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## PRESIDENT'S COLUMN



*"It was the best of times, it was the worst of times...":*  
Navigating the paradoxical current state of clinical psychology

Although Charles Dickens wrote the seemingly contradictory opening lines of *A Tale of Two Cities* about the lead-up to the French Revolution, these renowned words also apply to the current tensions and state of our field.

**It was the best of times:** The past 40 years have witnessed remarkable scientific advances that have firmly established clinical psychology as a sophisticated and rigorous discipline. Innovations in intervention science, progress in the formal specification of clinical strategies, and increasingly refined clinical trial methodologies and data analytic techniques have collectively led to a proliferation of evidence-based psychological treatments for a wide range of well-defined mental disorders. Research has demonstrated how very successful psychological treatment methods can be, and has begun to examine the underlying mechanisms responsible for their success.

**It was the worst of times:** To date, the remarkable advances in clinical psychological science have not yielded a meaningful public health impact. The vast majority of individuals affected by emotional or behavioral problems do not receive any mental health care. Among the minority of affected individuals who do receive care, median delays in treatment initiation after initial onset of problems often spans several decades. Geographical shortages in the mental health workforce, racial and ethnic disparities in care, stigma-related concerns about visiting a mental health facility, lack of parity in mental health coverage, and transportation obstacles all interfere with the availability, accessibility, and acceptability of mental health care. Long waitlists and high staff turnover at underfunded mental health facilities further slow the speed of service delivery, and limited success in the dissemination of evidence-based treatment practices has constrained the quality of care typically received. When our most well-supported treatments are successfully implemented in everyday settings, clinical outcomes rarely outperform usual care. Further, treatment-related symptom reductions do not always translate into improved patient functioning or quality of life.

**Being right, versus having reach and relevance – can clinical psychology have it all?** As clinical scientists, perhaps we have clung a bit too tightly to being right at the cost of pursuing reach and relevance. Intervention science has historically prioritized internal validity over external validity. Targeting defined symptom clusters with highly-specified treatment protocols under tightly controlled settings with selected/recruited samples has afforded powerful causal conclusions about the impact of psychological treatments. When a tightly controlled clinical trial demonstrates superior outcomes of a psychological treatment over a control condition, we are able to determine that it was the psychological treatment itself, and not other extraneous or confounding factors, that was indeed responsible for the successful outcomes. We can confidently conclude we were right about the efficacy of the psychological treatment. Such rigorous demonstrations have been—and continue to be—essential in establishing clinical psychology as a rigorous science, validating the heroic work of frontline practitioners, and supporting the tremendous value of psychological services in the context of less-than-favorable reimbursement/payer decision-making.

Given the strength of our science and the extent to which its rigor has allowed us to conclude that we are right about treatment effects, it can be tempting to approach non-replications with skepticism and even scorn. When a specific treatment has been supported in numerous clinical trials and then fails to outperform a control condition in a new trial, we appropriately question whether the new trial implemented the treatment correctly, whether participants received the treatment as intended, whether outcomes were measured correctly, whether participants were appropriately screened, and a host of other key factors. Sometimes we even question whether there may have been a level of bias in the design or interpretation of the new trial. These are all important academic questions that can help account for unexpected findings. But none of these questions probe the treatment itself or its potential lack of generality across alternative contexts. When we know we are right, we tend to look outward, not inward, to explain the unexpected.


When the “new trial” is everyday mental health care, being right is not enough. Being frustrated with those who fail to replicate our rigorous findings is misguided when the (non)replicators are in fact the very populations of providers and patients to which we are trying to apply our work. Explaining poor uptake, satisfaction, and outcomes in terms of how

positive the effects could have been had things only been set up differently is relatively futile when pushing up against the realities, limitations, and constraints of our existing mental health care system, patient preferences, provider capacities, and implementation feasibilities. Sometimes our field comes across like a physicist with a laboratory on the surface of the moon who has repeatedly and elegantly demonstrated how long a baseball can remain in air after being tossed up. The measurements and predictive models may indeed be perfect, but they nonetheless lack relevance to the realities of mechanical relationships on Earth. Bemoaning the downward force of gravity on the surface of the Earth will accomplish little.

In recent years, we have seen increasing investments in the development and evaluation of treatment innovations in the actual contexts in which they are to be ultimately applied, pragmatic clinical trials, and hybrid effectiveness-implementation studies. These have been critical steps for optimizing the potential reach and relevance of our work, forcing us to confront the realities and constraints of our mental health care system, provider capacities, and patient preferences and valued outcomes at the earliest stages of evaluation. In addition, some of the most exciting unfolding innovations in clinical psychology are technology-based strategies that leverage passive sensing devices and machine learning algorithms to monitor and directly intervene upon previously inaccessible aspects of human functioning. Such “Just-in-Time Adaptive Interventions” (JITAs) can afford unprecedented reach into the everyday lives of our patients and can provide opportune smart prompts and related “micro-interventions” in moments of maximal relevance. Advances in micro-randomized trials (MRTs), in which individuals are randomly assigned to alternative micro-interventions (e.g., smart prompts) hundreds or even thousands of times across a study, are providing rigorous methodologies with which to test these promising JITAs. Along these lines, I’m excited to share that this Spring one of the Division 12 presidential taskforces I initiated on technology-based treatments will be holding an all day in-person meeting to make progress on developing standards for appropriately evaluating behavioral intervention technologies.

Perhaps the most essential front in improving the reach and relevance of clinical psychology pertains to improving the diversity, representation, and cultural responsiveness of our work and workforce. Disappointing progress in this respect over the years has been one of the most disappointing failures of our

field and a key obstacle to achieving a meaningful public health impact. As I complete my term as President of the Society of Clinical Psychology, I'm so very excited that Dr. Elizabeth Yeater is taking the reins and using her presidential term to squarely focus on the extensive and much-needed work to be done improving the diversity, representation, and cultural responsiveness of our work and workforce. This is exactly the direction in which we need to be moving as a Society and as a field.

If our field continues to navigate forward on our most recent path of simultaneously embracing both rigor and relevance, I expect that the tale of clinical psychology will soon come closer to approximating “a tale of one city” – one in which realities, constraints, and practical obstacles are directly informing and shaping our science, and in which our scientific progress is indeed achieving a meaningful public health impact. 



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## The Windy Road from Treatment Development to Dissemination and Implementation

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 Is the so-called “bench to bedside” pipeline for scientific innovation just a fallacy? Although there are stunning exceptions (e.g., Clark, 2018), most scientific innovation stops well before reaching the “bedside.” In other words, relatively few innovative, scientifically-derived treatment development efforts for mental illness ever get implemented and sustained in routine practice settings. There are many reasons for this, yet this gap is truly a disservice to the ever evolving and complex needs of the public.

Now, after two decades of contributions to basic science and treatment development, we have become passionate about responding to the call from Dr. Francis Collins—the Director of the National Institutes of Health—to ensure research investments are maximized for the needs of those whom the research was originally intended: the public. As such, we are currently embracing the challenge of adding the science of dissemination and implementation to our research program. Here, we share our path from treatment development to implementation science.

Following the treatment development traditions of Clark (1999), Salkovskis (2002), Onken (2014) and others, our program of research began with an interest in chronic insomnia. We noticed that the cognitive level of explanation had been minimally studied.

The published work, along with the reports from our clients with insomnia, seemed to clearly indicate a need to better understand the role of cognitive processes. We began by scouring the existing literature for science related to cognitive processes in insomnia and sleep. At the same time, we delved into the literature on cognitive processes and cognitive therapy for other mental disorders. We treated many individuals with insomnia and learned from their first-hand experiences as to which elements of current treatments they found effective or ineffective. We then summarized our findings and observations in a theoretical framework of the maintenance of insomnia at the cognitive level of explanation (Harvey, 2002). Our goal was to use this framework as a map for guiding the next phase of our research. The central idea in the framework is that, regardless of the original trigger, chronic insomnia is maintained by a cascade of cognitive processes operating during the night and the day. The framework specifies the following cognitive processes: worry/rumination, attentional bias toward sleep-related threat, misperception of sleep and daytime functioning, unhelpful beliefs about sleep and the use of safety behaviors that prevent correction of unhelpful beliefs about sleep. We then set about empirically evaluating the framework by (1) conducting experiments that manipulate each cognitive process (see Kaplan, Talbot, & Harvey, 2009 for review) and (2) refining and testing a new cognitive treatment designed to reverse the cognitive processes specified in the framework. The results from an initial open trial of this treatment suggested that reversing cognitive maintaining processes was indeed helpful for people with chronic insomnia. Insomnia severity reduced and the cognitive processes we sought to reverse did indeed improve (Harvey, Sharpley, Ree, Stinson, & Clark, 2007). However, we consider the results of this open trial to be limited because we cannot rule out the possibility that they are simply due to the passage of



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time or to the positive effects of seeing a therapist. Hence, in a next step, we began to collaborate with Dr. Charles Morin's group at the Université Laval in Québec, Canada. At this point we added the Laval cognitive approach targeting unhelpful beliefs about sleep (Morin, Stone, Trinkle, Mercer, & Remsberg, 1993) to the treatment just described. We then conducted a randomized controlled trial of 188 adult clients with chronic insomnia who were recruited and treated at UC Berkeley or at the Université Laval. Our main goal was to examine the unique contribution of behavior therapy (BT) and cognitive therapy (CT) relative to full cognitive behavior therapy (full CBT). All treatments were individually delivered across 8 weekly sessions. There were significant improvements across all three conditions on measures of insomnia symptom severity, nighttime sleep disturbances, and daytime functioning, and these improvements were generally sustained at 6-month follow-up. Full CBT was associated with greatest improvements, the improvements associated with BT were faster but not as sustained and the improvements associated with CT were slower and sustained (Harvey et al., 2014). The latter result seems particularly interesting because the different trajectories of change may provide

unique insights into the process of behavior change via behavioral versus cognitive routes. These findings point to a need for future research to identify why an intervention targeting behavioral change generates faster improvement but is not as well sustained, while an intervention targeting cognitive processes generates slower but more sustained change.



**Nicole Gumport, M.A.**

Meanwhile, Professor Guy Goodwin, from Oxford University, was encouraging us to apply our findings to individuals diagnosed with bipolar disorder, given the great need for a sleep treatment among this group. We expected that CBT for insomnia (CBT-I) would be an excellent match. To our surprise, as we started to treat clients, and examine the literature, it quickly became

apparent that in addition to insomnia, hypersomnia (Kaplan & Harvey, 2009), delayed sleep phase (Giglio et al., 2010) and irregular sleep-wake schedules (Gruber et al., 2009) were all common among people diagnosed with bipolar disorder. Hence, we decided to modify traditional CBT-I to address this broader range of sleep and circadian dysfunctions. We again scoured the scientific literature to seek guidance on how to target these complicated features of sleep and circadian functioning in bipolar disorder. We realized that we may be able to target this diverse set of sleep and circadian problems by supplementing CBT-I with elements from three existing evidence-based treatments: Interpersonal and Social Rhythm Therapy (Frank et al., 2005), chronotherapy (Wirz-Justice, Benedetti, & Terman, 2009) and Motivational Interviewing (Miller & Rollnick, 2002). We then conducted a pilot test of this approach, which we refer to as 'transdiagnostic' because we aim to treat the broader group of sleep and circadian problems in bipolar disorder. Alongside standard psychiatric care, individuals who met diagnostic criteria for bipolar disorder and who were also inter-episode were randomly allocated to the new treatment—the modified version of Cognitive Behavior Therapy for Insomnia for bipolar disorder (CBTI-BP;  $n = 30$ ) or Psychoeducation (PE;  $n = 28$ ) as a comparison condition. Outcomes were assessed at baseline, the end of 8 sessions of treatment and 6 months later. During the 6-month follow-up, the CBTI-BP group had fewer days in a bipolar episode relative to PE (3.3 days vs. 25.5 days). The CBTI-BP group also experienced a significantly lower hypomania/mania relapse rate (4.6% vs. 31.6%) and a marginally lower overall mood episode relapse rate (13.6% vs. 42.1%) compared to the PE group. Relative to PE, CBTI-BP reduced insomnia severity and led to higher rates of insomnia remission at post-treatment and marginally greater at 6 months. Both CBTI-BP and PE showed statistically significant improvement on selected sleep and functional impairment measures. The effects of treatment were well sustained through follow-up for most outcomes, although some decline on secondary sleep benefits was observed (A.G. Harvey et al., 2015). Furthermore, it appeared that CBTI-BP was safe for individuals with bipolar disorder (K.A. Kaplan & Harvey, 2013).

This outcome was encouraging as it seemed that a broader approach to sleep and circadian problems was feasible. When combined with other experiences, such as working with Dr. Dan Freeman's group from Oxford on schizophrenia (Waite et al., 2016) and with Dr. Greg Clarke from Kaiser Oregon on depression in adolescence (Clarke et al., 2015), we were left with a strong and clear sense of the need for one treatment to address a range sleep and circadian problems and in a way that would be useful across mental and physical illness, and maybe even across some stages of development. Not only did converging evidence support





**Caitlin E. Gasperetti, M.A.**

(Weisz, Ng, & Bearman, 2014). Indeed, a key advantage of one treatment that tackles multiple problems is the substantial cost advantage to training providers (McHugh & Barlow, 2010). Hence, the Transdiagnostic Sleep and Circadian Intervention (TranS-C) (Harvey & Buysse, 2017) was born.

Inspired by Drs. Chorpita and Weisz's work on MATCH (e.g., Weisz et al., 2012), TranS-C takes a modular approach. It is comprised of cross-cutting core and optional modules, which allows the treatment sessions to be more time efficient and 'personalized' to the specific sleep problem(s) experienced by each client. As such, it is more time efficient and focused on each individual client's presenting problem. Table 1 displays the modules. The process for deriving TranS-C from the sleep and circadian literature and its grounding in the sleep health framework (Buysse, 2014) is described elsewhere (A.G. Harvey & Buysse, 2017). Two initial tests of TranS-C—one with 178 teenage night-owls (A.G. Harvey et al., 2018) and one with 121 adults with a mixed mental illness diagnoses (in preparation)—yielded encouraging findings.



**Courtney C. Armstrong, B.S.**

and reading the dissemination and implementation literature, we are acutely aware that many levels of scientific questions remain before we know if TranS-C will be scalable and sustainable.

First, we acknowledge that TranS-C, as is, may

this 'transdiagnostic' approach, there were also practical reasons motivating us to move beyond developing more disorder-focused treatments. Specifically, we knew that further disorder-focused variants of CBT-I would only add to the burden on providers who often do not have the resources or time to learn multiple disorder-focused treatments

It is at about this point where we might stop and think 'Great! TranS-C is on the path to becoming an empirically supported treatment. Our work here is done'. However, bearing in mind Dr. Collins' urging to maximize research for the needs of the public,

actually not 'fit' the true needs of the public. Despite our extensive efforts to recruit samples reflecting the diversity of our community, when we conduct research within the university setting our samples are different to the surrounding routine practice settings. In particular, people who are most comfortable attending a university setting for treatment tend to be Caucasian and university educated. Also, the clients recruited in a university setting typically differ from routine practice in domains such as the age, race, ethnicity and culture of clients as well as the complexity of client's challenges (Chambers & Norton, 2016). Therefore, examples of science questions we are ready to ask include: Are the encouraging findings that have accrued thus far replicated in routine practice settings? Is the current version of TranS-C an optimal fit with any, some or all of the client's served in routine practice settings? If adaptations are needed to optimize the 'fit' with various clients and settings, how should they be made? Which modules within TranS-C are most powerful for promoting sustained behavior change? Do the effectiveness of the modules vary according to specific client characteristics?

Second, as mentioned, we know that time and resources are scarce in routine practice settings. When we conduct treatment research and employ the providers within a university setting, the providers often have training and experience in delivering evidence-based practices and there is typically ample time for training and supervision. In contrast, providers in routine practice settings come from a variety of backgrounds and may not have received prior training in evidence-based practices (Rodríguez, Southam-Gerow, O'Connor, & Allin Jr, 2014; Weissman et al., 2006). Routine practice settings are often under-resourced, so providers tend to shoulder a great number of responsibilities, including a large caseload of clients. Supervision, an important component of most evidence-based practices in research trials, may or may not be built into the routine practice of some settings. Moreover, reimbursements for the additional time needed for training and supervision are often not available. Therefore, examples of science questions we are ready to ask include: Are the findings replicated when TranS-C is delivered by providers in routine practice settings? What dose and type of supervision and training are needed? Which organizational characteristics best promote sustainment of implementation efforts, and how can they be cultivated? Which modules within TranS-C are most and least often delivered and why? Does this differ between clinics and why (e.g., organizational culture or leadership characteristics, etc.)? Do providers see TranS-C in its current form as a fit for their patients and treatment environment or do adaptations need to be made so that providers are more willing to sustain it?

Third, within research conducted in university settings,

**Table 1: Description of TranS-C**

<b>Cross-cutting modules</b>			<b>Common sleep-circadian (S-C) problems experienced by clients diagnosed with a mental illness</b>	<b>Treatment module</b>
Functional Analysis	Education	Motivational Enhancement Goal Setting	Irregular sleep-wake times	Core Module 1
			Difficulty winding down	Core Module 1
			Difficulty waking up	Core Module 1
			Daytime impairment	Core Module 2
			Unhelpful beliefs about sleep	Core Module 3
			Poor sleep-efficiency	Optional Module 1
			Too much time in bed	Optional Module 2
			Delayed or Advanced phase	Optional Module 3
			Sleep-related worry	Optional Module 4
			Promoting compliance with CPAP/ Exposure Therapy for claustrophobic reactions to CPAP	Optional Module 5
			Negotiating sleep in a complicated environment (e.g., group home)	Optional Module 6
			Maintenance of behavior change	Core Module 4

the inclusion and exclusion criteria for research conducted in university settings are somewhat narrow, often excluding comorbidity and complexity. Therefore, examples of science questions we are ready to ask include: Are the findings replicated when 'all comers' are invited into the study? How do various groups within a heterogeneous sample respond similarly or differently to the intervention as a whole and to individual modules? How does TranS-C need to be adapted to meet the needs of the broadest group of clients?

To chase down answers to such questions, we are embarking on a test of TranS-C in which we are recruiting and training 108 routine practice providers who will deliver TranS-C to 648 adults with a severe mental illness. This study will be conducted across a network of Californian community mental health centers (CMHCs). CMHCs are important settings as they are major publicly funded providers of treatment for serious mental illness. They provide for the poorest and most underserved members of the community who experience high rates of comorbidity and complexity. Within this field of dissemination and implementation there are several theoretical frameworks that can guide us as to the multitude of variables that will need to be addressed to truly reach the needs of the community (e.g., Aarons, Hurlburt, & Horwitz, 2011; Damschroder et al., 2009). These include the intervention characteristics, the outer setting in which

the intervention will be scaled (e.g., client needs and resources, reimbursements), the inner setting in which the intervention will be scaled (e.g., culture, leadership engagement), the characteristics of the individuals involved, and the process of implementation. Our hope is that through developing these community-academic partnerships with CMHCs we will gain much needed insight and contributions to answering the plethora of questions that remain as we take the path to work out, and document, what it really takes to truly meet the complex needs of the public.

In sum, our path to this phase in our research program was neither direct nor exemplary. However, with the help of our colleagues and clients, we recognized along the way that this is where our research should be heading. We must continue to learn about, embrace and seek to contribute to the exciting science of dissemination and implementation, in order to realize the potential of novel scientifically developed and tested, effective and efficient treatments. For us, this phase is a truly exciting time of ongoing growth and retooling in order to determine how close we can get to delivering TranS-C to the 'bedside,' as well as address science questions on implementation and sustainment as we go.

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## Ethics Column: Identifying and Responding to Signs of Distress when Dealing with the Loss of a Loved One

Adam Fried, Ph.D.  
Melissa Flint, Psy.D., C.T.  
Midwestern University

 A number of articles and chapters have been published on the topic of provider distress and impairment, and for good reason. In their seminal research on therapist practices, Pope, Tabachnick, and Keith-Spiegel (1987) found that over half of their sample of psychologists had worked when distressed to the point that it impacted their effectiveness. Others (e.g., Johnson & Barnett, 2011) have written about the effects on professional work when faced with significant health issues, substance abuse, depression, and other personal problems. Little, however, has been written about how a clinician's work may be affected by the death of a loved one. When a personal loss occurs, such as the death of a spouse, parent, sibling, child, or close friend, how do we know when our responses might be severe enough to affect our work? How do we know when we should take steps to intervene?

### Experiencing Grief

First, and most important, we must acknowledge that the symptoms of grief are a normal reaction to the loss of a loved one. As clinicians assess these symptoms in their clients, so, too, should they look for them in their own lives following a loss. Experiencing a loss can elicit a variety of responses across all domains of being (physical, emotional, spiritual, cognitive and behavioral/interpersonal) and represents a complicated interplay of psychological, physiological, and psychosocial interactions (Cacciatore & Flint, 2012).

Experiencing a death may bring forth feelings of being physically tired or drained, altered sleep patterns (often lack of sleep), lack of self-care, appetite alterations, as well as complaints of body aches. One might withdraw from people, procrastinate, feel a need to blame others, or voice excessive complaints. Clinicians experiencing deep grief might struggle with substance use or other addictive behaviors. Cognitively, it is not uncommon for clinicians to report diminished concentration, a loss of meaning, apathy, rigidity, and minimization.

### Ethical Considerations

Although grief is a normal part of life, there are times when grief-related distress can negatively impact our work. Some possible effects may include low motivation, avoidance of job tasks, increased mistakes, and impatience. Grief-related responses

may also negatively impact clinical decision-making abilities, quality of therapeutic relationship, and ability to maintain an appropriate distance from patient/client issues (e.g., over and under-identification of client/patient issues, especially related to grief and loss; Cacciatore & Flint, 2012). Unresolved provider stress (in this discussion, caused by their own grief) has been identified as a factor adversely affecting patient satisfaction with treatment, compliance, and even their trajectory of recovery (Coulehan, 2005).

*Standard 2.06 from the APA Ethics Code (2017) states:*

“(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from their performing work-related activities in a competent manner, (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties” (APA, 2017).

But how do we know if our professional work is being significantly negatively impacted and whether we are operating in an impaired state? There has been little research on how psychologists rate their own impairment<sup>1</sup>. In fact, it is widely thought that clinicians may not be good judges of their own impairment, especially when in a distressed state (Johnson & Barnett, 2011). Relying on colleagues to intervene is also fraught with problems, including difficulty identifying relevant signs of distress, both due to the nature of the symptoms and because the work of psychologists is often independent (Smith & Moss, 2009). In addition, colleagues may fear that intervening would make the situation worse and/or they may be unclear as to whether a clinician's distress may necessarily affect their clinical work (Floyd et al., 1998; Johnson et al., 2012). Finally, clinicians experiencing significant distress may be hesitant to reach out to other colleagues due to fears of judgment, resulting in stigma and shame (Zerubavel & O'Dougherty Wright, 2012).

In addition to concerns about the negative effects on professional work and impairment, some clinicians struggle with the question about whether and/or how much to tell clients/patients about their loss. There are times when a client/patient may learn about the loss without being told, such as when a loss is made public through death notices or newspaper stories. There are other times when clinicians feel that they owe an explanation, especially if they have taken a break from

<sup>1</sup> See: Williams, Pomerantz, Segrist, & Pettibone (2010) for an interesting study on how psychologists rate depression and substance use-related distress and impairment among other clinicians



clinical work in order to grieve the loss and take care of more practical matters. While self-disclosure isn't inherently harmful, clinicians should consider important factors related to maintaining appropriate boundaries (see Standard 3.05 Multiple Relationships), such as whether it's important for the client/patient to know, the level of detail communicated, and how this information may be received and/or used by the client/patient (Zerubavel & O'Dougherty Wright, 2012)

### Addressing Grief-related Distress

Clinicians are at great risk when they experience symptoms that influence their clinical work. Many may acknowledge what is happening, but choose to ignore symptoms or believe that they do not have an effect on their work. Being mindfully aware of the impact of the loss on ourselves as personal beings, but also on ourselves as professional beings is particularly important. Self-assess with a gentle, yet intentional critical eye. Is my experience of grief impacting my ability to work? Are my own grief-related thoughts interfering with my ability to concentrate? Below are a few recommendations for clinicians to consider when experiencing grief:

1. Remember that the grief reactions demonstrated in clinicians are as varied as those exhibited by clients. The therapist might be "okay" for a while, then it may hit at unexpected times (e.g., holidays without parent for the first time, deceased child's first birthday not physically present in this world, a client/patient presents with a similar story of loss, etc.). Continuing to monitor reactions, especially when triggered, will be key.
2. When a clinician returns from bereavement leave, it is important to review and perhaps modify the work load. For example, attempt to give yourself space between clients, and avoid loading up back-to-back bereavement/trauma-related cases.
3. Be intentional about practicing self-care each day. For some, this can include spending time in meditation, prayer or other contemplative quiet time between sessions or throughout the day. Others find benefit from exercise and surrounding oneself with caring people. Practicing healthy escapes (get outside in the sunshine, take your lunch break away from the desk) and avoiding unhealthy escapes (substance use, isolation, etc.) are also important.
4. Finally, engaging in consultation and peer support can be critical tools in assessing and addressing potential impacts on our work (Barnett, 2008; Johnson & Barnett, 2011; O'Connor, 2001). Even if we don't see the signs ourselves, reaching out to colleagues and letting them know what you're experiencing can be helpful (or even ethically mandated, as in the case of trainees who are being supervised). This is particularly important for psychologists in independent practice

settings, as this work tends to be socially isolating, making it difficult for others to pick up on signs that one's work may be negatively affected. Johnson et al. (2012) discussed the idea of developing a "competence constellation" (p. 566) of individuals; these include colleagues, supervisors, and even a personal therapist who can provide support and/or serve in consultative roles, especially during times when personal distress may impact our competence.

### Conclusion

In their review "The Dilemma of the Wounded Healer", Zerubavel and O'Dougherty Wright (2012) distinguished between the "wounded healer" (e.g., a person who has their own painful experiences, adversity, or suffering yet has worked through these issues) versus the impaired professional. Suffering a profound personal loss can most certainly force even the most competent clinician into an impaired state. One of the key things for clinicians to remember is that it is up to them to "fiercely guard" their own mental health. This includes (and is even more important in) times of personal grief. Clinicians are at the greatest risk when they fail to balance the need to care for oneself with their job to care for others.

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## SCP Member Spotlight on Dr. Shannon Wiltsey-Stirman

 Dr. Shannon Wiltsey-Stirman is the Acting Deputy Director of the Dissemination and Training Division of the National Center for PTSD with the Department of Veterans Affairs, and an Associate Professor in the Department of Psychiatry and Behavioral Sciences at Stanford. She is the Principal Investigator at the Fidelity, Adaptation, Sustainability, and Training (FAST) Lab, where she conducts research focused on implementation science and optimizing the delivery and sustainment of evidence-based practices. Dr. Wiltsey-Stirman has authored over 80 peer-review publications, and was awarded the Association of Behavior and Cognitive Therapy's Mid-Career Innovator award in 2018. Her research has been funded by the National Institute of Mental Health and the Canadian Institute for Health Research. Dr. Wiltsey-Stirman also serves on APA's Board of Directors as a Member at Large. We had the opportunity to learn more about Dr. Wiltsey-Stirman through our Q&A correspondence. Read on to learn more!

### Please provide an overview of your work

My research focuses on implementation science—in particular, questions around sustainment of evidence based treatments, fidelity, adaptation, and training strategies. My wonderful lab members and I are currently working on a few studies in these areas: <http://med.stanford.edu/fastlab.html>

I think of the work that I do as an effort to identify ways to increase access to evidence-based treatments by identifying ways to support therapists as they learn and provide these treatments, and to help systems and organizations address barriers to their sustained implementation. Areas of clinical focus include PTSD, depression, anxiety and suicide prevention.

### Where did you complete your training?

I did my graduate work at the University of Pennsylvania in clinical psychology, where I worked in Rob DeRubeis's lab. I started out doing projects that involved assessing outcomes like social functioning in clinical trials and assessing CBT fidelity, then I shifted my focus to implementation. I did my internship at the Palo Alto VA, and then returned to Penn for a postdoc in the department of psychiatry with Aaron Beck and Paul Crits-Christoph.

### What is your current position/occupation?

I'm an Associate Professor in the Department of Psychiatry and Behavioral Sciences at Stanford and the Acting Deputy Director at the National Center for PTSD.

**How long have you been a member of SCP? Have you gotten involved in any roles within SCP (e.g., leadership, committees, task forces, etc.)?**

I don't remember when I originally joined, but I think it was while I was in graduate school. A few years ago Torrey Creed and I worked together on the webpage on implementation: <https://www.div12.org/implementation/>



**Shannon Wiltsey-Stirman, Ph.D.**

### What roles have you had with APA or other organizations?

At the beginning of 2019 I joined the APA Board of Directors as a Member at Large. I also serve on the board of the Society for Implementation Research Collaboration as the Chair of the Established Network of Expertise. I'm also serving as the Program Chair for the Association for Behavioral and Cognitive Therapies in 2020.

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

I think we need to continue to embrace technology and figure out how to use it to expand access to evidence-based care. We need to find models to keep people engaged, support their recovery, and help them get the tools and support they need in accessible, affordable ways. I think we also need to continue to work with professionals across disciplines and lay health workers in non-traditional settings to expand access to care as well. I think we also need to have a seat at the table to ensure that our science informs policy. We also need to continue to increase the rigor and transparency of our research and make our findings accessible and easy to implement.

### What are your hobbies?

Running, hiking, cooking, and reading. I took a break from novels to focus on politics and news/current events for a couple of years but need a bit more balance so I joined a book group that actually discusses the books, which has been a lot of fun.



**What led to your interest in clinical psychology?**

I don't remember what got me interested at first, but I think I decided in high school that I wanted to be a psychologist. How I found my way to cognitive therapy is kind of funny. I looked back at my college essays recently when my son was writing his own essays, and in one of them I said that I thought a psychologist's role was to ask open-ended questions and let people discover the answers for themselves—but I didn't encounter Beck's Cognitive Therapy for Depression until I found it in a stack of books at a yard sale while I was in college. I had ended up at St. John's College, which is a Great Books Program with no majors, so I was reading a lot of Socratic Dialogue in Freshman year when we read Plato. So when I found the CBT book at the yard sale, everything came together and I knew where I needed to be. 📖

**Special Interest Groups in Section 8:****A Model for Engagement****Wendy L. Ward, Ph.D., ABPP****Elizabeth Kalb, Ph.D****Nathaly Desmarais, Psy.D**

Special interest groups, as utilized in the context of professional associations, are defined as a community within a larger organization with a shared interest in advancing a specific area of clinical knowledge and/or research where members collaboratively engage in work projects that advance that knowledge or research. Many divisions and some sections of divisions within APA have special interest groups which provide thriving learning communities. SIGs within a division or section have served to assimilate, engage, support, and develop trainees and early-career professionals as well as giving early- and mid-career professionals SIG Chair and other officer or committee roles in which they can practice leadership skills (Davis, Ward, Armstrong, Devine, & Schurman, 2017). More generally, SIGs may serve as a membership engagement tool and as such may be one factor in the recruitment and retention of members in divisions. Membership recruitment and retention efforts are critical for divisions at a time when membership in APA (Grohol, 2018) and some divisions (APA, 2015) may be dwindling.

Membership in a professional association is a key career goal as it supports professional networking, staying in touch with the latest clinical innovations and research findings, and provides a professional community. Many initiatives are put into play to acquire and retain members. Opportunities for members to be more involved in areas of interest may be an important

factor for membership engagement. For example, the Association of Psychologists in Academic Health Centers (APAHC; Division 12, Section 8) started its first interest group in 2016 via an open call for members interested in interprofessional education (IPE) on the APAHC listserv. A series of phone calls resulted in several processes including: a) a review of the history of the IPE and Interprofessional Collaborative Practice intertwined movements, b) sharing event materials as well as lessons learned related to event design and implementation, and c) evaluation tools. An APAHC membership survey in 2017 included questions about the degree of involvement of its members in medical education, IPE, and faculty development that included training needs and resources available (Robiner, under review). Both a keynote and a panel discussion at the 2017 APAHC conference extended this conversation to the APAHC membership at large, and the panel presentation was later published (Ward, Zagoloff, Rieck, & Robiner, 2018). The IPE workgroup had time at the conference to meet in person and led to the establishment of three workgroups that each identified a work project: a) a review of IPE with psychology trainees in comparison to other professional trainees, b) a survey of psychology trainees across learner level regarding their IPE experiences, and c) a survey of psychology training directors regarding their engagement in and barriers to IPE. A joint submission of these three projects to TEPP will occur in early December 2019. Posters related to this work have already been presented at an APA Convention, two different APAHC conferences, and the international Collaborating Across Borders (IPE) conference. The 2019 APAHC conference included a workshop providing IPE Facilitator and Event Design Training and another in-person IPE meeting where two additional workgroups emerged, with one focusing on the development of a toolkit for those charged with creating and/or implementing IPE events (and resources for leaders in charge of programs) and the other with a focus on looking at a variety of research opportunities in IPE. The leaders of the interest group have engaged APA in conversations at the genesis of the interest group and ongoing about the national need for psychology engagement in IPE, barriers, and need for training and resources.

More recently, the APAHC Professional Wellness (PW) interest group was created. This group began by members with a vested interest in professional wellness speaking with one another in order to create specific work project ideas. Currently, the initial work project is focused on creating a specific survey that addresses the many factors related to professional wellness for psychologists working in health/medical settings. More specifically, this PW workgroup is taking the results of the 2017 membership survey (which included a few professional wellness and burnout questions;

Williams et al, 2019) and extending it to working with parallel interest groups in Division 38 and Division 54 in order to survey psychologists across divisions also associated with a health/medical work setting to better understand the extent of burnout, sources of stress, potential points of impact that would reduce stress and/or promote wellbeing in psychologists working in these settings. Wellness surveys in these settings targeting other professions are occurring with frequency and comparison of psychologists with physicians, nurses, pharmacists, and others would also be fruitful. Advocating for a speaker on professional wellness at the APAHC annual conference, provision of workshops or other trainings that support psychologists' readiness for leadership roles in professional wellness programs (either faculty-, employee-, or student-focused), highlighting the need for resiliency skill-building in the psychologist workforce, contributing to APAHC webinars on the subject, and engaging in additional work projects are all potential next steps. To further this initiative, these three PW interest groups have created a chat room that has built an interdivisional community of leaders in PW roles and other interested psychologists where they can easily develop partnerships and share materials/lessons learned. The recently-released NAM Clinician Wellbeing Report (NAM, 2019) is being read and discussed amongst the interdivisional community. Additionally, conversations with APA leaders regarding the need for psychology to be part of the national conversation on PW have been occurring as well.

APAHC (Division 12, Section 8) has had an increase in members over the past several years. It is difficult to say if that relates to the interest groups that have arisen, other membership drive initiatives, external forces, or the combined effects. However, what is clear is that interest groups provide an opportunity to develop a community around a shared area of interest that can lead to significant partnerships and research productivity including conference presentations/posters/workshops, publications, resources, and national advocacy. With this high level of member engagement and accomplishments, members may strengthen their engagement in the division or section where the SIG lives. Further, SIG projects have the ability to positively impact SIG members directly, but also members in the association not involved in the SIG, and the larger community of psychologists.

Note: SIG membership is open to any APAHC member. Email Elizabeth Kalb (eakalb@USI.EDU) to join the IPE interest group. Email Nathaly Desmarais (ndesmara@fiu.edu) to join the Wellness interest group.

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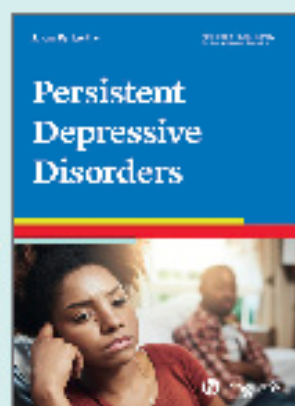
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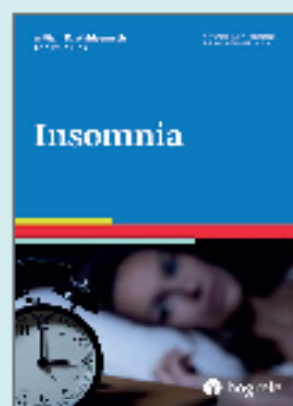
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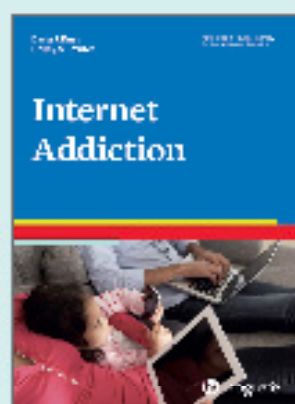
Expert, evidence-based guidance on persistent depressive disorder (PDD) for busy practitioners who need to know how to assess, diagnose, and treat this difficult to identify and potentially life-threatening disorder. The therapies that have the strongest evidence base are outlined, and in particular the cognitive behavioral analysis system of psychotherapy (CBASP), a treatment specifically developed for PDD. Printable tools in the appendices can be used in daily practice.



## William K. Wohlgemuth/ Ana Imia Fins **Insomnia**

Vol. 42, 2019, viii + 94 pp.  
ISBN 978-0-88937-415-7  
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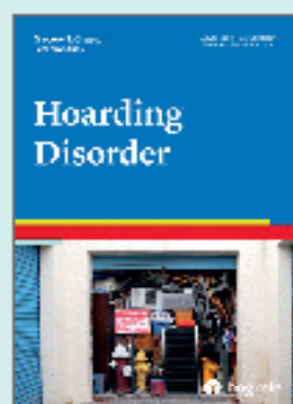
This concise reference written by leading experts for busy clinicians provides practical and up-to-date advice on current approaches to diagnosis and treatment of insomnia. Professionals and students learn to correctly identify and diagnose insomnia and gain hands-on information on how to carry out treatment with the best evidence base: cognitive behavioral therapy for insomnia (CBT-I). Copyable appendices provide useful resources for clinical practice.



## Daria J. Kuss/Halley M. Pontes **Internet Addiction**

Vol. 41, 2019, iv + 86 pp.  
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Internet use is an integral part of our daily lives, but at what point does it become problematic? What are the different kinds of internet addiction? And how can professionals best help clients? This accessible, evidence-based book by leading experts answers these questions by outlining the current assessment and treatment methods for internet addiction. Includes a 12–15 session treatment plan using the method and setting with the best evidence: group CBT, and printable tools for assessment and treatment.



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Vol. 40, 2019, viii + 76 pp.  
ISBN 978-0-88937-407-2  
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Hoarding disorder presents particular challenges in therapeutic work, including poor treatment adoption. This evidence-based guide written by leading experts presents the busy practitioner with 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 psychosocial approaches to ensure successful treatment. Printable tools help practitioners carry out therapy.



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