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## PRESIDENT'S COLUMN



## Did You Prescribe Exercise This Week?

Michael W. Otto, Ph.D.

Let's be clear, exercise is a loaded topic for many people. Talking about exercise can evoke memories of successes or failures in athletics in grade-school and beyond: memories of being picked first or last for the kickball team, catching or dropping the fly ball in outfield, or being cheered at the track or running laps as a punishment for not paying attention in gym. Discussion of exercise may also evoke feelings of failure relative to attempts to control weight or shape during the adulthood years. However, the good news is that exercising for mood is a very different undertaking than exercising for fitness (see below), and is deserving of consideration regardless of an individual's history with exercise or athletics. And of course, clinicians routinely discuss loaded topics and help patients create a fresh frame, so that new opportunities are not overly burdened by past experiences.

I believe it is time for exercise prescriptions to become a regular part of clinical practice. Quite simply, exercise represents an undervalued but surprisingly strong treatment for both major depression and anxiety disorders. Let me burden you with some of the evidence. Meta-analysis of 23 randomized-controlled depression trials showed that exercise offered benefits in the range of large effect sizes over non-active control, and a moderate effect relative to treatment as usual (Kvam et al., 2016). A smaller but still strong literature shows efficacy for exercise for anxiety disorders, with benefits rivaling those for antidepressant medications (see Asmundson et al. 2013). There is also a wealth of evidence that exercise acts as a cognitive enhancer, improving attention, memory, and some executive functions (McMorris & Hale, 2012; Smith et al., 2010), presumably as a result of effects on brain-derived neurotrophic factor (BDNF, Szuhany et al., 2015). Exercise additionally contributes to improved sleep (Kredlow et al., 2015).

In recent years, there has also been an expansion of the precision application of exercise. For example, based on the rapid effects of exercise on anxiety sensitivity (fears of anxiety-related sensations) as well as mood, Smits and colleagues (2016) showed that exercise aids smoking cessation for patients with elevated anxiety sensitivity scores. Likewise, based on the effects of exercise on memory enhancement and anxiety reduction, Powers

and colleagues (2015) used exercise to enhance exposure therapy in the treatment of posttraumatic stress disorder. Finally, a number of research groups have applied cognitive-enhancing effects of exercise to ameliorate the cognitive deficits associated with schizophrenia (Firth et al., 2017).

### **There is No Wrong Time to Prescribe Exercise**

A recent article in JAMA Psychiatry recommended exercise as an initial intervention in a stepped approach to the treatment of anxiety disorders, prior to referral to cognitive behavior therapy (CBT) or pharmacotherapy (Stein & Craske, 2017). Exercise has also been shown to be an efficacious adjunctive treatment to either medication or cognitive-behavior therapy (e.g., Merom et al., 2008; Mura et al., 2014), and exercise interventions have been shown to be an efficacious alternative for treatment-resistant depression (e.g., Mota-Pereira et al., 2011). In addition to outpatient applications of exercise, we have also shown that patients in a partial hospital setting are responsive to exercise for mood interventions, particularly if they have a history of previous engagement in exercise (Hearon et al., 2016). In other words, psychosocial therapists are in an excellent position to offer exercise interventions at the initiation of treatment, as an adjunct to ongoing psychotherapy, as a strategy for enhancing cognition or resilience for other interventions, prior to referring for medication, or as an alternative treatment for an individual who has failed to respond to previous interventions.

### **Getting Used to the Idea of Prescribing Exercise**

Exercise interventions fit more readily with therapies that use weekly assignments as part of treatment. Hence, exercise interventions are an obvious fit with behavioral activation treatments for depression as well as exposure-based treatment for anxiety disorders, and fit fairly well with any treatment that relies on active goal setting and monitoring, including value-based, eclectic, or cognitive-behavioral interventions. For more dynamically-oriented treatments, greater consideration will have to be given for how to frame the benefits of and strategies for regular exercise in relation to the overall process of treatment. Admittedly this may be a challenge, but the broad spectrum of efficacy for exercise makes it a tempting tool for a wide range of clinical applications.

### **Considerations for Exercise-for-Mood Prescriptions**

Based on the broader literature and treatment

resources (e.g., Hearon et al., 2016; Otto & Smits, 2011; Smits & Otto, 2009; for Division 12 CE on this topic by Dr. Smits see <https://www.div12.org/webinar-recordings-non-members/>), a number of principles for exercise-for-mood prescriptions include:

- Exercise for mood is different. Exercise for weight control, shape, or health is a difficult endeavor, requiring months of regular workouts to achieve initial goals. Unlike the delayed contingencies that define exercise-for-health/shape goals, exercise for mood effects occur much earlier. Indeed, many mood effects from exercise are felt within 30 minutes of workout completion.
- Target moderate intensity exercise. High intensity exercise (including interval training) can be a great way to build muscle and burn fat, but it is also a great way to hate exercise. Pleasure during exercise predicts the amount of future exercise, and pleasure takes a nosedive with higher-intensity workouts. Moderate intensity exercise is clearly enough to confer mood benefits (e.g., walking at a quick pace). If you can talk comfortably while you are exercising, you are at a moderate or lower level. The most common exercise prescriptions for mood target 4 episodes of 40-minute exercise per week.
- Target fun. A crucial part of the exercise prescription is finding an exercise that sounds fun. If your patient chooses walking, then the discussion should be about where, when, and with whom to walk for the best views and the best company. If your patient was a competitive swimmer in college, then picking any exercise but for swimming may be the best way to provide a fresh and enjoyable exercise experience (and one that is free from perfectionistic expectations or intensive performance demands based on a long history of training).
- Starting Off. Initiation of exercise is always a stepwise process targeted to the level of fitness of the individual. Although regular exercise routinely reduces cardiac risk, the nature and intensity of exercise needs to be matched to the current level of risk. Exercise approval by the patient's primary care physician helps facilitate this process. Contraindications to exercise include when it is used as an exclusive emotional regulations strategy, or as a calorie neutralization strategy in eating disorders.
- Remove barriers and cue exercise. Few people complete a planned exercise if they have trouble finding their left sneaker. Exercising before going home (where the couch is waiting), keeping exercise gear in a prominent location, putting a "do this for your mood" card in your shoe, scheduling exercise with a friend,

posting exercise goals on the fridge – these are all good strategies for establishing an exercise program.

- Monitor benefits. Low moods can demotivate adaptive actions, and so the application of exercise for mood takes some training. Mood disruption becomes the reason to exercise rather than a reason to avoid exercise. I like the adage, “skipping a workout when your mood is low is like specifically not taking an aspirin when you have a headache.”
- Combine motivations. Music, audiobooks, time with a friend – these are all excellent motivators to combine with exercise to make the experience more pleasant.
- Consider attention. “My left knee hurts” is a poor attentional focus for a walk or run. Learning to direct attention to the most pleasant aspects of an exercise experience is an emergent and valuable skill. For therapists who provide mindfulness training, mindful exercise is an excellent therapeutic goal.
- Attend to Self-Talk. Exercise can provide great training to avoid perfectionistic expectations about performance, and even a chance to become good at being bad at something (a pre-requisite to enjoy anything new in adulthood). Also, exercise provides a great way to practice saying “good job” to oneself after completing a planned effort.

### Closing Comments

I have gotten all the way to the conclusion of this article focusing on the mental health benefits of exercise—improved mood and wellbeing, reducing anxiety, greater anxiety-related resilience, enhanced cognition, and improved sleep—while delaying mention of the obvious: regular exercise also has powerful effects on physical health and longevity. By helping people focus on the contingent and timely mood benefits of exercise, rather than the important but delayed physical health outcomes, psychologist may have a powerful role in bringing more people to this mood-enhancing and life-giving intervention. Have you prescribed exercise this week? 🏃‍♂️

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## Upcoming SCP CE webinars!

### **Dr. Brad Karlin: Dissemination and Implementation of Evidence-Based Psychological Treatments in Health Care Systems: Bridging the Great Divide**

**Thursday, July 27, 2017, 12 PM – 1 PM ET**

**Overview:** This webinar will be based on seminal research and practice in the area of dissemination and implementation and the presenter's significant experience and scholarship associated with leading broad dissemination and implementation of evidence-based psychological treatments in large public and private health care systems, including the largest dissemination and implementation of evidence-based psychotherapies in the nation. Objectives: (1) Increase understanding of strategic models and principles for promoting the dissemination and implementation of psychological treatments; (2) Promote awareness of barriers and facilitators to the implementation and sustainability of evidence-based psychological treatments; (3) Increase awareness of innovative approaches and tools for promoting the uptake and delivery of evidence-based psychological treatments; (4) Target audience: Beginner, Intermediate, and Advanced: The webinar will target psychologists and other mental health care professionals with limited formal knowledge of the field of applied or scientific dissemination and implementation, though content will also be appropriate for those with more intermediate and advanced level knowledge.

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

**Thursday, October 26, 2017, 12 PM – 1 PM ET**

**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.

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

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# **Society of Clinical Psychology/ Division 12 Election Results**

We are very pleased to announce the results of the Society of Clinical Psychology/Division 12 Elections. We had an impressive slate of candidates this year, including many well established leaders of the field.



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Jonathan S. Comer, Ph.D.

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Jonathan Weinand, Ph.D.

## **Council Representatives**

Kenneth J. Sher , Ph.D.

Mark B. Sobell, Ph.D., ABPP

Congratulations to each of the elected candidates, and a sincere thank you to all who ran. It is only with strong candidates that we are able to ensure strong leadership and a prosperous future for the organization. We hope a number of others will consider running for leadership positions of the Society in the future.

Jonathan S. Comer, Ph.D. - Editor

## Some Current and Future Directions in Mindfulness- and Acceptance-Based Behavioral Therapies for Anxiety and Related Challenges: Identifying Common Factors and Addressing Specific Contexts

**Lizabeth Roemer, Ph.D.**


**Jennifer H. Martinez, M.A.**

**Elizabeth H. Eustis, M.A.**

*University of Massachusetts Boston*

**Susan M. Orsillo, Ph.D.**

*Suffolk University*

 We (LR & SMO) have spent the last sixteen years developing, refining, delivering, examining, supervising, providing training in, and writing about acceptance-based behavioral therapies (ABBTs), with a primary focus on a treatment we developed to address generalized anxiety (GAD) and comorbid disorders (Orsillo & Roemer, 2011; 2016; Roemer & Orsillo, 2009 [new edition in preparation]). Here we will focus on some of the most recent findings regarding common mechanisms of change and their clinical implications, and then explore two areas of current/future directions aimed at meeting mental health care needs: adaptations of ABBTs for use in different contexts aimed at increasing access to care and adaptations to address psychological symptoms stemming from systemic discrimination.

We use the term (mindfulness and) acceptance-based behavioral therapies to refer to a broad class of treatments underneath the cognitive behavioral therapy (CBT) umbrella that aim to enhance clients' willingness to acknowledge and allow the presence of internal experiences (e.g., thoughts, emotions, memories, physical sensations) based on the model that experiential avoidance and behavioral constriction, driven by habitual critical entanglement and fusion with internal experiences, maintain psychological distress and diminished quality of life. Our ABBT for GAD draws from CBT for GAD (e.g., Borkovec, Alcaine, & Behar, 2004), acceptance and commitment therapy (ACT: Hayes, Strosahl, & Wilson, 2012), mindfulness-based cognitive therapy (MBCT; Segal, Teasdale, & Williams,

2013), and dialectical behavior therapy (DBT; Linehan, 1993).

Studies of ABBT for GAD have revealed significant large effects on worry, anxiety, depression, quality of life, and number of comorbid disorders that are not seen in a waitlist condition and are comparable to an empirically-based CBT for GAD (applied relaxation [AR]; see Roemer & Orsillo, 2014, for a review). Arch and colleagues (2012a) similarly found comparable efficacy for ACT and CBT in a mixed anxiety disorder group. Identifying mechanisms of change, particularly those that may be common across evidence-based therapies, may help us develop more effective and efficient interventions and adapt them for different contexts and targets (Kazdin, 2007). We describe some initial findings that we think have important implications for clinical practice, although considerably more research is needed.



**Lizabeth Roemer**

### Potential common mechanisms of change

When we designed our randomized controlled trial (RCT) comparing ABBT to AR, we predicted that ABBT would be more efficacious because it directly targets experiential avoidance (attempts to control or avoid distressing internal experiences despite behavioral consequences; Hayes et al., 1996) and a critical, fused relationship with internal experiences. We were careful to design an AR condition that delivered the full intervention (early cue detection, relaxation training leading to cue recall, and applied relaxation to early cues; Öst, 2007; Bernstein, Borkovec, & Hazlett-Stevens, 2000), was matched to ABBT in length of sessions (AR was extended to 16 sessions), and delivered competently. Although our therapists did not directly suggest that clients in AR consider thoughts, emotions, or sensations to simply be responses that arise and abate or accept them, they also did not encourage suppression or experiential control. As described in Bernstein and colleagues (2002), relaxation was presented as a new habit to apply flexibly in response to early cues.

Partway through our RCT we began to wonder about common mechanisms of change – therapists came to supervision concerned that their clients in AR spontaneously “discovered”, through monitoring and

observation, that thoughts and sensations weren't necessarily dangerous and didn't need to be controlled or avoided. Adherence ratings confirmed that our therapists didn't violate protocol, yet the techniques of AR led some clients to independently make observations that were similar to those often made by clients in ABBT (see Hayes-Skelton et al., 2012, for a case series from the trial), without therapists leading them in that direction.

Statistical analyses confirmed these anecdotal and case study observations. We found that changes in reports of decentering – the ability to observe experiences as they are, as mental events that come and go instead of as inherently self-defining truths (e.g., Fresco, Segal, Buis, & Kennedy, 2007) – predicted subsequent changes in reports of general anxiety symptoms in both treatment conditions (Hayes-Skelton et al., 2015). Arch, Wolitzky-Taylor, Eifert, & Craske (2012b) similarly found that change in cognitive defusion (another term used for decentering) mediated changes in worry, behavioral avoidance, and quality of life outcomes across both ACT and CBT in a mixed anxiety disorder sample.

Although decentering (or distancing from thoughts) has always been considered a core feature of cognitive restructuring (Beck, 1982), little attention has been paid to its relevance to other CBT techniques, such as AR. Yet in AR, clients are encouraged to view thoughts (and other components of the anxiety response) as cues of rising anxiety and to respond to all cues by practicing a relaxation response. In other words, clients in AR are encouraged to cultivate a new relationship to internal experiences that is less entangled and fused. If future studies replicate findings that decentering is a mechanism common to both ABBT and AR, this may have implications for clinical practice. As Hayes-Skelton, Roemer, Orsillo, and Borkovec (2013) suggest, therapists may want to use language that explicitly cultivates defusion when teaching AR – for instance “You noticed you had a thought that...” or “You noticed sensations in your muscles...” Relatedly, early cue detection and progressive muscle relaxation may be strategies that could be used in ABBT to provide experiential opportunities to observe responses in a way that promotes decentering.

Analyses from our trial also provide evidence that experiential acceptance may be a mechanism common to different forms of CBT. Clients in both AR and ABBT became less experientially avoidant (i.e., more experientially accepting) over the course of therapy (although the magnitude of the decrease in the ABBT condition was significantly greater; Eustis, Hayes-

Skelton, Roemer, & Orsillo, 2016). Across condition, changes in self-reported experiential avoidance significantly predicted improvement in both worry and quality of life, even after controlling for changes in decentering. At first glance, it may seem surprising that AR enhances acceptance because attempting to relax could be perceived as an effort to control or reduce anxiety. However, Hayes-Skelton and colleagues (2012) suggest that AR involves approaching anxiety – through imaginal exercises to identify early cues, self-monitoring of early cues, and continuing with the relaxation response even as worrisome thoughts and sensations arise, which could all help to promote acceptance.



**Jennifer H. Martinez**

Acceptance is also implicitly cultivated in another CBT strategy – exposure therapy (Arch & Craske, 2008) – which encourages clients to willingly experience anxiety while approaching threatening stimuli. Repeated exposure to a feared stimulus without the feared outcome is thought to promote new learning (i.e., inhibitory learning), such that a previously feared stimulus (e.g., dog) acquires different context-specific meanings (dangerous, safe). If acceptance is a common mechanism underlying a broad array of CBTs, strategies used to enhance acceptance in one approach could be integrated into others. For example, methods for improving treatment delivery that draw from inhibitory learning theory, like designing exposures that maximally violate expectancies about the dangerous outcomes likely when a feared stimulus is encountered (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014) may inform AR. The practice of applying relaxation when anxiety arises provides numerous opportunities for clients to use their newly developed coping skills and violate their expectancies about their inability to tolerate, cope with, or manage these contexts (Hayes-Skelton et al., 2013). Therapists highlighting this violation of expectancies more explicitly may help consolidate the new learning and improve outcomes.

One important methodological feature of our trial that should be considered when interpreting our findings is that therapists saw clients across conditions; consequently they were skilled in and had



experience providing both ABBT and AR. Therapists' experience with ABBT may have caused them to be more observing and accepting of their AR clients' anxious responses, a therapist factor that could at least partially explain our finding that decentering and acceptance were common mechanisms across the two treatments. More research is needed to examine this possibility; in the meantime, given findings that mindfulness of therapists is associated with positive outcomes (Grepmaier et al., 2007), it may be beneficial for therapists providing a range of CBT interventions to explore some mindfulness- and acceptance-based practices for themselves to promote these potentially therapeutically beneficial responses. Moreover, some studies have not found acceptance to be a common mechanism; Niles and colleagues (2014) found that early decreases in experiential avoidance predicted improvements in social anxiety for clients in an ACT, but not a CBT, condition. More research is needed to determine if experiential acceptance is a common or specific mechanism of change. It may depend on the type of CBT and/or the disorder being targeted, as our study differed from the Niles study on these features.

The finding of common mechanisms underlying interventions that, on the surface, appear to have contradictory goals highlights the importance of attending to the function, rather than form, of our interventions. Although it is possible that relaxation strategies could be delivered in a way that promotes experiential avoidance (e.g., as a potential method of controlling or managing anxiety), mindfulness strategies can also be used for this purpose. We have worked with clients who try to use meditation as a way to distract themselves from worries and achieve a state of calmness. Attending to the function, and not the form, of clinical strategies allows us to draw from a variety of techniques, which may be more or less acceptable to a particular client, to target the processes contributing to the development and maintenance of psychological problems (see Mennin, Ellard, Fresco, & Gross, 2013, for another discussion of common function across disparate techniques).

### **Acceptance-based behavioral approaches in novel contexts**

Despite advancements in the development of evidence-based treatments, mental health service use remains low, with most individuals meeting criteria for a psychological disorder not receiving any care in the prior year (Wang et al., 2005). Moreover, only one-third of those who receive services get adequate or evidence-based treatment (Wang et al., 2005). Consequently, we must find ways to provide evidence-based interventions

to people in more abbreviated, accessible ways. Innovative work is being done to address this gap in service delivery; we highlight a few examples of acceptance-based behavioral approaches here.

#### *Primary care*

Given that the majority of people receiving services for a psychological disorder are seen by a general medical provider (Wang et al., 2005), offering treatment in primary care is one way to increase access to evidence-based care. Acceptance-based behavioral approaches, specifically ACT, have been developed to help patients in primary care relate differently to a range of symptoms, engage in treatment, and engage more fully in their lives (cf., Robinson, Gould, & Strosahl, 2010). Glover and colleagues (2016) recently examined the impact of a four-session abbreviated group ACT group on the psychosocial functioning of veterans presenting in primary care. At post-treatment, veterans reported significantly better quality of life and fewer symptoms of depression, and a trend emerged suggesting a potential reduction in anxiety. Fuchs and colleagues (2016) designed an acceptance- and mindfulness- based group to be feasible in the context of integrated primary care; results indicated that participants experienced a significant decrease in reports of depressive and anxious symptoms.

#### *University settings*

College is a critical time during which individuals experience transition and stress (e.g., Sieben, 2011; Zivin, Eisenberg, Gollust, & Golberstein, 2009). Often, universities don't have the resources to meet the mental health needs of students, and barriers such as mental health stigma limit treatment seeking (e.g., Corrigan & Matthews, 2003). Health promotion efforts in this context may effectively reach individuals just developing habits of anxiety and may also provide alternatives for individuals with clinical levels of anxiety who are not receiving treatment.

Several studies have demonstrated that one or two-session acceptance-based workshops provide some benefit to students (e.g., Brown and colleagues, 2011); here we focus on those conducted by our (SO and LR) research teams. Danitz and colleagues (Danitz &



**Elizabeth H. Eustis**

Orsillo, 2014; Danitz, Suvak, & Orsillo, 2016) developed the Mindful Way through the Semester (MWTS), a one-session 90-minute ABBT workshop with three follow-up “tips” sent via email or text over the course of the semester to remind students to practice their skills. Compared to those in a wait-list condition, students who volunteered to participate in the MWTS reported significantly lower depression and higher acceptance at three-month follow-up (Danitz & Orsillo, 2014), although a subsequent study investigating the impact of the workshop embedded in a first year seminar course found that, among those who received the MWTS, only students with higher levels of depression at baseline demonstrated a significant decrease in depressive symptoms at follow-up. Increases in acceptance over the course of the semester were associated with reductions in depression in both studies (Danitz & Orsillo, 2014; Danitz et al., 2016). A similar 90-minute stress management workshop that included psychoeducation about the nature of anxiety was associated with significant decreases in social and general anxiety that were maintained at the 4-week follow-up assessment among a racially, ethnically, and economically diverse sample of undergraduate students (Eustis et al., 2017).

Taken together, these studies suggest that participation in even a brief intervention may help university students. The workshop format may be destigmatizing and allow students to learn that others struggle with stress and anxiety, which may help them to cultivate self-compassion and acceptance of their responses. Further, the availability of online mindfulness resources makes it easier for students to choose to continue to practice and build skills after a workshop, which may make the impact of the workshop more long-lasting. We (LR, EHE, JM), along with others, started offering this workshop, as well as adapted versions of it, on our campus in collaboration with various stakeholders. We incorporate cultural and systemic considerations into these workshops (described more below). We have been struck by how positively students rate the helpfulness of these sessions, and plan to more systematically examine the impact of these offerings when they are embedded in existing structures.

#### *Technology-based approaches on campuses*

Although scaling back the length of interventions and bringing them into contexts where students already are (e.g., classes or clubs) remove some barriers, it may still be challenging for students balancing multiple responsibilities, in addition to their coursework, to attend scheduled sessions. Further, some students may be wary of attending in-person workshops due to mental

health stigma. Web-based interventions (accessed via computer and/or mobile phone) have been proposed as one way to address these barriers in the broader context of mental health services delivery (e.g., Dimeff, Paves, Skutch, & Woodcock, 2011a; Muñoz, 2010).

Recently, some studies have begun to investigate the acceptability, effectiveness, and efficacy of web-based mindfulness- and acceptance-based (MAAB) approaches to addressing anxiety. Randomized controlled trials comparing MAAB web-based programs, with or without email support from a therapist or administrator, ranging from 4-8 sessions, to waitlist or open online support groups, have revealed significant effects on anxiety, depressive symptoms, and related outcomes (Boettcher et al., 2014; Dahlin et al., 2016; Levin et al., 2017). An online version of the MWTS without support did not produce significant reductions in depression among participants compared to those on a waiting list, although engagement in mindfulness and values practice was associated with decreases in depression (Sagon, Danitz, Suvak, & Orsillo, 2017). Interestingly, participants in this study were more symptomatic than those in previous studies (Danitz & Orsillo, 2014; Danitz et al., 2016), suggesting that online workshops may attract students at higher risk. These findings suggest that a one-session workshop delivered online without clinician support is likely not powerful enough to produce enduring reductions in depression.

A recent randomized controlled trial compared a (brief) 3-session therapist-supported online version of the ABBT health promotion workshop we developed for the racially, ethnically, and economically diverse students on our campus (Eustis et al., 2017) to a waitlist condition. Preliminary findings (Eustis, Hayes-Skelton, Orsillo, & Roemer, in preparation) indicate significant effects on reports of general anxiety, depressive symptoms and quality of life, as well as targeted mechanisms of change of decentering and experiential acceptance (and changes in these mechanisms were significantly associated with changes in outcomes). These findings suggest that a brief online program, which included written practice assignments (self-monitoring, mindfulness, valued action), and clinician feedback and support, to facilitate skill development and generalization, can have a meaningful impact on a diverse sample of students facing numerous stressors even over the course of the semester.

When developing and testing web-based approaches for college students (and other populations) with the aim to increase access to flexible evidence-based care, it is critical that access to technology is considered.



**Susan M. Orsillo**

We have delivered our web-based program via software that all students on our campus have free access to, to ensure lack of technology (e.g., personal laptop/internet access, smartphone) was not a barrier to participation (i.e., program could be completed on school computers if needed). These considerations are also important in community and other

contexts (for an example see: Aguilera & Muñoz, 2011).

### **Promoting adaptive, empowering responding to systemic factors**

Concurrent with these lines of research, we have been working to better address cultural and systemic factors within the context of ABBT delivery. As with all therapies, cultural considerations need to be incorporated in all aspects of delivery (see Hays, 2008; Sue & Sue, 2015, for extensive discussions of these considerations), including consideration of the role of systemic inequities in our clients' lives. Observations by our study therapists and information from a small qualitative study we conducted led us to identify ways of improving cultural responsiveness when delivering ABBTs to individuals who present with a range of marginalized identities (e.g., Fuchs et al., 2013; Fuchs et al., 2016; Sobczak & West, 2013)<sup>1</sup>. Extensively and explicitly validating the reality of clients' pain and the real external barriers that may limit their ability to do things that matter to them is essential. Similarly, acknowledging the ways in which intentional avoidance and distraction in response to chronic injustice and stressors can enhance physical safety and can be functional, particularly if the response is not habitual or generalized, is validating and contributes to alliance-building. Therapists should explore concerns that their clients may have about mindfulness, particularly that it is not consistent with a client's religious or nonreligious cultural beliefs; exploring these, and considering methods of cultivating the skills of mindfulness that are congruent with cultural beliefs and practices is an important part of establishing a shared conceptualization and treatment plan (see also, Woods-Giscombe & Gaylord, 2014). Relatedly, drawing explicit connections between clinical strategies and the client's concerns is

essential for promoting client engagement; clients may react negatively to mindfulness (or other) exercises if the practices are seen as unrelated to their presenting problems (Fuchs et al., 2013; Sobczak & West, 2013). Finally, the values clarification process needs to be responsive to the client's personal and cultural beliefs and preferences. For instance, therapists need to honor the beliefs of clients who hold collectivist views and therefore choose to enact values held by their family, rather than imposing a more individualistic orientation on clients. Additionally, clinicians should be sensitive to the possibility that values clarification and valued actions may result in family conflicts due to intergenerational differences in values, and help their clients to navigate these conflicts in values-congruent ways, as well as help clients reconcile internal conflicts between collectivistic and individualistic values.

Although some participants in our qualitative study appreciated the flexibility of ABBT and felt it was responsive to their individual needs, some struggled to find time to engage in out of session practices (Fuchs et al., 2013; similar concerns emerged in Spears et al., 2017). In our trials, we found that the frequency of informal mindfulness practice (i.e., bringing the skills of mindfulness to one's engagement in daily activities) and not frequency of formal practice (i.e., set aside time for specific mindfulness exercises), was associated with maintenance of gains following therapy (Morgan et al., 2014). Thus, although we always work with clients to try to find some time in their challenging, busy lives for formal practices that can help with skill development, we have seen some clients benefit from consistently bringing mindfulness to daily activities like feeding their baby or waiting for the bus. Further, clients reported being more willing to engage in informal practices if they tie mindfulness activities to cultural and communal practices or images, such as religious practices, spiritual hymns, "shelling peas", or imagining one's grandmother on a rocking chair (Woods-Giscombe & Gaylord, 2014). Attending to the function of the practice (i.e., the skills we want them to learn and apply) can help with adapting between session exercises to better fit with the realities of client's lives.

Research examining how best to address the psychological impact of discrimination/marginalization/hate crimes on clients' lives is needed to inform therapists working with clients with a range of marginalized identities, particularly given the current socio-political environment in the U.S. and other countries (e.g., Otto, 2017). Findings on the most effective methods of buffering the effects of discrete personal and interpersonal stressors may not be



generalizable to individuals coping with racism and discrimination given that these stressors occur at more complex, systemic levels and are often discounted, denied, or ignored (e.g., Harrell, 2000). For example, in one correlational study, general emotion regulation strategies typically considered adaptive were actually associated with poorer psychological functioning in the context of systemic discrimination (i.e., oppression; Perez & Soto, 2011).

Preliminary research suggests that acceptance-based behavioral strategies may buffer the impact of racism on psychosocial functioning. Correlational research indicates that dispositional mindfulness is associated with a reduced or eliminated relation between experiences of discrimination and symptoms of anxiety and depression (e.g., Brown-Iannuzzi, Adair, Payne, Richman, & Frederickson, 2014; Graham, West, & Roemer, 2013; Lyons, 2016). We (JM, EHE, LR) recently found that experiential avoidance moderated the relations between reports of racial discrimination and self-reported symptoms of depression and anxiety among people of color, indicating that both frequent and rigid use of experiential avoidance may exacerbate these psychological costs of racist experiences (Martinez et al., in preparation). Another correlational study revealed that reports of living consistently with values moderated the association between reports of discrimination and symptoms of depression and anxiety among a sample of Black Americans (Graham, West, & Roemer, 2015), and an experimental study found that a brief values clarification exercise reduced reports of stress in response to a racist incident in a small sample of Black Americans (West, Graham, & Roemer, 2013). Several pieces written for a general audience describe how flexible, intentional use of mindfulness skills and values clarification and action may be beneficial in response to experiences of racism and discrimination (Graham-LoPresti, Abdullah, & Calloway, 2016; Roemer, Suyemoto, Rollins, & Abdullah, 2017; Suyemoto, Roemer, Abdullah, & Rollins, 2017). Research that examines the temporal unfolding of the use of these strategies in response to a discriminatory experience and their consequences is needed to enhance our understanding of the complexities of coping effectively with these chronic, ongoing external and societal stressors.

One psychological consequence of discrimination that is important to target in therapy is internalization of stigmatizing messages (e.g., Graham-LoPresti et al., 2016; Speight, 2007). Individuals who consistently receive both explicit and more subtle (i.e., microaggressions) diminishing, stereotyping, stigmatizing messages about one or more aspects of

their cultural identity may, not surprisingly, incorporate those views into their self-image, leading to a host of clinical and social challenges. Cognitive interventions can address these internalizations (see, Graham, Sorenson, & Hayes-Skelton, 2013; Seager & Aldao, 2016, for examples). Additionally, psychoeducation about the process and consequences of being socialized in a society that devalues components of one's cultural identity paired with mindfulness practices aimed at cultivating a decentered stance toward internalized thoughts and judgments may decrease the distress associated with these thoughts and the influence they have on behavior (e.g., Graham-LoPresti et al., 2016). Correlational findings preliminarily support the potential buffering role of decentering in the relation between internalized heterosexism and psychological distress among sexual minority participants (Puckett, Mereish, Levitt, Horne, & Hayes-Skelton, 2017).

In collaboration with Dr. Karen Suyemoto, and our doctoral students, I (LR) developed a 2-hour two-session coping with racism workshop for students of color<sup>2</sup> that synthesizes methods of raising awareness and understanding to promote validation, empowerment, and resistance from the racism-related stress literature (e.g., Brondolo et al., 2009; Harrell, 2000; Low, Okubo, & Reilly, 2012; Shorter-Gooden, 2004; Sue, 2003) with ABBT strategies aimed at promoting awareness, validation, self-compassion/self-nourishment, and intentional engagement in valued actions. A lay description of the workshop we have piloted a few times, is available at [anxiety.org](http://anxiety.org) (Roemer et al., 2017; Suyemoto et al., 2017). The main additions/adaptations we think are beneficial are: 1) psychoeducation about various forms of racism and its impacts, and an opportunity for participants to share their experiences so group leaders and members can provide validation<sup>3</sup>, 2) explicit use of this information and sharing to enhance self-validation, self-compassion, and awareness of the reality of exposure to discrimination and its consequences, 3) a culturally responsive approach to describing mindfulness (such as describing specific skills, like awareness, instead of using the term “mindfulness,” or exploring reactions to the term), emphasizing how mindfulness/awareness can promote grounding, a connection to one's intentions and values, and an ability to choose actions rather than reacting, while also minimizing associations with “peace” or pleasant emotions, which may not be feasible in the face of discrimination, and 4) acknowledgment of external barriers to valued actions (e.g., one may choose not to respond to a racist comment, despite valuing genuine communication, because of a power differential between the speaker and recipient – e.g., professor



– student), and incorporation of empowerment and resistance, relationally and societally, in discussions of valued actions. We discuss methods of coping while a specific incident is occurring, during recovery, and in response to ongoing chronic discrimination, in each case emphasizing self-nourishment, flexibility, and intentional behavioral choices that take context into account. We continue to refine this program and plan to solicit additional feedback from participants and assess the impact more systematically.

### Conclusion

Despite promising findings suggesting that ABBTs can be beneficial in the treatment of anxiety and related disorders, considerably more research is needed to better understand mechanisms of change and guide adaptations of these treatments to contexts that will increase their accessibility. We look forward to learning more about how best to efficiently and responsively meet the needs of clients in varying contexts. ❏

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# The Ethics of Soliciting Client Testimonials and Reviews

**Adam Fried, Ph.D.**  
Fordham University



The Internet has become a primary marketing tool for mental health professionals. While dramatically increasing the reach and visibility of professionals, use of the Internet for advertising can raise a number of unique ethical dilemmas for psychologists, including the ethics surrounding client testimonials and reviews.

## The Importance of Testimonials and Reviews

Prospective psychotherapy clients look to many sources to find a therapist that best fits their needs, goals and personality. Clients may search through possibly hundreds of therapist profiles (depending on the geographical area) before finding the “right” one. Many, if not most, psychologists in private practice have professional websites where they provide information directed at prospective clients about their training, specialties, and approach. Therapists looking for novel ways to make their websites stand out (both in terms of visibility and content) may see testimonials on their professional website and positive reviews on various websites (such as Yelp and Google) as powerful validators of their competence and effectiveness and a demonstration of positive consumer feedback. Miranda Palmer, co-founder of Zynnyme LLC, a firm that provides private practice marketing advice and consultation for mental health practitioners notes that, “Online reviews and testimonials can be helpful for search engine optimization and building credibility. However, many therapists have built and continue to build successful practices without using reviews or testimonials.”

Some therapists are highly concerned about the impact of positive (and negative) reviews on prospective client decision-making and may go to great (and sometimes unethical or at least ethically questionable) lengths to solicit positive feedback. For example, a psychotherapist recently wrote to the New York Times Ethicist column (February 26, 2017) about her concerns about the impact of a lack of client reviews on her future business and asked whether it would be ethically acceptable for her to write positive reviews of herself posing as her own satisfied clients (using fictitious client names). As another example, I recently

heard about a therapist who was considering a new practice policy where she would forgo assessing a financial penalty for a “no show” appointment if the client posted an online review.

Other therapists may eschew reviews, wary of the circumstances that lead some clients to post reviews and the ethical issues associated with soliciting testimonials. For example, a client unhappy with the outcome of an evaluation may be tempted to post a negative review out of anger, even though the evaluation process and conclusion may have been valid. Palmer notes that, “Mental health professionals feel ambivalent about online reviews. They know how easily reviews can be taken out of context and that every situation is different.”

## The Ethics of Testimonials and Reviews

Psychologists should be aware of the ethical standards specific to soliciting testimonials. The American Psychological Association (APA) Ethics Code standard on testimonials (5.05) states, “Psychologists do not solicit testimonials from current clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence” (APA, 2017), with the latter applying to individuals who may be vulnerable to “undue influence” due to their mental status, the circumstances surrounding their treatment and termination, and the nature of the relationship. For example, a client who is seeking an evaluation or receiving court-ordered treatment may be particularly vulnerable to undue influence and requests for testimonials could be considered exploitative (Fisher, 2017).

In addition to the standard on testimonials, psychologists should ensure that their actions do not violate other standards, including Maintaining Confidentiality (4.01) and Avoiding Harm (3.04). For example, psychologists must be careful to avoid using names and other identifiable information; this can be especially difficult if the review or testimonial itself contains identifiable information (concerns that may be particularly relevant on public websites that can be accessed by anyone). Another issue that many therapists struggle with is addressing negative reviews posted by clients on various websites. While psychologists may be tempted to directly respond to negative reviews, doing so can violate confidentiality rules and laws. Readers may wish to read at the APA Monitor’s article “One-star Therapy” for helpful recommendations on how to legally and ethically address negative reviews (Chamberlain, 2014).

### **Unsolicited Testimonials**


Despite explicit rules about testimonials, Palmer warns there continue to be other ethical “grey” areas, such as unsolicited testimonials. Even when a client volunteers to create a testimonial for the therapist, some caution is warranted, especially if confidentiality cannot be maintained by omitting or disguising the client’s name or details. For example, a client who posts a testimonial video to a therapist’s Facebook page or who volunteers to create a video for the therapist’s website can raise unique confidentiality concerns.

Another consideration for therapists with clients who volunteer a testimonial is whether the client understands what they are agreeing to and if there’s a mechanism for them to change their mind about providing a testimonial. The American Counseling Association’s code of ethics includes language indicating that the counselor has a responsibility to discuss with clients the implications of their testimonial, which may be good ethical practice for most therapists. Telling clients who wish to provide testimonials about any confidentiality risks (and methods implemented by the clinician to minimize these risks) and that they can request to have their testimonial removed in the future upon request may be helpful in clarifying expectations and avoiding misunderstandings.

Palmer also warns that client reviews may be solicited without the therapist’s knowledge or consent. “Certain websites actually email clients after sessions and ask for a review of the experience and there isn’t a setting for therapists to turn off this feature.” Therapists may wish to include language on their website and/or practice policies acknowledging the possibility of a third-party request for review, making clear that the therapist does not initiate these requests, and that the decision to provide a review rests fully with the client and will not affect services in any way.

### **Alternatives to Soliciting Client Testimonials**

For therapists concerned about using client testimonials, alternatives exist that do not violate ethical standards and can be just as effective. Palmer notes that clients are not the only ones who may be able to provide valuable feedback that psychologists can integrate into their marketing. “Many therapists are finding a middle ground by asking colleagues who have intimate knowledge of their clinical work to post reviews of their work on Yelp and Google ‘My Business’ listings. Professionals may often ask for feedback from psychoeducational trainings and ask if they can have permission to share them and post those appropriately.”

Finally, Palmer encourages therapists to think beyond the notion that testimonials and client reviews are the only way to effectively market a practice. “Ultimately, prospective clients are looking to get to know the therapists and whether they can trust them. One of the best things you can do as a professional is to have a website allows your community to get to know you, your style of therapy, and what they can expect from the process. Video introductions, video blogs, and writing can be just as powerful as online reviews and testimonials.” 

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# APA Convention Programming

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WEDNESDAY 8/2		THURSDAY 8/3			FRIDAY 8/4	
8 AM	Exposure-Based Cognitive Therapy: Application of Principles of Exposure to Depression	Careriving in Context: Implications for Intervention and Research (146-C)	Innovative Interventions: Serious Mental Illness and Medical Conditions (151-B)			
9 AM	Dual Diagnosis: Evidence-Based Treatment for Co-Occurring Substance Uses and Mood/Anxiety Disorders		Evidence-Based Psychotherapy for PTSD: Advances and Future Challenges (145-A)	Enhancing Diversity in Psychological Sciences: Discussions with Distinguished Journal Editors (204-B)	College Student Sexual Victimization and Risky Sexual Relationships (154-B)	It's Never Too Early to Learn About Healthy and Successful Aging (151-B)
10 AM	Lives at Risk: Evaluating and Managing Behavioral Emergencies	Teaching Research Ethics in the Age of the Hoffman Report (149-B)	NIMH Update: Priorities and Perspectives from the Director Invited Address by Joshua Gordon, PhD (144-C)		Tackling Common Interview Questions: Externship, Internship, and First-Job Interviews (103-B)	
11 AM						
12 AM	All Division 12 Pre-Convention CE Workshops are scheduled for 8:00-11:50 AM in the Renaissance Hotel.  <a href="#">Enroll here</a>  or call the CEP Office at 800-374-2721, ext. 5991, option 3.	Challenges and Opportunities: Application of Research Findings to Health Practice and Policy (144-C)	SBIRT: Skills for Managing the Continuum of Substance Use via Early Identification and Intervention (159)	How to Master the Internship Application Process (207-B)	SCP POSTER SESSION #1 Advances in the Treatment of Children, Adolescents, and Medical Populations (Halls D & E)	
1 PM		Global Violence Against Women: Impact and Interventions (208)	Suicide Prevention Among Older Adults: From Theory to Practice (143-A)	Have we Failed at Replication? A Panel Discussion/Debate on Psychology's Replicability "Crisis" (151-A)	APF EMPathy Symposium (144-C): Division 3: During Intense or Emotionally Arousing Moments, How Does the Brain Select What to Focus On? Division 8: The Altruistic Brain Division 12: Emotion in Therapy: Where East Meets West	
2 PM		Beyond Cultural Competence: Understanding Ethnic Disparities through Psychotherapy Process Research (147-A)	Yoga for Depression: New Research on Efficacy, Mechanisms, and Acceptability (152-A)		SCP POSTER SESSION #2: Assessment and Treatment in Adult and Aging Populations (Halls D & E)	
3 PM					Jousting with Memories: Translational Strategies for Enhancing Treatment Outcome	
4 PM					Division 12 Presidential Address by Michael W. Otto, PhD (143-C)	
5 PM					SCP Early Career/Student Social and Speed Mentoring Event (Marriott Marquis, Union Station Room) #SCP Mentor	
6 PM				SCP Awards Ceremony and Social Hour (Marriott Marquis, Liberty Salon 1)		
7 PM						



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### SATURDAY 8/5

### SUNDAY 8/6

8 AM	Caregiver, Care for Yourself: Skills and Strategies for Self-Care Among Psychology Practitioners (144-B)	Innovative Interventions that Mitigate Stigma, Shame, and Face Loss Issues Among Asian Americans (150-A)			
9 AM	Randomized Clinical Trials for Combat-Related PTSD and Comorbid Conditions: Results from STRONG STAR (147-B)		Promoting Integrated Primary Care Through Interprofessional Education (151-A)	Mindful Touch: Incorporating Sensate Focus into Couples and Sex Therapy (145-A)	Assessment of ADHD and Sensory Processing: Theory, Research, and Differential Diagnosis (209-A)
10 AM			Integrating the Work of Luria and Vygotsky in Modern Cognitive and Personality Testing (148)		
11 AM	SCP POSTER SESSION #3: Personality, Professional and Training Issues, College Student Mental Health (Halls D & E)		Bridging Research and Practice to Eliminate Ethnic Disparities in Clinical Care (143-C)		Routine Outcome Monitoring in Psychology Training Clinics: Evaluating the Implementation Process (209-A)
12 PM	Treatment Advances for Intervening with Medical and Psychiatric Patients Invited Address by Steven Satren, PhD (159)		The American Election and Political Trauma: The Psychologist's Role in Healing America (143-A)		
1 PM	Data from Randomized Clinical Trials Reveal Much More than the Main Effects of Treatments Invited Address by Robert DeRubeis, PhD (144C)				



Kaitlin P. Gallo, Ph.D. - Editor

## Section II: Society of Clinical Geropsychology


Submitted by Victor Molinari, Ph.D., ABPP



The results of the SCG 2017 elections are in. Our new President-Elect is Nancy Pachana, PhD, FAPS, FASSA U-Queensland, Brisbane, Australia. Our new Secretary is Veronica Shead, PhD from the St. Louis VA. We had a strong slate of candidates and those who did not win the election have been encouraged to consider joining a SCG committee either as a member or chair.

Regarding a bylaws vote, we had strong majority (>2/3 vote) support to eliminate the APA membership requirement to be a member of SCG. However, the Aging Leadership group consisting of members of all the geropsychology organizations have recently raised significant issues with this proposed change warranting further board discussion. There were no pros & cons statement attached to the proposed byways change which Aging Leadership feels needs to be included in any future bylaws changes.

There was also a noticeable decline in membership this year, possibly related to problems with online renewals via PayPal. SCG has been actively trying to remedy the situation. The Action Plan to increase membership includes the following points:

- 1) Development of promotional materials for highlight benefits of membership in SCG
- 2) Setting up a separate link to PayPal for new/renewing members
- 3) Work with education committee regarding programming for members across the training spectrum, from graduate student to mid-career
- 4) Recruit potential members from other aging interest groups within APA
- 5) Recruit potential members from state associations in states that have an aging or aging/ long-term care CE requirement
- 6) Following up with possible collaboration via joint membership for Division 20 (Adult Development & Aging) and SCG 

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For more information about the mentorship program, please visit [www.div12.org/mentorship](http://www.div12.org/mentorship) to become a mentor today.

Kaitlin P. Gallo, Ph.D. - Editor

# Section IV: Clinical Psychology of Women

Submitted by Kalyani Gopal, Ph.D.

## Call to Action: Misogyny and Sexual Harassment



The old boys' network has served for centuries to initiate boys into male dominated workplaces, while women have had to prove themselves as being tough enough to handle a "man's" work. As bosses, women without the antecedent role models to show the way, have had to temper their tone, voice, and carriage to accommodate male sensitivities. There is no doubt thanks to extensive research that the male and female brains are wired differently especially in areas of spatial and emotional responsivity. One would think that women would support other women, yet research has shown that this is by no means linear. Further, 9/10 women have reported sexual harassment. Misogyny is so pervasive that according to a recent Harvard Graduate School of Education, Making Caring Common Report (May, 2017):

"In our national survey of 18 to 25-year-olds, 87% percent of women reported having experienced at least one of the following during their lifetime: being catcalled (55%), touched without permission by a stranger (41%), insulted with sexualized words (e.g., slut, bitch, ho) by a man (47%), insulted with sexualized words by a woman (42%), having a stranger say something sexual to them (52%), and having a stranger tell them they were "hot" (61%). Yet 76% of respondents to this survey had never had a conversation with their parents about how to avoid sexually harassing others." ([https://mcc.gse.harvard.edu/files/gse-mcc/files/mcc\\_the\\_talk\\_final.pdf](https://mcc.gse.harvard.edu/files/gse-mcc/files/mcc_the_talk_final.pdf), page 2)

So, how is it that women who historically ran households, sent men their merry way after birthing a child, and selecting the next eligible male – are now struggling against a tide of abuse and suppression? No matter what the field of work, women find ourselves more often than less in a sub-standard situation.

Take for example the police force. I was speaking to a female police officer as a part of regular clinical intake and she shared that sexual harassment in the workplace is not uncommon where she came from. As she stated, "The guys say there are three kinds of females, the bitch, the crazy, the whore." Apparently, the bitch is the one who is your no-nonsense colleague or boss. The current environment of misogyny that we are all being exposed to in daily nauseating doses is truly nothing more than what was once hidden or privately held views, emboldened by the recent events. Moreover, three times as many women own guns for solely for protection as compared to their male counterparts based on research on 1269 gun owners in the US (PEW Research, June 2017).

While recognizing the embedded and now emboldened misogyny, how do we combat it?

To answer this question, in June 2017, a group of feminists got together at a family restaurant on the Northside of Chicago to address concerns. Four teams were formed. The "On the Table" Event co-sponsored by the IPA Women's Section, Illinois Kennedy Forum, Chicago and the Chicago Community Trust held a simple, "Can We Talk?" Forum. Dr. Colleen Cira facilitated a table conversation in which the participants discussed their personal experiences with gender bias, identifying that it begins in infancy and gets worse over time. They also discussed possible ways to overcome it, focusing on psychoeducation about implicit bias and the important role of empathy in terms of being able to truly understand someone else's perspective.

We can all take action against microaggressions or overt aggressions, each of us in our own way, doing our bit to change the conversation.

- Be assertive. If as a doctor someone calls you "honey" or "darling" do not allow it unless you absolutely know it does not come from a sexist standpoint
- Speak up. If you see sexism in the workplace report it or walk up to the person and address it, especially if it is a colleague you know.
- Have meaningful and constructive conversations with young people about what it means to be "female" or "male" or "transgender."
- Explore Stereotypes and question beliefs. What if? Why? How?
- Talk to youth about what a mature dating relationship can look like. How is your communication? What is the body language? Verbal cues?
- Provide guidance. Answer questions honestly and frankly. Educate what it means to be a victim of sexual assault, the experience and the traumatic sequelae.
- Discuss the markers of healthy versus unhealthy relationships. How does one make informed decisions and the difference between infatuation, lust, and love.
- Identify films and media that promote gender equality.
- Address ethical issues such as dating your best friend's girlfriend, age of consent, what constitutes sex versus rape, how to handle knowledge about two of your closest friends when one is cheating on the other. This and many such discussions increase awareness of actions.
- Create pockets of awareness via dance, music, theatrical performances, and Sexual Assault Awareness Days on campuses, workplaces, and in community activities.

In the end, it is each person who is aware transforming the culture of misogyny. The greater the anger and sense of injustice, the greater the impetus to combat what we all know exists in every single walk of life. ♡

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.

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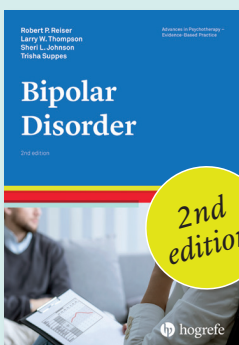
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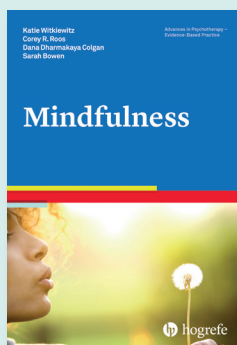
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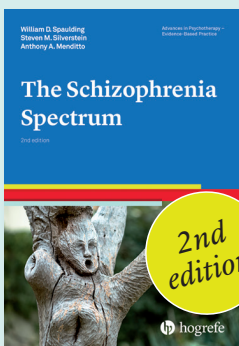


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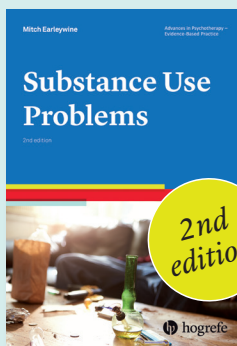


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The literature on diagnosis and treatment of drug and substance abuse is filled with successful, empirically based approaches, but also with controversy and hearsay. Health professionals in a range of settings are bound to meet clients with troubles related to drugs – and this text helps them separate the myths from the facts. It provides trainees and professionals with a handy, concise guide for helping problem drug users build enjoyable, multifaceted lives using approaches based on decades of research. Readers will improve their intuitions and clinical skills by adding an overarching understanding of drug use and the development of problems that translates into appropriate techniques for encouraging clients to change behavior themselves. This highly readable text explains not only what to do, but when and how to do it.

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