Psychology Students

Adam Fried, Ph.D.

Fordham University

Colby Kant Harris, Ph.D.

Private Practice, Scottsdale, AZ



By now, most mental health professionals are likely aware that job-related stress can have profound effects on both their professional work and personal life, leading to negative outcomes such as psychological distress, compassion fatigue reduced professional self-efficacy, burnout, and job-turnover (Barnett, et al., 2007; Collins & Long, 2003; Newell & MacNeil, 2010; Webb, 2011). Strategies to address professional stress (commonly referred to as “self-care”) are now widely recognized by the field as being essential to competent and ethical practice (APA, 2006; APA, 2010; Johnson et al., 2011).

While specific self-care strategies may be highly individualized, in general, they refer to methods of recognizing and addressing stress by targeting psychological, physical, social, and/or spiritual needs (Baker, 2003). Self-care activities can include mindfulness and meditation, attending to physical well-being (getting enough sleep, integrating exercise into daily routines), setting aside dedicated time with family and friends, seeking personal therapy, supervision or just general collegial support, and spiritual activities.

While much of the literature on professional stress and implementing self-care strategies is germane to the work of established professionals, a body of research and scholarship is emerging on distinct stressors affecting graduate psychology students and the importance of self-care for this population. We will discuss some of the stress vulnerabilities unique to graduate students, recent research on the effectiveness of self-care for graduate students, and recommendations for training programs, supervisors and mentors.

Graduate Student Stress

Graduate psychology students experience a wide range of developmental and clinical stressors during their training that advanced professionals may not. Students may struggle with negotiating an emerging professional identity with the increased demands of clinical work and graduate training (Shapiro & Carlson, 2017; Turner et al., 2005). As noted by the American Psychological Association Committee on Colleague Assistance (2006), “Trainees are challenged with navigating the professional socialization process in addition to balancing academic coursework with developing the skill-set necessary to conduct clinical work competently.” (p. 11).

Lack of experience, uncertainty about performance, novel treatment and ethical dilemmas and lack of confidence in one’s abilities may also uniquely contribute to graduate student stress (Pakenham & Stafford-Brown, 2012). For example, Rodolfa, Kraft, and Reilly (1988) found that practicum and intern trainees perceived lack of client progress, inability to help clients feel better, and giving painful feedback to clients as more stressful than veterans did. Moreover, trainees may hold fears about sharing feelings about being stressed, overwhelmed or uncertainty about the quality of their professional work with supervisors or faculty who have grading or other evaluative authority.

Integrating Self-Care into Graduate Programs, Supervision and Mentoring

A recently published meta-analysis (analyzing 17 studies with 1,800 participants) on the efficacy of self-care for psychology graduate students (Colman et al., 2016) provided further support for the relationship between self-care strategies and positive outcomes for graduate psychology students. Specifically, self-care strategies were associated with reductions in psychological distress and increases in self-compassion and sense of personal accomplishment. Interestingly, there did not appear to be significant outcome differences based on the type of self-care strategy used or the participant characteristics.

These results bolster existing calls for graduate programs to proactively institute policies and create cultures that embrace and model self-care (Bamonti et al., 2014; Barnett & Cooper, 2009). While a few programs have incorporated self-care into their coursework, this practice appears to be far from the norm. As noted by Shapiro and Carlson (2017), relying on students to implement self-care strategies themselves may be unrealistic: “The demand of patient loads, as well as the curricular demands of graduate programs, seldom leaves space for explicit self-care and stress management intervention” (p.118).

In addition to formal integration of self-care as part of the curriculum or training experience, programs can establish environments that advocate self-care. For instance:

- Supervisors and mentors may be in a unique position to encourage trainee self-awareness and self-compassion, reflection on professional and personal values and model and share their own effective self-care behaviors.
- Graduate programs and training sites can provide opportunities for trainees and staff to discuss stressful work-related situations, such as through debriefing sessions.
- Programs and sites can also promote environments where students feel comfortable sharing work-related stress experiences and feelings; this may be especially important for trainees who may fear that disclosure of personal stress will be reflected in evaluations or who may otherwise feel uncomfortable discussing stress

with supervisors.

- Faculty can integrate self-care as part of class discussions or group supervision meetings. Topics can include identifying potential stressors as well as self-care techniques that resonate with the student. Frequent follow-up, including questions such as “What are the things you’ve done this week to care for yourself?” can become part of typical discourse.
- Programs can offer workshops on specific methods of developing self-care skills, such mindfulness training.

Graduate training is a time of significant knowledge acquisition and growth, both personally and professionally. Not only do students learn the technicalities associated with their craft, but they also learn a great deal about themselves, including how they manifest, respond and resolve stress. Training experiences are also socialization opportunities in which graduate students internalize professional norms and observations of others professionals may serve as a template for their own work habits. Given the negative outcomes that can result from significant and prolonged professional stress, it is critically important for graduate programs, supervisors and mentors to consider ways of creating a “culture of self-care” (Barnett & Cooper, 2009) in which teaching, discussing, and modeling effective methods of recognizing and addressing personal and professional stress are core components of training. ▮

References and Resources

APA Committee on Colleague Assistance (2006). Advancing colleague assistance in professional psychology. Retrieved from <https://www.apa.org/practice/resources/assistance/monograph.pdf>

Baker, E.K. (2003). *Caring for Ourselves: A therapist's guide to personal and professional well-being*. Washington, DC: American Psychological Association.

Bamonthi, P.M., Keelan, C.M., Larson, N, Mentrikoski, J.M., Randall, C.L., Sly, S.....(2014). Promoting ethical behavioral by cultivating a culture of self-care care during graduate training: A call to action. *Training and Education in Professional Psychology*, 8, 253-260.

Barnett, J.E., Baker, E.K., Ellman, N.S., & Schoener, G.R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice*, 38, 603-612.

Barnett, J.E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice*, 16, 16-20

Carter, L.A. & Barnett, J.E. (2014). *Self-care for clinicians in training: A guide to psychological wellness for graduate students in psychology*. New York: Oxford University Press.

Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for

mental health-care workers—A literature review. *Journal of Psychiatric and Mental Health Nursing*, 10, 417-42.

Fried, A.L., & Fisher, C.B. (2016). Moral stress and job burnout among frontline staff conducting clinical research on affective and anxiety disorders. *Professional Psychology: Research and Practice*, 47, 171-180.

Guy, J.D. (1987). *The personal life of the psychotherapist*. New York: Wiley.

Johnson, B. W., Johnson, S. J., Sullivan, G. R., Bongar, B., Miller, L., & Sammons, M. T. (2011). Psychology in extremis: Preventing problems of professional competence in dangerous practice settings. *Professional Psychology: Research and Practice*, 42, 94-104.

Newell, J. M., & MacNeil, G. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians. *Best Practices in Mental Health*, 6, 57-68.

Norcross, J.C., & Guy, J.D. (2007). *Leaving it at the office: A guide to psychotherapist self-care*. New York, NY: Guilford Press.

Pakenham, K.I. & Stafford Brown, J. (2012). Stress in clinical psychology trainees: A review of current research and future directions. *Australian Psychologist*, 47, 147-155.

Rodolfa, E.R., Kraft, W.A., & Reilley, R.R. (1988). Stressors of professionals and trainees at APA-approved counseling and VA medical center internship sites. *Professional Psychology: Research and Practice*, 19, 43-49.

Shapiro, S.L. & Carlson, L.E. (2017). *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions*. Washington, DC: American Psychological Association.

Sherman, M.D., & Thelen, M.H. (1998). Distress and impairment among psychologists in clinical practice. *Professional Psychology: Research and Practice*, 29, 79-85.

Turner, J.A., Edwards, L.M., Eicken, I.M., Yokoyama, K., Castro, J.R., Ngoc-Thuy Tran, A., et al. (2005). Intern self-care: An exploratory study into strategy use and effectiveness. *Professional Psychology: Research and Practice*, 36, 674-680.

Webb, K. (2011). Care of others and self: A suicidal patient's impact on the psychologist. *Professional Psychology: Research and Practice*, 42, 215-221.

What the Trump? Anticipated Rejection and Concern about Rights are Associated with Suicide Risk in LGBTQ Communities, but Can Resilience Trump Risk?

Jameson K. Hirsch, Ph.D.¹

Andrea Kaniuka, M.A.¹

Byron Brooks, M.A.¹

Kitty K. Hirsch, M.A.²

Abbey Mann, Ph.D.¹

Stacey L. Williams, Ph.D.¹

Tracy J. Cohn, Ph.D.³

Julia Dodd, Ph.D.¹

¹Department of Psychology, East Tennessee State University

²Department of Sociology, East Tennessee State University

³Department of Psychology, Radford University



It is common knowledge that LGBTQ (lesbian, gay, bisexual, transgender, and queer) communities experience disparate rates of mental health concerns, including greater levels of self-reported depression, anxiety, substance abuse, and suicidal behavior (Bränström, Hatzenbuehler, & Pachankis, 2016). As an example, gay and bisexual men are four times as likely and lesbian and bisexual women are 2 times as likely, to attempt suicide compared to heterosexual counterparts (King et al., 2008). Between 25-43% of transgender persons have a lifetime history of suicide attempts, compared to 5% of the general US population (Nock & Kessler, 2006). Such poor mental health outcomes may be due, in part, to a lack of acceptance by society in the form of discrimination and unequal rights, and to rejection by family, friends and the self, including internalized homophobia, concealment and shame (Skerrett, Kölves, & De Leo, 2016). LGBTQ persons are also more likely to have experienced trauma, including physical and sexual abuse, as well as interpersonal violence by intimate partners, family and strangers (Langenderfer-Magruder, Whitfield, Walls, Kattari, & Ramos, 2016). LGBTQ communities, therefore, constitute a vulnerable and marginalized population, who are already at risk for rejection and abuse with consequent deleterious effects on physical and mental health, including risk for suicide.

And then came the 2016 election season... Full of divisiveness and tumult, the quadrennial political machinations of the United States delivered a surprising

result, with the election of Donald J. Trump as the 45th President of the United States. Running a campaign and presidency rife with bigotry, xenophobia, and sexism, President Trump has consistently threatened, literally and figuratively, numerous marginalized and vulnerable groups, including LGBTQ communities. Further, by installing a Cabinet and governmental officials with political records that are in opposition to equal rights (e.g., Jeff Sessions, Attorney General; Roger Severino, Head of Department of Health and Human Resources Office of Civil Rights, and Neil Gorsuch, Supreme Court Justice), Trump has begun to make good on his threats. In the works are efforts to revoke and repeal the Affordable Care Act, which includes a number of provisions that specifically benefit sexual and gender minority patients (Human Rights Campaign, 2017). In addition, there are numerous other state and federal preemptive laws being proposed that open the door for housing and workplace discrimination and discriminatory practices in the provision of services (e.g., conscience clause for clinicians). Indeed, even the ability to assert one's identity and be "counted" as a member of an LGBT community is in jeopardy, as LGBT-related classification choices will not be included in the upcoming US Census.

LGBTQ groups in the United States, as well as other marginalized groups (e.g., immigrants, religious groups, and women), are exposed to daily, government-sanctioned doses of micro- and macro-aggressions, as well as to more overt experiences of rejection by members of their social networks and communities, and even to direct violence. For LGBTQ persons, these threats extend to health care (e.g., hormonal treatments; safe sexual health), equal rights (e.g., adoption, insurance), and physical safety (e.g., the Southern Poverty Law Center, ProPublica, and NYPD each report increased post-election LGBTQ hate crimes). Concern and worry that other recent and fiercely-earned rights, such as marriage equality, military rights and protected-class status are also at risk (Byrne, 2017).

In a recent study we conducted, we built upon our past work (Hirsch, Hirsch, et al., 2017; Hirsch, Kaniuka, et al., 2017), positing that anticipated rejection, anticipated discrimination and concern and worry about pending repeal of rights based on sexual orientation/gender identity, are linked to suicide risk. Previous findings show that LGBTQ persons who were "concerned or worried" about their rights, or who had a fear of physical violence or anticipated rejection from family and friends after the election and due to their sexual orientation/gender identity, reported elevated levels of perceived stigma, a lack of hope and feelings of hopelessness, intense emotional pain (i.e., psychache), and symptoms of anxiety and depression (Hirsch, Hirsch, et al., 2017). Critical to this assertion are previous studies indicating that pending identity threats (e.g., discrimination, stigma) and other forms of anticipatory concern, whether or not the events actually ever happen, are related to distress among LGBTQ communities (Frost & Fingerhut, 2016; Hatzenbuehler et al., 2014;

Sawyer, Major, Casad, Townsend, & Mendes, 2012).

Yet, not all persons who experience worry, rejection or discrimination become suicidal, perhaps due to the presence of individual-level protective characteristics (e.g., self-compassion, hope, forgiveness, gratitude) that might offset suicide risk (Huffman et al., 2014); we hypothesized that these characteristics would be related to less suicide risk in our LGBTQ sample. In exploratory analyses, we also assessed the most robust risk and protective factors, in independent and combined models.

Respondents in our nationally-drawn sample (N=496) had a mean age of 35.18 (SD=16.31), ranging from 18 to 76 years of age, were mostly White (74%; n=365), and were recruited via support organizations and social media. They self-identified as male (n=135; 30.1%), female (n=201; 44.8%), transgender male (n=21; 4.7%), transgender female (n=14; 3.1%), genderqueer (n=21; 4.7%), genderfluid (n=8; 1.8%), non-binary (n=17; 3.8%), agender (n=6; 1.3%), two-spirit (n=5; 1.1%), intersex (n=2; .4%), and other (n=18; 4.0%). Self-identified sexual orientation included: lesbian/gay (n=209; 47%), heterosexual/straight (n=28; 6%), bisexual (n=82; 18%), pansexual (n=37; 8%), asexual (n=11; 3%), and queer (n=62; 14%). Participants completed election-related questions focused on stigma, discrimination and worry, as well as measures of mental health functioning (i.e., Suicidal Behavior Questionnaire – Revised) and protective factors (i.e., Gratitude Questionnaire, Fetzer Forgiveness Scale, Trait Hope Scale, Self Compassion Scale), as part of a larger study on LGBTQ health and wellness.

As we have previously reported, of those who answered our election-related questions, 72% (n=247) of respondents reported being “very” or “extremely” worried or concerned that their rights would be “infringed upon, restricted or taken away” (Hirsch, Hirsch, et al., 2017); in the current study, we used this item as a predictor of suicide risk. As well, the majority of LGBTQ respondents in our study (57%; n=194) reported moderate to strong fear of discrimination from strangers (a score of 4, 5 or 6), feared being verbally insulted (56%; n=189), and feared physical violence (39%; n=131), because of their sexual orientation or gender identity and as a result of the election (Hirsch, Kaniuka, et al., 2017). Along with 4 other items assessing anticipated rejection by employers, supervisors or instructors, and rejection by coworkers or fellow students, these rejection-based items (scored 0 [not likely] to 6 [very likely]) were summed to form a total rejection score, which was also used as an independent variable. As a final predictor (i.e., anticipated discrimination), we also summed 6 items focused on rights discrimination (i.e., ability to marry same-sex partner, legal protections, work-based discrimination, ability to adopt, housing discrimination, and discrimination from businesses), where each item (e.g., “Given the political climate and considering your sexual orientation and/or gender identity, how much do you think your rights will be infringed upon, restricted, or taken away”) was

scored from 0 (not likely at all) to 4 (extremely likely).

We also examined numerous potential protective factors as possible buffers against post-election suicide risk, including gratitude, forgiveness, hopefulness and self-compassion. We selected these variables specifically for their relevance to the experience of rejection, discrimination and concern and worry about the future. For instance, finding elements of one’s life to be grateful or thankful for, despite rejection or discriminatory fears, or engaging in forgiveness toward those who are discriminatory, may help a person to “weather the storm,” so to speak, by allowing a type of transcendence of discriminatory experiences (Kleiman, Adams, Kashdan, & Riskind, 2013; Webb, Hirsch, & Toussaint, 2015). Similarly, hope for the future, with its components of agency (e.g., setting goals) and pathways (e.g., problem solving), may help to overcome stressors as they occur, and self-compassion, which is comprised of kindness toward the self, sense of common humanity and mindfulness, may help to soothe and ameliorate negative thoughts about the self that arise due to discrimination or stigma (Cheavens, Cukrowicz, Hansen, & Mitchell, 2016; Sirois, Kitner, & Hirsch, 2015).

In bivariate analyses, all risk and protective factors were significantly related to engagement in suicidal behavior ($p < .01$), including: concern/worry about rights ($r = .29$), anticipated rejection ($r = .29$), and anticipated discrimination ($r = .18$), as well as hope ($r = -.48$), self-compassion ($r = -.48$), forgiveness ($r = -.34$) and gratitude ($r = -.45$). Using hierarchical linear regressions, covarying age and race/ethnicity, we examined all risk factors (i.e., concern/worry about repeal of rights, anticipated rejection, anticipated discrimination) together in a single model, which was significant, $F(5, 294) = 11.95$, $p < .001$, $R^2 = .17$. The effects of worry/concern about rights ($t = 3.40$, $p = .001$), anticipated rejection ($t = 4.66$, $p < .001$), and anticipated discrimination ($t = 2.08$, $p < .05$) on suicidal behavior were significant. In our protective factor model, $F(6, 267) = 23.76$, $p < .001$, $R^2 = .35$, the effects of self-compassion ($t = -3.66$, $p < .01$), gratitude ($t = -2.86$, $p < .01$), and hope ($t = -3.27$, $p < .01$) on suicidal behavior were significant. Finally, in a combined risk and protective factor model, $F(9, 249) = 15.62$, $p < .001$, $R^2 = .36$, the effects of concern/worry about rights ($t = 2.62$, $p < .01$) and anticipated rejection ($t = 2.10$, $p < .05$), as well as the effects of self-compassion ($t = -3.14$, $p < .01$) and hope ($t = -3.44$, $p < .01$), on suicidal behavior, remained significant.

To summarize, concern/worry about rights, and anticipated rejection and discrimination, were positively associated with suicide risk, whereas forgiveness, self-compassion, hope and gratitude were negatively related to suicide risk. In our multivariate models, all risk factors (i.e., concern/worry, anticipated rejection and discrimination) were significantly related to suicidal behavior, and in the protective factor model, self-compassion, gratitude and hopefulness were inversely related to suicide risk ($p < .05$). Finally, in an overall

model of both risk and protective factors for suicide, two predominant risk factors emerged (concern/worry about repeal/removal of rights; anticipated rejection) and, as well, two protective factors emerged as simultaneously significant (hopefulness; self-compassion).

Our findings suggest that LGBTQ individuals in the US are fearful of structural stigma, but are particularly concerned about the repeal and removal of equal rights, and interpersonal rejection, after the Trump nomination and election and because of their sexual orientation/gender identity. Importantly, these election-related concerns exist in addition to the general zeitgeist of negativity and animosity directed toward LGBTQ persons, and appear to be linked to suicide risk (Bogart, Revenson, Whitfield, & France, 2014). Advocates, allies, politicians and policy-makers, and researchers and clinicians alike, must work to alleviate the sociocultural and psychological stigma and penalties experienced by marginalized groups, and to promote health and well-being in these typically neglected and underserved communities (Berkes & Ross, 2013).

Yet, our findings also highlight some areas of resiliency, and potential points of intervention, in that hope and self-compassion remained associated with less suicide risk, despite the presence of the aforementioned anticipated election-based stress and rejection. It is noteworthy that these two specific factors emerged as the most robust protective factors. First, hopefulness is a future-oriented, cognitive-emotional construct that is predicated on goal setting and attainment (Snyder et al., 1991); therefore, that this protective factor is activated post-election suggests that persons in LGBTQ communities can “see past” their current sociocultural and interpersonal stressors to a better time, complete with goals and a sense of how to achieve them. Second, self-compassion, or the ability to be kind to the self in times of distress, seems particularly applicable with regard to minority-group discrimination and rejection, especially when these hostilities are internalized. The additional components of self-compassion are mindfulness, which may allow LGBTQ persons to acknowledge and “let go” of negative emotions stemming from the current political climate, and common humanity, which may provide a sense of connectedness to a larger group, with the knowledge that they are not “the only one” to be experiencing such distress (Neff, Kirkpatrick, & Rude, 2007). Although only marginally significant at the multivariate level, but significant at the bivariate level, forgiveness and gratitude were also related to less suicide risk. Forgiveness of self, forgiveness of others and feeling forgiven by God may be important areas of exploration for LGBTQ persons, particularly given the distress they often experience with regard to self-punitive thoughts, offenses from others, and conflict with religious beliefs (Hirsch, Webb, & Jeglic, 2011). Similarly, the ability to find a silver lining, or things to appreciate and be thankful for in one’s life, despite the existence of worries or stressors, can be a critical lifeline on dark days (Kleiman et al., 2013).

Our results highlight the negative impact of the 2016 election, including fear of losing rights, discrimination and being rejected as a result of sexual orientation/gender identity, on suicide risk. These are concerns that should, potentially, be pro-actively addressed with LGBTQ persons currently under psychological care, as an overwhelming number of our respondents (92%) reported that they did, indeed, feel concern and worry about their rights after the election. On the other hand, we found that areas of resiliency and strength remain for LGBTQ communities despite (or perhaps in spite of) post-election distress, namely a sense of hopefulness and compassion focused toward the self, which were related to less likelihood of engaging in suicidal behavior. Strategies for promoting these and other potentially-protective characteristics are readily available, and can be utilized by LGBTQ persons on their own, or can be encouraged in the context of provision of mental health services. For instance, goal-setting, problem-solving and self-efficacy training can promote sense of hopefulness, and compassionate journaling or kindness-based mindfulness can promote feelings of self-compassion (Chang, Yu, Kahle, Jeglic, & Hirsch, 2013; Neely, Schallert, Mohammed, Roberts, & Chen, 2009).

As our research team continues to explore the ramifications of the 2016 election and current political climate on the psychological health and wellbeing of LGBTQ persons, we will continue to examine risk factors but will focus our efforts on the investigation of adaptive and growth-oriented characteristics that can be promoted to encourage resilience and thriving in this stressful political climate, as well as in other stressful or traumatic situations. We welcome potential collaborators to contact us (hirsch@etsu.edu), so that together we might exact some measure of change at the public health as well as individual and therapeutic levels to address the current socio-political stressors affecting LGBTQ individuals and to promote the strengths of LGBTQ persons and communities, for an empowerment-based approach to improving LGBTQ well-being. 📧

References

- Berkes, F., & Ross, H. (2013). Community Resilience: Toward an Integrated Approach. *Society & Natural Resources*, 26(1), 5–20. <https://doi.org/10.1080/08941920.2012.736605>
- Bogart, L. M., Revenson, T. A., Whitfield, K. E., & France, C. R. (2014). Introduction to the special section on Lesbian, Gay, Bisexual, and Transgender (LGBT) health disparities: where we are and where we’re going. *Annals of Behavioral Medicine*, 47(1), 1–4.
- Bränström, R., Hatzenbuehler, M. L., & Pachankis, J. E. (2016). Sexual orientation disparities in physical health: age and gender effects in a population-based study. *Social Psychiatry and Psychiatric Epidemiology*, 51(2), 289–301. <https://doi.org/10.1007/s00127-015-1116-0>
- Byrne, W. (2017). Sustaining Progress Toward LGBT

- Health Equity: A Time for Vigilance, Advocacy, and Scientific Inquiry. *LGBT Health*, 4(1), 1–3. Retrieved from <http://dx.doi.org/10.1089/lgbt.2016.0211>
- Chang, E. C., Yu, E. A., Kahle, E. R., Jeglic, E. L., & Hirsch, J. K. (2013). Is doubling up on positive future cognitions associated with lower suicidal risk in Latinos?: A look at hope and positive problem orientation. *Cognitive Therapy and Research*, 37(6). <https://doi.org/10.1007/s10608-013-9572-x>
- Cheavens, J. S., Cukrowicz, K. C., Hansen, R., & Mitchell, S. M. (2016). Incorporating Resilience Factors Into the Interpersonal Theory of Suicide: The Role of Hope and Self-Forgiveness in an Older Adult Sample. *Journal of Clinical Psychology*, 72(1), 58–69.
- Frost, D. M., & Fingerhut, A. W. (2016). Daily exposure to negative campaign messages decreases same-sex couples' psychological and relational well-being. *Group Processes & Intergroup Relations*, 19(4), 477–492. <https://doi.org/10.1177/1368430216642028>
- Hatzenbuehler, M. L., Bellatorre, A., Lee, Y., Finch, B. K., Muennig, P., & Fiscella, K. (2014). Structural stigma and all-cause mortality in sexual minority populations. *Social Science & Medicine*, 103, 33–41. <https://doi.org/10.1016/j.socscimed.2013.06.005>
- Hirsch, J. K., Hirsch, K. K., Mann, A., Williams, S. L., Dodd, J., Cohn, T. J., & Chang, E. C. (2017). Post-Election Concerns about Rights and Safety are Related to the Mental Health of LGBTQ Communities: This is Not Fake News. *Forward Newsletter*, Society for the Psychological Study of Social Issues, 257.
- Hirsch, J. K., Kaniuka, A., Brooks, B., Hirsch, K. K., Cohn, T. J., & Williams, S. L. (2017). Post-Election Distress and Resiliency in LGBTQ Communities: An Overview of Real Data, Not Alternative Facts. In *Division 44 Newsletter* (pp. 1–4). Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues.
- Hirsch, J. K., Webb, J. R., & Jeglic, E. L. (2011). Forgiveness, depression, and suicidal behavior among a diverse sample of college students. *Journal of Clinical Psychology*, 67(9). <https://doi.org/10.1002/jclp.20812>
- Huffman, J. C., DuBois, C. M., Healy, B. C., Boehm, J. K., Kashdan, T. B., Celano, C. M., ... Lyubomirsky, S. (2014). Feasibility and utility of positive psychology exercises for suicidal inpatients. *General Hospital Psychiatry*, 36(1), 88–94. <https://doi.org/10.1016/j.genhosppsych.2013.10.006>
- Human Rights Campaign. (2017). What the Affordable Care Act means for LGBTQ people and their families. Retrieved from <http://www.hrc.org/resources/what-the-affordable-care-act-means-for-lgbt-people-and-their-families>
- King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8(1), 70. <https://doi.org/10.1186/1471-244X-8-70>
- Kleiman, E. M., Adams, L. M., Kashdan, T. B., & Riskind, J. H. (2013). Gratitude and grit indirectly reduce risk of suicidal ideations by enhancing meaning in life: Evidence for a mediated moderation model. *Journal of Research in Personality*, 47(5), 539–546. <https://doi.org/10.1016/j.jrp.2013.04.007>
- Langenderfer-Magruder, L., Whitfield, D. L., Walls, N. E., Kattari, S. K., & Ramos, D. (2016). Experiences of Intimate Partner Violence and Subsequent Police Reporting Among Lesbian, Gay, Bisexual, Transgender, and Queer Adults in Colorado: Comparing Rates of Cisgender and Transgender Victimization. *Journal of Interpersonal Violence*, 31(5), 855–871. <https://doi.org/10.1177/0886260514556767>
- Neely, M., Schallert, D., Mohammed, S., Roberts, R., & Chen, Y. J. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students well-being. *Motivation and Emotion*, 33(1), 88–97.
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, 41(1), 139–154. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0092656606000353>
- Nock, M. K., & Kessler, R. C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology*, 115(3), 616–23. <https://doi.org/10.1037/0021-843X.115.3.616>
- Sawyer, P. J., Major, B., Casad, B. J., Townsend, S. S. M., & Mendes, W. B. (2012). Discrimination and the Stress Response: Psychological and Physiological Consequences of Anticipating Prejudice in Interethnic Interactions. *American Journal of Public Health*, 102(5), 1020–1026. <https://doi.org/10.2105/AJPH.2011.300620>
- Sirois, F. M., Kitner, R., & Hirsch, J. K. (2015). Self-compassion, affect, and health-promoting behaviors. *Health Psychology*, 34(6). <https://doi.org/10.1037/hea0000158>
- Skerrett, D. M., Kölves, K., & De Leo, D. (2016). Factors Related to Suicide in LGBT Populations. *Crisis*, 37(5), 361–369. <https://doi.org/10.1027/0227-5910/a000423>
- Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., ... Harney, P. (1991). The will and the ways - development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology*, 60(4), 570–585.
- Webb, J. R., Hirsch, J. K., & Toussaint, L. (2015). Forgiveness as a positive psychotherapy for addiction and suicide: Theory, research, and practice. *Spirituality in Clinical Practice*, 2(1), 48–60.

Opinions published in Letters to the Editor represent the views of the authors and not those of SCP or the APA. Letters to the Editor representing differing views, comments, and opinions are always welcome. Submissions can be sent by email to jocomer@fiu.edu.

Congratulations to our 2017 Division 12 Award Winners!

Award for Distinguished Scientific Contributions to Clinical Psychology presented to **Thomas H. Ollendick, Ph.D.** and **William Ellerbe Pelham, Jr., Ph.D.** for distinguished theoretical or empirical contributions to Clinical Psychology throughout their careers.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology presented to **Sandra A. Graham-Bermann, Ph.D.** for distinguished advances in psychology leading to the understanding or amelioration of important practical problems and outstanding contributions to the general profession of clinical psychology.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology presented to **Donna Kiyo Nagata, Ph.D.** for remarkable contributions to the understanding of human diversity and whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind.

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology presented to **Denise May Sloan, Ph.D.** for excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty.

David Shakow Early Career Award for Contributions to Clinical Psychology presented to **James Franklin Boswell, Ph.D.** and **Aidan G.C. Wright, Ph.D.** for contributions to the science clinical psychology by a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to science and to practice.

Theodore Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology presented to **Randy P. Auerbach, Ph.D., ABPP** for professional accomplishment and promise in Clinical Psychology. Accomplishments may include promoting the practice of clinical psychology through professional service; innovation in service delivery; novel application of applied research methodologies to professional practice; positive impact on health delivery systems; development of creative educational programs for practice; or other novel or creative activities advancing the service of the profession.

The American Psychological Foundation Theodore Millon Award presented to **Adam Leventhal, Ph.D.** for outstanding mid-career advances in the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. This award is given jointly by The American Psychological Foundation and the Society of Clinical Psychology.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology presented to **Paul Perrin, Ph.D.** for an early career psychologist who has made exemplary contributions to diversity within the field. Such contributions can include research, service, practice, training, or any combination thereof.

Distinguished Student Research in Clinical Psychology Award presented to **Jessica Leigh Hamilton, M.A.** and **Christopher R. DeCou** for exemplary theoretical or empirical contributions to research in clinical psychology.

Distinguished Student Practice in Clinical Psychology Award presented to **Jonah N. Cohen, M.A.** for outstanding clinical practice contributions to the profession.

Distinguished Student Service in Clinical Psychology Award presented to **Alex Thibeault, Med, MA, LPA, HSP-PA** for outstanding service contributions to the profession and community.

Division elections are open!

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

PRESIDENT-ELECT:

Jonathan S. Comer, Ph.D.

Elizabeth A. Yeater, Ph.D.

TREASURER:

James H. Bray, Ph.D.,

Gerald P. Koocher, Ph.D., ABPP

Jonathan Weinand, Ph.D.

DIVISION 12 REPRESENTATIVE TO APA COUNCIL:

Patricia Hillis-Clark, LCSQ, PsyD, BCBA

Barry A. Hong, Ph.D.

Kenneth J. Sher, Ph.D.

Mark B. Sobell, Ph.D., ABPP

Statements submitted by the candidates, and candidate bios, are as follows:

President-Elect

Jonathan S. Comer, Ph.D.



Dr. Comer is a Professor of Psychology and Psychiatry at Florida International University, where he directs the Mental Health Interventions and Technology (MINT) Program, an interdisciplinary clinical research program devoted to expanding the quality, scope and accessibility of quality mental health care. He is a Fellow of

the American Psychological Association and of the Society of Clinical Psychology. Dr. Comer's program of work examines four areas of overlapping inquiry. First, his research evaluates mental health treatments and services, with particular focus on the development

of innovative methods to reduce systematic barriers to effective care. To this end he conducts research examining the role of new technologies—such as videoconferencing and mobile platforms—for meaningfully expanding the reach of mental health care. He also uses epidemiologic datasets to document problems in the quality of mental health services and geographic disparities in care. Second, his work examines the assessment, phenomenology, and course of anxiety disorders, disruptive behavior disorders, and traumatic stress disorders, with particular focus on early-onset problems. Third, his work examines the psychological impact of disasters and terrorism on children and families. He has published extensively on children affected by the 9/11 terror attacks and on children affected by the Boston Marathon bombing, and he served as a consultant throughout the federal trial of United States v. Dzhokhar Tsarnaev. Fourth, in recent years, Dr. Comer's work has expanded to also consider biological markers of child psychopathology and neurocircuitry patterns associated with the intergenerational transmission of internalizing problems.

Dr. Comer has published over 120 scholarly articles, chapters, and handbooks, and his research has been funded by the National Institute of Mental Health and by the National Institute of Child Health and Human Development, as well as by several private foundations and non-profit organizations. His work has been recognized through the receipt of several early career awards, including early career awards from the Society of Clinical Psychology, the American Psychological Association, the Association for Behavioral and Cognitive Therapies, and the Association for Psychological Science. He currently serves as Associate Editor of Behavior Therapy as well as Editor-in-Chief of the Clinical Psychologist, and is an elected Officer in the Society of Clinical Child and Adolescent Psychology where he serves on the Board of Directors.

Candidate Statement

I am tremendously honored to be nominated for President-Elect of Division 12. Despite the staggering public health burden of mental illness, the Society and its membership has been at the forefront of leading efforts to identify quality treatment practices for a diverse range of individuals and to promote the uptake of evidence-based care in practice settings. Yet the majority of work is still ahead.

If elected, I would relish the opportunity to help lead the Society in its continued pursuit to improve the accessibility and acceptability of quality mental health care. I've devoted my career to leveraging technology to meaningfully expand the scope and reach of evidence-based practices. As a Division 12 Fellow, I bring years of leadership experience and service to the profession, including key governance positions in ABCT, Division 12, and Division 53, and I currently serve as Associate Editor of Behavior Therapy and Editor-in-Chief of the Clinical Psychologist. I've held faculty positions in both psychology and psychiatry departments, supervised countless trainees, collaborated with colleagues in VA and military

settings, and maintained a private practice—thus, I'm intimately familiar with the diverse settings in which psychologists work and with what's needed to support professional advancement in each of them.

I've spent my career working to promote the discipline and profession of clinical psychology, and I'm excited to bring my passion and creativity to work with and support our members, to sustain our firm commitment to a science-practice integration, and to support public policies in the public interest.

Elizabeth A. Yeater, Ph.D.



Elizabeth A. Yeater is an Associate Professor and Director of Clinical Training in the Department of Psychology at the University of New Mexico. Her research program investigates cognitive and behavioral factors that increase college women's risk for sexual victimization. Dr. Yeater's work uses a Social Information Processing Model (SIP) and methods borrowed

from cognitive science to examine women's ability to detect and respond to risky situations, as well as to explore whether aspects of alcohol use (i.e., intoxication, alcohol problems, and alcohol expectancies) and sexual attitudes (i.e., sociosexuality, rape myth acceptance) influence these processes. Dr. Yeater's work is currently funded by the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Her clinical expertise is in the treatment of anxiety disorders.

Candidate Statement

I am Director of Clinical Training and Associate Professor in the Psychology Department at the University of New Mexico (UNM). I serve in multiple roles in my current position – clinical supervisor, researcher, teacher, mentor, and Head of our APA Accredited Doctoral Program in Clinical Psychology. In my research role, I investigate cognitive and behavioral factors that increase college women's risk for sexual victimization. Specifically, I use methods translated from cognitive science to examine women's ability to detect and respond to risky situations, as well as to explore whether aspects of alcohol use (i.e., intoxication, alcohol problems, and alcohol expectancies) and sexual attitudes (i.e., sociosexuality, rape myth acceptance) influence these processes. Broadly, then, my programmatic line of research uses basic cognitive science and behavioral assessment methods to test potential etiological factors related to women's risk for victimization. My work is currently funded by National Institutes of Alcohol Abuse and Alcoholism (NIAAA).

The University of New Mexico (UNM) is a unique program, known for its attention to ethnic diversity issues, including those that arise in our richly multicultural region of the United States. I have served

membership in the Society of Clinical Psychology (SCP, Division 12, APA) through my role on the Diversity Subcommittee for Division 12. I am also pleased to have served as a faculty presenter for our SCP 2017 Graduate Student Summit. I am now seeking to extend my service to SCP as a candidate for division President. I will bring to this role my expertise with and perspectives from our youngest members – my job at UNM is quite simply to launch clinical psychologists into the field by preparing students for internship, arranging practicum experiences, and developing and evaluating our program content. I want to increase the value of SCP for these future lifetime members, while also retaining and enhancing value for the seasoned clinical psychologists that make up our ranks. As a trainee of Dick McFall at Indiana University, I have pursued my entire career with a devotion to the science of clinical psychology. I now want to take my turn serving the membership of Division 12 to further its mission to: "encourage and support the integration of psychological science and practice in education, research, application, advocacy and public policy, attending to the importance of diversity." Through proper dissemination and training, I believe we can obtain our mutual goal of reducing human suffering.

Treasurer

James H. Bray, Ph.D.



James H. Bray, Ph.D. is a psychologist and an Associate Professor of Family and Community Medicine. He was the 2015 President of the Texas Psychological Association and the 2009 President of the American Psychological Association.

His presidential themes were the Future of Psychology Practice and Science and Psychology's Contribution to Ending Homelessness. He is also president of the Division of Professional Practice of the International Association of Applied Psychology. Dr. Bray's NIH funded research focuses on adolescent substance use, divorce, remarriage and stepfamilies. He has published over 200 articles in major journal and books. He is the director of a federal HRSA faculty development program for physicians and was the director of the SAMSHA funded project on screening, brief intervention and referral to treatment (SBIRT) project. He is a pioneer in collaborative healthcare and primary care psychology. He has presented his work in 20 countries. He also maintains an active clinical practice focusing on health psychology, children and families.

Candidate Statement

It is an honor to stand for election as treasurer of the Society of Clinical Psychology. I am eager to contribute my knowledge and passion for clinical psychology to help the division accomplish its goals and objectives. Division 12 plays a critical

role within APA by standing for the integration of psychological science into the practice of psychology. I have the experience and established working relationships to get things done for Division 12.

Unlike other candidates, there will be no learning curve for me. I have been treasurer of five other APA Divisions (34, 37, 43, 46, 55) and on the APA Board of Directors budget subcommittee (2008-2010). In addition, I have managed budgets on large NIH grants.

James H. Bray, Ph.D. (University of Houston, 1980) is Associate Professor of Family and Community Medicine and Psychiatry, Baylor College of Medicine and the 2009 APA President. Dr. Bray was previously on the faculty at Texas Woman's University. He teaches psychology students, resident physicians, and medical students and directs faculty development. Dr. Bray's NIH funded research focuses on adolescent substance use, divorce, remarriage and stepfamilies. He is a pioneer in collaborative healthcare and primary care psychology. He maintains an active clinical practice specializing in children and families and behavioral medicine. He has been active in APA governance for over 20 years involved in practice, science, education, and state issues. He is a fellow of 12 APA Divisions (5, 7, 12, 29, 31, 34, 37, 38, 42, 43, 46, 55).

Internationally Recognized Scholar and Researcher: Over 200 publications (Multivariate Analysis of Variance with Scott Maxwell, SAGE; Handbook of Family Psychology with Mark Stanton, Blackwell Publishing). Editorial board member and reviewer for 13 journals. Four NIH grants: Alcohol, Psychosocial Factors and Adolescent Development (two RO1s from National Institute of Alcoholism and Alcohol Abuse); SAMHSA grants on Screening, Brief Intervention and Referral to Treatment (SBIRT).

Gerald P. Koocher, Ph.D., ABPP



Gerald P. Koocher, PhD, earned a Ph.D. in clinical psychology at the University of Missouri. He serves as Professor and Dean of the College of Science and Health at DePaul University in Chicago. Prior to moving to Chicago in 2013, he was Professor of Psychology and Associate Provost at Simmons

College, Boston. He previously served as Chief of Psychology at Boston's Children's Hospital and Judge Baker Children's Center, and as Associate Professor and Executive Director of the Linda Pollin Institute at Harvard Medical School. Dr. Koocher served as founding editor of the journal *Ethics & Behavior* and editor of the *Journal of Pediatric Psychology*. He has published more than 350 articles and book chapters and authored or edited 17 books including *Ethics in Psychology* and the *Mental Health Professions*, the *Psychologists' Desk Reference*, and *The Parent's Guide to Psychological First Aid*. Elected a Fellow of twelve divisions of the American Psychological Association (APA) and the American Association for

the Advancement of Science (AAAS), Koocher earned five specialty diplomas from the American Board of Professional Psychology (Clinical, Clinical Child / Adolescent, Family, Forensic, and Health Psychology). He holds active psychology licenses in Illinois, Massachusetts and New Hampshire. He served as Treasurer (1995 – 2005) and as President of the APA (2006). He currently serves as Chair of the Board of the American Insurance Trust.

Candidate Statement

I feel honored to be considered as a candidate for treasurer. I served in that capacity once before (1991 – 1993), followed by ten years as treasurer of APA. Both the division and APA have changed a great deal since then, but it remains important to have an attentive eye monitoring fiscal operations. If elected, I promise transparency in division finances and attentive collaborative participation in helping the Society to achieve continued success.

Jonathan Weinand, Ph.D.



Jonathan Weinand, Ph.D. received his doctorate in clinical psychology from the Illinois Institute of Technology, and completed his internship at the University of Mississippi Medical Center/VA Consortium. He has been in clinical practice for over 25 years, centering on child and adolescent psychology. He is currently in practice at the Family Behavioral HealthCare of Iowa. He also is associate editor of "Evidence-Based

Practice in Child & Adolescent Mental Healthcare". Jon currently serves as Treasurer of the Society of Clinical Psychology. He has presented and published his work centering on family assessment and continuing educational issues at numerous conferences, including ABCT and APA.

Candidate Statement

I am grateful for the opportunity to run for a second term as the Treasurer for the Society of Clinical Psychology. I received my graduate training at Illinois Tech and completed my internship at University of Mississippi/VA Consortium. I am currently in Independent Practice, and serve as an associate editor of the Division 53 clinical journal, *Evidence-Based Practice in Child & Adolescent Mental Health*. I am a member of ABCT, SCCAP, SSCP and am a Fellow of SCP and APA.

Throughout the years, I have served in several positions within SCP including chairing the presidential task force on education and training, the education & training committee, and serving as co-chair on SCP's recent CE committee.

As current Treasurer of SCP, I have had an opportunity to develop a wide range of budget and finance

associated initiatives. These include re-working the SCP budget to meet APA accounting guidelines while increasing transparency, developing the accounts related to special projects, presidential initiatives, and continuing education. In addition, we continue to work on developing processes to increase the working value of our general fund via financially sound investment fund growth.

Our membership continues to be pressed by significant funding challenges at the education, science and practice levels of our profession. The Society of Clinical Psychology will be well-served by continuing to develop financially sound, integrated processes as we work towards providing high-quality, science-based education and training to our membership. I look forward to your consideration of my candidacy for this position.

Council Representatives

Patricia Hillis-Clark, LCSW, PsyD, BCBA



Dr. Patricia Hillis-Clark has worked in the child and adolescent behavioral health care field for over 20 years. She has a history of partnering with state and local policy makers to address issues affecting the mental health field and understands the complexities facing psychologists today.

Throughout her entire career, she has served in the private non-profit sector. She has held various positions ranging from clinician to clinical director. Additionally, Dr. Hillis-Clark has held teaching faculty positions, been engaged in grant funded work and has overseen an APA approved internship program. She specializes in working with a highly-traumatized population; including sexually exploited and trafficked youth. Dr. Hillis-Clark's areas of research and development include program evaluation and outcomes monitoring of evidenced based practices. She is a Certified Trauma Focused Cognitive Behavior Therapist and has her Diplomate from the Academy of Cognitive Therapists. She has served as a past Division 12 reviewer for the Annual Convention Submissions for Presentation. Dr. Hillis-Clark received her Doctorate in Clinical Psychology from Chestnut Hill College, her Master's degree from Temple University and is a Board Certified Behavior Analyst. She is actively involved in her community, is a triathlete, and a mother of three.

Candidate Statement

I have worked in the child and adolescent behavioral health care field for over 20 years; currently serving as the Clinical Director for Children's Behavioral Health Services in Pennsylvania at Devereux Advanced Behavioral Health. I specialize in working with a highly-traumatized population; including sexually exploited and trafficked youth. I have a long history of partnering

with state and local policy makers and working with national subject matter experts to implement clinical best practice models. My areas of research and development include program evaluation and outcomes monitoring of evidenced based practices. I have held teaching faculty positions, been engaged in grant funded work and have overseen an APA approved internship program. I received my Doctorate in Clinical Psychology from Chestnut Hill College and my Master's degree from Temple University.

I have gained experience in APA governance by serving as a past Society of Clinical Psychology (SCP) reviewer for the Annual Convention Submissions for Presentation and presently as a member of the Mentorship Work Group. My experience in APA and with the SCP places me in a unique position to advocate for initiatives that not only strengthen the science and profession of clinical psychology, but also help to advance psychology's advocacy agenda. I want to make sure that the voice of clinical psychology is well represented by policy makers at the state and national levels. I humbly ask for your support.

Barry A. Hong, Ph.D.



Dr. Barry Hong is a Professor of Psychiatry at Washington University School of Medicine. He holds joint appointments in the Department of Medicine and in the Department of Psychology. He is the Vice-Chairman for Clinical Affairs in Psychiatry and the Chief Psychologist for Barnes-Jewish Hospital. Dr. Hong has been a consultant with the United Network of Organ Sharing (UNOS) and the Division of Transplantation

(HRSA). His research has been funded by the National Institutes of Health (NIH) concerning living organ donors, hepatitis C treatments and the study of interstitial cystitis (functional pain). He has been one of a team of NIH investigators who have conducted medical and psychological follow-up studies of over 2,500 living kidney donors and several hundred living lung donors from multiple transplant centers. Presently, he is working with the National Living Donor Assistance Program (NLDAC), a federally sponsored project which has facilitated over 3,500 living kidney transplants and developing a proposal to reimburse lost wages to living donors.

He has his PhD from Saint Louis University and is a Diplomate in clinical psychology from the American Board of Professional Psychology.

Candidate Statement

I am asking for your vote to serve on the APA Council. I am at Washington University School of Medicine in St. Louis where I am the Vice-Chairman of Clinical Affairs in Psychiatry and the Chief Psychologist at Barnes-Jewish Hospital. In my career I have served

in many capacities, occupying positions which before were held by physicians. I have been an active clinician seeing patients in medicine and surgery and an active researcher with grants presently in pain and organ donors. Recently I began a religious foundation grant to reduce violence and homicide. All of these experiences have opened up unusual opportunities for a clinical psychologist. I was the Consultation Director for the AIDS Clinical Trials Unit at Washington University, the Director of the Missouri AIDS Training Center, the Director of the Missouri Kidney Program and a consultant to the New York Department of Health post-911 on disaster mental health training. I served on the revision committee of the Medical College Admission Test (MCAT) which resulted in more emphasis given to psychology.

These experiences provided a perspective which will be helpful in discussion of integrated care, relations with medicine, health care and the place of psychology in biomedical research. I believe that I can be a bridge "representative" who can span research, practice, professional and pressing social issues.

Lastly, I will be a strong advocate for Clinical Psychology and the Society upholding the traditional emphases of practice, research and scholarship. I would like to be a strong voice about this within the APA.

Kenneth J. Sher, Ph.D.



Kenneth J. Sher received his Ph.D. in psychology (clinical) from Indiana University in 1980 and completed his internship in clinical psychology from Brown University in 1981. He's been a faculty member in the clinical psychology training program at the University of Missouri since then and currently holds the title of Curators' Distinguished Professor of Psychological Sciences. He has a long history of service to professional societies including serving on

the Board of Scientific Affairs, the Policy and Planning Board, and the Commission on Accreditation of APA as well as providing professional service to APA as Associate Editor of Psychological Bulletin and the Journal of Abnormal Psychology. His research on the etiology and diagnosis of alcohol use disorders has been funded by the National Institute on Alcohol Abuse and Alcoholism throughout his career. His research and scholarly contributions have been recognized for its excellence and impact by funding agencies (e.g., a MERIT award from NIH), professional societies (i.e., distinguished research awards from APA's Division 50 and the Research Society on Alcoholism), and the University of Missouri Campus and system. He currently directs an NIH-funded predoctoral and postdoctoral training program for alcohol research and a summer research program for undergraduates from across the United States.

Candidate Statement

My name is Ken Sher and I am finishing my first term as one of your Division 12 representatives. I hope to be reelected for a second term in order to continue my work representing the Division on Council, addressing a number of key issues confronting the Association and the field of psychology. These include: (1) keeping APA relevant in an era of more specialized professional societies, (2) promoting the quality of training across the discipline, (3) increasing recognition of our discipline's critical roles in health care, research, education, and policy, and (4) Association governance reform. Despite the Association's challenges in recent years (e.g., the Hoffman Report findings, the APA-APAO class-action suit), APA remains the primary professional association representing the breadth of our discipline and holds a key place in promoting psychological research and practice and informing policy for the benefit of Society. It is especially important to insure our discipline remains strong and valued in the current political environment where funding for research and affordable health care is increasingly threatened and the role of scientific evidence in decision-making is increasingly questioned. I bring to my role as Council Representative considerable experience in Association governance (including membership on APA's Board of Scientific Affairs and Policy and Planning Board), scientific peer review (e.g., former Associate Editor of the Journal of Abnormal Psychology and Psychological Bulletin; membership on NIH and private foundation review committees), quality assurance (Commissioner on APA's Commission on Accreditation), and education from the undergraduate level to mentoring mid-career scientists.

Mark B. Sobell, Ph.D., Ph.D., ABPP



Mark B. Sobell, Ph.D., is a Professor at Nova Southeastern University (FL). He is nationally and internationally known for his research in the addictions field. He is a Fellow in American Psychological Association (APA) Divisions 1, 3, 12, 25, 28, 38, and 50, and is Board Certified in Behavioral and Cognitive Psychology, American Board of Professional Psychology. He

has given over 200 invited presentations/workshops, published over 270 articles and book chapters, and authored 9 books. He is a past editor of the Journal of Consulting and Clinical Psychology and serves on 8 peer-review journal editorial boards. He is a Council Representative for Division 12 to the APA.

Dr. Sobell is past president of the Society of Clinical Psychology. He is also on the APA Publications and Communications Board and currently is the Chair of that Board (7/16-6/17). For over four decades he has been the recipient of grants from several federal agencies. In recognition of his research accomplishments, he has received several awards including the Distinguished Scientific Contribution Award from Society of Clinical

Psychology, APA; the 2008 Charles C. Shepard Science Award (most outstanding peer-reviewed research paper on prevention and control published by Centers for Disease Control/ATSDR scientists 2007); Lifetime Achievement Award from Addictions Special Interest Group, Association for Behavioral and Cognitive and Therapies; Jellinek Memorial Award for outstanding contributions to knowledge in the field of alcohol studies; Distinguished Scientific Contributions to the Application of Psychology Award. American Psychological Associations (APA) Division 50; and Brady/Schuster Award for Outstanding Behavioral Science Research in Psychopharmacology and substance abuse, Division 28, APA.

Candidate Statement

I was President of the Society of Clinical Psychology (SCP, Division 12) in 2013, and I have been one of the Society's Council Representatives to APA since 2014. I am seeking re-election to the Council of Representatives. When I was President of the SCP I felt that our 8 sections were a great strength, but it

also was very challenging to govern such a diverse organization. After being elected to the Council of Representatives of APA, I found that leading the SCP was relatively simple compared to the APA where the Council of Representatives has more than 170 members reflecting all the divisions, and state and territorial associations including some from Canada. My point in mentioning this is that it takes some time, certainly more than a year, to understand how APA governance works and the nature of the numerous constituencies and issues. I would very much appreciate being re-elected to Council so I can continue to put this acquired knowledge to work in representing the Society of Clinical Psychology. Clinical psychology, especially, is changing in important ways, ranging from psychologists being part of integrated healthcare services to continuing concerns about how to define evidence-based practice. It is important that psychology have a major influence on how these and other serious matters evolve, and Council is an important forum for policy discussions and formulation. I believe that having been involved in SCP governance for several years provides me an informed perspective on APA matters important to our division.

Refreshing the Look for the *Society of Clinical Psychology*

Bradley E. Karlin, PhD, ABPP, Past President

As part of efforts to promote the internal and external identity and impact of the Society of Clinical Psychology (SCP), we are pleased to announce the release of a new SCP logo. The new logo to the right, along with other activities, are designed to refresh the SCP look and image and corresponds with a number of activities and programs for increasing membership and engagement, particularly students and early and mid-career psychologists. If you look closely, you will see a dark link in the center of the logo, which is designed to artistically represent the bridge from research to practice, a core component of SCP's mission. The development of the new logo, the first in many years, is part of a larger strategic communications and branding initiative that will be reflected in increased social media and online presence, new organizational and program brochures and other communications materials, and targeted outreach. Keep an eye out for the rollout of the new logo as we begin to announce SCP events for the APA Convention!

SOCIETY OF
CLINICAL PSYCHOLOGY



DIVISION 12
American Psychological Association

BECOME A DIVISION 12 MENTOR

Section 10 (Graduate Students and Early Career Psychologists) has developed a Clinical Psychology Mentorship Program. This program assists doctoral student members by pairing them with full members of the Society.

We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit www.div12.org/mentorship to become a mentor today.

THE CLINICAL PSYCHOLOGIST



A publication of the Society of Clinical Psychology (Division 12, APA)

The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Div 12 of the APA). Its purpose is to communicate timely and thought provoking information in the domain of clinical psychology to the Division members. Also included is material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. In addition, The Clinical Psychologist includes archival material and official notices from the Divisions and its Sections to the members.

Inquiries and submissions should be sent
to the Editor, Jonathan S. Comer, Ph.D. at: jocomer@fiu.edu

To subscribe, contact Tara Craighead
404.254.5062 | division12apa@gmail.com

INSTRUCTIONS FOR ADVERTISING IN THE CLINICAL PSYCHOLOGIST

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

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

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

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

Previously aired Society of Clinical Psychology webinars available-NOW WITH THE OPTION OF CE CREDIT!

You can now view all of our archived webinars in our recorded webinars section at div12.org/webinar-recordings! CE credit is also available for recorded webinars at a reduced rate.

Recording only: FREE for SCP (Division 12) members, \$10 for non-members

Recording with CE credit*: \$10 for SCP members, \$40 for non-members

*To receive CE credit, email Central Office at division12apa@gmail.com with the webinar you viewed and request for CE credit. You will receive a link to take the CE quiz. Results are emailed to Central Office and a CE Certificate will be emailed to you within the week.

Previously aired webinars (1 CE credit each):

- ***David Tolin:** Treatment of Obsessive-Compulsive and Related Disorders
- ***Todd Smitherman & Don Penzien:** Behavioral Interventions for Recurrent Headache Disorders
- ***Eric Youngstrom: Working Smarter, Not Harder:** Evidence-based Assessment in Clinical Practice
- ***Jacqueline Gollan:** Using Behavioral Activation Treatment to Treat Perinatal Mood Disorders
- ***Bunmi Olatunji:** Treatment of Disgust in Anxiety and Related Disorders
- ***Antonette Zeiss:** Geriatric Primary Care: Psychologists' Roles on the Interprofessional Team
- ***John Pachankis:** Uncovering Clinical Principles and Techniques to Address Minority Stress, Mental Health, and Related Health Risks among Gay and Bisexual Men
- ***Jennifer Moye:** Promoting Psychological Health after Cancer Treatment
- ***Allan Harkness:** Evaluation of Emotion, Personality, and Internal Models of External Reality: Implications for Psychological Intervention
- ***Keith Dobson and Michael Spilka:** Promoting the Internationalization of Evidence-Based Practice: Benchmarking as a Strategy to Evaluate Culturally Transported Psychological Treatments
- ***David Tolin:** Empirically Supported Treatment: Recommendations for a New Model
- ***Steve Hollon:** Is Cognitive Therapy Enduring or Are Antidepressant Medications Iatrogenic?
- ***Kenneth Sher & Rachel Winograd:** Binge Drinking and Alcohol Misuse among College Students and Young Adults
- ***David Corey:** Ethics of Consulting with Government Agencies
- ***Robyn Walser:** Mindfulness and Mental Health: Creating Awareness, Flexibility and Freedom
- ***Robert Reiser:** Bipolar Disorder – Advances in Evidence-based Practice

Earn 5 CE credits for reading volumes of the *Advances in Psychotherapy* book series

New

“Clinical and counseling psychologists appreciate the importance of ensuring that the treatments they provide are grounded in empirical research, but they often have trouble keeping up with the latest research findings. *Advances in Psychotherapy – Evidence-Based Practice* is a book series developed by The Society of Clinical Psychology (APA Division 12) to address this problem.

The Society is delighted to be working with the National Register and Hogrefe to make books in the series available to National Register members at a substantial discount along with the potential for earning continuing education credit. Reading these books will inform your practice and expand your skills.”

Danny Wedding, PhD, MPH, APT series editor

Morgan Sammons, PhD, National Register Executive Officer

How does it work?

Psychologists and other healthcare providers may earn continuing education credits for reading volumes from the *Advances in Psychotherapy – Evidence-Based Practice* book series and taking a multiple choice exam.

This continuing education program is a partnership of Hogrefe Publishing and the National Register of Health Service Psychologists. National Register members can take these exams free of charge, nonmembers can purchase each exam for \$25 or access to the entire series of exams for \$200. National Register credentialed psychologists receive a 15% discount on volumes of the book series. The National Register of Health Service Psychologists is approved by the American Psychological Association to sponsor continuing education for psychologists. The National Register maintains responsibility for this program and its content.

Visit <https://us.hogrefe.com/cenatreg> to find out more!

The book series

Developed and edited with the support of the Society of Clinical Psychology (APA Division 12)

Series editor:

Danny Wedding

Associate editors:

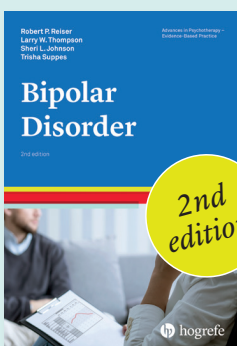
Larry Beutler
Kenneth E. Freedland
Linda Carter Sobell
David A. Wolfe

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

The first volume in a new strand dealing with methods and approaches rather than specific disorders is now starting with the release of *Mindfulness*.

 hogrefe

New titles



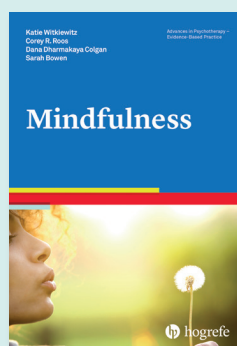
Robert P. Reiser /
Larry W. Thompson /
Sheri L. Johnson / Trisha Suppes
Bipolar Disorder

Vol. 1, 2nd ed. 2017. viii + 120 pp.
ISBN 978-0-88937-410-2
Also available as eBook

This extensively updated new edition integrates empirical research from the last 10 years to provide clear and up-to-date guidance on the assessment and effective treatment of bipolar disorder.

The expert authors describe the main features of bipolar disorder based on DSM-5 and ICD-10 criteria, current theories and models, along with decision trees for evaluating the best treatment options. They outline a systematic, integrated, and empirically supported treatment approach involving structured, directive therapy that is collaborative and client-centered.

This new edition includes completely updated medication management guidelines in the form of very concise and user friendly tables.

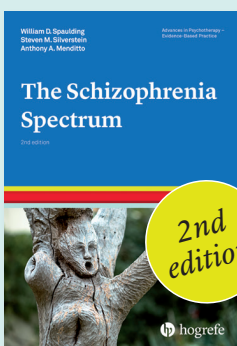


Katie Witkiewitz /
Corey R. Roos /
Dana Dharmakaya Colgan /
Sarah Bowen
Mindfulness

Vol. 37, 2017. viii + 80 pp.
ISBN 978-0-88937-414-0
Also available as eBook

This clear and concise book provides practical, evidence-based guidance on the use of mindfulness in treatment: its mechanism of action, the disorders for which there is empirical evidence of efficacy, mindfulness practices and techniques, and how to integrate them into clinical practice.

Leading experts describe the concepts and roots of mindfulness, and examine the science that has led to this extraordinarily rich and ancient practice becoming a foundation to many contemporary, evidenced-based approaches in psychotherapy. The efficacy of mindfulness-based interventions in conditions as diverse as borderline personality disorder, post-traumatic stress disorder, depression, alcohol and substance use, attention-deficit hyperactivity disorder, chronic stress, eating disorders, and other medical conditions is also described.

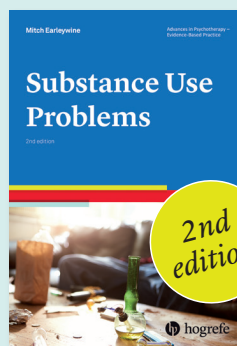


William D. Spaulding /
Steven M. Silverstein /
Anthony A. Menditto
The Schizophrenia Spectrum

Vol. 5, 2nd ed. 2017. viii + 94 pp.
ISBN 978-0-88937-504-8
Also available as eBook

The new edition of this highly acclaimed volume provides a fully updated and comprehensive account of the psychopathology, clinical assessment, and treatment of schizophrenia spectrum disorders.

The compact and easy-to-read text provides both experienced practitioners and students with an evidence-based guide incorporating the major developments of the last decade: the new diagnostic criteria of the DSM-5, introducing the schizophrenia spectrum and neurodevelopmental disorders, the further evolution of recovery as central to treatment and rehabilitation, advances in understanding the psychopathology of schizophrenia, and the proliferation of psychological and psychosocial modalities for treatment and rehabilitation.



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.

All volumes at a glance

1. Volumes on a Disorder or Group of Disorders

Children & Adolescents

- **Childhood Maltreatment** CE
by Christine Wekerle / Alec L. Miller / David A. Wolfe / Carrie B. Spindel (2006)
- **Chronic Illness in Children and Adolescents**
by Ronald T. Brown / Brian P. Daly / Annette U. Rickel (2007)
- **Elimination Disorders in Children and Adolescents**
by Edward R. Christophersen / Patrick C. Friman (2010)
- **Growing Up with Domestic Violence**
by Peter Jaffe / David A. Wolfe / Marcie Campbell (2011)
- **Phobic and Anxiety Disorders in Children and Adolescents**
by Aimee E. Grills-Tauchel / Thomas H. Ollendick (2012)
- **Language Disorders in Children and Adolescents**
by Joseph H. Beitchman / E. B. Brownlie (2013)
- **ADHD in Children and Adolescents** CE
by Brian P. Daly / Aimee K. Hildenbrand / Ronald T. Brown (2016)

Anxiety and Related Disorders

- **Social Anxiety Disorder** CE
by Martin M. Antony / Karen Rowa (2008)
- **Hypochondriasis and Health Anxiety**
by Jonathan S. Abramowitz / Autumn E. Braddock (2011)
- **Generalized Anxiety Disorder** CE
by Craig D. Marker / Alison Aylward (2011)
- **Obsessive-Compulsive Disorder in Adults** CE
by Jonathan S. Abramowitz / Ryan J. Jacoby (2014)

Behavioral Medicine and Related Areas

- **Heart Disease**
by Judith A. Skala / Kenneth E. Freedland / Robert M. Carney (2005)
- **Treating Victims of Mass Disaster and Terrorism** CE
by Jennifer Housley / Larry E. Beutler (2006)
- **Chronic Pain** CE
by Beverly J. Field / Robert A. Swann (2008)
- **Public Health Tools for Practicing Psychologists**
by Jalie A. Tucker / Diane M. Grimley (2011)
- **Headache**
by Todd A. Smitherman / Donald B. Penzien / Jeanetta C. Rains / Robert A. Nicholson / Timothy T. Houle (2014)
- **Multiple Sclerosis** CE
by Pearl B. Werfel / Ron E. Franco Durán / Linda J. Trettin (2016)

Addictions and Related Disorders

- **Problem and Pathological Gambling**
by James P. Whelan / Timothy A. Steenbergh / Andrew W. Meyers (2007)
- **Alcohol Use Disorders**
by Stephen A. Maisto / Gerard J. Connors / Ronda L. Dearing (2007)
- **Eating Disorders**
by Stephen W. Touyz / Janet Polivy / Philippa Hay (2008)
- **Nicotine and Tobacco Dependence**
by Alan L. Peterson / Mark W. Vander Weg / Carlos R. Jaén (2011)
- **Binge Drinking and Alcohol Misuse Among College Students and Young Adults** CE
by Rachel P. Winograd / Kenneth J. Sher (2015)
- **Women and Drinking: Preventing Alcohol-Exposed Pregnancies**
by Mary M. Velasquez / Karen Ingersoll / Mark B. Sobell / Linda Carter Sobell (2015)
- **Substance Use Problems, 2nd ed.** CE
by Mitch Earleywine (2016)

Sexual Disorders

- **Sexual Violence**
by William R. Holcomb (2010)
- **Sexual Dysfunction in Women** CE
by Marta Meana (2012)
- **Sexual Dysfunction in Men** CE
by David Rowland (2012)

Other Serious Mental Illnesses

- **Suicidal Behavior**
by Richard McKeon (2009)
- **Depression**
by Lynn P. Rehm (2010)
- **Nonsuicidal Self-Injury**
by E. David Klonsky / Jennifer J. Muehlenkamp / Stephen P. Lewis / Barrent Walsh (2011)
- **Autism Spectrum Disorder**
by Lisa Joseph / Latha V. Soorya / Audrey Thurm (2014) CE
- **ADHD in Adults**
by Brian P. Daly / Elizabeth Nicholls / Ronald T. Brown (2016)
- **Bipolar Disorder, 2nd ed.** CE
by Robert P. Reiser / Larry W. Thompson / Sheri L. Johnson / Trisha Suppes (2017)
- **The Schizophrenia Spectrum, 2nd ed.** CE
by William D. Spaulding / Steven M. Silverstein / Anthony A. Menditto (2017)

2. Volumes on Methods and Approaches

- **Mindfulness** CE
by Katie Witkiewitz / Corey R. Roos / Dana Dharmakaya Colgan / Sarah Bowen (2017)

CE CE credits available (more titles coming soon)

New
Strand

Forthcoming volumes

- **Panic Disorder and Agoraphobia**

by Simon A. Rego

- **Hoarding Disorder**

by Jedidiah Siev / Gregory S. Chasson

- **Childhood Obesity**

by Denise E. Wilfley / John Best /
Jodie Cahill / Dorothy J. van Buren

- **Dating Violence**

by Jeff R. Temple

- **Insomnia**

by Ana J. Fins / William K. Wohlgenuth

- **Body Dismorphic Disorder**

by Fugen Neziroglu / Sony Khemlani-Patel

- **Bullying and Peer Victimization**

by Amie E. Grills / Melissa K. Holt

- **Posttraumatic Stress Disorder**

by Terence M. Keane

- **Internet Addiction**

by Daria Kuss / Halley Pontes

About the editors



Danny Wedding, PhD, MPH, Distinguished Consulting Faculty Member, Saybrook University. After retiring from the University of Missouri, Danny taught for Alliant International University and the American University of the Caribbean. He has published 12 books, edits *PsycCRITIQUES*, and is a Past President of the Society of Clinical Psychology.



Linda Carter Sobell, PhD, ABPP, Professor, Center for Psychological Studies, Nova Southeastern University, Ft. Lauderdale, FL; Professor in the Center for Psychological Studies, Nova Southeastern University, FL; Internationally known for her clinical research in the addictions field, particularly brief motivational interventions



Larry E. Beutler, PhD, Professor, Palo Alto University / Pacific Graduate School of Psychology, Palo Alto, CA; Consulting Professor of Psychiatry, Stanford University, School of Medicine; Past President of the Society for Clinical Psychology, of the APA Division of Psychotherapy, and of the Society for Psychotherapy Research.



David A. Wolfe, PhD, RBC Chair in Children's Mental Health, Centre for Addiction and Mental Health, University of Toronto, ON; Professor of Psychiatry and Psychology, University of Toronto, ON; Fellow of the American Psychological Association and past President of Division 37 (Child, Youth, and Family Services).



Kenneth E. Freedland, PhD, Professor of Psychiatry and Clinical Health Psychology, Washington University School of Medicine, St. Louis, MO; Professor of Psychiatry and Clinical Health Psychology, Washington University School of Medicine, St. Louis.

Order and price information

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

Special prices for members of APA Division 12:

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

In order to obtain the membership discount you must first register at www.hogrefe.com and sign up for the discount.

Hogrefe Publishing
30 Amberwood Parkway
Ashland, OH 44805
Tel. 800 228 3749
Fax 419 281 6883
customerservice@hogrefe.com
www.hogrefe.com