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PRESIDENT'S COLUMN

Benefitting from Multiple
Voices: A Choice for Clinical
Psychology

Gary R. VandenBos, Ph.D.

There is much political division in Washington, DC these days. More and more it is reported that Republicans only listen to Republican news outlets, and Democrats only listen to Democratic news outlets. Pre-conceived opinions get reinforced, and citizens increasingly do not know or understand the reasoning and facts behind alternative political views. This generates distrust of other political viewpoints – even hatred. Today, compared to just 20 years ago, more people actively dislike the candidate from the “other party.” We have created a divided nation, lacking in understanding of “the other.” This is not good.

The same thing happens in Psychology, particularly along theoretical lines. When we only read material that is consistent with our own biases, we lose a broad and rich understanding of the field – of human behavior, cognitive processes, and emotion. It is not good to live in a theoretical silo, but that is what too many of us do. It takes work to avoid it.

As a journal editor, I use an approach that tries to capitalize on different points of view to enrich and broaden the perspectives explored and discussed in journal articles. In selecting potential reviewers for a given manuscript, I first consider what qualified reviewer will “love” the article and results, and then what qualified reviewer will “hate” the article and results – often this is along theoretical lines it turns out. I also pick a third qualified reviewer who is generally knowledgeable about the broad research area without strong biases. Occasionally I get a review from a reviewer who simply cannot tolerate the alternative viewpoint and tries to “beat it to death” in their review (which I do not use), but mostly I get thoughtful reviews that describe the pros and cons of the methodological design and statistical analysis and consider the findings in context. As the editor, I try to help the author sort through the potential conflicting assessments and recommendations. I believe this process improves the resulting eventual publication.

As a clinical supervisor, I attempt to do something similar. After listening to a new case, I will frequently ask how the trainee conceptualizes the patient's problem and how it should be addressed. Then, assuming the supervisory

relationship on the case will be ongoing, I will ask the trainee to attempt to conceptualize the case (and potential intervention) in one or two other theoretical perspectives. I generally am trying to insure that the trainee thinks about the case from a dynamic, CBT, and humanistic (or emotion focused) perspective. They may proceed with the case within the model of their dominant training, but the exploration frames the groundwork for their thinking more broadly. If the case does not turn out to be a success (which half the time it does not), then it is easier to explore whether a different treatment approach might have been more successful. This also opens the door to more “integrative” thinking about patients, symptoms, interventions and outcomes.

I believe it is also important to engage in a similar process in association governance. When asked to suggest someone for a position in an organization, for an editorship, or for an award I always strive to make several suggestions – and a set that reflects

theoretical diversity, or age group diversity, as well as the typical gender and ethnic diversity. Including more viewpoints generally results in better decisions, because more factors and data are considered. I encourage all of us to encourage greater theoretical diversity in our research project, training programs, our clinical programs, and our journals – and our own professional reading habits. Consider voting for a Divisional candidate who thinks differently than you on issues. Consider nominating someone for a Divisional award who utilizes a different theoretical perspective from you. ■■



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Adolescent Depression Prevention:

Using Risk-Informed Personalization to Move the Field Forward

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U Depression is a common, debilitating, and costly illness. The World Health Organization ranks depression as the number one most burdensome disease in the world for total disability-adjusted years and the leading cause of disability for ages 15-44 (WHO, 2012). To put these facts in perspective, depression claims more disability-adjusted years than war, cancer, and AIDS combined. Although a number of effective pharmacological (e.g., SSRIs) and psychosocial treatments (e.g., cognitive behavioral therapy, interpersonal psychotherapy) for depression have been identified, these existing treatments can only reduce a third of the burden associated with depression. This is due to the large number of cases of depression (322 million individuals worldwide according to WHO estimates), half of whom do not seek treatment, and limited access to evidence-based treatments (Andrews, Sanderson, Corry, & Lapsley, 2000).

These facts have led to a call to reduce depression incidence through prevention efforts, with a particular focus on adolescence when many individuals experience their first episode of depression. For instance, our (Hankin) research, along with other developmental epidemiological studies (e.g., Costello, Mustillo, Erklani, Keeler, & Angold, 2003; Merikangas et al., 2010), demonstrates that prevalence rates of DSM-defined depressive episodes surge during adolescence. Approximately 3% of middle adolescents (age 15) from the general community received a depression diagnosis, and this rate skyrocketed 6-fold to about 18% by the end of adolescence (age 18) (Hankin et al., 1998). We (Hankin & Young) have replicated these depression trajectories in our recently completed Gene Environment Mood (GEM) study which tracked depression episodes every 6 months for 3 years among community youth from ages 8 to 17 (Hankin et al., 2015). Depression is a highly recurrent disorder; about 60% of individuals will experience multiple episodes over the lifespan (Monroe & Harkness, 2005).

Moreover, adolescent-onset depression confers a 6-fold increased risk for recurrence in adulthood (Rutter, Kim-Cohen, & Maughan, 2006). Preventive interventions can help reduce the burden of depression because they can reach a larger number of people and because these programs intervene prior to the development of a depressive episode and its associated impairments (Muñoz, Cuijpers, Smit, Barrera, & Leykin, 2010).



Depression Prevention

Jami F. Young

In the past three decades, there has been increasing focus on developing and testing of prevention interventions for depression for older children and adolescents. Preventive interventions are classified as universal, selective, or indicated (Gordon, 1983). Universal interventions are provided to the entire population regardless of their level of risk. Selective interventions are provided to a subsample with a known risk factor. In the case of depression, selective programs have focused predominately on youth with a depressed parent (e.g., Compas et al., 2009; Garber et al., 2009), youth whose parents have divorced (e.g., Wolchik et al., 2002), and bereaved children (e.g., Sandler, Wolchik, Ayers, Tein, & Luecken, 2013), all documented risk factors and/or stressful life events associated with the development of depression and other mental health difficulties. Finally, indicated prevention, which has been the focus of much of our (Young) work, targets individuals with subthreshold symptoms of a disorder. Research supports a focus on indicated depression prevention as elevated depressive symptoms in adolescence are associated with considerable impairment (Lewinsohn, Solomon, Seeley, & Zeiss, 2000) and increase the risk for depression in adulthood (Fergusson, Horwood, Ridder, & Beautrais, 2005).

Depression Prevention Programs. A number of preventive interventions that specifically focus on depression have been developed and tested. Importantly, there are also a number of preventive interventions that do not specifically target depression but which have shown significant effects on depression (e.g., Connell & Dishion, 2008; Perrino et al., 2014), though this is outside of the scope of this paper. The majority of depression prevention programs are based on cognitive-behavioral approaches and target cognitive and behavioral risks for depression, including cognitive distortions, problem-solving difficulties, and lack of engagement in pleasurable activities. The most well-researched cognitive-behavioral prevention programs for children and adolescents are the Penn Resiliency Program (PRP; Jaycox, Reivich, Gillham, & Seligman, 1994), Coping with Stress (CWS; Clarke & Lewinsohn, 1995), and the Blues Group. (Stice et

al., 2007). For more information on these and other depression prevention programs, readers are referred to a recent review by Brunwasser and Garber (2016). Fifteen years ago, we (Young & Mufson, 2003) developed Interpersonal Psychotherapy–Adolescent Skills Training (IPT-AST) as an alternative, and potentially complementary, intervention to cognitive-behavioral prevention programs to help address the significant public health issue of depression.

IPT-AST is an interpersonally-oriented prevention program for adolescents that is based on interpersonal psychotherapy (IPT) for depression (Weissman, Markowitz, & Klerman, 2017) and its adolescent adaptation (Mufson, Dorta, Moreau, & Weissman, 2004). Unlike cognitive-behavioral prevention programs, IPT-AST targets interpersonal vulnerabilities for depression, including high levels of conflict in peer and family relationships, ineffective interpersonal problem-solving, and low levels of social support. IPT-AST teaches adolescents communication strategies and interpersonal problem-solving skills to address problematic relationships and promote positive connections with others (Young, Mufson, & Schueler, 2016). We thought that IPT-AST offered promise as an intervention to decrease risk for depression and that an interpersonal focus would resonate well with adolescents. This has been confirmed by the research we have conducted on IPT-AST over the past 15 years.

Summary of IPT-AST Research. In the first study of IPT-AST (Young, Mufson, & Davies, 2006), we compared IPT-AST to usual school counseling (SC) in 41 adolescents (age: $M = 13.4$; 85.5% female; 92.7% Hispanic) with elevated symptoms of depression in parochial schools. IPT-AST had large effects on depression ($d = 1.52$ at post-intervention, $d = 1.09$ at 6-month follow-up) and overall functioning ($d = 0.96$ at post-intervention, $d = 1.21$ at 6-month follow-up). IPT-AST adolescents also experienced fewer depression diagnoses than SC adolescents through the 6-month follow-up (IPT-AST: 3.7%, SC: 28.6%). The results from this study provided preliminary support for IPT-AST as an indicated prevention program. Furthermore, secondary analyses demonstrated that youth in IPT-AST experienced significant decreases in mother-child conflict, whereas youth in SC reported an increase in conflict over time (Young, Gallop, & Mufson, 2009). This was an initial indication that IPT-AST effectively targets interpersonal conflict as intended.

In a second study of 57 adolescents (age: $M = 14.5$; 59.7% female; 73.7% Hispanic; 38.6% African American), IPT-AST youth had significantly lower depression scores ($d = 0.80$) and better overall functioning ($d = 1.27$) than SC youth at post-intervention. These differences persisted at 6-month follow-up (depression: $d = 0.50$; functioning: $d = 0.61$). In addition, the rates of depression diagnoses were significantly different between the two conditions (0% vs. 19.1%) through the 6-month follow-up. Although adolescents in IPT-AST continued to report lower levels of depressive symptoms and rates of diagnoses and higher levels of overall functioning than adolescents in SC through longer-term follow-

up, these differences were not significant at the 12 and 18-month follow-up, suggesting more modest long-term effects of IPT-AST (Young, Mufson, & Gallop, 2010). In addition to the positive effects on depression and overall functioning, youth in IPT-AST experienced significant improvements in social functioning and emotional engagement in school, and were less likely to be asked to leave school for academic or behavioral reasons than youth in SC (Young, Kranzler, Gallop, & Mufson, 2012). Finally, in analyses that combined data from these two studies, there was evidence of a significant difference in anxiety symptoms between IPT-AST and SC at post-intervention ($d = 0.68$) and 6-month follow-up ($d = 0.53$). These findings suggest that IPT-AST has a transdiagnostic effect on depression and anxiety.

In our recent large-scale indicated prevention study, the Depression Prevention Initiative ($N = 186$; age: $M = 14.0$; 66.7% female; 38.2% Hispanic; 32.3% racial minority), we examined the efficacy of IPT-AST delivered by research staff in comparison to enhanced group counseling (GC) delivered by school counselors in public middle and high schools. GC was a rigorous comparison as counselors saw teens for the same number of sessions as IPT-AST, including 4 booster sessions following the group programs. IPT-AST resulted in significantly greater reductions in depression symptoms ($d = 0.31$), general internalizing symptoms ($d = 0.33$), and overall functioning ($d = 0.31$) compared to GC from baseline to the 6-month follow-up (Benas et al., 2016; Young et al., 2016). However, unlike in our earlier trials, there was no significant difference in rates of depression diagnoses between IPT-AST and GC (5.3% vs. 2.2%). During the follow-up period (6- to 24-month follow-up), GC youth experienced significant decreases in depressive symptoms whereas IPT-AST youth experienced a small non-significant increase in symptoms ($d = 0.41$). IPT-AST youth demonstrated a significant worsening in overall functioning, whereas GC youth had relatively stable overall functioning ($d = 0.33$) (Young et al., 2018). Thus, there was limited evidence of the long-term benefits of IPT-AST relative to GC in this study, even with the addition of booster sessions. These findings are similar to what has been found in recent meta-analyses, particularly in studies with an active control condition (Hetrick, Cox, Witt, Bir, & Merry, 2016; Merry et al., 2011).

The results from our own work and from these meta-analyses suggest that more needs to be done to enhance the effects of these prevention programs, particularly in the long-term. Nonetheless, it is important to note that, despite these modest effects,



Benjamin L. Hankin

two reviews concluded that 22% to 38% of major depressive episodes could be prevented if currently existing depression prevention programs, including IPT-AST, were implemented (Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009; Cuijpers, van Straten, Smit, Mihalopoulos, & Beekman, 2008). This would have a substantial impact for individuals as well as the larger society. Further, as others (Brunwasser & Garber, 2016) have argued, even the positive short-term effects on symptoms and diagnoses that have been demonstrated for IPT-AST and several cognitive-behavioral prevention programs are meaningful and may lead to benefits in other domains of functioning. For all of these reasons, we believe it is important to continue to focus on depression prevention efforts.

Moving the Depression Prevention Field Forward.

There are a number of ways to move the field of adolescent depression prevention forward. We briefly highlight a few of these and then focus on our attempts to personalize depression prevention efforts as one potential way to advance the field. First, we need more studies that compare existing prevention programs to attention placebo comparisons (Hetrick et al., 2016). This will allow us to determine whether the positive effects seen in the literature are placebo effects or if there are simpler and less costly interventions that can result in similarly positive outcomes. Second, we should continue to develop novel interventions that, if effective, could be more easily disseminated than existing interventions. This may include self-help or internet-based interventions, both of which have evidence for reducing depressive symptoms (e.g., Stice, Rohde, Seeley, & Gau, 2008; Van Voorhees et al., 2009). Third, we need more research on the effectiveness of prevention programs when delivered by providers in community settings, such as schools, primary care, and after-school organizations. To date, there is mixed evidence about whether youth depression prevention programs demonstrate significant effects when delivered by community providers. Additionally, several preventive interventions, including IPT-AST, have not been tested in effectiveness studies. Fourth, we need to investigate ways to lengthen the long-term effects of these interventions. This might include delivering booster sessions more flexibly and for a greater length of time than has been done in the literature and/or identifying which youth may have the greatest need for these booster sessions. Finally, as we discuss in more detail below, we need to consider innovative ways to individualize prevention interventions given the large number and range of risk factors and stressors that have been linked with the development of depression (e.g., Hankin, 2015).

Personalized Medicine and Evidence-Based Intervention Approaches

The significance and importance of evidence-based personalized, or precision, medicine, has been emphasized recently in both physical and mental health (Hamburg & Collins, 2010; Kapur, Phillips & Insel, 2012). In 2015, President Obama announced the Precision Medicine Initiative to stimulate personalized

medicine research that could assist clinicians in selecting interventions that will work best for particular patients, as opposed to the current standard of “one size fits all” treatments geared toward the average patient. While relatively new, precision medicine has led to revolutionary improvements in individualizing treatments for particular diseases, especially in oncology, where interventions are tailored to match the genetic profile of individuals’ tumors. Another example of the potential and promise of precision medicine comes from cystic fibrosis (CF). Basic research in genotyping of CF has identified a subset of patients with a particular genetic signature (e.g., at least one G551D-CFTR mutation), and these CF patients demonstrate improved clinical response to a drug (Ivacaftor) that is personalized based on this specific CF genotype (Ramsey et al., 2011). Presently there exists no system for personalizing psychosocial depression prevention programs in adolescents, although there have been calls for using behavioral and cognitive “biomarkers” to stratify individuals at risk and identify who may respond better to one intervention or another (Kapur, Phillips & Insel, 2012).

Personalizing Depression Prevention

Our (Hankin & Young) current work is examining whether we can enhance the effects of existing interventions by personalizing who gets which prevention program. We believe that one explanation for the relatively modest impact of depression prevention programs is that these interventions have not been designed for individualization based on presumed risk factors. In other words, these programs are based on a “one size fits all” approach, and most depression prevention programs target one class of vulnerability factors. A given program may be particularly effective if there is a match between that individual’s risk for depression and the focus of the intervention. In the case of IPT-AST, for instance, we have research to suggest that adolescents who report high levels of conflict with their mothers demonstrate the most significant improvements following the program (Young et al., 2009). On the other hand, IPT-AST may be less relevant and consequently less effective for adolescents who have relatively positive interpersonal functioning and who have other risk factors for depression that are not targeted in this program.

We (Young & Hankin) have an ongoing randomized controlled trial, the Personalized Depression Prevention (PDP) study, which is examining one approach to personalization to depression prevention. Specifically, we are investigating two evidence-based prevention programs, CWS, a cognitive-behavioral prevention program, and IPT-AST, an interpersonal prevention program, for youth at low and high cognitive and interpersonal risk for depression to determine whether youth who receive an intervention matched to their risks have better outcomes. There are a large number of documented cognitive, behavioral, and interpersonal risk factors for depression (e.g., see Hankin, 2012, for review). In the PDP study, we are focusing on those risk factors which are specifically targeted in either CWS

or IPT-AST. CWS emphasizes the identification and reduction of negative thinking patterns that contribute to depression (Clarke et al., 1995) and IPT-AST aims to reduce conflict in close relationships and increase support from these relationships (Young et al., 2016). For this reason, we have chosen to focus our risk classification system on these specific vulnerabilities.

Risk Classification Groupings to Inform PDP. Here we summarize the steps we used to develop and validate the risk classification system we are using in the PDP study (see Hankin, Young, Gallop & Garber, 2018 for details). Results were based on analyses conducted on data from a general community sample of adolescents (N = 467; age: M = 13.14; 57% females) who were followed prospectively for 3 years. In brief, we began by conducting an exploratory factor analysis of commonly used, reliable measures of a variety of cognitive and interpersonal vulnerabilities to examine the latent structure of these vulnerabilities. We found that the cognitive variables all loaded onto one factor, and the interpersonal risks loaded onto two factors, one focused on negative aspects of relationships and the other on interpersonal support. We used the measures that loaded highest on each of these factors to form the basis of our classification system. We included 3 cognitive measures: rumination, negative cognitive style, and dysfunctional attitudes, and one interpersonal measure which included a negative interaction scale and a support scale. For the interpersonal factors, we specifically focused on parental conflict and peer social support as we believe that it is important to capture information from both parent and peer relationships.

Next we sought to establish easy, practical cutoffs to indicate whether an individual adolescent is high or low risk based on cognitive or interpersonal vulnerability. One goal in establishing these cutoffs was to identify scores which would lead to a relatively balanced number of individuals in each of four cells for the PDP study (see Figure 1): (1) low cognitive and low interpersonal risk, (2) low cognitive and high interpersonal risk, (3) high cognitive and low interpersonal risk, and (4) high cognitive and high interpersonal risk. The low/high and high/low off-diagonal groups are particularly relevant for our question about personalization; the high/high group is also important for prevention given these youth are at increased risk for depression. We found that a tertile cutoff on each of the five measures resulted in a relatively equal number of youth in each of the four cells using baseline data. The factor structure and cutoffs were replicated when we examined the 18-month follow-up data.

Finally, we examined the extent to which these high and low cognitive and interpersonal groups predicted the subsequent onset of a DSM-based episode of depression. We validated this risk classification twice, first looking at whether baseline classification predicted depression onset over the following 18-months, and second looking at whether classifications based on the 18-month follow-up data predicted depression onset from the 18-month follow through the 36-month follow-up. In both logistic regression analyses, we found evidence for acceptable predictive validity of

this classification system. For example, approximately 8% of the low/low risk group, 15-20% of the high/low risk groups, and 24% of the high/high risk group experienced a DSM-defined episode of depression over the initial 18-month followup. These findings provide important validity for our classification groups because, as we would expect, the low/low group had the lowest rates of depression, the high/high group had the highest rates of depression, and the other two groups were in between.

PDP Project Description. The Hankin et al. (2018) paper demonstrated that we can reliably, validly, and relatively easily classify adolescents as being at low or high cognitive and interpersonal risk. These analyses set the stage for the current PDP project which has several aims. The first aim is to examine whether we can bend longitudinal trajectories of depression for adolescents who receive IPT-AST or CWS as compared to a natural history control group of adolescents who have been followed longitudinally. In addition, we will be able to evaluate whether these interventions bend depression trajectories over time given our relatively unique design in which all adolescents in the PDP study completed at least one year of pre-prevention assessments and are being followed for 3 years after the prevention groups. Thus, we can examine this question via between subjects (comparison of receipt of CWS or IPT-AST vs. natural history control group) and within person changes in depression trajectories (how much an individual's depression levels change from pre-prevention through post-prevention follow-ups).

The second aim is to examine whether youth who receive a match between their particular risk and randomized prevention group (e.g., adolescents with high interpersonal risk/low cognitive risk receiving IPT-AST) experience fewer depression symptoms and diagnoses over time as compared to youth who receive non-personalized prevention (e.g., adolescents with high cognitive risk/low interpersonal risk receiving IPT-AST). This aim focuses specifically on the low cognitive/high interpersonal and high cognitive/low interpersonal groups from the classification system. The third aim is to examine potential mechanisms that may account for possible effects of bending depression trajectories and to test whether these prevention programs operate via their hypothesized processes. In other words, do youth randomized to CWS demonstrate significant reductions in cognitive risk variables relative to IPT-AST youth, and do adolescents assigned to IPT-AST exhibit greater reductions in interpersonal risk variables? Further, we will be able to examine whether these changes mediate intervention effects on depression. These aims are in line with NIMH's more recent priorities, including their emphasis on applying the Research Domain Criteria (RDoC) initiative to prevention (Goldstein & Morris, 2016) and their focus on experimental therapeutics.

Summary

Given the increasing rates of depression during adolescence and the risks and impairment associated with adolescent-onset depression, there is a need for a

continued focus on prevention during this developmental period. A number of depression prevention programs have been developed and evaluated, and there is evidence of efficacy for a number of selective and indicated prevention programs, including IPT-AST, although the longer term effects of these programs are more modest (Hetrick et al., 2016; Merry et al., 2011). Nonetheless, it is important to continue depression prevention research and to invest in these prevention efforts. We have outlined a number of ways to move the field the forward, including a focus on personalized prevention. Our hope is that the results from the PDP study will have a significant impact on the research community by guiding and informing other attempts at personalization, and that it will help clinicians determine whether a particular prevention program may be more or less effective for a given adolescent. A sustained emphasis on depression prevention in adolescence has the potential to help reduce rates of depression with its associated impairments and societal costs. ■■

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Figure 1. Cognitive and Interpersonal Risk Classification Groups

Cognitive Vulnerability		Interpersonal vulnerability	
		Low	High
	Low	Low Cognitive Vulnerability/ Low Interpersonal Vulnerability (~27%)	Low Cognitive Vulnerability/ High Interpersonal Vulnerability (~25%)
	High	Low Cognitive Vulnerability/ High Interpersonal Vulnerability (~25%)	High Cognitive Vulnerability/ High Interpersonal Vulnerability (~23%)

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Advancing and disseminating the science of clinical psychology through American Psychological Association's Clinical Practice Guidelines

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We appreciate this opportunity to share information about the American Psychological Association's (APA) Clinical Practice Guidelines initiative. The initiative was authorized by the APA Council of Representatives in 2010, based on recognition that guidelines provide an important way for APA to share information with patients and their families, practitioners, policy makers, and administrators about what treatments work best, on average, for a given disorder or problem based on a systematic review of the evidence. Critically, the guidelines allow psychologists to have a direct voice in promoting the science of clinical psychology and to make clear the important ways psychology can help reduce mental illness and enhance well being.

The first APA Clinical Practice Guideline, "Treatment of Posttraumatic Stress Disorder in adults," was approved in February, 2017 and released summer 2017, along with a comprehensive, user-friendly educational website (<http://www.apa.org/ptsd-guideline>) directed at providers, and patients and their families. That guideline has been accepted into the National Guideline Clearinghouse; an important step to establish the scientific rigor of the guideline. More recently, the second APA Clinical Practice Guideline, "Multicomponent behavioral treatment of obesity and overweight in children and adolescents: Current state of the evidence and research needs," was approved in March, 2018, and a third guideline, "Treatment of depression in children, adolescents, and young, middle aged, and older adults" will be ready for public comment soon.

The psychology community has raised many important

questions about APA's Clinical Practice Guidelines initiative, and we have been heartened to see the high level of engagement on this important venture. It is clear that our community cares deeply about determining the optimal ways for psychologists to relieve patients' suffering. We welcome this ongoing conversation about how we can do the guidelines in the best way possible and appreciate this opportunity to share our perspective in *the Clinical Psychologist*.

Goals of APA's Clinical Practice Guidelines Initiative

A central goal of the Clinical Practice Guidelines initiative is to make it easier for providers, patients and their families to have the information they need to make informed decisions about treatment. It can be overwhelming to wade through the options and difficult for the public to know which treatments have good research evidence to support their use. The guidelines provide a synthesis of the available efficacy research so that busy providers do not have to spend the time doing this but guidelines do not contain all research that may be relevant.

The guidelines are not meant to be rigidly proscriptive or diminish the value of patient preferences, the importance of attending to individual differences, and the value of clinical judgment. These are all valuable considerations when developing a treatment plan. The guidelines help providers make informed choices about which treatment to deliver while recognizing that it is not a decision-making process based on one criterion alone, but that using our best research is a key part of making treatment decisions. We want people to be informed about this research so that they have the information they need to make choices. Ultimately, we want to make it easier for patients to learn about and gain access to efficacious treatments.

Another valuable use of the guidelines is to identify gaps that need to be addressed by future research. For instance, the guidelines may point out that we do not have enough research to inform us how a given treatment that tends to work well *on average* works for a particular subpopulation (e.g., if there are different results for older adults, or persons with a particular racial or ethnic background or identity). Also, for many disorders, we do not have sufficient information about the extent treatments lead to improvement due to non-specific factors that are present in many treatments (e.g., therapeutic alliance) vs. due to specific elements of a given intervention (e.g., use of exposure techniques). Gaps often also exist in our knowledge about the impact of treatments on important outcomes beyond symptoms, such as quality of life and changes in relationships. Moreover, there are many widely practiced interventions that have not yet been adequately evaluated, and the guidelines can help clarify these gaps given that 'absence of evidence' for a treatment is not the same as 'evidence of absence' with respect to treatment efficacy. Interventions that are widely practiced in the therapeutic community deserve to be tested and guidelines can point that out. We hope this can spur further research in these areas so we can

address these important gaps in our knowledge.

Guidelines can help patients gain access to efficacious treatments in numerous ways. In some health care systems, guidelines may be used as part of a decision-tree process to prompt providers to offer a given service. Notably, this does not mean that specific service should always be offered. Rather, the provider uses the prompt and guideline information about which services tend to be helpful based on the research literature, and combines this essential information with information specific to that individual (e.g., their unique background, their preferences) to jointly arrive at a decision about care. Thus, the provider is supported in laying out the rationale to the client for their optimal treatment plan.

Access can also be improved by informing people about what psychology has to offer to help reduce the burden of mental illness and improve well being. Despite the considerable efficacy of psychotherapy and its enduring effects, psychotherapy has been losing market share to medication treatment in the United States for the last two decades (see Olfson & Marcus, 2010). We have a lot to offer but we need to spread the word! Guidelines are thus very helpful for educating other health care professionals, students, the public, and policy makers about efficacious treatments. Insurance companies already reference guidelines routinely among their resources, but are often relying on psychiatry and other field's guidelines because psychology has not been developing their own guidelines. This is a serious problem if we want psychology's potential contributions to be recognized. Notably, even when insurance companies refer to guidelines, they typically include disclaimers to clarify that these are guidelines that help with making recommendations, but are not a rule or rigid standard of care, and do not replace consideration of patient preferences and clinician's judgment. Guidelines help people make informed choices; they do not remove the ability to make choices.

Finally, guidelines can help protect our patients. They provide a review of the balance of potential benefits vs. harms of a treatment so people can make reasoned choices. One of the misunderstandings about the guideline process is that only randomized controlled trials are used to develop guidelines. While these research studies are the primary source of evidence used to complete systematic reviews (i.e., the primary evidence base for efficacy questions), this review is considered by the panel along with evidence (including information from observational studies and clinician and consumer input) about potential harms or burdens of a treatment as well as patient values and preferences.

Limits of Clinical Practice Guidelines

Clinical Practice Guidelines do not answer all of the questions providers and patients need to consider when making treatment decisions. Thus, we have included a document at the APA Clinical Practice Guidelines web site to help psychologists place the guidelines

in context and better understand what the guidelines do and do not offer: <http://www.apa.org/about/offices/directorates/guidelines/context.aspx>. As described in the document, we want people to understand that the guidelines complement consideration of patients' preferences and histories, providers' expertise and judgment, nonspecific factors in psychotherapy, and patients' individual differences, among other factors. Also, as we describe in this document, there are important strengths but also limitations to developing guidelines following Institute of Medicine standards (Institute of Medicine, 2011a, 2011b), especially in terms of what sources of evidence are considered in developing guidelines.

Another way that APA is addressing the limits of what Clinical Practice Guidelines offer is development of a Professional Practice Guideline to offer providers additional guidance on how the guidelines can be integrated into treatment provision in a practical and thoughtful way that recognizes the complexities of real-world clinical care. Development of this guideline is overseen by the APA Board of Professional Affairs and the Committee on Professional Practice and Standards (COPPS). Once this document is completed, it will be shared for public comment.

To learn more about the distinction between Clinical Practice Guidelines and Professional Practice Guidelines, and other information about the strengths and weaknesses of the Clinical Practice Guidelines, we encourage readers to view <http://www.apa.org/about/offices/directorates/guidelines/clinical-practice.aspx>. For instance, one key limitation of guidelines for many problem areas is that the empirical literature does not yet provide a basis for strong, evidence-based treatment recommendations tied to consideration of patients' diverse identities and backgrounds. Recent advances in the generation of treatment selection algorithms based on "big data" and machine learning hold out real hopes for the near future in that regard.

Conclusion

We look forward to learning from readers' responses to this letter and the Clinical Practice Guidelines initiative more broadly. We want this important conversation about how we can do the guidelines in the best way possible to continue. Along these lines, we hope interested readers will join us for an upcoming Town Hall discussion, "Next steps for APA's Evidence-based Practice Policy: The role and application of guidelines", at the upcoming APA convention in August in San Francisco.

We believe development of Clinical Practice Guidelines by APA provides a critical opportunity to advance and disseminate the science of clinical psychology. This is essential as we work together to get the best help we can to the millions of people suffering with mental illness. ■■

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We Need a Principle-Based Approach to Practice Guidelines

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 The debate surrounding the PTSD Practice Guidelines is an important one, as it raises key questions regarding the relationship between the science and practice of professional psychology. I did not support the petition supporting the Guidelines, nor the petition challenging them. In contrast to those who developed the petition against the Guidelines, I did not see the issue as being about "Protecting Treatments that Work." By framing the issue in terms of defending specific treatments that work, the petitioners were essentially agreeing with how the panel framed the issue. In contrast, my primary concern was with how the Guidelines were framed, and the lack of specification about what they meant for practice.

I do consider the Guidelines to be a valuable resource, as they offer a strong literature review of Randomized Controlled Clinical Trials (RCTs) for PTSD. However, this brings me to my first critique of the Guidelines, which is that a literature review does not translate into guidelines for practice. Consider the most basic finding from the panel, which is that the "panel *strongly recommends* the use of the following interventions for adult patients with PTSD (in alphabetical order): cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), cognitive therapy (CT), and prolonged exposure therapy (PE). The panel *suggests* the use of brief eclectic psychotherapy (BEP), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET)."

This conclusion gives rise to the question of what exactly the panel is recommending. Specifically, is the panel interpreting the findings as meaning that these treatments represent discrete entities that need to be followed as closely as possible to the manuals upon which the findings were based? Or is the panel recommending that the findings be interpreted to mean that a practitioner should extract general principles

from these manualized treatments and apply those principles in their work? These are two very different interpretations.

I adopt a principles-based approach to interpreting the findings. From my perspective, PTSD is characterized by a traumatic injury to the psychosocial system that cannot be integrated at either the level of narrative and meaning making (beliefs about self, others, world and future) and/or at the level of emotionally laden episodic memories, thus leading to distress, vigilance, and maladaptive avoidance patterns. Addressing the meaning making system involves cognitive/narrative/existential perspectives that explore avenues for transforming maladaptive justifications into more accurate, adaptive and growth promoting ones. Addressing the traumatic episodic memories involves developing new associative learning patterns (e.g., desensitization and habituation and working through problematic avoidance behaviors). This interpretation is based on a unified theoretical framework that bridges existing evidence from personality, psychopathology and psychotherapy (Henriques, 2017).

What is confusing for me in reading the Guidelines is that I have no idea if my approach to working with PTSD patients is either: (a) applauded by the Guidelines because it works to cut across the best of the best interventions and follows key evidence based principles and processes that are grounded in the science of psychotherapy; or (b) I violate the guidelines because I am not practicing from any of the specific manuals listed. Interpretation (a) follows if the Guidelines are really meant to be highlighting principles of good practice. Interpretation (b) follows if the Guidelines are meant to strongly endorse the specific treatments listed, and they are listed to be practiced as they were tested.

That the panel may have meant (b) is implied by the fact that it used RCTs only and did not specify any translation instructions or principles to be followed. And yet to claim that a practitioner must choose one of the treatments listed and only work within that frame is problematic for a host of reasons. First, it artificially reifies these interventions in ways that do not line up with the realities of practice (e.g., consider that not many practitioners would view cognitive therapy, cognitive behavior therapy, and cognitive processing therapies as *distinct* entities). Second, asking practitioners to learn discrete treatment packages for specific disorders is impractical and onerous. Third, the need for sharp discriminations between interventions arises primarily as a function of the methodological frames of RCTs, rather than the necessities of clinical practice. Fourth, there is a very good case to be made that what is key in effective psychotherapy is being guided by evidence-based principles and processes, rather than steadfast adherence to any particular manual.

Another critique of the Guidelines is that they employ the frame of matching a specific disorder to specific interventions, with little attention to the process of psychotherapy with specific individuals, the expertise of the therapists, or the context of treatment delivery.

Put differently, the Guidelines seemed to jump the field back two decades to the Empirically Supported Treatment movement and away from principles of Evidence Based Practice (APA, 2006). Part of that shift stemmed from the empirically demonstrable value of viewing psychotherapy as a psychosocial process. When viewed as such, the focus of therapy is less in terms of specific diagnoses matched to interventions, and more in terms of a process of forming a strong healing relationship, developing a shared conceptualization of the problem, developing clear and agreed-upon tasks in the therapy that foster adaptive change, and monitoring the relationship and change processes for effectiveness. Much research suggests that when this process is done well, good outcomes follow, and when this is done poorly, poor outcomes follow. This has been found repeatedly in the literature, so long as a practitioner is using a bona fide approach to treatment (meaning a credible approach stemming from any of the major frameworks, such as CBT, humanistic existential, psychodynamic or family systems). Nothing in the Guidelines suggested that this process view was not valid, and it is important to keep in mind that the vast majority of the RCTs involved comparing the tested intervention to relatively simplistic control conditions, rather than to bona fide treatment approaches.

My final critique is that methodological conflicts over RCT research are entangled with philosophical conflicts between the proponents of the major therapeutic paradigms, specifically those who view the practice of psychotherapy more from a CBT lens versus a psychodynamic or humanistic/existential lens. For a whole host of reasons, some of which are more historical and sociological than substantive in nature, proponents of the former tend to be much more supportive of RCTs than proponents of the latter. As such, we see those from psychodynamic perspectives critiquing the Guidelines and those from CBT perspectives supporting them. But this CBT versus psychodynamic split is highly problematic from a more unified, principles-based perspective on the field.

I know of some clinical scientists who argue that the commitment to empirical research moves them beyond the “paradigm wars.” However, empirical research per se does not free individuals from the need for conceptual schemes from which to design, interpret, and apply that research. Ultimately, what is needed in addition to empirical research is a serious and systematic effort to develop meta-theoretical perspectives that allow for the conceptual organization of the field at higher levels of analysis. Such conceptual schemes do the important work of placing the paradigms in relationship to one another and allowing both researchers and practitioners a way to assimilate and integrate key findings and insights into a coherent whole. This would allow practitioners to be guided by holistic models of human functioning and evidence-based change principles in the therapy room. ■

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Adherence to Clinical Practice Guidelines in Psychology: Concerns over Uptake of Updated Guidelines for the Treatment of Adults with Posttraumatic Stress Disorder

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 It is with great interest that we have followed the discussion on the APA Division 12 listserv pertaining to the recent APA clinical practice guideline (CPG) for the treatment of adults with posttraumatic stress disorder (PTSD; American Psychological Association, 2017). We have observed praise and concern, and the development of petitions in support and opposition of the updated guidelines. This is not atypical of what is observed across professional psychology or within mainstream medicine. While it is arguably important that all perspectives be thoughtfully considered, it seems pertinent to highlight the purpose of CPGs, along with their utility and the potential consequences associated with failing to enact recommendations in the absence of contraindications for not doing so.

CPGs are the primary means of synthesizing the best available evidence and providing recommendations to support dissemination of current best practices across a range of clinical disorders. The purpose of CPGs are to assist providers in making informed decisions about treatments that are based on empirical evidence, clinical expertise, and patient characteristics, rather than to promote rigid adherence to manualized interventions. Implementation and adherence to CPGs have been effective in improving the process and structure of care, and has led to improved patient outcomes (Lutenberg, Burgers, & Westert, 2009). Despite strong evidence supporting the benefits of their use, health care practitioner adherence to CPGs in medicine is remarkably low, with studies reporting rates of nonadherence in excess of 50% (refer to Lavoie, Rash, & Campbell, 2017). Similar results have been noted in the field of professional psychology. For

example, an evaluation of six Veteran Affairs medical centres reported that only 10% of PTSD specialists and generalist mental health providers routinely provided guideline recommended psychological treatment for PTSD (Rosen et al., 2004). Provider nonadherence to CPGs despite a clear indication to implement recommendations in the absence of contraindications is referred to as *clinical inertia* (Lavoie et al., 2017). The impact of clinical inertia on patient outcomes has been well documented in the field of medicine, where it holds major importance in patient outcomes. For example, it has been estimated that provider nonadherence to CPGs account for up to 80% of myocardial infarctions and strokes in the context of sub-optimally treated hypertension, diabetes, and dyslipidemia. Unfortunately, comparable evidence has not yet been synthesized in the field of psychology.

Barriers to the implementation of CPGs involve a complex interaction between three factors: 1) organizational and system factors, such as time constraints or lack of resources; 2) patient factors, such as preferences or low adherence; and 3) provider factors, such as agreement with guidelines (Lavoie et al., 2017). In medicine, the strongest contributors to clinical inertia are provider-related factors, accounting for more than 50% of variance. There are numerous reasons why healthcare providers deviate from CPGs. Our team has identified five factors that are particularly salient: i) knowledge or awareness of clinical guidelines, ii) agreement with guidelines or their applicability, iii) cognitive biases, iv) motivational factors, and v) self-efficacy to implement guidelines. While the study of clinical inertia in psychology is still in its infancy, it is likely that similar factors are at play. Members of APA Division 12 have voiced several concerns over the updated CPGs for the treatment of adults with PTSD that fall within these categories. Some of the most frequently occurring concerns included: i) disagreement with guidelines, particularly with the synthesis of evidence solely from RCTs; ii) uncertainty whether recommendations will apply to diverse patients typically seen in clinical care; iii) lack of familiarity with control conditions utilized in trials that influenced guideline recommendations; iv) low confidence to enact guideline recommendations with diverse trauma presentations; and v) low readiness to change current practice.

The updated CPG for the treatment of adults with PTSD was based on a systematic review of studies published between 1980 and 2012 and examined the current research pertaining to: i) the efficacy of psychological and medication treatment; ii) comparative effectiveness; iii) treatment effects in the context of patient characteristics; iv) and the influence of patient preference and potential harm (American Psychological Association, 2017). Based on this review, the CPG strongly recommends cognitive-behavioural therapy (CBT), cognitive processing therapy (CPT), cognitive therapy (CT), and prolonged exposure therapy (PE). The CPG also suggests the use of brief eclectic psychotherapy (BEP), narrative exposure therapy (NET), and the pharmacotherapies fluoxetine, paroxetine, sertraline, and venlafaxine.

Recommendations were based on: i) strength of evidence; ii) treatment outcomes and the balance of benefits vs. harms and burdens of interventions; iii) patient values and preferences; and iv) applicability of the evidence to various treatment populations. We fully appreciate the difficulties inherent in evaluating the effectiveness of psychological treatments given that treatment effects are composed of intervention effects, provider-expertise, common factors, and patient preferences and expectancies, among other influences. It is also challenging to conduct rigorously controlled trials that parse out this myriad of influences while highlighting the empirically-supported processes of change. Fortunately, trials synthesized in the updated CPG for the treatment of adults with PTSD provide evidence pertaining to these challenges and are summarized within the appendices (refer to <http://www.apa.org/ptsd-guideline/index.aspx>).

Several interventions have been developed to reduce clinical inertia and improve the utilization of CPGs in the field of medicine (refer to Lavoie et al., 2017 for a review). At present, there is insufficient information on clinical inertia in the context of psychological treatments to help guide decision-making. For example, a review of PubMed from inception until April of 2018 using the terms ("Guideline Adherence"[Mesh]) AND "Stress Disorders, Post-Traumatic"[Mesh]) resulted in 23 citations with few citations of clear relevance. Given the comments on APA Division 12's Listserv, we suspect that clinical inertia will be a concern to the implementation of the updated CPGs for the treatment of adults with PTSD. It will be necessary to determine if provider decisions not to implement these CPGs will be due to empirically informed decision-making regarding the appropriateness of the treatment for particular clients, or clinical-inertia. Further, it will be important to elucidate provider-related concerns so that strategies can be implemented to improve dissemination, systematically improve available evidence, and, ultimately, advance patient care. ❧

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Considering the strength of nonspecific treatment effects in PTSD

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We are writing to you today to address some issues relevant to the *American Psychological Association's PTSD Guidelines*. As you are probably aware, there has been a backlash in response to these guidelines, including the circulation of an online petition (<https://www.thepetitionsite.com/takeaction/480/492/776/?cid=headerClick>) asserting that the guidelines “did not take into account the evidence for intensive ‘talk therapy’ and for other treatments that have helped countless thousands of traumatized people get back on their feet and change their lives.” In this brief communication, we would like to give some perspective on this issue. Bear with us for a few paragraphs while we set the stage for some interesting evidence for supportive/psychoeducational treatment effects in PTSD.

As you may know, the guidelines were based on evidence from randomized clinical trials (RCTs). RCTs give an estimate of the strength of treatment effects when they are compared to either no treatment (e.g., a waitlist condition) or to some sort of “psychological placebo” condition. These “placebo” interventions are, in general, designed to control for the non-specific but nonetheless valuable common elements of treatment: things like establishing a supportive relationship with a caring clinician and receiving information about the disorder to normalize symptoms and to spur problem-solving efforts. Sometimes more complex treatments are also included as “placebo” conditions. This is the case with some PTSD treatment trials; for example, Present-Centered Therapy (PCT) has been used as a comparison condition to trauma-focused cognitive-behavior therapy. PCT is an interesting comparison condition because it is not a trauma-focused therapy and instead emphasizes active problem-solving training to minimize the effects of trauma and trauma-related responses on patients’ lives.

A strength of RCTs, then, is that a treatment undergoing evaluation must offer an outcome that is significantly stronger than the waitlist and/or active comparison conditions. Moreover, when it comes to summaries of studies as used in meta-analyses and the APA Guidelines process, a treatment must beat these comparison conditions repeatedly, so that we know that the overall outcomes averaged across trials represent more than just a lucky finding. Reliability of findings matters, because it means that benefit was observed across studies, across research settings, and, in the case of PTSD, across many different patients with

many different traumas.

In the petition, there is a complaint that the guidelines were reliant on this sort of averaging process from well-controlled trials. Specifically, the petition asserts that, “Due to the exclusive reliance on RCT outcomes in formulating the guideline, other legitimate research findings crucially and commonly supporting additional forms of PTSD treatment were not considered in the assignment of ‘strong’ recommendations.” Ironically, however, the information provided by RCTs can give us some additional insight into some of the alternative forms of treatment, insofar as they were included as control or comparison interventions in addition to the targeted treatment. As such, let’s turn our attention to the research evidence for *the strength of these comparison interventions*.

This process is aided by the very recent publication of a meta-analysis by Carpenter and associates (2018) (<https://www.ncbi.nlm.nih.gov/pubmed/29451967>) examining the efficacy of CBT relative to “psychological placebo” conditions rather than to waitlist control conditions. Accordingly, this is a meta-analysis of the ability of targeted treatments to beat a higher standard – namely to outperform clinical interventions emphasizing common elements like clinician support and psychoeducation. In general, the answer from this meta-analysis for anxiety disorders is that CBT offers efficacy over and above these alternative approaches. More importantly for the topic at hand, the Carpenter et al. (2018) meta-analysis can also be used to provide an index of the strength of these comparison treatments for PTSD. We recently asked the first author to break out this statistic from the overall results, and here is the result: For all of the psychological treatment control conditions (e.g., supportive treatments and PCT) included in the Carpenter (2018) meta-analysis, the *within-group* Hedges’ *g* is 0.54 (95% CI = 0.41-0.67). This includes 13 studies total.

This means that there is reliable evidence of improvement from pre-treatment to post-treatment in these comparison conditions. This effect is certainly part of what is observed in clinical practice, and is consistent with the claim in the petition of evidence “for other treatments that have helped countless thousands of traumatized people get back on their feet and change their lives.” But how strong are these treatment effects? After all, the within-group pre-treatment to post-treatment effect size does not control for non-treatment-related recovery effects, making it difficult to get an estimate of how well a comparison treatment works relative to no treatment. To estimate this effect we would need to include a waitlist condition in addition to the common elements comparison condition, which is rare to find in an RCT. Fortunately, we were able to identify four stalwart PTSD research teams that have done exactly this. Based only on these four studies, it turns out that “psychological placebo” treatments used in RCTs have an advantage over no treatment (waitlist control) on the order of a moderate effect size: *d* = 0.57 (between-groups Cohen’s *d* effect size at post-treatment).

We have to admit some surprise at the strength of this effect for supportive and PCT interventions for PTSD. We tend to think of PTSD as difficult to treat, perhaps because it is often emotionally painful for clinician and patient alike. In this context, we are surprised at how well supportive, psychoeducational, and problem-solving treatments did. As such, we agree fully with one specific assertion from the authors of the petition – a range of treatments can offer benefit to PTSD patients!

But of course, the purpose of the Guidelines was not to show that patients can get some benefit from any treatment. The purpose, as we understand it, was to identify the treatments that have reliable evidence for *strong* benefits. Based on our review of the APA PTSD Guideline effect sizes, treatments emphasizing prolonged exposure ($d = 1.27$) and treatments emphasizing other cognitive-behavioral and cognitive interventions ($d = \sim 1.0$) have effects that are roughly *double* that of the comparison treatment estimate noted above ($d = .57$). That is, to our eyes, the guidelines correctly direct attention to the treatments that seem to be offering the very best outcome to patients as evaluated by repeated controlled trials. Other treatments provide benefit, but the most reliable evidence for the strongest benefits is for trauma-focused treatments emphasizing prolonged exposure, cognitive behavioral therapy, cognitive processing therapy, or cognitive therapy. It is for these reasons and others that clinical researchers are now circulating a very different petition (<https://www.thepetitionsite.com/780/537/970/support-the-apa-ptsd-treatment-guidelines/>) to underscore their support for the PTSD Guidelines.

A core feature of the mission of Division 12 of APA is “to represent the field of Clinical Psychology through encouragement and support of the integration of clinical psychological science and practice in education, research, application, advocacy and public policy...” As clinical researchers and clinicians we think the guideline process is valuable for encouraging treatment approaches that have shown their mettle under the bright lights of scrutiny that controlled trials offer. Given these successes, it seems only right that the APA guidelines encourage us to shine our own attention on these treatments when we consider what is right for our patients suffering from PTSD. This is what guidelines are supposed to do. ■



Clinical practice guidelines are based on the literature we have, not the literature we wish we had: Response to Henriques, Saunders, and Otto

Bethany A. Teachman, Ph.D.


Chair of the Advisory Steering Committee of the American Psychological Association Clinical Practice Guidelines initiative; Department of Psychology, University of Virginia

Lynn Bufka, Ph.D.

Associate Executive Director, Practice Research and Policy, American Psychological Association

Steve Hollon, Ph.D.

American Psychological Association Board of Professional Affairs; Former Chair of the Advisory Steering Committee of the American Psychological Association Clinical Practice Guidelines initiative; Department of Psychology, Vanderbilt University

 We greatly appreciate the ideas raised in the Comments and the diversity of thoughtful perspectives about what clinical practice guidelines offer. A theme across the three Comments concerns whether clinical practice guidelines offer something incremental (compared to principles of change, as discussed by Henriques; compared to non-specific factors, as discussed by Otto et al.; and compared to practicing without guidelines, as discussed by Saunders et al., following from their important work in the field of medicine). The question of incremental validity is an excellent one and we consider the important points raised by the three Comments in turn.

Dr. Henriques raises a number of points in his critique of clinical practice guidelines with which we largely agree, but also suggests some arguments that we would not endorse. For example, we strongly agree with the principle that it would be best if the field moved toward principles of change to guide practice, rather than treatment packages. We read the recent PTSD guideline as an endorsement of the principle of exposure (the interventions most strongly recommended utilized various strategies to encourage patients to confront their traumatic experiences) as much as an endorsement of the particular treatment packages recommended (i.e., prolonged exposure, cognitive processing therapy, cognitive therapy, and others). The problem is that most of the controlled experiments conducted in the existing literature test treatment packages, rather than principles. We do not think it is a big leap to go from the fact that those packages that all utilize exposure in one form or another have garnered the most empirical support to the notion that

exposure is likely the efficacious component of those packages. As Penny would say to Leonard on the Big Bang Theory: "Do not overthink it". Thus, we strongly endorse the notion of a principle-based approach, and believe it is unfortunate that the field has largely tested packages, not principles. We can do better, and hope that one day soon we will have the empirical literature base that will allow for the development of clinical practice guidelines based on principles of change.

We would not insist that someone slavishly follow any specific treatment package and we do not do that in our own research or clinical care. Treatment manuals are aspirational and their implementation often involves modifying the approach to fit the needs of the given patient, treatment setting, etc. That said, one of the challenges facing the field is we do not know how much modifying is 'okay' before one can no longer generalize from the initial evidence base supporting the intervention. The concept of "*flexibility within fidelity*" provides helpful guidance on this challenging issue (Hamilton, Kendall, Gosch, Furr, & Sood, 2008). If Dr. Henriques implements exposure principles within the context of a supportive therapeutic relationship and sets clear treatment goals and monitors progress toward those goals, then we think that he is operating within the spirit of the guideline recommendations. We are advocates of clinical practice guidelines because we think that those interventions that have been shown to be efficacious deserve to be promulgated to the public, but we do not assume a rigid one-size-fits-all model of care.

We also agree with Dr. Henriques that the nature of the therapeutic relationship likely plays a role in outcomes, but we caution against assuming that it necessarily plays a causal role. Randomized controlled trials (RCTs) compare treatment packages to control conditions to allow causal inferences to be made. Process research often is correlational in nature and thus, while suggestive, does not allow causal inferences to be drawn. For example, it is well established that patients who respond to treatment have more positive impressions of the quality of the therapeutic relationship (Norcross, 2011). While it is tempting to draw a causal inference from such correlational data, it could be that patients who do better in treatment rate the quality of the therapeutic relationship more positively (reverse causality) or that some third variable leads to both better outcomes and perceived quality of the therapeutic relationship (epiphenomenon). While we share Dr. Henriques' belief that the treatment process likely contributes to the quality of the outcome, we cannot prove that this is the case. As we said in our opening Comment, absence of evidence is not evidence of absence, and we are in no way suggesting that the treatment process is not important. However, clinical practice guidelines are by necessity based on a systematic review of the literature we have, not the literature we wish we had.

Finally, we strongly agree with Dr. Henriques that interventions that have yet to be adequately tested may indeed be efficacious. For instance, John Markowitz has data suggesting that interpersonal psychotherapy

(IPT) may be efficacious in the treatment of PTSD despite the fact that it does not involve explicit exposure. Further, Peter Fonagy's response to dynamic therapies not being recommended in early versions of the NICE guidelines has been to conduct RCTs to investigate the efficacy of dynamic therapy in the treatment of patients with personality disorders, and its enduring effects in the treatment of depression (Fonagy et al., 2015). Guidelines must reflect the existing empirical evidence, but gaps in the evidence can be filled by subsequent RCTs that test the efficacy of traditional interventions.

We consider the critique by Dr. Saunders and colleagues as largely supportive of the guideline, and appreciate their thoughtful comments on cautionary tales from medicine that will likely also apply in the practice of psychosocial therapies. The authors call for treatment decisions to be based on the best available evidence as filtered through clinical expertise in a manner consistent with patient preferences and predictions (Institute of Medicine, 2001). The authors go on to point out that non-response is highly related to non-adherence to the treatment protocols. The authors do a good job of laying out barriers to successful implementation: 1) operational and systematic factors; 2) patient factors, such as time constraints and lack of resources; and 3) provider factors, such as agreement with guidelines. The authors go on to cite multiple factors that can undercut adherence to guidelines: i) disagreement with guidelines, particularly with the synthesis of evidence solely from RCTs; ii) uncertainty about whether recommendations will apply to diverse patients typically seen in clinical care; iii) lack of familiarity with control conditions utilized in trials that influenced guideline recommendations; iv) low confidence to enact guideline recommendations with diverse trauma presentations; and v) low readiness to change current practice. The Saunders article provides valuable guidance as we move from generation of guidelines to their dissemination and implementation, and points to numerous gaps in the literature about the best ways to address barriers to the adoption of guidelines by mental health providers.

Dr. Otto and colleagues use meta-analytic principles to decompose the relative contributions of the different components of psychosocial treatment. This analysis is extremely valuable to determine what, if anything, the specific treatments identified in the guideline offer for patients beyond the important benefits that they show will follow from non-specific factors. In essence, Otto and colleagues provide a basis for drawing causal inferences based on trials using different sets of comparison conditions, and it is impressive. Treatments that include trauma-specific factors appear to have approximately double the effect size compared to conditions with nonspecific factors alone, but both have valuable effects. An important question raised by their thoughtful analyses is how much these nonspecific effects account for larger or smaller amounts of variance across different disorders and populations. There is a critical need for more studies that can tease apart which factors are necessary and sufficient to achieve the positive outcomes we all desperately want for our

patients. As we noted in our discussion about the lack of research on principles of change, and our discussion about the gaps in our knowledge about best practices to dissemination and implementation of mental health treatment guidelines, so too we need more research across problem areas on the causal role of nonspecific factors.

Nonetheless, we are optimistic – while clinical practice guidelines are based on a systematic review of the (all too limited) literature we have, not the literature we wish we had, we are hopeful that guidelines, along with helpful exchanges like those raised in these Comments, will encourage this important research to be conducted. We hope the literature will have matured so that clinical practice guidelines will look very different 20 years from now!

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Upcoming SCP CE webinar!

Dr. Christine Maguth Nezu: Becoming Board Certified by the American Board of Professional Psychology (ABPP)

May 16, 2018, 12-1 PM EST

Overview: This webinar will provide a rationale regarding the importance of specialty certification in professional psychology with a particular focus on the areas of specialization that may be of interest to Division 12 members, student members, and fellows who are not currently board certified. Several important benefits of board certification will be described as well as the benefits and the importance of board certification to professional psychology in general. The sequence of board certification including the examination process as well as opportunities for both an early application process and the senior examination process will underscore the value of board certification across the spectrum of professional development. The Functional and foundational competencies that are the focus of the ABPP board certification will be illustrated and discussed.

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SCP Member Spotlight on Kelly J. Rohan, Ph.D.

Dr. Kelly J. Rohan is one of a handful of clinical psychologists in the world who conducts research on winter depression (A.K.A., seasonal affective disorder; SAD). Among her most significant accomplishments is developing and testing a cognitive-behavioral therapy protocol for SAD (CBT-SAD).

In a series of randomized clinical trials, Dr. Rohan has shown that CBT-SAD results in symptom improvements and post-treatment remission rates comparable to light therapy. However, CBT-SAD is superior to light therapy in terms of its long-term outcomes, including winter depression recurrences and symptom severity following treatment. Durable treatment effects are critical for recurrent forms of depression like SAD, and Dr. Rohan's research is truly a significant contribution to the field.

We had the opportunity to learn more about Dr. Rohan and her work through our Q&A correspondence over the past month. Read on to learn more!

Training Background and Current Positions

Doctoral Training: University of Maine (Clinical Psychology Program)

Internship and 2-year postdoctoral fellowship: University of Mississippi Medical Center/Veterans Affairs Medical Center Consortium, Jackson

Current position: Professor of Psychological Science and Director of Clinical Training, University of Vermont

SCP and other memberships/leadership positions:

- SCP Member since 2001
- Program Committee Member for the Association for Behavioral and Cognitive Therapies (ABCT) Annual Convention every year since 2002

What's something nobody would know about you?

I will give you two: (1) I am first-generation college student from a low SES family background. This is what I attribute my grit to. My mother took out loans she could not afford to send me, her youngest child of three, to college. Thanks, Mom! (2) If I were not a clinical psychologist, I like to think that I would be hosting my own show on HGTV.

What are your hobbies?

I think it's important for me to practice what I preach in CBT-SAD. I enjoy walking or jogging outside for 4 miles every day, year-round, regardless of the weather. In the winter in Vermont, this might require ski pants and even snow shoes, but I embrace the challenge and do it anyway because I enjoy it.



What led to your interest in seasonal affective disorder (SAD)?

Kelly J. Rohan

I was in the right place at the right time. I did my clinical psychology graduate training at the University of Maine in Orono, ME in the 1990s, working under the tutelage of Dr. Sandy Sigmon whose work focused on adult depression. In working on those studies, I noticed an influx of depressed people to study in the fall and winter months, but you could hear crickets in the lab during the spring and summer months. Observing this seasonal ebb and flow in our depression studies made me aware of seasonal patterns in depression and led me to explore the new, but growing research on winter depression (A.K.A., seasonal affective disorder or SAD). I noticed that the field was then dominated by biological psychiatrists and circadian biologists who were interested in the biological clock's role in SAD and the development of chronobiological treatments such as light therapy. I saw an opportunity for a cognitive-behaviorally minded clinical psychologist to bring a fresh perspective. I decided to focus on this topic for my doctoral dissertation, which was a longitudinal study comparing SAD patients and non-depressed controls on cognitive and behavioral vulnerabilities to depression in the fall, winter, and summer. The results suggested that the same cognitive and behavioral vulnerabilities that are involved in non-seasonal depression (e.g., dysfunctional attitudes, rumination, low pleasant event frequency/enjoyment) applied to SAD as well. This led me to develop and test the cognitive-behavioral therapy for SAD (CBT-SAD) intervention as a way to target these vulnerabilities.

What are some of the unique aspects and challenges of your research area?

Even though ancient physicians and philosophers wrote about the impact of changing seasons on mood and people have been talking about the "winter blues" around the water cooler since the beginning of time, this subtype of recurrent depression was not formally recognized until 1984 when Norman Rosenthal and colleagues at the National Institute of Mental Health published their seminal paper (Rosenthal et al., 1984,

Archives of General Psychiatry). It is, therefore, a relatively new research area. The field, then and now, is dominated by biological psychiatrists and circadian photobiologists. This has been an interesting experience for me as a perceived “outsider” working in this research area. The application of cognitive-behavioral theories and therapy to SAD is viewed as “controversial” by this camp. For example, a SAD researcher once said to me, “Thoughts? These patients don’t have thoughts. Why do you care about their thoughts?”

Many clinical psychologists I know run in circles where they are surrounded by like-minded people, where sharing their ideas and findings is like preaching to the choir. Early in my career, I was both hurt and confused by the pushback I experienced from the field. I was clearly seen as a threat in that my work challenged beloved central dogma, and, as a result, it was much harder for me to publish and get grants than it should have been in light (pun intended) of my data. I would give a presentation at the Society of Light Therapy and Biological Rhythms that felt like walking into the “lion’s den.” Over time, however, I have come to find it intellectually engaging to present and defend my work in these circles. I know my graduate students have benefited from seeing me model taking a calm, empirical stance each time I am put on the defensive. My mantra is “Let the data speak.”

Tell us about the recent features on your research in media/news outlets! What has it been like to have your work receive so much attention?

Last month at the University of Vermont, Tim Appenzeller, the News Editor of Science Magazine is giving a talk, titled “Why is that Study in the News: Getting Your Research Covered in the Popular Science Press.” Jokingly, I said that I should launch a talk on how to get the media to leave you alone. One consequence of doing research that challenges dogma is the press takes notice. I am extremely popular in the fall and winter months. SAD is a popular topic in the lay public, probably because it occurs on a continuum and most people at a high latitude can relate to it. I am not sure why I have become one of the main spokespersons for SAD in the popular press. Perhaps it is because I am a psychologist and well-versed in explaining complex concepts and research findings to diverse and lay audiences.

My biggest media splash occurred in 2016 when I published the results of my most recent CBT-SAD trial in the American Journal of Psychiatry. That paper was covered by more than 350 media outlets around the globe, including BBC News, Washington Post, Huffington Post, The Pacific Standard, the Atlantic, New York Magazine, Smithsonian, Web MD, Medscape, Science Daily, Daily Mail, US News and World Report, and Medical News Today. For a single

weekend, “seasonal affective disorder” was trending in the top 10 on Yahoo (with all the coverage of my study) right behind two Kardashians and some controversy surrounding a dangerously plunging neckline sported by Kylie Jenner. “Now you’ve really made it,” my family joked.

As I was doing a 12-city radio tour with the Canadian Broadcast Company (CBC) about the study, I asked myself, “Why am I doing this?” For most academic faculty members (myself included), media appearances are a major time suck for which we do not receive any tangible rewards. It does not even count as service in our workloads. However, with time, I have come to accept its importance. As psychologists, we have a responsibility to educate the public about research findings and their implications. We are trained to be effective communicators, and this type of service is one way we can “give back” to the field.

Please submit nominations to:

Member Spotlight: <https://www.div12.org/member-spotlight/>



SCP Member News

The Membership Committee is pleased to share the extraordinary accomplishments and ongoing contributions made by SCP members to the field of Clinical Psychology.

Marvin R. Goldfried

Dr. Goldfried, a former President of SCP, has received the American Psychological Foundation/American Psychological Association 2018 Gold Medal for Life Achievement in the Application of Psychology. This award recognizes a distinguished career and enduring contribution to advancing the application of psychology through methods, research, and/or application of psychological techniques to important practical problems.

Rachel Hershenberg

Dr. Hershenberg recently published a self help book for depression and low motivation entitled, "Activating Happiness: A Jump Start Guide to Overcoming Low Motivation, Depression, or Just Feeling Stuck." The book includes a forward by SCP Past President, Marvin Goldfried and was recently featured in the Atlanta Journal Constitution and US News & World Report. Dr. Hershenberg's book was also selected by Success Magazine as one of 72 of 2017's Best Books to Make You Successful.

Adam Leventhal

Dr. Leventhal, an Early Career Psychologist Member, served as psychologist member of the National Academies of Sciences, Engineering, and Medicine panel investigating vaping. He was recently quoted in a NY Times article entitled "Vaping Can Be Addictive and May Lure Teenagers to Smoking, Science Panel Concludes" ([click here to link to Article](#)).

Danny Wedding and Raymond Corsini

Cengage released the 11th edition of Current Psychotherapies in March 2018, edited by Dr. Wedding (a former SCP President) and Raymond J. Corsini. This foundational text helps students learn, compare, and apply the major systems of psychotherapy. It has been continually in print since 1960, has been translated into more than a dozen languages, and is used in top Psychology, Counseling, and Social Work graduate programs. Four other past Presidents of SCP have contributed to the book: Carl Rogers, Martin Seligman, Larry Beutler and John Norcross.

Please submit nominations to:

Members in the News: <https://www.div12.org/members-in-the-news/>

Upcoming SCP CE webinar!

Dr. Rebecca Allen: Ethical Practices in Geropsychology

June 5, 2018, 12-1PM EST

Overview: The content of this webinar is supported by the scientific and clinical practice activities completed by Dr. Rebecca Allen following completion of her Ph.D. at Washington University in St. Louis in 1994. Dr. Allen became board certified by the ABPP in Geropsychology in 2014 and, along with Dr. Shane Bush, she has helped develop the ethics vignettes used in the ABPP oral examination. Dr. Allen holds scientific expertise in: (a) the design of interventions to improve quality of life for individuals near the end of life and their families and (b) diversity as it influences medical decision making. Dr. Allen is a First-Generation Scholar committed to a career in teaching/training the next generation.

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The Importance of Acknowledging Sexual Violence Against Women in our Current Sociopolitical Context

Elizabeth Yeater, Ph.D.

University of New Mexico



Sexual violence against women is a significant public health problem, and one that creates untold suffering for victims. While men and women of various ages are sexually victimized, women report higher rates of sexual violence than men, with approximately 12-22% of women in the United States experiencing adult sexual assault (Balsam et al., 2005; Martin et al., 2011). Additionally, college women are a particularly high-risk group for being assaulted, with 25% of these women reporting an attempted or completed rape (Fisher et al. 2000; Krebs et al. 2007).

The sequelae of sexual violence are substantial and involve both psychological and physical health problems, including problematic alcohol use and alcohol-related problems (Bedard-Gilligan et al., 2011; Hughes et al., 2010; Ullman & Brecklin, 2003); posttraumatic stress disorder (PTSD; Faravelli et al., 2004); sexual, eating, and mood disorders (Faravelli et al., 2004); sexually transmitted infections (STIs); and rape-related pregnancies (Holmes et al., 1996; Kuehn, 2011). Myriad studies also have demonstrated a robust relationship between a history of victimization, either in childhood or emerging adulthood, and sexual revictimization (e.g., Classen et al., 2005; Messman-Moore & Long, 2003). Notably, sexual revictimization has been linked to significant increases in risk for depression, posttraumatic stress disorder, and heavy episodic drinking (Casey & Nurius, 2005; Kimerling et al., 2007).

Despite the high prevalence and significant impact of sexual violence on women, sexual assault cases are often addressed inadequately by our criminal justice system, and the majority of reported cases are never prosecuted (Rennison, 2010; Truman & Planty, 2012). Moreover, less than half of women who experience an act of sexual violence meeting the legal definition of rape acknowledge their experience

as such (Bondurant, 2001; Kahn et al., 1994), and women who have difficulty labeling their experience appropriately experience greater difficulty recovering from the psychological sequelae of rape (Kahn et al., 1994; Bondurant, 2001; Littleton et al., 2006). In our current sociopolitical climate, women may be even more reluctant to come forward to report a sexual assault or to ask for help dealing with the effects of these violent acts. It has been argued by those in the field (e.g., Becker-Blease & Freyd, 2006; Yeater, Miller, Rinehart, & Nason, 2012) that there is a significant cost to our science and practice (and, hence, to victims themselves) when we fail to inquire about possible traumatic experiences. Thus, to be silent about sexual violence is tacitly to support such acts; thus, it is incumbent upon us to inquire about possible acts of sexual violence among our clients. ■■

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Upcoming SCP CE webinar!

Dr. Patricia J. Robinson: Clinician Wellness: Mindfully Building Resiliency Day by Day

June 13, 2018, 12-1PM EST

Overview: This webinar is intended for all audience levels, from students to advanced professionals. The webinar describes use of mindfulness and value-based behavior change planning to enhance resilience at work and in “the rest-of-life”. It will provide a brief introduction to Acceptance and Commitment Therapy (ACT) and an adapted version of ACT, known as fACT. Participants will learn about tools to assist them with identifying sources of and magnitude of stressors in their lives and for measuring their current level of psychological flexibility. Psychological flexibility is the result of skills that promote resilience in encountering the stresses of work and life mindfully and persisting in the pursuit of chosen meaningful life directions. Participants will be guided through worksheets to assist the with development of a plan to enhance resiliency. The recommended approach has been used with a variety of workers in Great Britain and found to be associated with greater job satisfaction, a higher sense of job control, and better retention of workers. The approach is used increasingly in the United States in primary care settings, where behavioral health providers and medical providers work together in providing team-based care.

CE Credits Available: 1

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

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



Society of Clinical Psychology, Division 12 2018 Election Ballot, Slate of Candidates

We would like to introduce our 2018 Slate for the 2018 Division Elections. Voting Members, those who are fellows and/or Full Members of Division 12 and APA are eligible to vote beginning April 16. The election will run through May 30, 2018. You will be able to vote via the APA Website.

Please see all Candidate Statements below. If you would like to see a copy of a candidate's CV, please contact the Division 12 Central Office at division12apa@gmail.com. These will also be viewable on the Division 12 website and with APA.

Names appear in alphabetical order for each position.

President-Elect: 2 Candidates

Douglas Mennin, Ph.D.

I am honored to be nominated for President of SCP/Division 12. I have been an affiliate or member of SCP since I was in graduate school. In my prior professional roles including serving on the SCP board, I have spearheaded initiatives to increase professional awareness of these organizations, grow memberships, and promote greater awareness in the general public regarding the science and practice of modern mental health approaches. I am particularly excited about serving a leadership position in SCP given its premier role in representing not only the interests of clinical psychologists but also their identity. In divisive times when we can find ourselves on opposing lines of science and practice as well as greater divisions in our society at large, I remember what is so special about the clinical psychology profession: the ability to serve in multiple professional identities and integrate these roles to the betterment of public well-being and healthy functioning. I would welcome organizing efforts to draw together our best scientific and professional roles in service of addressing current societal problems where the field of clinical psychology can be a shining light of validation and transcendence including such problems as mental health stigma, violence and trauma, and the opioid crisis. Further, the organization can do better in involving young professionals and introducing them to the storied history of the Society but also listening to them in terms of their thoughts for carrying the field of clinical psychology forward in the 21st century.



Elizabeth Yeater, Ph.D.

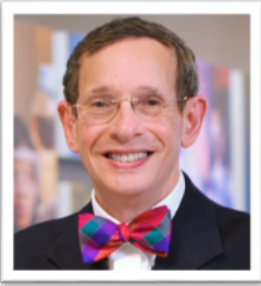
I am Director of Clinical Training and Associate Professor in the Psychology Department at the University of New Mexico. I serve in multiple roles in my current position – clinical supervisor, researcher, teacher, mentor, and Head of our APA Accredited Doctoral Program. My research investigates cognitive 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 influence these processes. My work is funded by NIAAA.



I have served for the Society of Clinical Psychology (SCP, Division 12) through my role on the Diversity Subcommittee. I have also 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 to launch careers of clinical psychologists. I want to increase the value of SCP for future members, while also enhancing value for psychologists who make up our ranks. As a trainee of Dick McFall at Indiana University, I have pursued my 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 of integrating science and practice. Through proper training, we can achieve our goal of reducing human suffering.

Counsel-Representative:

2 Candidates



Gerald Koocher, Ph.D., ABPP

Since earning my Ph.D. in clinical psychology at the University of Missouri, I have served as Chief Psychologist at Boston Children's Hospital, Executive Director of the Linda Pollin Institute at Harvard Medical School, as

Dean and Associate Provost at Simmons College, and currently Professor and Dean of the College of Science and Health at DePaul University in Chicago.

In Division 12, I formerly served as Treasurer, President, and Editor of *The Clinical Psychologist*. I founded the journal *Ethics & Behavior*, edited the *Journal of Pediatric Psychology*, and serve as Associate Editor of *Practice Innovations*. I have 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 Clinician's guide to evidence-based practices: Mental health and the addictions*.

I earned Fellow status in twelve APA divisions and the American Association for the Advancement of Science, as well as five specialty diplomas from the American Board of Professional Psychology (Clinical, Clinical Child /Adolescent, Family, Forensic, and Health Psychology). I hold active psychology licenses in Illinois, Massachusetts and New Hampshire. I served as Treasurer (1995 – 2005) and President of APA (2006). I currently serve as a Trustee of the American Insurance Trust and Parliamentarian of APA.

I would be honored to serve as one of your Council Representatives and respectfully ask for your vote.



Kim Penberthy, Ph.D., ABPP

I am the Chester F. Carlson Professor of Psychiatry & Neurobehavioral Sciences at the University of Virginia School of Medicine and Health System, where I have been on faculty since finishing my fellowship in 2000. I

am a practicing clinical psychologist, researcher and educator. I am honored to have the opportunity to ask

for your vote for the position of APA Division 12 Council Representative, where I hope to continue the good work of our representatives in addressing the key concerns confronting APA and psychology. APA remains the principal professional association for our discipline and plays a pivotal role in promoting and supporting research, education, and training as well as informing practice and policy for psychology. Important issues include APA reorganization, masters' level training, and clinical practice guidelines as well as more generally promoting the relevance and strength of the science of psychology in today's environment. Additional issues regarding the role of psychology in health care, issues of diversity and inclusion, education, and global expansion of technology are of additional importance.

I believe that I am an excellent choice for this position due to my experience with APA and Division 12 (SCP) specifically, and my strong ability to work both collaboratively and as a leader, in an effective and collegial way. As a member of a large, diverse and multidisciplinary health care system and academic hospital, I know understand the importance of collaboration in getting things accomplished. I am currently the SCP Chair of Diversity and SCP Member-at-Large and the marketing chair for ABCP. I have served on the APA Continuing Education Committee since 2014 and am the current Vice-Chair. These roles have provided me with a strong background on issues likely to come before Council and I would sincerely value the opportunity to use my experience and skills to help promote the science and practice of clinical psychology and the larger discipline of Clinical Psychology as your Council Representative.

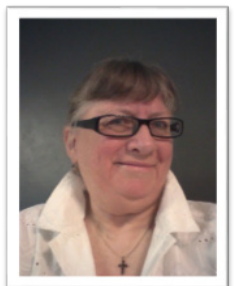
Member-at-Large:

3 Candidates

**This position is also the Division's Diversity Committee Chair*

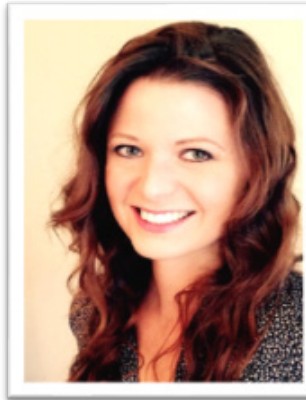
Mary Gregerson, Ph.D.

At this moment in our professional history I am honored to stand for election as Member-at-Large for APA Division 12 Society for Clinical Psychology. The scope and impact of our future contributions rest in the teleology of decisions we make today. I want representative leadership



for Division 12 members at this crucial crossroads for Clinical Psychology. My innovation record includes pioneering environmental health psychology in addition to telepsychology/telemedicine within APA as well as bringing together psychologically-based creative arts therapies within military medicine. The strength of my innovative vision and discernment rests solidly in knowledge of and respect for our traditions and lore. Moreover, I am a true representative of all members so have an “open door” approach welcoming input and fostering inclusion. I humbly request your vote.

Lindsey Hopkins, Ph.D.



I very much would like to continue my service to Division 12 by serving as Member-at-Large. To date, I have had two primary roles with our Division. I served as our Division's Program Co-chair for the 2017 APA Convention in Washington, DC. Among the most rewarding aspects of this

experience was the emphasis on diversity-related programming. Of the 26 sessions for which D-12 was lead sponsor, 27% were directly focused on issues related to underserved minority populations. I am also serving our organization on the D-12 Membership Committee (2017-2019). My perspective from both of these roles is the importance of responsiveness to members. As an early career professional, I will be sensitive to the needs of students and young professionals as they transition into their career. D-12 should be there for them in terms of offering networking, mentorship, and an intellectual home; including continued expansion of mentorship and informational events that are offered both through the web and at our annual conference. Likewise, I am committed to making sure that D-12 continues to be a resource across one's professional life.

In my research and practice at the San Francisco VA Medical Center, I seek commonalities across mental and physical health problems and treatments. In my service and leadership roles, I seek to uncover common interests and build bridges across diverse professional roles, settings, and areas of expertise. I believe this attitude of collaboration and inclusiveness is important for the position of Member-at-Large. I would be honored to have your vote.



Randall Salekin, Ph.D.

I am incredibly honored to be considered for the member-at-large position for the Division 12 of the American Psychological Association. I have served on other executive committees within

APA, but have not had the honor of doing so for one of my home divisions – Division 12 (Clinical Psychology). Given the major health burden that mental illness has on society, I have been impressed with the Society and its membership's response to the many problems that prevail in our society. The society has offered a great deal in identifying quality assessment and treatment practices and has helped to promote the use of evidence-based treatments in the community. However, few could deny that much work continues to lie ahead.

If elected, I would be pleased to serve the Division in a manner that advances Clinical Psychology and the populations its members treat. I have devoted much of my career to training future clinical psychologists through teaching didactic courses and running practicum teams. I have worked in psychology and psychiatry settings and I frequently maintain an active caseload during the academic semesters in addition to providing supervision to peer supervisors and student clinicians. I maintain a firm commitment to science-practice integration tradition, and would, along with committee members, work with others to help support initiatives and policies in the public interest.



**SOCIETY OF
CLINICAL PSYCHOLOGY**

Congratulations to Division 12 Fellow, Marvin Goldfried, recipient of the 2018 APA/APF Gold Medal Award for Life Achievement in the Application of Psychology



The APA/APF Gold Medal Award for Life Achievement in the Application of Psychology recognizes a distinguished career and enduring contribution to advance the application of psychology through methods, research, and/or application of psychological techniques to important practical problems. Eligibility is typically limited to psychologists 65 years or older residing in North America. To be eligible, this research should have led to innovative applications in psychology, including but not limited to assessment, consultation, instruction or intervention. Research involving the original development of procedures, methodologies or technical skills that significantly improve the application of psychological knowledge and provide direct solutions to practical problems will be considered. Original integration of existing theories or knowledge is also eligible for consideration. Additional criteria may include distinguished service, achievement of excellence, extraordinary recognition and significant contributions.

Here is the official citation for Dr. Goldfried:

Marvin R. Goldfried is recognized for his enduring contributions to advancing the application of psychology. A preeminent psychotherapy scholar and dedicated mentor, his contributions have profoundly shaped the field and impacted generations of psychologists. Always a creative, outspoken innovator, he was instrumental in the development of behavior and cognitive-behavior therapies, and groundbreaking contributions on principles of change and psychotherapy process. Working tirelessly to bridge the gap between science and practice, he is the driving force behind the psychotherapy integration movement. His dedication to LGBT issues greatly contributed to LGBT research becoming part of mainstream psychology. His intellectual brilliance, dedication, and integrity has made him a luminary in the field.

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
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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.

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

“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 Division 12 and 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
Past President, Society of Clinical Psychology
Advances in Psychotherapy Series Editor



Morgan T. Sammons, PhD, ABPP
Executive Officer, National Register
Fellow, Society of Clinical Psychology

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Advances in Psychotherapy

Evidence-Based Practice

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

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. A new strand is dealing with methods and approaches rather than specific disorders. 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.

39 volumes plus 4 new editions have been published to date. The first volume in a new strand dealing with methods and approaches started with the release of *Mindfulness*.

- **Practice-oriented:** The main emphasis is on information that therapists and practitioners can use in their daily practice.
- **Easy-to-read:** The most important information is summarized in tables, illustrations, or displayed boxes, and marginal notes.
- **Compact:** Each volume consists of 80-100 pages.
- **Expert authors:** We recruit genuine authorities to write for the series; many of our authors are leaders in the Society of Clinical Psychology (APA Div. 12).
- **Regular publication:** We aim to publish 4 volumes each year.
- **Reasonably priced:** The list price is under \$30 per volume. Discounts are available.

About the editors



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David A. Wolfe,
PhD

Content and structure

1 Description

- 1.1 Terminology
- 1.2 Definition
- 1.3 Epidemiology
- 1.4 Course and Prognosis
- 1.5 Differential Diagnosis
- 1.6 Comorbidities
- 1.7 Diagnostic Procedures and Documentation

2 Theories and Models of the Disorder

3 Diagnosis and Treatment Indications

4 Treatment

- 4.1 Methods of Treatment
- 4.2 Mechanisms of Action
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- 4.4 Variations and Combinations of Methods
- 4.5 Problems in Carrying out the Treatment
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5 Case Vignette; Further Reading; References

6 Appendix: Tools and Resources

Order and price information

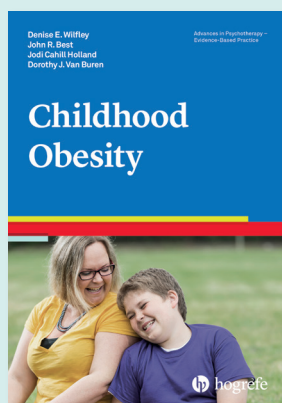
The volumes may be purchased individually or by Series Standing Order (minimum of 4 successive volumes). The advantages of ordering by Series Standing Order: You will receive each volume automatically as soon as it is released, and only pay the special Series Standing Order price of US \$24.80 – saving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

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

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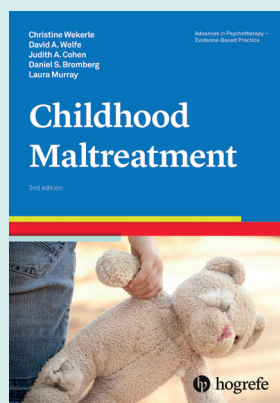


Denise E. Wilfley /
John R. Best / Jodi Cahill Holland /
Dorothy J. Van Buren

Childhood Obesity

Vol. 39, 2018, x + 76 pp.
ISBN 978-0-88937-406-5
Also available as eBook

One in every six children, and more in some ethnic groups, are obese, which can lead to serious health problems in adulthood. Successful treatment of young patients is complex, requiring time-intensive, evidence-based care delivered by a multidisciplinary team. Help is at hand with this well written, compact book by leading experts, which gives health professionals a clear overview of the current scientific knowledge on childhood obesity, from causality models and diagnosis to prevention and treatment.

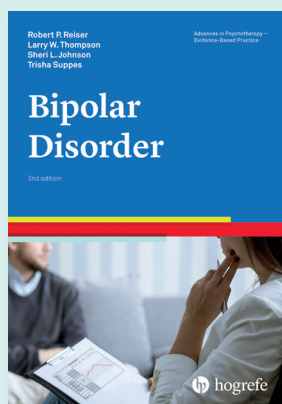


Christine Wekerle /
David A. Wolfe / Judith A. Cohen /
Daniel S. Bromberg / Laura Murray

Childhood Maltreatment

Vol. 4, 2nd ed. 2018, viii + 100 pp.
ISBN 978-0-88937-418-8
Also available as eBook

The new edition of this popular, evidence-based guide compiles and reviews all the latest knowledge on assessment, diagnosis, and treatment of childhood maltreatment – including neglect and physical, sexual, psychological, or emotional abuse. Readers are led through this complex problem with clear descriptions of legal requirements for recognizing, reporting, and disclosing maltreatment as well as the best assessment and treatment methods. The focus is on the current gold standard approach – trauma-focused CBT.

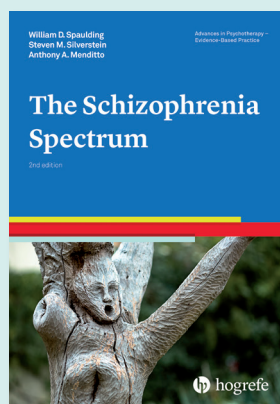


Robert P. Reiser /
Larry W. Thompson /
Sheri L. Johnson / Trisha Suppes

Bipolar Disorder

Vol. 1, 2nd ed. 2017, viii + 124 pp.
ISBN 978-0-88937-410-2
Also available as eBook

This extensively updated new edition of this acclaimed book 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, a team of psychotherapists and medical practitioners, begin by describing the main features of bipolar disorder based on DSM-5 and ICD-10 criteria. Current theories and models are described, along with decision trees for evaluating the best treatment options. They then outline a systematic, integrated, and empirically supported treatment approach involving structured, directive therapy that is collaborative and client-centered.



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. It emphasizes functional assessment and modern psychological treatment and rehabilitation methods, which continue to be under-used despite overwhelming evidence that they improve outcomes. 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.

Volumes available for CE credits

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- **ADHD in Children and Adolescents** by Brian P. Daly / Aimee K. Hildenbrand / Ronald T. Brown (2016)
- **Childhood Maltreatment, 2nd ed.** by Christine Wekerle / David A. Wolfe / Judith A. Cohen / Daniel S. Bromberg / Laura Murray (2018)
- **Childhood Obesity** by Denise E. Wilfley / John R. Best / Jodi Cahill Holland / Dorothy J. Van Buren

Anxiety and Related Disorders

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Behavioral Medicine and Related Areas

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