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Honoring David Barlow's Contributions to Clinical Psychology

 A Festschrift refers to a book honoring the achievements of a respected academic. Loosely translated from German to “party writing,” a Festschrift also involves a celebration. Last month, David H. Barlow, Ph.D., was honored with a Festschrift to commemorate his broad and enduring contributions to clinical psychology, hosted by his former mentees Drs. Anne Marie Albano, Gayle Beck, and Michelle Craske.

The festivities began with a symposium, moderated with great affection by Terence Keane, Ph.D., in which distinguished speakers extolled Dr. Barlow's influence on the field. Allen Frances, M.D., provided much insight into Dr. Barlow's seminal achievements in the classification of mental disorders, and most specifically, his sustained and sage focus on neuroses and the transdiagnostic nature of emotional functioning. Outlining Dr. Barlow's contributions to the study of panic disorder and agoraphobia was Katherine Shear, M.D., who provided an historical perspective on the monumental shift in the conceptualization and treatment of individuals who suffer with these conditions as a result of work conducted “during the Albany years.” Terence Wilson, Ph.D., a longtime friend and colleague, provided a first-hand view of Dr. Barlow's rise through the field of clinical psychology and behavioral therapy, describing the development of the Mississippi and Brown predoctoral internship programs, which continue today to be unique scientist-practitioner training experiences for aspiring clinical psychologists. These talks allowed Steve Hollon, Ph.D., to offer a cogent walk through Dr. Barlow's scholarly study of the nature of emotional disorders, and the systematic, empirical research that led to the Unified Protocol for addressing mental health conditions. Finally, Vikram Patel, MBBS, Ph.D., presented on the global impact of Dr. Barlow's work, in focusing on the dissemination of Barlow's ideas and therapeutic programs to undeveloped countries, while simultaneously prompting much excitement with possibilities for further extending Dr. Barlow's contributions around the globe in novel programs and research. Dr. Barlow also received an official commendation from APA President Jessica Henderson-Daniel, Ph.D., for his commitment to educating students from all backgrounds. Dr. Barlow's ever-supportive family was also in attendance, including his wife, Beverly Barlow, daughter,

Deneige Nash, and mother, Doris Lanigan.

Following the symposium, guests proceeded to a cocktail party hosted by long-time colleague and friend, Bonnie Brown, with support from the Boston University Department of Psychology. Then, a formal dinner was held in Boston University's Trustees Ballroom. Drs. Albano, Beck, and Craske toasted Dr. Barlow, and Drs. Ed Craighead, Gail Steketee, David Somers, Mike Detweiler, and Lynn Bufka also gave speeches. Drs. Aaron Beck, David Clark, and Alan Kazdin joined the festivities with video messages. Finally, the city of Boston honored Dr. Barlow with a Red Sox World Series win!

Looking around the Festschrift ballroom, it was impossible not to be moved by the academic caliber of the attendees, many of whom had been personally touched by Dr. Barlow's mentorship before making large contributions to the field themselves. It is safe to say that Dr. Barlow will continue to influence clinical psychology for decades to come. The Society of

Clinical Psychology sends Dr. Barlow best wishes for the next chapter ahead! 🍷



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Lead Article: Frequently Asked Questions About Adaptive Interventions: Implications for Sequentially-Randomized Trials

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What is an adaptive intervention (AI)?

Clinical practice often involves making repeated decisions about treatment. An adaptive intervention is a sequence of decision rules that guide whether, how, or when—and, importantly, based on which measures—to make critical decisions about intervention (Almirall, Kasari, McCaffrey and Nahum-Shani, 2018; Almirall & Chronis-Tuscano, 2016; Nahum-Shani, et al., 2012a; Murphy, Collins and Rush, 2007; Collins, Murphy and Bierman, 2004; Murphy and McKay, 2004). This includes whether, how or when to alter the dosage (duration, frequency, or amount), type, or delivery of interventions to patients. Adaptive interventions (AI) seek to address the individual and changing needs of patients as they progress through intervention.



Daniel Almirall

A key rationale for adaptive interventions is that patients are heterogeneous in their needs, in how they respond to intervention, or in why they respond or do not respond to intervention. A second key rationale is that not all patients can (or ought to) be provided all available interventions in all circumstances (i.e., there

may be real-world cost or time-burden constraints that preclude the use of certain treatments at certain time points or for certain patients). Statisticians and epidemiologists use the phrase “dynamic treatment

regimen” to describe adaptive interventions (Chakraborty and Moodie, 2013).



Connie Kasari

Figure 1 provides an example adaptive intervention to improve language outcomes in children with autism spectrum disorder (ages 5-8) who are minimally verbal. Here, children are offered a highly-structured intervention based on applied behavior analysis (ABA) known as Discrete Trial Teaching (DTT; Smith, et al., 2001). In stage 1 (weeks 1-6), they receive two sessions per week and children who respond at the end of 6 weeks continue with DTT in stage 2 (weeks 6-12). In contrast, children who are slower to respond are offered a combined intervention consisting of DTT+ a complementary intervention called JASPER in stage 2, also in two sessions per week. The Joint Attention Symbolic Play Engagement and Regulation intervention (e.g., JASPER; Kasari et al, 2014) intervention specifically targets social communication. In this example AI, response vs slow response is based on a 7-item Clinical Global Impressions-Improvement scale (CGI-I, Guy, 1976) adapted for use with children with autism. The CGI-I is rated by the therapist on a weekly basis as part of the DTT intervention based on session data and their clinical judgement. Response is defined as CGI-I values of 1 or 2 at week 6; slower response is defined as CGI-I values of 3 to 7 at week 6. The CGI measure is known as a tailoring variable because it is used to tailor the stage 2 intervention.

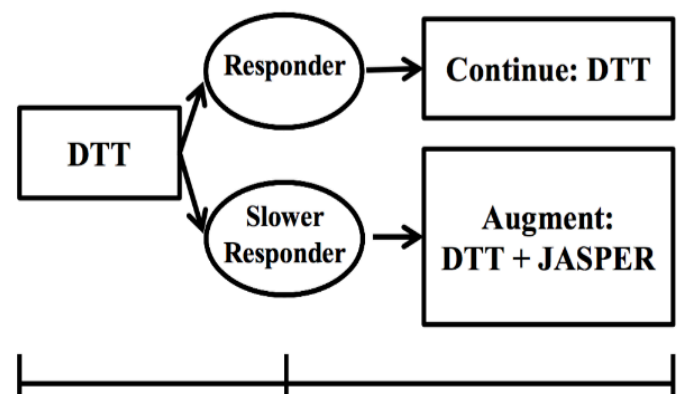


Figure 1. An example adaptive intervention for improving language outcomes in children with autism who are minimally verbal. This is an intervention design; this is not a randomized trial design (it does not involve any randomization).

What is a sequential multiple assignment randomized trial (SMART)?

A SMART is a type of multi-stage, experimental design that was developed explicitly for constructing (or evaluating the components of) high-quality adaptive

interventions (Dawson and Lavori, 2004; Lavori and Dawson, 2004; Murphy, 2005; Murphy, et al., 2007). By “high-quality” we mean (at minimum) adaptive interventions that are (i) applicable (or have a strong potential to be applicable) in actual practice settings, (ii) replicable (or have a strong potential to be replicable) both by practitioners and by future scientists, and (iii) empirically-supported.

The sequential randomizations in a SMART enable researchers to efficiently address multiple scientific questions concerning the selection and individualization of intervention options at various decision points of an adaptive intervention. Stated differently, the sequential randomizations in a SMART enable researchers to draw causal conclusions about how best to make the decisions that make up an adaptive intervention.

Figure 2 provides an example SMART. Here, children with autism who are minimally verbal are randomized to start intervention with either DTT (2 sessions per week) or JASPER (2 sessions per week). This randomization helps to answer the question “Which intervention should we start with—DTT or JASPER—for children with autism who are minimally verbal?” At week 6, children who are slower responders to stage 1 intervention are re-randomized to either combined intervention (DTT+JASPER, keeping the intensity of intervention at 2 sessions per week) or intensified intervention (increasing the intensity of the stage 1 intervention to 3 sessions per week). This randomization helps to answer the question “Among children who are slower responders by week 6, should we intensify the stage 1 intervention (from 2 to 3 sessions per week) or should we offer combined DTT+JASPER?”

What is the purpose of this commentary?

Despite the critical role adaptive interventions already play (and will continue to play) in various domains of practice (e.g., medical, psychological, and educational) and policy, the use of randomized trial designs to systematically optimize adaptive interventions is still at a relatively early stage. Although not all research on adaptive interventions requires a SMART (Almirall, Kasari, McCaffrey and Nahum-Shani, 2017; Almirall, Nahum-Shani, Wang and Kasari, 2018), these are novel randomized trial designs that enable scientists to address new questions for constructing high-quality AIs. See Nahum-Shani et al. (2012a,b) and Almirall, et al. (2014) for an overview of the various types of scientific questions that can be addressed in a SMART. Unfortunately, because SMARTs are relatively new, most researchers have not been exposed to them as part of their formal training. While this is changing (e.g., a limited number of institutions are beginning to offer courses in this area, and research on AIs and SMART designs has grown significantly in the past few years), many questions remain about the design of AIs

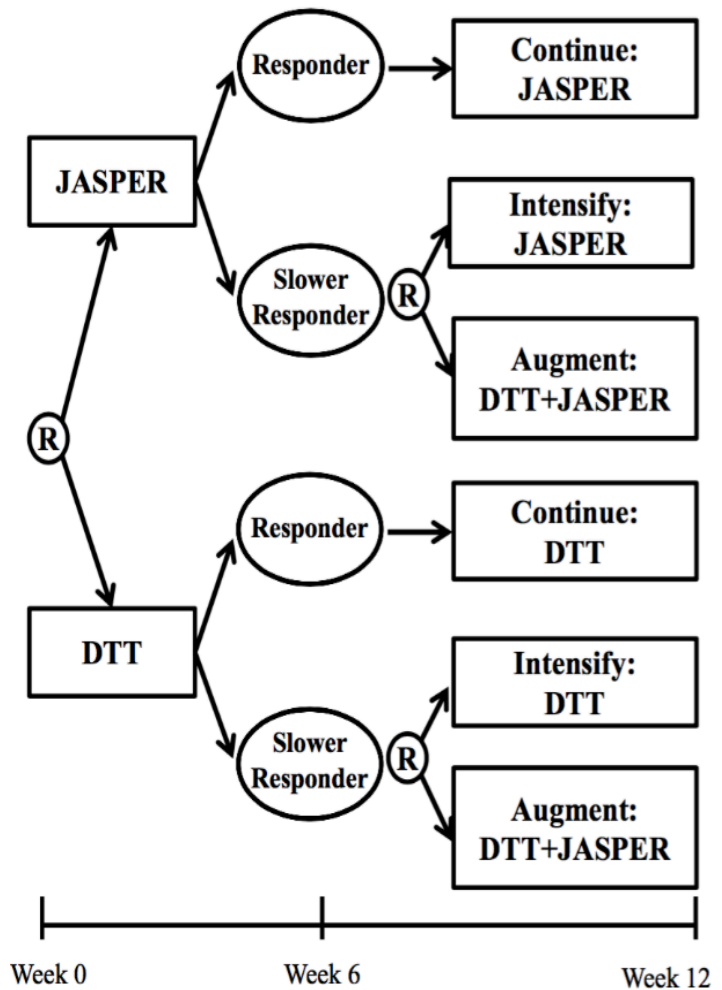


Figure 2. An example sequential multiple assignment randomized trial (SMART) to answer scientific questions related to the construction of an adaptive intervention to improve language outcomes in children with autism who are minimally verbal. This is a randomized trial design; it includes four adaptive intervention designs.

and SMARTs. This is true both among practitioners who might use or implement AIs, as well as among scientists who are interested in answering questions about AIs.

In this commentary, our goal is to provide answers to some frequently asked questions (FAQ) about adaptive interventions that arise among scientists working in this area. Often, these questions arise in the form of concerns, misconceptions, or myths. For some of the FAQs below, we discuss implications for research (e.g., for the design of a SMART). However, we do not include in this commentary a discussion of FAQs about SMART designs. In future work, we will expand this list of FAQs to include additional questions concerning adaptive interventions, as they arise in our research, as well as questions concerning the analysis and design of SMARTs. We will post updated/expanded versions of this FAQ on our website: d3lab-isr.com.

Frequently Asked Questions About Adaptive Interventions

FAQ 1. In the example in Figure 2, I see that slower responders are randomized to two different intervention options. Are you suggesting that, when implementing this intervention in actual practice, we ought to randomize slower responders as part of our intervention?

This is not what is being suggested. Adaptive interventions do not involve randomization. It is important to understand the distinction between an adaptive intervention design (such as the one shown in Figure 1) and a SMART design (such as the one shown in Figure 2). An adaptive intervention design (e.g., Figure 1) is a multi-component intervention that could be implemented in actual practice settings, for example, by therapists at a clinic for children with autism. A SMART design (e.g., Figure 2), on the other hand, is an experiment conducted by researchers to answer scientific questions about how best to construct an adaptive intervention.

In fact, most SMARTs have multiple adaptive interventions embedded within them (Almirall, Nahum-Shani, Sherwood, Murphy, 2014). For example, the adaptive intervention shown in Figure 1 is one of four adaptive interventions embedded in the SMART in Figure 2. The four adaptive interventions in the SMART in Figure 2 are defined based on two factors, each with two levels: (1) stage 1 intervention (either DTT or JASPER) crossed with (2) stage 2 interventions among slower responders (intensify stage 1 treatment vs combined DTT+JASPER treatment). All four adaptive interventions continue stage 1 treatment for responders.

FAQ 2. What do you mean that all four adaptive interventions continue stage 1 treatment for responders? I thought that the four adaptive interventions in Figure 2 comprise only the four intervention options provided to slow responders?

This is a common misunderstanding. Each of the four adaptive interventions embedded in the SMART design in Figure 2 include the following: (1) a stage 1 intervention option, (2) how to monitor progress (i.e., the tailoring variable), (3) how to treat responders at stage 2, and (4) how to treat slower responders at stage 2. Thus, an adaptive intervention provides guidance on how to treat both responders and slower-responders.

FAQ 3. Is it the case that an adaptive intervention must recommend a single intervention option at each critical decision point or for each level of a tailoring variable?

There is no requirement that an adaptive intervention be “overly prescriptive” in the sense of recommending a single intervention option at each critical decision point

(Laber, Lizotte and Ferguson, 2014). While the goal is to provide guidance for intervention decision-making, it may be that there are time points or individuals for whom the evidence does not clearly support one intervention option over another. At any one or more time points (or for a subgroup of patients at any one or more time points), an AI could recommend a set of intervention options instead of a single intervention option.

For example, consider a case where there is no clear evidence (on average or even among subgroups of slower responders) in favor of augmented or intensified treatment for slower responders to DTT. In this case, guidelines might replace the example AI shown in Figure 1 with “augment DTT with JASPER (at 2 times per week) or intensify the provision of DTT from 2 to 3 times per week” among children who are slower responders to DTT.

FAQ 4. Are adaptive interventions intended to replace clinical judgement?

It is a common misconception that AIs seek to replace clinical judgement. The goal of an adaptive intervention is to guide, not replace, clinical practice related to how best to sequence treatment.

Often, clinical judgement will play an important role in the assessment or collection of the tailoring variable(s) used in an adaptive intervention. For example, consider the use of the CGI in the AI in Figure 1, which is a measurement taken by the clinician. In addition, in cases where an adaptive intervention recommends a set of intervention options (see FAQ 3, above), clinical judgement, the preference of the patient or clinician, or a shared decision-making approach between the patient and clinician could be used to make the ultimate decision about which intervention to recommend next.

For example, in Figure 1, consider an AI that replaces the guidance to “augment DTT with JASPER (at 2 times per week) for children who are slower responders to DTT” with the guidance “augment DTT with JASPER (at 2 times per week) or intensify the provision of DTT from 2 to 3 times per week”. Here, the ultimate decision to provide augmented or intensified intervention among slower responders might be left, for example, up to information the clinician has about the child or his/her family that is not currently part of the adaptive intervention (e.g., practical concerns such as the family’s preference to visit the clinic for treatment 2 times per week rather than 3 times per week). Finally, as is the case with most or all manualized interventions, the intervention options that make-up an adaptive intervention might rely on clinical judgement.

FAQ 5. I’m concerned about adaptive interventions because in practice we may not always know the value of the tailoring variable. For example, what if the patient

does not show up to the clinic to provide the tailoring variable?

This is a critically important real-world concern that points to an adaptive intervention that is not well-defined (and therefore not replicable) in actual practice settings. As with any real-world intervention, it is important to plan for common contingencies, including how to decide on an intervention option at a subsequent stage if the tailoring variable is not available/known. Importantly, this is not a research-specific problem; e.g., this is not a statistical problem (as in a missing data problem in a research study). Rather, this is an intervention concern.

For example, in Figure 1, if a child is not available to provide the week 6 CGI measure, the child's previous known CGI-I measure could be used to make the classification. Other approaches are also possible (see Almirall et al., 2012).

Implications for researchers:

- The tailoring variable(s) that are part of adaptive interventions embedded in a SMART are not research assessments. Rather, tailoring variables are part of the intervention.
- As a result, tailoring variables are not incentivized (e.g., participants do not receive gift cards for providing tailoring variable) unless the incentives are understood to be part of how the adaptive intervention will unfold in actual practice.
- Adaptive intervention designers should plan for contingencies that are common in actual practice settings, including how to move forward with subsequent treatment (i.e., how and when to assign treatment) in the absence of a tailoring variable (e.g., if a family does not attend the week 6 clinic visit).

FAQ 6. Is it true that adaptive interventions do not tailor intervention as a function of baseline covariates, such as the severity at baseline (or at program entry)?

Though the example adaptive intervention shown in Figure 1 does not tailor on the basis of baseline variables, it is a misconception that adaptive interventions do not tailor intervention as a function of baseline measures. Certainly, an adaptive intervention may also include decision rules that tailor stage 1 intervention (or intervention at subsequent stages) as a function of baseline covariates.

For example, in our motivating example concerning children with autism, some children could be assigned DTT at stage 1 (as in the Figure 1) and other children could be assigned JASPER at stage 1; and this decision could be based on how much language the child uses at the start of intervention (or at program entry).

Implication for researchers:

- The first stage intervention in an adaptive intervention (including those embedded in a SMART) could be tailored based on baseline information about the participant.
- The data analysis of a SMART could result in a proposal for an adaptive intervention that recommends different intervention options at stage 1 depending on the value of a baseline covariate (Nahum-Shani et al., 2012b).

FAQ 7. Can the tailoring variable be different for different patients?

Yes the tailoring variable can be different for different patients. There is no requirement that the same tailoring variable be used for all individuals in an adaptive intervention.

For example, consider the adaptive intervention described in FAQ 6 where some children are assigned DTT at stage 1 and others are assigned JASPER at stage 1 (based on a measure of social communication at baseline). In this example, the week 6 tailoring variable (i.e., the end of stage 1 assessment) could be designed to differ based on stage 1 intervention (DTT vs JASPER). It may be especially useful to design the adaptive intervention this way in settings where the different stage 1 intervention options target different proximal mechanisms. For example, in the autism example, DTT and JASPER target different aspects of language, thus here, it may make more sense to have different tailoring variables based on stage 1 intervention.

In a second example, the cutoff used to identify a child as a responder at the end of stage 1 could be a function of the child's severity at baseline (e.g., the tailoring variable could be the amount of change in social communication from baseline). Other examples are possible.

Implication for researchers:

- The tailoring variable embedded in a SMART (or learned about in the analysis of data arising from a SMART) could be different for each individual, for example, based on baseline covariates, treatment assigned at stage 1, and/or any information known about the patient up to the end of stage 1.

FAQ 8. Are adaptive interventions relevant only in the treatment domain?

Adaptive interventions are relevant beyond just the treatment domain. Adaptive interventions are relevant in any domain where sequential (or dynamic) intervention decision making is necessary. Outside of the treatment

domain, some examples include (but are not limited to) adaptive interventions in the domain of preventive interventions designed to reduce risky behavior (Hall, et al., 2018), education interventions targeting academic achievement or absenteeism (<https://www.air.org/project/impact-evaluation-parent-messaging-strategies-student-attendance>), health promotion or lifestyle interventions designed to encourage healthy habits (Fu, et al., 2017;), implementation interventions aimed at improving the uptake of evidence-based treatments (Kilbourne, et al., 2014; Kilbourne, et al., 2018), or in the mobile health domain in the form of just-in-time adaptive interventions (Klasnja, et al., 2015; Nahum-Shani, et al., 2017).

Implication for researchers:

- Adaptive interventions, and therefore randomized trial designs seeking to evaluate (e.g., standard RCTs) or optimize them (e.g., SMARTs), could be conducted across a wide range of domains.

References

- Almirall, D., Compton, S. N., Gunlicks-Stoessel, M., Duan, N., & Murphy, S. A. (2012). Designing a pilot sequential multiple assignment randomized trial for developing an adaptive treatment strategy. *Statistics in medicine*, 31(17), 1887-1902.
- Almirall, D., Nahum-Shani, I., Sherwood, N. E., & Murphy, S. A. (2014). Introduction to SMART designs for the development of adaptive interventions: With application to weight loss research. *Translational behavioral medicine*, 4(3), 260-274.
- Almirall, D., & Chronis-Tuscano, A. (2016). Adaptive interventions in child and adolescent mental health. *Journal of Clinical Child & Adolescent Psychology*, 45(4), 383-395.
- Almirall, D., Kasari, C., McCaffrey, D. F., & Nahum-Shani, I. (2018). Developing optimized adaptive interventions in education. *Journal of Research on Educational Effectiveness*, 11(1), 27-34.
- Almirall, D., Nahum-Shani, I., Wang, L., & Kasari, C. (2018). Experimental designs for research on adaptive interventions: Singly and sequentially randomized trials. In L. Collins & K. Kugler (Eds.), *Optimization of Behavioral, Biobehavioral, and Biomedical Interventions* (pp. 89-120). New York, NY: Springer, Cham.
- Chakraborty, B., & Moodie, E. E. (2013). *Statistical methods for dynamic treatment regimes*. New York, NY: Springer.
- Collins, L. M., Murphy, S. A., & Bierman, K. L. (2004). A conceptual framework for adaptive preventive interventions. *Prevention Science*, 5(3), 185-196.
- Dawson, R., & Lavori, P. W. (2004). Placebo-free designs for evaluating new mental health treatments: The use of adaptive treatment strategies. *Statistics in Medicine*, 23(21), 3249-3262.
- Guy, W. (1976). *ECDEU assessment manual for psychopharmacology*. Rev. Rockville, MD: U.S. National Institute of Health, Psychopharmacology Research Branch.
- Hall, K., Nahum-Shani, I., August G., Patrick, M., Murphy, S.A., Almirall D. (2018). Adaptive intervention designs in substance use prevention. In Z. Sloboda, H. Petras, L. Robertson, R. Hingson (Eds.). *Advances in Prevention Science*.
- Kasari, C., Lawton, K., Shih, W., Landa, R., Lord, C., Orlich, F., King, B., Wetherby, A., Senturk, D. (2014). Caregiver-mediated intervention for low-resourced preschoolers with autism: An RCT. *Pediatrics*, 134 (1), 72-79.
- Kilbourne, A.M., Almirall, D., Eisenberg, D., Waxmonsky, J., Goodrich, D. E., Fortney, J. C., ... & Kyle, J. (2014). Adaptive Implementation of Effective Programs Trial (ADEPT): Cluster randomized SMART trial comparing a standard versus enhanced implementation strategy to improve outcomes of a mood disorders program. *Implementation Science*, 9(1), 132.
- Kilbourne, A. M., Smith, S. N., Choi, S. Y., Koschmann, E., Liebrecht, C., Rusch, A., ... & Almirall, D. (2018). Adaptive School-based Implementation of CBT (ASIC): Clustered-SMART for building an optimized adaptive implementation intervention to improve uptake of mental health interventions in schools. *Implementation Science*, 13(1), 119.
- Klasnja, P., Hekler, E. B., Shiffman, S., Boruvka, A., Almirall, D., Tewari, A., & Murphy, S. A. (2015). Microrandomized trials: An experimental design for developing just-in-time adaptive interventions. *Health Psychology*, 34(S), 1220.
- Lavori, P. W., & Dawson, R. (2004). Dynamic treatment regimes: Practical design considerations. *Clinical trials*, 1(1), 9-20.
- Laber, E. B., Lizotte, D. J., & Ferguson, B. (2014). Set-valued dynamic treatment regimes for competing outcomes. *Biometrics*, 70(1), 53-61.
- Murphy, S. A., & McKay, J. R. (2004). Adaptive treatment strategies: An emerging approach for improving treatment effectiveness. *Clinical Science*, 12, 7-13.
- Murphy, S. A. (2005). An experimental design for the development of adaptive treatment strategies. *Statistics in medicine*, 24(10), 1455-1481.

Murphy, S. A., Oslin, D. W., Rush, A. J., & Zhu, J. (2007). Methodological challenges in constructing effective treatment sequences for chronic psychiatric disorders. *Neuropsychopharmacology*, 32(2), 257.

Murphy, S. A., Collins, L. M., & Rush, A. J. (2007). Customizing treatment to the patient: Adaptive treatment strategies. *Drug and Alcohol Dependence*, 88(2), S1.

Nahum-Shani, I., Qian, M., Almirall, D., Pelham, W. E., Gnagy, B., Fabiano, G. A., ... & Murphy, S. A. (2012a). Experimental design and primary data analysis methods for comparing adaptive interventions. *Psychological Methods*, 17(4), 457.

Nahum-Shani, I., Qian, M., Almirall, D., Pelham, W. E., Gnagy, B., Fabiano, G. A., ... & Murphy, S. A. (2012b). Q-learning: A data analysis method for constructing adaptive interventions. *Psychological Methods*, 17(4), 478.

Nahum-Shani, I., Smith, S. N., Spring, B. J., Collins, L. M., Witkiewitz, K., Tewari, A., & Murphy, S. A. (2017). Just-in-time adaptive interventions (JITIs) in mobile health: Key components and design principles for ongoing health behavior support. *Annals of Behavioral Medicine*, 52(6), 446-462.

Smith, T., Donahoe, P. A., & Davis, B. J. (2001). The UCLA young autism project. In J.S. Handleman & S.L. Harris (Eds.) *Preschool Education Programs for Children with Autism* (pp. 29-48). Austin, TX: Pro-Ed. ♻




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Ethical Dilemmas in Diagnosis

Adam Fried, Ph.D.

 Diagnosis is considered an essential component of psychological services. Accurate diagnosis requires knowledge of the various diagnostic codes and symptoms, training on how to make differential diagnoses, and a commitment to assigning diagnoses that reflect the profession's principles of integrity and responsibility. Many, however, experience conflicts in the diagnostic process that may lead to behaviors that may be considered unethical. Some of these conflicts may be characterized by the clinician as a moral dilemma wherein assigning an inaccurate diagnosis (or refusing to assign a diagnosis) is meant to benefit the client/patient. Other dilemmas include pressure from or collusion with clients/patients to assign diagnoses for a particular reason. Finally, some clinicians engage in intentional misdiagnosis for some sort of personal financial gain. This column will explore the ethical implications of several of these types of situations.

Why Diagnose?

For most, diagnosis is an essential component of practice, though many students are unclear about the necessity. There are several important purposes of diagnosis. First, diagnosis can have clinical utility for a number of reasons, including treatment planning and communicating with other providers across disciplines. Second, diagnosis, rather than simply a description

of core symptoms, can be helpful for clients/patients who wish to learn more about their symptoms, course of treatment, and prognosis. For example, Persistent Depressive Disorder may have very different implications than Borderline Personality Disorder, even though both may share negative affect/lack of positive affect. For some clients/patients with fears that their thoughts are symptomatic of irreversible cognitive conditions or the onset of a yet-undiscovered psychotic disease, understanding that their thoughts, feelings and perceptions actually fit a recognized pattern that has a name can be quite reassuring. Finally, diagnostic codes are required for insurance reimbursement and documentation purposes.

Diagnostic Dilemmas

Unintentional misdiagnosis can occur due to a number of factors, including misunderstanding or lack of proficiency with various diagnostic systems, such as the Diagnostic and Statistical Manual of Mental Disorders. There are some disorders for which a clinician may have an insufficient understanding of and/or education about, or for which they question the validity, which can certainly impact accurate diagnosis, therapeutic alliance, and treatment outcome [for example, see Plioplys, Abbas, & Smith (2017) for an interesting discussion about clinician attitudes toward psychogenic nonepileptic seizures].

Therapists who intentionally assign inaccurate diagnoses may be doing so for their own gain (e.g., in order to be reimbursed for services) or in an attempt to serve what they believe are the best needs of their clients. These latter situations might be considered a

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type of moral stress dilemma (Fried, 2015; Jameton, 1984), whereby clinicians feel that their profession's ethics, rules, and laws impede their ability to provide the services that they believe the client needs. For example, clinicians may feel that the only way to provide much-needed psychological services is by assigning an inaccurate diagnosis so that their client/patient will be covered for psychotherapy services.

Another type of moral stress dilemma that has been voiced by clinicians (and many students) involves the decision about whether to assign a diagnosis, even if the client/patient meets full criteria for one. These questions are often based on the belief that assigning a mental health diagnosis may be stigmatizing to clients/patients and, therefore, create harm. Indeed, public stigma related to mental illness has been found to be pervasive (Parcesepe & Cabassa, 2013) and is a potent barrier to receiving mental health services [see Gebhardt (2016) for an interesting discussion on how this stigma may be fueling interest in coaching services, which is not focused on identifying and treating specific mental health disorders]. Clinicians and students who are sensitive to this perceived stigma may believe that by not assigning a diagnosis or assigning a diagnosis that may be viewed as less stigmatizing, they are benefiting the client. As with the previous example, the clinician experiences a type of moral stress conflict between what their professional obligations (including ethical standards and professional expectations) and what they believe is best for the client/patient whom they serve. While their motives to reduce stigma and encourage mental health services may be laudable, these actions are inconsistent with their professional responsibilities and may violate laws and ethical standards (see below for a discussion of unintended harms). Another dilemma that some clinicians find themselves in is when the client/patient attempts to pressure the clinician into assigning a particular diagnosis. For example, a client/patient may present for an intake or assessment prepared with a diagnosis that they have found on the Internet that they believe best fits them and/or they are invested in receiving.

There may also be financial reasons that a client/patient may pressure a therapist to assign a particular diagnosis, such as for disability claims or to qualify for reimbursement from a third party. "Upcoding" or "overdiagnosing" are terms that have been used to describe the practice of assigning an inaccurate diagnosis (usually one that may be more severe) solely for the purpose of facilitating reimbursement (e.g., from an insurance company) or for some secondary gain. There is reason to believe that this practice may not be rare. For example, Danzinger and Welfel (2001) found that 44% of their sample of 108 mental health counselors had either changed a diagnosis or were willing to do so to facilitate reimbursement from an insurance company.

These types of dilemmas can be challenging, as clinicians may experience conflict between doing what they believe aligns with their professional responsibility and what they think might be of benefit for the client/patient or consistent with the client/patient's wishes. For example, clinicians may reason that they are acting in the client/patient's best interest, especially for those who may not be able to afford the clinician's services by paying out-of-pocket. These situations also raise questions about how best to discuss diagnoses with clients/patients. Fisher (2017) helpfully distinguishes between diagnostic discussions versus collusion with clients/patients. For the latter, colluding with clients about which diagnosis will appear in their record goes against the clinician's professional responsibility to assign a diagnosis that is based upon proper assessment and the clinician's informed professional judgment, accurately reflecting the client/patient's symptoms. Fisher argued that assigning an incorrect diagnosis based solely on the client/patient's request can foster client/patient mistrust in the clinician's professional abilities and communicate the message that deceit is an acceptable practice in the field. Dialogue about a client's diagnosis and the treatment implications, on the other hand, may prove beneficial, serving as a form of psychoeducation and potentially furthering therapeutic goals. In most cases, clients have access to information about their diagnosis; for example, under Health Insurance Portability and Accountability Act (HIPAA; 1996), clients/patients may have access to such information; in many cases, clients/patients can also call their insurance company to ask for the diagnosis submitted to process claims.

Unintended Harms

Intentional assignment of incorrect diagnosis potentially violates several APA Ethics Code (2017) standards and principles, including our commitment to conducting oneself in a professional manner and taking professional responsibility for our work (Principle B: Fidelity and Responsibility) and performing our work honestly and accurately (Principle C: Integrity). Diagnoses that are made without proper assessment or otherwise unsubstantiated also may be in violation of Standard 9.01 (Bases for Assessment), and intentionally submitting an inaccurate diagnosis to an insurance company for financial gain (e.g., so that the clinician can be reimbursed for service) may violate conflict of interest and recordkeeping standard (Standard 3.06 Conflict of Interest and Standard 6.06 Accuracy in Reports to Payors and Funding Sources, respectively), as well as specific laws.

As many (e.g., Brennan, 2013; Fisher, 2016) point out, diagnoses become part of the client/patient's permanent health record that can be used as the basis for future health care coverage, life insurance, and other determinations. Relatedly, diagnoses that become

part of the client/patient's record may also be used by an insurance company as evidence of a pre-existing condition. Incorrect diagnoses can also unintentionally create unnecessary or even harmful treatments based upon the incorrect diagnosis. For example, physicians may prescribe medications and other clinicians may base specific psychotherapy recommendations upon the diagnosis in the client/patient records (Zimmerman, 2016).

Conclusion:

Dilemmas related to diagnosis can be tricky. In our quest to do good and benefit our clients/patients, we can sometimes become lost in a sea of ethical conflicts, especially when faced with the prospect of actions that we think may be of benefit (or less harmful) to the individuals with whom we work but, at the same time, may violate the profession's ethical standards. While the intent of the clinician may be admirable, purposefully assigning an incorrect diagnosis (even if it is meant to benefit the client) is ethically risky, can result in unintended harms, and is inconsistent with our professional responsibilities and our code of conduct.

References

American Psychological Association (2017). Ethical principles of psychologists and code of conduct (Amended January 1, 2017). Retrieved October 25, 2018 from <http://www.apa.org.ethics>

Braun, S. A., & Cox, J. A. (2005). Managed mental health care: Intentional misdiagnosis of mental disorders. *Journal of Counseling and Development*, 83, 425-433.

Brennan, C. (2013). Ensuring ethical practice: Guidelines for mental health counselors in private practice. *Journal of Mental Health Counseling*, 35, 245-261.

Danzinger, P. R., & Welfel, E. R. (1002). The impact of managed care on mental health counselors: A survey of perceptions, practices, and compliance with ethical standards. *Journal of Mental Health Counseling*, 23, 137-150.

Fisher, C. B. (2017). *Decoding the Ethics Code: A Guide for Psychologists*, 4th Edition. Thousand Oaks, CA: Sage.


Fried, A. L. (2015). Moral stress in mental health practice and research. *The Clinical Psychologist*, 68, 18-20.

Gebhardt, J.A. (2016). Quagmires for clinical psychology and executive coaching? Ethical considerations and practice challenges. *American Psychologist*, 71, 216-235.

Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice Hall.

Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research*, 40, 384-399.


Plioplys, S., Abbas, S., & Smith, B. (2017). Clinician's response to the diagnosis. In B. A. Dworetzky & G. Baslet (eds.) *Psychogenic Nonepileptic Seizures: Toward the Integration of Care*. New York: Oxford University Press

Zimmerman, M. (2016). A review of 20 years of research on overdiagnosis and underdiagnosis in the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) Project (2016). *Canadian Journal of Psychiatry*, 61, 71-79. 



Members in the News

Thomas G. Plante, Ph.D.

 Given recent headlines about clergy sexual abuse, we wanted to highlight the work of Dr. Thomas Plante on this issue. Dr. Plante's work with regard to sexual abuse by Roman Catholic Priests has been covered in Time Magazine and numerous other media outlets over the years. For the past 30 years, Dr. Plante has evaluated, treated, and consulted on clergy sex offenders. His work with both perpetrators and victims (at the individual, group, and societal levels) has always been rooted in empirically supported and evidence based practices. His research in this area has resulted in numerous publications, including three edited books (Plante, 1998, 2004, 2011). During these decades, Dr. Plante has also served as a consultant and advisory board member for the Church at local, regional, and national levels. Additional details about Dr. Plante's work and thoughts on the current crisis in the Catholic Church may be found at: <http://www.scu.edu/tplante>, and his regular Psychology Today blog is available here: <https://www.psychologytoday.com/us/blog/do-the-right-thing>. Dr. Plant is currently the Augustin Cardinal Bea, S.J. University Professor of Psychology at Santa Clara University and Adjunct Clinical Professor of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine.

Steven Proctor, Ph.D.

Dr. Steven Proctor was one of 23 research scientists accepted to Yale University's Inaugural Innovation to Impact: Entrepreneurship Training Program for Substance Abuse Researchers. His accepted product idea involves a recovery management app for patients transitioning to the "continuing care" phase of treatment. Yale's Innovation to Impact program is funded by a \$1.25 million NIDA grant and aims to speed to market innovations that directly fight addiction. Dr. Proctor's innovation leverages the benefits of contingency management and self-monitoring so that patients are incentivized to take a more active role in their recovery, while providers are afforded with real-time, clinically-meaningful outcome data. Dr. Proctor is a licensed psychologist and founder of PRO Health Group, a Miami-based research and outcomes monitoring company. He is the Chief Research Officer at AiR Healthcare Solutions, and is also a Senior Research Professor, Institutional Center for Scientific Research, Albizu University-Miami.

Nick Grant, Ph.D.

Dr. Nick Grant is an early career psychologist whose work focuses on the cross-section of health psychology, LGBTQ psychology, and multicultural psychology. In 2016, Dr. Grant moved to Washington, D.C. to serve as APA's Congressional Fellow, where he was named an APA William A. Bailey Health and Behavior Fellow, based on his extensive background in LGBTQ clinical practice, research, and community involvement. He served in the Office of U.S. Senator Kirsten Gillibrand (D-NY), where he worked on military/veterans, healthcare, and LGBTQ legislative portfolios. In 2018, Nick was awarded the Distinguished Alumni Award from Palo Alto University for his work and contributions toward combating attempts to ban transgender Americans from serving in the military. Also in 2018, Dr. Grant was recognized with the APA Presidential Citation as a Citizen Psychologist award, for his years of service and ongoing efforts towards improving the

lives and communities of LGBTQ people. 




Welcome New Editors



You may have noticed that the editorial reins of *The Clinical Psychologist* have changed hands. Given that this is the first issue with the new editorial team, we thought we'd take the opportunity to introduce ourselves! We'd also like to wish outgoing Editor, Jonathan Comer, Ph.D., our very best as he assumes the role of Division 12's President.

Editor: Shannon Sauer-Zavala, Ph.D. is a Research Associate Professor in Boston University's Department of Psychological and Brain Sciences. Her research is broadly focused on refining existing interventions for emotional disorders by ensuring that all components included in a treatment package engage the transdiagnostic, psychopathological mechanisms that maintain symptoms. Against this backdrop, she is particularly interested in treatment improvement for higher-risk presentations (e.g., borderline personality disorder, suicidal thoughts and behaviors). Additionally, as the Director of the Unified Protocol Institute, Dr. Sauer-Zavala routinely provides training workshops for evidence-based treatment approaches.

Associate Editor: Stephanie Jarvi Steele, Ph.D. is a Postdoctoral Fellow in Boston University's Department of Psychological and Brain Sciences. She received her doctorate in Clinical Psychology from Suffolk University and completed her pre-doctoral internship at the Warren Alpert Medical School of Brown University. Dr. Steele's research focuses on furthering understanding of the risk factors and transdiagnostic mechanisms that maintain self-injurious thoughts and behaviors. She is also interested in the role of identity in the context of risk behaviors, personality psychopathology, and laboratory-based behavioral methodology.

Editorial Assistant: Julianne Wilner, M.A. is a senior graduate student in Boston University's doctoral program in Clinical Psychology. Ms. Wilner's research is centered on investigating transdiagnostic mechanisms that maintain emotional disorders, and how to efficiently target these mechanisms in treatment. She is specifically interested in understanding the functional overlap amongst symptoms of emotional disorders, including suicidal thoughts and behaviors and interpersonal conflict. Additionally, as Assistant Director of the Unified Protocol Institute, Ms. Wilner coordinates and delivers training for clinicians and graduate students in implementing evidence-based, transdiagnostic treatment. 


Section 8: The Association of Psychologists in Academic Health Centers

Donna LaPaglia, Psy.D.



The Association of Psychologists in Academic Health Centers (APAHC) has had a fruitful year in terms of accomplishments and membership growth. To begin, some of the work we've undertaken has been behind the scenes, but still important. The entire APAHC Board helped shepherd a revamping of our Bylaws and Officers' Manual. Other developments include APAHC producing CE-offering educational webinars; the reinstatement of our professional newsletter—*The Grand Rounds* and continuation of the *Journal of Clinical Psychology in Medical Settings* both with new editors at the helm. As those projects were completing, the association worked with a web-development firm to completely redo our public and members-only websites: ahcpsychologists.org. In addition, you can now keep on top of all APAHC news by following us on Facebook and Twitter! And finally, with the help of a membership drive in 2018 we grew! In the span of a few weeks, we went from just over 200 members to nearly 700. What is even more exciting is that nearly half of those members are trainees - the future of this organization.

With 2018 coming to a close we invite you to our APAHC Conference in New Orleans, LA, February 7th - 9th, 2019. The theme of the conference is *Psychology on the Cutting Edge: Celebrating Psychologists' Roles, Contributions, and Diversity in Academic Health Centers*. In addition to the conference agenda, APA is offering Internship Self-Study and Site Visitor training on Thursday, Feb 7th. Visit the conference registration website: <https://ahcpsychologists.org/upcoming-conferences/>

Early Bird registration ends December 31st, 2018 and registration for the conference closes January 25th, 2019. 

Update on the Cross-Divisional (D12, D28, D50) Task Force on Clinical Response to the Opioid Crisis

R. Kathryn McHugh, PhD¹ and Michael W. Otto, PhD²

¹McLean Hospital/Harvard Medical School

²Department of Psychological and Brain Sciences, Boston University



Regardless of a psychologist's role as educator, researcher, advocate, counselor, or clinician, most psychologists will interact professionally with an individual or family affected by the opioid crisis. In the United States, over 42,000 people died of opioid overdose in 2016, 11.5 million people misused prescription opioid painkillers, almost 950,000 people used heroin, and 2.1 million people suffered from opioid use disorder. The devastating impact of opioid misuse on individuals, families, communities, and the health care system resulted in the United States declaring the opioid crisis a National Emergency in 2017.

Addressing this crisis will require efforts at all levels of the health care system. We believe that, due to their multiple roles in society, psychologists are in an excellent position to influence the early detection, referral, and care of people who misuse opioids and their families. Accordingly, in 2017, Division 12 initiated the Cross-Divisional (D12, D28, D50) Task Force on Clinical Response to the Opioid Crisis. This task force has the core purpose of engaging the expertise of members of these divisions to generate informational resources for mental health professionals and educators who will encounter people who use opioids or concerned family members and friends who are in need of information, guidance, and referral.

We are pleased to announce that the Task Force has now completed production of 13 resource sheets on the opioid crisis, and these resource sheets have been adopted by APA for dissemination. Topics for the resource sheets include:

- Informational Overview
- Understanding Opioids
- Safe Medication Storage and Disposal
- Assessing Opioid Use
- Locating Treatment
- Evidence-Based Treatment

- Resources for Families
- Self-Help Resources
- Cultural Competency
- Adolescents
- Pain
- Opioid Overdose Risk
- Recognizing and Treating Overdose

These resources will be available by December 15, 2018 on our Division 12 website (<https://www.div12.org/>) under the Resources tab. We hope you will take a look at this information in preparation for the ways in which you will confront the opioid crisis through your role as a psychologist, but please also consider sending individuals to this web site should need emerge. We would also like to thank all those individuals who offered their time and expertise in producing these resource sheets. The full task force membership follows:

R. Kathryn McHugh, PhD; McLean Hospital/Harvard Medical School (Co-Chair)

Katie Witkiewitz, PhD; University of New Mexico (Co-Chair)

Sarah M. Bagley, MD; Boston University School of Medicine

Kathleen M. Carroll, PhD; Yale University School of Medicine

Sandra D. Comer, PhD; Columbia University/New York State Psychiatric Institute

Kelly Dunn, PhD; Johns Hopkins University School of Medicine

Robert N. Jamison, PhD; Brigham and Women's Hospital/Harvard Medical School

Michael W. Otto, PhD; Boston University


Jane Ellen Smith, PhD; University of New Mexico

Kevin E. Vowles, PhD; University of New Mexico

Sharon L. Walsh, PhD; University of Kentucky

Monica Webb-Hooper, PhD; Case Western Reserve University School of Medicine

SCP Member Spotlight on Les Greene Ph.D.

 Dr. Les Greene's illustrious and multifaceted career in Clinical Psychology has involved a wide range of activities spanning clinical, research, and teaching domains. Dr. Greene has particular expertise in group therapy, for which he has received numerous awards including several Alonso Awards for Excellence in Psychodynamic Group Theory, and The Arthur Teicher Group Psychologist of the Year Award (from Division 49). He was also recently recognized as a "Distinguished Psychologist for Contributions to Clinical Care", by the Connecticut VA. We had the opportunity to learn more about Dr. Greene and his work through our Q&A correspondence over the past month. Read on to learn more!

Where did you complete your training?

Steeped in the Boulder tradition, beginning with my doctoral studies at Yale in the late 1960's, I have dedicated my career to efforts aimed at integrating science and practice, keeping in mind both broad psychological truths derived from laboratory research (as in evidence-based practice) with patient-specific truths identified in the clinical setting (as in practice-based evidence). I applied this approach to my primary and enduring interest, namely the study of the individual-in-the-group. I found mentors in the formative stages of my career who helped me explore both realms – the study of the individual, particularly personality development and developmental psychopathology, and a depth study of group, ranging from small unstructured self study groups to community life and culture. I've spent my entire career exploring and elucidating the complicated relationship between the individual and the group and have applied these psychosocial formulations in a variety of clinical settings, whether it be establishing a therapeutic milieu on a long-term psychiatric ward, directing a day treatment program for adults with personality disorders, or supervising psychology interns and psychiatry residents in the intricacies of group and couple therapies (see Greene, 2012). I've always tried to empirically study aspects of these clinical settings. My studies on borderline patients' use of splitting defenses in a psychotherapy group, on patients' preferences for structured vs. unstructured groups as a function of their forms of psychopathology, and patients' construal of authority relations on an inpatient ward are representative of the kinds of empirical works that reflect this view of group life as complex interactions of personality and the social system, as well as my enduring value to integrate

research with practice.

What is your current position/occupation?

I'm a multimodal, multitasking psychologist: 1) I serve on the staff of the West Haven VA Medical Center where I initially directed a group and milieu therapy program on a long-term psychiatric ward and currently practice and supervise in the Mental Hygiene Clinic; 2) I serve on the clinical faculty of the Department of Psychiatry at Yale where I offer some seminars and supervise individual, couples, and group psychotherapy; 3) I have a number of professional roles and duties, particularly for two group therapy organizations (American Group Psychotherapy Association and the Group Foundation for Advancing Mental Health), as well as serving on several journal editorial boards; and 4) I have a private practice.



Les Greene, Ph.D.

These days I'm less involved in conducting my own research; rather, I have been more focused on helping to bridge the gap between research and practice as reflected in one of my most recent papers (Greene, 2017) as well as a forthcoming co-edited volume titled, *Core principles of group psychotherapy: A theory-, practice-, and research-based training manual*, and a manuscript in preparation, "Implications of the CRSPPP recognition of group as a specialty for the training of group psychotherapists."

How long have you been a member of SCP?

I've been a card-carrying member of APA since my graduate school days at the end of the 60's and a Fellow in Divisions 12, 29, 39, and 49 for most of that time. I've served for many years on the editorial boards of *Psychotherapy* (Division 29) and currently for *Group Dynamics* (Division 49), and most recently I've been volunteering to serve as a Convention Program reviewer for Division 12.

Please describe any roles you have with APA or other national, state, or local organizations.

Much of my professional work over the years has been with two sister organizations, the American Group Psychotherapy Association and the Group Foundation for Advancing Mental Health. Among the many roles I've have been honored to hold in AGPA are Editor of their journal, *International Journal of Group Psychotherapy*, President 2014-2016, and currently co-chair of the Science-to-Service Task Force. With regard to the Group Foundation, a Foundation that

provides hundreds of scholarships to students and young professionals to attend the annual conference of AGPA, as well as provides research funding for group therapy studies, my current roles are member of the Board of Directors and Chair of the Scientific Advisory Committee.

I've also held governance roles in our local Division 39 affiliate, the Connecticut Society for Psychoanalytic Psychology.

What do you see as an important direction for the field of Psychology?

I have been, and remain, stimulated by the many challenges in the field as a whole. In particular, I am deeply invested in promoting dialogue between what too often are balkanized and split off domains, as between the clinical psychology of Division 12 and the related fields of psychotherapy (Division 29) and psychoanalysis (Division 39), and between group and individual psychologies, and especially between empiricism and other epistemological approaches to knowledge, truth, and meaning. My position regarding the unfortunately chronic tension between research and practice was reflected in a comment on a paper published in the *American Psychologist* a few years ago, where I decried the author-researcher's self-proclaimed mission to 'disseminate' evidence-based research findings to clinicians, and his or her frustration at facing clinicians' resistances to this approach. I argued at that time, as I do today, that dialogue, rather than dissemination, where researcher and clinician can learn from each other's perspective, is likely to prove to be a more constructive process.

What's something nobody would know about you?

I trust that most of the closest people in my life know pretty much all there is to know. I suppose those who are more at a distance don't have access to my 'alter-ego' as a stand-up comic, a role I developed in childhood, driven by my wish to have my father smile and laugh. I do love my sense of humor and my capacity to make others (sometimes) laugh at the foibles of the human condition, an element that can often be an effective part of the psychotherapeutic process.

What are your hobbies?

Playing with my dog. I think I've been a latent dog person all my life, something my wife has intuitively known better than me. About 4 years ago she adopted a rescue dog for me and literally, my world and worldview changed-- I suppose proving that you can teach an old dog new tricks. These days I love watching *Animal Planet*, faithfully walk Moishe 3 or 4 times day to our neighborhood parks, socialize with other dog people, and, ever the psychologist, am even considering leading a support group for those grieving humans who have lost their pets.

What led to your interest in clinical psychology and/or area of interest?

In adolescence I figured that surely Freud could help me with my anxieties, inhibitions, and curiosities about sex, love, and romantic relationships, and so began reading some of his classic works. It helped, although my intellectual interests really blossomed during my undergraduate years at Brown where I found my home in the Psychology Department.

References

Greene, L. R. (2012). Group therapist as social scientist, with special reference to the psychodynamically oriented psychotherapist. *American Psychologist*, 67, 477-489. <http://dx.doi.org/10.1037/a0029147>

Greene, L. R. (2017). Group psychotherapy research studies that therapists might actually read: My top 10 list. *International Journal of Group Psychotherapy*, 67, 1-26. <http://doi.org/10.1080/00207284.2016.1202678>



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/> 



Reflections on the Cultural Climate around Sexual Violence

Elizabeth Yeater, Ph.D.

University of New Mexico

 I wrote a piece for the Diversity Corner several months ago that focused on sexual violence against women – specifically, what the research tells us about its prevalence and psychological consequences, and what we can do as psychologists to help clients who have been victimized. That piece was somewhat academic in tone; this commentary will be much more conversational, in part due to recent events that have transpired in our country.

Earlier this year, I was asked by my Project Officer at National Institutes on Alcohol Abuse and Alcoholism (NIAAA) to present my funded work at a summit at the National Institutes of Health. Other experts in my research area were also asked to present their work, including Dr. Mary Koss, who was among the first researchers to measure the prevalence of sexual victimization in a methodologically sound way. The goal of this meeting was to discuss current funded projects focused on alcohol use and sexual assault and to facilitate collaboration among experts in the field.

Little did we know, at that time we were invited to the meeting, that we would be discussing our research during the Kavanaugh hearing, which paradoxically, was taking place just down the road. It was a surreal experience to see this high-profile case example illustrating our research findings. Specifically, we have data from a multitude of studies showing that sexual assault occurs at alarmingly high rates (Balsam et al., 2005; Martin et al., 2011) and we know that women commonly do not acknowledge that they have been assaulted or report the assault to others (Bondurant, 2001; Kahn et al., 1994). We also know that women report a variety of reasons for not reporting their assault, including guilt over having been intoxicated, fear of being treated poorly by the police or justice system, and fear of reprisal by the perpetrator.

Although we do not what transpired between Dr. Ford and Mr. Kavanaugh, the events of the hearing are likely to have significant impact on the climate in which victims of sexual violence come forward. If a research psychologist from a privileged background was not

believed – or worse yet – believed but her account disregarded for political motives – what does this mean for other women who come from less advantaged, even marginalized, backgrounds? As a research scientist specializing in understanding sexual violence, I believe that events such as the Kavanaugh hearing will make it even more difficult for women to come forward to report acts of sexual violence.

During our summit meeting, Dr. Koss noted the importance of focusing more broadly on changing our cultural context to make sexual violence against women less likely. I couldn't agree more. The words of our leaders about women, how to behave with women, and how to treat other disadvantaged, marginalized populations matter. These words can either create a context that promotes violence or inhibits it. There is a program called "No Means No," originally implemented in Kenya, has reduced significantly the rates of rape in that country. The program focuses on teaching girls self-defense skills and boys appropriate behavior around girls. Importantly, adults, including adult men, model appropriately how to treat women. It is odd to me that the United States, with all of its resources, is not doing better in reducing sexual violence than a country that has significantly fewer resources. The burden of change in this area is often placed on women and other marginalized groups. We need more men and more people in power to step up to the challenge of setting a cultural context that does not condone sexual violence against women.

References

- Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the life span: a comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology, 73*, 477–487.
- Bondurant, B. (2001). University women's acknowledgment of rape. *Violence Against Women, 7*, 294–314.
- Kahn, A. S., Mathie, V., & Torgler, C. (1994). Rape scripts and rape acknowledgment. *Psychology of Women Quarterly, 18*, 53–66.
- Martin, S. L., Fisher, B. S., Warner, T. D., Krebs, C. P., & Lindquist, C. H. (2011). Women's sexual orientations and their experiences of sexual assault before and during university. *Women's Health Issues, 21*, 199–205.
- Holmes, M., Resnick, H. A., Kirkpatrick, D. G., and Best, C. L. (1996). Rape-related Pregnancy: Estimates and Descriptive Characteristics from a National

Sample of Women. *American Journal of Obstetrics and Gynecology*, 175(2), 320–325.

Hughes, T. L., Szalacha, L. A., Johnson, T. P., Kinnison, K. E., et al. (2010). Sexual victimization and hazardous drinking among heterosexual and sexual minority women. *Addictive Behaviors*, 35, 1152–1156.

Kahn, A. S., Mathie, V., & Torgler, C. (1994). Rape scripts and rape acknowledgment. *Psychology of Women Quarterly*, 18(1), 53–66.

Kimerling, R., Alvarez, J., Pavao, J., Kaminski, A., & Baumrind, N. (2007). Epidemiology and consequences of women's revictimization. *Women's Health Issues*, 17, 101–106.

Krebs, C. P., Lindquist, C. H., Warner, T. S., Fisher, B. S., & Martin, S. L. (December, 2007). The campus sexual assault (CSA) study. National Institutes of Justice: Bureau of Justice Statistics.

Kuehn, B. M. (2011). Group advises clinicians to routinely screen women for sexual assault history. *Journal of the American Medical Association*, 306, 1072.

Littleton, H. L., Axsom, D., Breitkopf, C., & Berenson, A. (2006). Rape acknowledgment and postassault experiences: How acknowledgment status relates to disclosure, coping, worldview, and reactions received from others. *Violence and Victims*, 21(6), 761–778.

Martin, S. L., Fisher, B. S., Warner, T. D., Krebs, C. P., & Lindquist, C. H. (2011). Women's sexual orientations


and their experiences of sexual assault before and during university. *Women's Health Issues*, 21(3), 199–205.

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimization of women: An empirical review and theoretical reformulation. *Clinical Psychology Review*, 23, 537–571.

Rennison, C. (2010). National crime victimization survey (NCVS). In B. Fisher, & S. Lab (Eds.), *Encyclopedia of victimology and crime prevention*. (pp. 579–583). Thousand Oaks, CA: SAGE Publications, Inc.

Truman, J. L. & Planty, M. (2012). *Criminal Victimization, 2011*, Bureau of Justice Statistics U.S. Department of Justice.

Ullman, S. E., & Brecklin, L. R. (2003). Sexual assault history and health-related outcomes in a national sample of women. *Psychology of Women Quarterly*, 27, 46–57.

Yeater, E. A., Miller, G. F., Rinehart, J. K., & Nason, E. E. (2012). Trauma and sex surveys meet minimal risk standards: Implications for Internal Review Boards. *Psychological Science*, 23, 780–787. 



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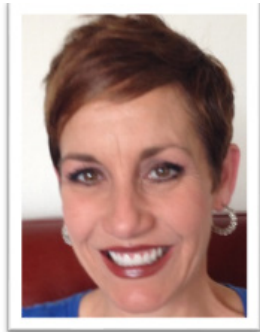
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Society of Clinical Psychology, Division 12 2018 Election Results

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



President-Elect:
Elizabeth Yeater



Member-At-Large:
Randall Salekin



Council Representative:
Kim Penberthy

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

APA Convention 2018 Award Ceremony

Thank you everyone for the making the 2018 APA Convention a huge success this year for the Society of Clinical Psychology, Division 12. We had some amazing programming, wonderful student posters, several well-attended Hospitality events, a successful speed mentoring event and Awards Ceremony. See below for photos from our Awards Ceremony. We look forward to seeing everyone in Chicago August 2019!



Update on Ongoing Quality Assurance for APA Continuing Education Offerings

Jonathan Weinand, PhD, Co-Chair, Summit on Issues in Professional Psychology Education

Antoinette Minniti, PhD, APA Office of CE Sponsor Approval

Division 12, as part of its central mission “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...” has devoted resources to sponsoring a Summit on Issues in Professional Psychology Education. This Summit is dedicated to discussion and evaluation of strategies for facilitating the degree to which APA Continuing Education (CE) activities reflect the latest in science-informed psychological practice. This Summit represents a strong collaboration between D12 and Section 3, the Society for a Science of Clinical Psychology, as well as with Division 53, The Society of Clinical Child and Adolescent Psychology. In this brief article we would like to provide an update on quality CE activities directly from the office of CE Sponsor Approval from Director, Antoinette Minniti, PhD.



The purpose of this article is to share updates on the work of the American Psychological Association’s Office of CE Sponsor Approval (APA CESA) and the Continuing Education Committee (CEC). The CESA office and the CEC continually engage in discussions with individuals and groups who want to promote and enhance quality continuing education (CE), including psychologists who represent the broad range of the discipline, approved and potential sponsors, and APA divisions, boards, and committees. This commentary represents an ongoing dialogue with the Society for the Science of Clinical Psychology (SSCP), which has included several constructive discussions with members of the SSCP Executive Board, an invitation to contribute to the SSCP’s Clinical Science newsletter (see: Fall 2016 publication), and communications such

as this article to provide current updates about the CESA office and the CEC.

The Fall 2016 Clinical Science editorial, Comment on Quality CE, outlined the role of the CESA office and the CEC, the sponsor approval process, and quality assurance measures. Readers are referred to the aforementioned editorial for a general overview of systems and processes. This current article will focus on updates as they pertain to initiatives on which the Office and Committee are presently working, with the purpose of continuing to advance quality continuing education. The past two years have included exciting growth on a number of levels (e.g., increased resources in terms of CESA staff and Committee membership, the 2017 Summit on Promoting Best Practices in Continuing Education and Continuing Professional Development, establishment of the Special Issue: Critical Conversations in Continuing Education to be published in 2019 in the Professional Psychology: Research and Practice journal, ongoing review of reporting processes, and new and enhanced support materials for sponsors and applicants.

Taken in turn, the CESA office recently welcomed a new staff member to the role of Quality Assurance Program Officer. In February 2018, our team expanded from four to five individuals with the newest role providing an important function to further progress quality assurance processes. Critically, revisions to our office’s current processes will rely on evidence-based data. Although still in its early days, the introduction of the online application system (CESA OAS) in 2016 translates to accessible data about our sponsors/applicants and, in turn, allows for analysis of meaningful patterns across and within these groups. As just one example, of those who are approved, we will be able to assess whether sponsors who are approved for five years are more or less likely to obtain subsequent five-year approval or, alternatively, one-year approval compared to their ‘new sponsor’ (two-year approval) counterparts. In real terms, this type of analysis translates to thoughtful and targeted support that would enable focusing of resources, further investigation as to why some sponsors may be more likely to maintain sponsorship compared to others, and an emphasis on supporting sponsors for the delivery of quality continuing education.

In addition to the developments related to CESA staff, there are now two additional CEC members for a total of 16 volunteer individuals who represent the breadth and depth of psychology. This growth in committee

membership not only reflects the range of the discipline, it also allows for greater support in respect of the steadily rising number of applications that the Committee reviews.

As well as the expansion of the Office and Committee, an important initiative in 2017 was led by APA's Office of CE Sponsor Approval and Office of CE in Psychology, in conjunction with the Association of State and Provincial Psychology Boards (ASPPB). Specifically, the Summit on Promoting Best Practices in

Continuing Education and Continuing Professional Development was conducted to promote excellence in the development, delivery, and accountability associated with continuing education and ongoing professional development (CPD) by bringing together psychological organizations with demonstrated interests in assuring ongoing professional competence in support of consumer protection. This summit addressed issues such as the purpose of CE and CPD, current challenges and best practices, and a review of its processes in light of other allied health professions (e.g., nursing, medicine, pharmacy). In addition to the discussions and open dialogue about CE and CPD, several action items emerged from the meeting.

One notable action item from the 2017 Summit that is currently in process is the Special Issue: Critical Conversations in Continuing Education that is anticipated to be published in early 2019 in *Professional Psychology: Research and Practice*. It is expected that over a dozen articles will comprise this special issue, including empirical and conceptual contributions submitted by a wide range of authors. Alongside the broad call for papers, invitations to submit were extended to SSCP individuals, as a clear objective of the special issue is to include the breadth of voices and valuable contributions to the literature which allow for further growth of quality continuing education.


As part of our ongoing assessment of annual and review reporting processes, the Office and Committee are continually evaluating ways to support, guide, and clarify aspects related to the Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists. Given the value and significance associated with delivering quality CE, it is important to ensure ample provision of information, examples, and helpful detail for sponsors. For example, the Office is currently compiling a communications grid to systematically outline which types of targeted emails

could be most helpful for various groups of sponsors in relation to the nature of queries that arise from their annual report submissions. In keeping with this thinking, by proactively supporting sponsors through the reporting processes, this educative and constructive approach is also likely to decrease complaints.

Similarly, as a direct consequence of our ongoing assessment we continually develop key resources designed to articulate best practices related to areas of the Standards such as learning objectives and provision of sufficient evidence-based support. In particular, our Resources webpage is always evolving and is currently organized to include materials by Standard. Our most recent resources include focused guidance for writing behavioral learning objectives (Standard C), and clarification of what sponsors and applicants should know about Standard D – i.e., particularly in relation to the importance of linking learning objectives (Standard C) with CE program descriptions/narratives and appropriate evidence support (Standard D), and promotional materials that accurately reflect the CE program, including avoidance of exaggerated claims that extend beyond the scientific evidence (Standard G).

The above updates reflect the continued commitment of the Office of CE Sponsor Approval and the Continuing Education Committee to evolve, grow, and engage with communities invested in delivery of quality continuing education. Beyond what was shared in this article, we consistently participate in a wide range of activities such as APA Convention sessions, invited presentations to groups such as the State, Provincial and Territorial Psychological Association, live and conference call meetings with individuals/groups seeking clarification about the Standards and related processes, and interprofessional continuing education conference presentations and panels/symposia. The work of the Office and the CEC has been and will continue to be focused on supporting sponsors/applicants while ensuring that achievement of quality remains at the forefront of continuing education programming. We welcome and value the ongoing dialogue with SSCP and appreciate the opportunity to share our most recent developments with the membership.


Reference:

Minniti, A. (2016). Comment on quality CE. *Clinical Science*, 19 (3), 5-6. 

An Update from the Co-Chairs of the Committee on Science and Practice

Rachel Hershenberg, PhD

Susan D. Raffa, PhD

 The American Psychological Association has identified “best research evidence” as a major component of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006), and Division 12 of APA has long been at the forefront of identifying and disseminating information on treatments with documented efficacy (Chambless & Hollon, 1998). Providing and updating this information is an ongoing process that is tasked to Division 12 Committee on Science and Practice. As Co-Chairs of that committee, we are pleased to provide Division 12 membership with an update on some of our recent work.

Changes we've made

If you've checked out the Division 12 website in the past two years, you have probably noticed some major updates to the Psychological Treatments section of the site.

In response to request from our members, and continuing the excellent work of the previous chair Evan Forman, the Committee has been working hard to update the treatment pages of numerous psychological treatments with promising effect sizes. In total, we have updated 20 treatments. Compared to the initial iteration of the pages that included a brief treatment description and rating of the treatment (per Chambless criteria for empirically supported treatments; Chambless & Hollon, 1998; Chambless & Ollendick, 2001; see below for more on the Chambless criteria), updated pages have more information and are designed to offer a variety of tools for clinicians and students including downloadable manuals, links to clinician and self-help treatment guides, video demonstrations, resources for training, downloadable measures and worksheets, and seminal articles (to see an example, go to <https://www.div12.org/treatments/> and click on any of the treatments labeled with NEW CONTENT). Data tracking has shown significant increases in traffic to the updated

webpages. For example, the Behavioral Activation for Depression webpage received 8,927 views in the nine months following its revision as compared to 132 views in the nine months prior to its update.

You may also notice a new tab called “Case Studies.” Under Michael Otto’s Division 12 Presidential Initiative, the Committee was tasked with continuing to make the website more engaging and useful to clinicians. One way of doing this has been our effort to develop case-based narratives with corresponding transdiagnostic symptoms. On the case studies pages, you can now click symptoms or diagnoses that are most descriptive of the patient you have in mind; specific symptoms and/or diagnoses navigate you to relevant prototypical cases, which then land you to the specific treatment page(s) that have demonstrated efficacy for that problem area. For example, if you search “emotion dysregulation,” you can read prototypical cases for borderline personality disorder, borderline personality disorder with comorbid alcohol use, bulimia nervosa, and tobacco use disorder – and each case maps onto the most relevant treatment page(s) for that problem. The “case studies” are still under development, and if you see omissions on which you’d like to contribute a case, please email us at division12apa@gmail.com.

Stay on the lookout

In addition, under the leadership of Past-President David Tolin, Division 12 ratified a motion to update the way in which empirically supported treatments are evaluated, in part to bridge the gap between the Chambless criteria, developed 20 years earlier, and the development of evidence-based treatment guidelines underway by the APA. (For a thorough discussion and description, please refer to Tolin, McKay, Forman, Klonsky, & Thombs, 2015 published in *Clinical Psychology: Science and Practice*.) Using this framework, the Committee on Science and Practice has been tasked with “translat[ing] the research findings into clear recommendations of very strong, strong, or weak, using well-established, widely accepted, and transparent grading guidelines” (Tolin et al., 2015, pg. 332) that are developed from an evaluation of published systematic reviews of each treatment. Our new Science and Practice Committee members are currently pilot testing the proposed system. Stay tuned for reflections on the process and a rating of our first evaluated treatment! 📊

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, Shannon Sauer-Zavala Ph.D. at: ssauer@bu.edu

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Danny Wedding, PhD, MPH
Past President, Society of Clinical Psychology
Advances in Psychotherapy Series Editor



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- **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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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
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- 4.4 Variations and Combinations of Methods
- 4.5 Problems in Carrying out the Treatment
- 4.6 Multicultural Issues

5 Case Vignette; Further Reading; References

6 Appendix: Tools and Resources

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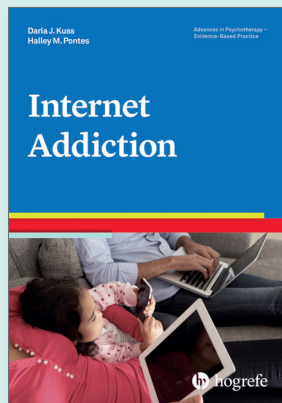
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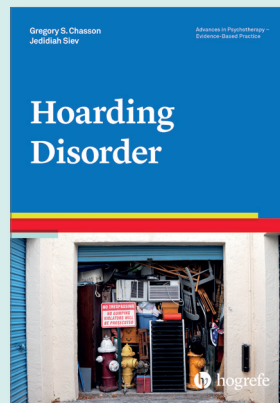


Daria J. Kuss / Halley M. Pontes

Internet Addiction

Vol. 41, 2019, viii + 94 pp.
ISBN 978-0-88937-501-7
Also available as eBook

This book examines how you can identify, assess, and treat Internet addiction in the most effective manner. Internet use has become an integral part of our daily lives, but at what point does Internet use become problematic? This compact, evidence-based guide written by leading experts from the field helps disentangle the debates and controversies around internet addiction and outlines the current assessment and treatment methods. The book presents a 12–15 session treatment plan for internet and gaming addiction using the method and setting with the best evidence: group CBT. Printable tools in the appendix help clinicians implement therapy. This accessible book is essential reading for clinical psychologists, psychiatrists, psychotherapists, counsellors, social workers, teachers, as well as students.

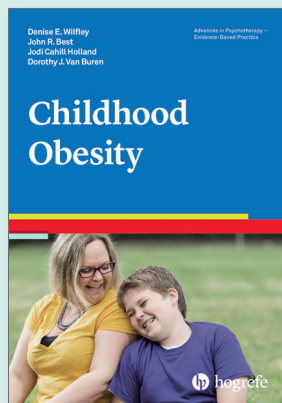


Gregory S. Chasson / Jedidiah Siev

Hoarding Disorder

Vol. 40, 2019, viii + 76 pp.
ISBN 978-0-88937-407-2
Also available as eBook

Hoarding disorder, classified as one of the obsessive-compulsive and related disorders in the DSM-5, presents particular challenges in therapeutic work, including treatment ambivalence and lack of insight of those affected. This evidence-based guide written by leading experts presents the latest knowledge on assessment and treatment of hoarding disorder. The reader gains a thorough grounding in the treatment of choice for hoarding – a specific form of CBT interweaved with psychoeducational, motivational, and harm-reduction approaches to enhance treatment outcome. Rich anecdotes and clinical pearls illuminate the science, and the book also includes information for special client groups, such as older individuals and those who hoard animals. Printable handouts help busy practitioners.

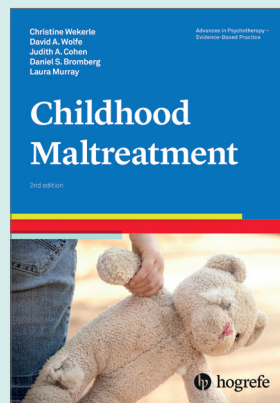


Denise E. Wilfley /
John R. Best / Jodi Cahill Holland /
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Vol. 39, 2018, x + 76 pp.
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Christine Wekerle /
David A. Wolfe / Judith A. Cohen /
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Childhood 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.

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