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

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2019 APA Convention Highlights

Division 12 Events & Awards

In August, the Society of Clinical Psychology (SCP, Division 12) welcomed its membership to the annual APA convention. Our Division's sensational program was put together by our outstanding SCP Convention Program Co-Chairs: Drs. Cassidy Gutner and Angela Fang. They worked tremendously hard to ensure a spectacular program full of cutting-edge keynotes, symposia, and panels that cover the pressing issues confronting our practice and our field. Thank you both!

In this year's Presidential Address, Dr. Jonathan Comer encouraged us to step outside of our comfort zone to expand the scope of clinical psychology in the 21st Century. Additionally, our invited keynote sessions addressed critical and very timely topics in clinical psychology. First, Dr. Marc Atkins presented on his exciting work supporting parenting in underserved communities. Additionally, Dr. David Mohr described the importance of rethinking our approach to digital mental health. Dr. Rosaura Orengo Aguayo presented on her trauma-focused work promoting psychological recovery after Hurricane Maria in Puerto Rico. And, in our final 2019 invited keynote session, Dr. Margaret Sheridan described what psychological science can tell us about the impactof child separation on mental health. Our Division also invited two pre-convention workshops. First, Dr. Shannon Sauer-Zavala provided a half-day training on the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders. Additionally, Drs. W. Edward Craighead and Allison LoPilato provided a workshop on behavioral activitation for adolecents with depression.

These invited addresses were just the tip of the iceberg when it comes to exciting and stimulating Division 12 program at this year's APA convention. There were a number of very interesting presentations by leading experts covering a range of vital practice and training topics, including suicide prevention, cultural factors in assessment and treatment, global mental health, the Clinical Practice Guidelines, and recruiting and retaining a diverse mental health workforce, among other subjects. And for early career trainees and psychologists, our annual Speed Mentoring Event was a great success with 9 mentors and 22 mentees.

As always, our Division's social events provided an excellent context to catch up with friends and colleagues. Additionally, our Awards Ceremony provided an opportunity to recognize the wonderful contributions of our impressive membership. Finally, we extend our thanks to Hogrefe Publishing for providing sponsorship for our 2019 Awards Ceremony and Social Hour.

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Division 12 Award Winners 2019

The *Award for Distinguished Scientific Contributions to Clinical Psychology* was presented to **Michael W. Otto,** Ph.D. for distinguished theoretical and empirical contributions to Clinical Psychology throughout his career.

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

The *Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology* was presented to **Michelle G. Newman,** Ph.D. for excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows, and junior faculty.

The *David Shakow Early Career Award for Contributions to Clinical Psychology* was presented to **Luke Williamson Hyde**, Ph.D. for his noteworthy contributions both to science and to practice within seven years of receiving his doctoral degree.

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

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

The *Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology* was presented to **P. Priscilla Lui**, Ph.D. for her exemplary contributions to diversity within the field.

The *Distinguished Student Research in Clinical Psychology Award* was presented to **Megan Brem**, M.A. for exemplary theoretical or empirical contributions to research in clinical psychology.

The *Distinguished Student Practice in Clinical Psychology Award* was presented to **Helen B. Murray** for outstanding clinical practice contributions to the profession.

The *Distinguished Student Service in Clinical Psychology Award* was presented to **Mian-Li Ong,** M.A. for outstanding service contributions to the profession.

The *Distinguished Student Diversity Award in Clinical Psychology* was presented to **Shannon M. Hughley** for exemplary contributions to diversity within the field.

The *Distinguished Student Leadership Award in Clinical Psychology* presented to **Natalie Arbid** for outstanding leadership to the profession.

The *Division 12 Dissertation Award* presented to **Jonah J. Meyerhoff** for excellence, innovation, and social justice in dissertation research.

The *Distinguished Student Scientist-Practitioner Award in Clinical Psychology* was presented to **Alexandra Wernt Czywczynsk**i, M.A. for outstanding contributions to both research and practice in clinical psychology and whose work demonstrates substantial reciprocity and complementarity between research and clinical interests.

Additionally, we would like to congratulate our Student Poster Winners: **Lauren Schaefer, Krista Herbert Rina Fox, and Priscilla Lui.**

We would also like to welcome our current and incoming Fellows: **Drs. Adam Leventhal, Eva Feindler, K. Mark Sossin, Robert Kinscherff, Steven D. Hollon, and Nicholas L. Salsman**.

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SECTION REPRESENTATIVES TO THE DIVISION 12 BOARD

EDITORIAL STAFF

Shannon Sauer-Zavala, Ph.D. - Editor

Lead Article: How About Improving Behavioral Health Care for All?

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Despite significant debate about the importance of healthcare for all, efforts to offer behavioral health services for all has been off the radar, rarely addressed by political candidates. It appears surprising given the epidemics of opioid deaths, suicides, alcoholism, and depression, that there has been limited progress addressing socioeconomic and ethnic/racial service disparities in behavioral health care (Cook et al., 2018). An ongoing narrative is that people of color are "the hard to reach populations," when instead the failure could be largely due to the limited attention to political, systemic, and structural barriers endemic to behavioral health care for people living in poverty and for ethnic and racial minorities, including immigrants. These disparities are even more severe for undocumented immigrants. In this article, we discuss potential reasons for the lack of progress and the urgency to improve behavioral health care for all. We argue that the following factors have impeded equity in behavioral health care services, predominantly affecting people living in poverty, racial/ethnic minorities, and immigrant populations: inadequate enforcement of mental health policies; policies that curtail behavioral health services; insufficient investment in behavioral health care (including budget cuts that hit the behavioral health care system), continued fragmentation of the system; lack of oversight for managed care companies; and provider shortages. We discuss potential solutions to these issues and further encourage research on positive spill-over effects of inclusive behavioral health services.

Margaríta Alegria, Ph.D.

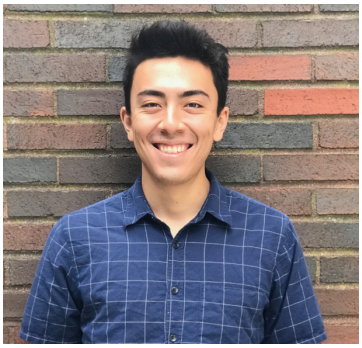
Inadequate Enforcement of Mental Health Policies

Since the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) built on the idea of equal insurance coverage for mental health and physical health, researchers have found a minimal increase in the utilization rate of behavioral health services, a small increase in the cost per enrollee for plans, and a modest decrease in patient out-of-pocket costs a decade after the implementation of this legislation (Mulvaney-Day, Gibbons, Alikhan, & Karakus, 2019; Peterson & Busch, 2018). However, in the face of these generally positive findings, a report evaluating enforcement of the policies post-implementation revealed that 32 of the 50 US states received a failing grade for their state-level mental health parity statutes (F on a letter grade scale); Illinois (A-100), Tennessee (C-79), Maine (C-76), Alabama (C-74), Virginia (C-71), and New Hampshire (C-71) received the highest scores for the implementation of the policy (Douglas et al., 2018). Although the MHPAEA had some small effects on previously unequal aspects of behavioral health care, anticipated changes and improvements because of its passage may be hampered due to inadequate enforcement of the law within state legislation.

Parwana Khazi

Policies That Curtail Behavioral Health Services or Do Not Encourage Servicing All

The interplay of regulations and legislation is a commonly identified barrier in the improvement of behavioral health, with tremendous repercussions for those living in poverty, ethnic and racial minorities, and immigrants. For instance, there is a dearth of political action to serve marginalized populations, such as refugees, asylum seekers and other migrants. Immigrant mental health is particularly affected by limited political action directed at increasing access and improving behavioral health



Steven Miyawaki

care. This remains an understatement for immigrant populations constantly feeling under siege and facing the adverse mental health consequences of raids, detentions, and family separations (von Werthern et al., 2018). Not surprisingly, undocumented immigrants, refugees, and asylum seekers experience heightened levels of behavioral health-related disparities and inequities in comparison to other immigrants (Chang, 2019). For example, undocumented immigrants under-utilize healthcare compared to documented citizens (7.9% and 30.1% respectively), with lower healthcare-related expenditures compared to their documented counterparts ($140 and $1385 respectively), and demonstrating once more, the tragic service disparities (Zallman et al., 2016). With current policies severely restricting immigration to the United States, undocumented immigrants and their families are increasingly delaying or forgoing medical care, particularly behavioral health services, as their distrust in health services grows (Kerani & Kwakwa, 2018). These disparities extend to both documented and undocumented immigrants and their families, including their US-born children. These children are significantly less likely to get the healthcare they need because of the legal status of their parents (Vargas & Pirog, 2016).

Marie Fukuda

Allocation of resources toward immigrant behavioral health has also been influenced by the notion of "deservingness," or whether immigrants, especially those who are undocumented, are worthy of the increased economic and societal costs of their health care (Castañeda et al., 2015). Some argue that undocumented immigrants are undeserving, and consequently they should not receive services. This translates into public funds should not be allocated toward immigrant-focused healthcare (Edwards, 2010), or if they do receive healthcare or social services (e.g. food stamps), these should count against eligibility for citizenship. Not only do these suggested policies curtail needed mental health and substance use treatment services, they erode the necessary patient-clinician relationship for investing in behavioral healthcare. But untreated mental health problems have consequences. A 2017 study revealed that Latinos who live in states with more stringent immigration policies reported a higher number of poor mental health days in comparison to those in states with less restrictive regulation (Hatzenbuehler et al., 2017). As such, strict policies pertaining to undocumented immigrants seem to result in indirect economic costs, emphasizing that the societal cost of not treating them is passed to the employment sector and to these families.

Insufficient Investment in Behavioral Health Care

Compared to other areas of healthcare, public behavioral health is underfunded, despite its high prevalence and disease burden (SAMHSA, 2017). According to the World Health Organization (WHO), the years lost to disease (YLDs) for mental health conditions in 2016 was 5.6 times that of cardiovascular diseases and 8 times that of cancer. Despite the higher burden of mental illnesses, public funding of mental health care continues to be disproportionately low compared to other conditions. US health-related funding schemas are typically based on life expectancy projections and mortality rates; but because mental health conditions rarely appear on death certificates, there is inadequate consideration of their contribution (Trautmann, Rehm, & Wittchen, 2016).

Individuals living with mental health and/or substance use disorders have higher medical spending on average than those without these conditions (Montz et al., 2016). Because of such findings, insurance companies seek to avoid enrolling individuals living with behavioral health conditions by structuring service offerings to discourage them from joining. This form of service discrimination, though prohibited by recent parity legislation, is particularly difficult to enforce. Anticipating the repercussions of enrolling clients that might have mental health and other comorbid conditions, plans often demonstrate little incentive to provide high quality care for high-cost mental illness and/or for treating people living with substance use problems; conversely, plans may provide too many services for patients who are "less seriously" ill to attract more of these "good" risks, a phenomenon that generates too much care in some areas and too little care in others like behavioral health (Frank, McGuire, Bae, & Rupp, 1997). Implementation of such strategies could explain why those suffering from severe mental illness, who tend to be poor, on average die 10 to 15 years younger than the general population (Roberts et al., 2017).

However, untreated behavioral health conditions increase social costs for individuals suffering these illnesses and other public systems. One method of calculating the social cost of such disorders is estimating their projected effect on the gross domestic product

(GDP), a measure impacted by labor and capital (Trautmann et al., 2016). Behavioral health conditions reduce both capital and labor due to high individual expenditures for services and disability (Larkin et al., 2009; Roehrig, 2016). Furthermore, mental health conditions are more likely than other diseases to affect individuals in the working-age population, enhancing their economic and social burden (Chen, Kuhn, Prettner, & Bloom, 2018). The impact of untreated mental health on poor families cannot be overstated. It deteriorates the social fabric of families and communities. As stated by McLoyd (1990), psychological distress for those in poverty weakens the ability for supportive parenting and exposes parents to the sapping effects of negative life events and the lessening of marital bonds.

Mental health and substance use treatment programs have experienced and continue to experience disproportionate budget cuts and decreased government funding. As reviewed by the National Alliance on Mental Illness (NAMI; 2017) the Fiscal Year (FY) 2018 President's Budget stripped millions allocated to support of the Mentally Ill Offender Treatment and Crime Reduction Act and cut approximately $400 million from SAMHSA. This SAMHSA cut reduced substance abuse prevention measures by one-third and decreased mental health allocations by 22%; it also completely defunded health workforce education and training. Additionally, the FY 2020 President's Budget proposes to eliminate the Primary and Behavioral Health Care Integration grants that support the establishment and sustenance of integrated programs (US Department ofBudget, 2019). The lack of investment in behavioral health is compounded by the lack of investment in racial/ethnic minority healthcare research projects. Asian American, Native Hawaiian, and Pacific Islander health in particular receive little financial attention, with only 0.17% of the NIH budget allocated towards clinical research projects focusing on these populations (Đoàn, Takata, Sakuma, & Irvin, 2019). Insufficient investment in research poses a serious challenge to behavioral health systems, especially for clinicians serving racial and ethnic minority populations that might lack a portfolio of evidence-based treatments.

Continued Fragmentation of the Behavioral Health Care System

The "deinstitutionalization" movement of the 1960s and 1970s decentralized behavioral health care and redistributed the responsibilities previously held by the state to other stakeholders, like private insurance companies (Falconer et al., 2017). Despite successfully changing perspectives of policymakers and services to be more community-oriented, this movement set an unfortunate precedent for disconnected and uncoordinated funding mechanisms, services, and programs (Falconer et al., 2017). For example, in New York State, standards of the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Department of Health (DOH) must all be met for providers and organizations to be licensed for practice (Ramanuj, Talley, Breslau, Wang, & Pincus, 2018). Fragmentation across state and federal-level departments of health and behavioral health makes it more difficult to expand the reach of behavioral health services during a time when the field already faces significant limitations, especially pertaining to marginalized and linguistic minority populations as well as serving those living in poverty. Fragmentation has made it difficult to recognize and address the complex needs of people living with mental health and substance use disorders, which often span a variety of domains and systems.

Lack of Oversight for Managed Care Companies

Since the years after deinstitutionalization, states have largely relegated their responsibility of behavioral health care to private organizations. With the lack of consistency and care continuity, individuals living in poverty with mental health and substance use conditions may slip through the cracks, increasing the chances of negative multisystemic outcomes such as homelessness, unemployment, and imprisonment. These outcomes disproportionately impact marginalized populations, who often find themselves stigmatized by the healthcare system (eg., Staiger, Waldmann, Oexle, Wigand, & Rüsch, 2018), and consequently decide to avoid it (eg., Weisz & Quinn, 2018). Without enough federal oversight on managed care companies regarding minimum standards of adequate care, there has been a lack of accountability for effective behavioral healthcare that avoids these negative outcomes, one that ensures the basic components of evidence-based care.

The Workforce Shortage

Given the demand for mental health and substance use services, the behavioral health workforce remains limited in size, racial and ethnic diversity, linguistic capability, cultural and religious competency, and distribution. Approximately 77% of US counties have a severe shortage of psychiatrists and almost 20% of counties have an unmet need for non-prescribers including but not limited to psychologists, advanced practice psychiatric nurses, social workers, licensed counselors, and therapists (Hoge et al., 2013). Salaries in behavioral health care are well below those for comparable positions in other health care sectors (Hoge et al., 2013). Some employers may decrease wages and benefits and increase the burden on individual workers to realize savings; this lends itself to higher levels of worker burnout and increased rates of turnover in a field that is already limited in personnel (Gabel, 2012).

Although measures have been taken to expand the size of the behavioral health workforce, it remains

deficient in terms of racial, ethnic, and linguistic diversity. According to SAMHSA (2018), less than 20% of America's general behavioral health workforce consists of racial or ethnic minorities. Eighty-seven percent of the individuals certified by the American Board of Professional Psychology are non-Hispanic white, while 3% identify as Hispanic/Latinx and another 3% identify as black (Frost et al., 2019). This lack of racial diversity in behavioral health especially limits care for non- English-speaking minority groups. A recent study of the conversations between Mexican-origin patients and their health care providers reveals that providers and patients with varying linguistic backgrounds may use different reference sets, which may result in miscommunication and misinterpretation (Magaña, 2019). Increasingly, patients' family members or companions serve as ad hoc interpreters, a phenomenon that is negatively correlated with the quality of care patients receive (Cox et al., 2019). Such discrepancies reveal the need to expand the linguistic capabilities of the current behavioral health workforce, whether through the recruitment of bi- or multi-lingual professionals or through the increased funding of translation services.

Significant barriers to the expansion and diversification of the behavioral workforce also exist in both general opinions toward and perspectives about careers relating to mental health and/or substance use disorders. In 2017, only 4.3% of students graduating from US medical schools attended psychiatry residencies or fellowships (Association of American Medical Colleges, 2018). Medical students generally rate psychiatry poorly as a career choice, attributed to its "lack" of scientific foundation, perceived low status, limited financial reward, and minimal opportunity to use clinical skills (Lyons, 2013). As such, the already limited workforce is at risk of further decreasing in size and diversity.

But what can we do, if we are truly serious about improving behavioral health care for all?

1. Increase support for behavioral health care systems through policy enforcements

It is critical that behavioral health be prioritized by those with the power to actively change public perception, implement new policies, and distribute resources in a manner that combats disparities and inequities (Shiffman & Smith, 2007). Expression of support for behavioral healthcare by political leaders can catalyze improving our behavioral health care system at state and federal levels, but only if budgets are committed to improving the system. For example, states can elect to prioritize the enforcement of current legislation like the MHPAEA to address the numerous behavioral health-related epidemics facing the US. The efficacy of parity laws can be improved by implementing regulations such as market conduct examinations and network adequacy assessments, carried out by state insurance regulators. The former verifies compliance of the plan with federal and state laws and the latter ensures the plan can support and serve its beneficiary population based on contracted services (Douglas et al., 2018). Such measures can improve quality and access to services by beneficiaries while decreasing costs accrued by states, curtailing behavioral health disparities and promoting behavioral health equity.

Health policy has historically led to numerous effective interventional and treatment-based changes relating to HIV, cancer, immunizations, and other conditions, making it an attractive lever for improving behavioral healthcare. One possibility is creating performance metrics for behavioral health care and monitoring and supervision of knowledge transfer that is implementable and sustainable in widely-ranging real-world practice settings. To be effective, such metrics should monitor whether clinicians are delivering essential components of evidence-based care and regularly identifying disparities in access and outcomes.

2. Invest in Medicaid and Medicare, including for undocumented immigrants

If we are to improve the system for all, we need to invest in behavioral health care. With over 90% of healthcare costs being managed by private insurance companies, many of which are for-profit operations, behavioral health disparities can be further perpetuated by inadequate funding mechanisms (Centers for Medicare & Medicaid Services, 2018). A study conducted in Oregon noted that Medicaid expansion led to significant improvements in symptoms of depression, one of the leading causes of disability in the US (Sommers, Gawande, & Baicker, 2017). Another economic study revealed that the Medicaid rate of $327,000-$867,000 per life saved was 8 to 21 times more remunerative compared to other public policies aimed at the same cause, suggesting that the expansion of public health insurance has been and can continue to be a worthwhile investment (Sommers, 2017).

Since adults living with serious mental illnesses are covered by Medicaid at a disproportionately high rate compared to other insurance types, it is crucial that funding for behavioral health in Medicaid is adequate (Altschul et al., 2018). To ensure that the investment is made in the most cost-effective manner, public risk adjustment algorithms used to pay health plans need to better reflect the costs of not treating behavioral health conditions, many of which are progressive and, when left untreated, accrue incrementally greater costs. Seeing that allocation of funding and resources among health conditions depends on the understanding of current economic burdens and the projection of future costs, algorithms with the highest predictive power should be employed. Previous literature has

focused almost entirely on parametric algorithms, yet much evidence suggests these traditional methods underestimate costs of various medical conditions (Montz et al., 2016). Using the more modern method of non-parametric machine learning, Rose (2018) found significant differences, compared to parametric methods, in the relative rank and effect sizes of the most expensive medical disorders. Chiefly, her results indicate that depression and bipolar disorder are among the five most costly medical conditions on average per individual, and that their marginal incremental costs to individuals may be over four times what insurers are paying (Rose, 2018).

Even with more accurate prediction of costs, insurance companies and local, state, and federal governments must also incentivize behavioral health providers to accept Medicaid and Medicare. In a recent study conducted in New Mexico, 24% of psychiatrists, 31% of psychotherapy providers, and 43% of substance use treatment providers did not have a single patient who was primarily covered by Medicaid; additionally, over half of all behavioral health providers did not serve any patients with Medicare as their primary payer (Altschul et al., 2018). To sufficiently address the needs of those in need of behavioral health services, clinicians must be willing to accept patients under public insurance such as Medicaid. By incentivizing and paying more to providers to accept Medicaid and Medicare in behavioral health services, public insurers may optimize the overall quality of care and increase health outcomes (Lubarsky, French, Gitlow, Rosen, & Ullmann, 2019).

At times however, the push for health equity for "all" is limited to "all with documentation." Undocumented immigrant populations are often the target of many restrictive policies enacted by different levels of government; consequently, this population has the lowest rate of insurance and therefore limited access to healthcare (Perreira & Pedroza, 2019). Some states have perpetuated this trend with its exclusion of undocumented immigrants from all federal health care (Viladrich, 2019). With budget cuts and increased immigration enforcement in recent years, there has been a significant decrease in the overall physical and behavioral health of immigrant populations (Perreira & Pedroza, 2019). However, research indicates that including both documented and undocumented immigrant populations in public insurance pools can improve healthcare coverage and access to healthcare for all vulnerable populations (Stimpson & Wilson, 2018). The reasons discussed are linked to immigrants being younger and healthier than the general population, and their less frequent use of medical care suggests that they could lower insurance premiums (Paskett et al., 2016).

3. Improve behavioral system's integration with inclusion of additional sectors of support

The current healthcare landscape necessitates a perspective change that views behavioral health as a role player in all facets of health rather than an isolated entity. Such a shift would allow for increased understanding of the lived experiences of those with several marginalized statuses, and greater attention to their interacting health needs (Richman & Zucker, 2019). The integration of behavioral and primary care has become a central point of discussion to minimize the adverse effects of our currently fragmented system. As approximately one-third of patients with mental health problems use primary care physicians as their only source of health care, such integration may help address the needs of those not currently receiving or seeking behavioral health treatments (Russell, 2010). Data show that 93% of Accountable Care Organizations (ACOs) built on an integrated care model under the ACA, met the maximum quality benchmark for provider communication between their services (Abrams et al., 2015). The continuation of such integration-focused elements of the ACA can decrease the negative impacts that arise when separate individuals and organizations assess and treat the same individual (Haffajee, Bohnert, & Lagisetty, 2018). However, there is a need to implement policy that improves quality care under these models; one-fifth of ACOs did not meet the minimum quality benchmark for depression screening; moreover, only one-fifth met the maximum quality benchmark (Abrams et al., 2015). According to the Centers for Medicare and Medicaid Services (2019), the current ACA standards consist of 23 quality measures, of which only one directly pertains to mental health (depression screening) and none involve substance use. These standards must be revisited and revised to reflect the widespread prevalence and increasing incidence of behavioral health conditions.

Additionally, integration of behavioral health services can also have financial benefits for patients, healthcare facilities, and insurance plans, if you add up the costs to society of untreated mental health problems. Primary care and behavioral health integration in Kansas City has been associated with over $860 of savings per member per year, reducing the economic cost of these same patients on the insurance plan by 10% (Ross et al., 2019). The downstream impacts of care integration can also lead to significant cost savings for both public and private entities. Considering service integration, the Primary Care Behavioral Health (PCBH) model has played a role in the evolution of Federally Qualified Health Centers (FQHCs), where facilities are reimbursed by the federal government for services provided to disadvantaged populations with little to no access to other resources, including those with concurrent behavioral health conditions (Ramanuj et al., 2018). FQHCs have established themselves as

a safety net without regard for insurance coverage, immigration status, or other such social determinants of healthcare. As such, they have increased the ability of health-related organizations to extend their services to a wider breath of individuals and conditions (Reiter, Dobmeyer, & Hunter, 2018). One example is the Connecticut-based nonprofit agency "The Connection," modeling its services to provide criminal justice, family, and housing support, in addition to behavioral healthcare, based on the interaction and correlation between these factors (Lee, Sells, Klimczak, Barber, & DeMatteis-Lepore, 2018). These and other similar organizations exhibit the potential to integrate health services with services that impact the well-being of vulnerable populations and marginalized communities and promote self-determination, mutual support, and hope (Lee, Sells, Hasson, Klimczak, & Barber, 2019).

Similarly, medical-legal partnership (MLP; a collaboration between a healthcare organization and a public interest law organization to address health-harming social needs with civil law remedies), can improve behavioral health disparities through the overlap of different systemic services (Tobin-Tyler & Teitelbaum, 2019). MLPs can improve patients' health outcomes, general well-being, and mental health state while reducing their overall stress levels and decreasing existing disparities (County Health Rankings & Roadmaps, 2019). MLPs can integrate currently disparate systems and improve health equity, especially for people of color, who are disproportionately incarcerated and involved with the legal system in the US (Jeffers, 2019). There is a need for structural interventions that not only address inequities in behavioral health outcomes and access to care that but also have enough flexibility to deliver services to diverse populations in a variety of community settings and healthcare organizations.

4. Expand the workforce

The implementation of appropriate and effective policy, intentional investment and adequate funding, and integration of behavioral and primary care cannot achieve its potential without a large, diverse, and competent workforce. As such, the alleviation of behavioral health care disparities is reliant on the recruitment, retainment, and training of professionals working at both individual and community levels. Recruitment for careers in behavioral health can begin as early as high school through pipeline programs between high schools and local colleges and universities, and particularly aimed at youth from historically underrepresented minority groups to increase awareness of the field and access to resources (Ching, 2019). Furthermore, increasing emphasis on psychiatry in medical school curricula can increase the breadth of the workforce, with research indicating that such exposure early in medical education has been positively correlated with entry into the field post-graduation (Wiesenfeld, Abbey, Takahashi, & Abrahams, 2014).

Limitations for behavioral health professionals extend to the bureaucratic systems that influence their practice. There are stringent state licensure regulations for clinicians working with patients with mental health and substance use disorders, restricting fluid movement of providers across state borders to improve distribution across the country. For instance, almost half of US counties lack a buprenorphine-waivered physician to treat patients with opioid dependence disorders because only 4% of all providers in the US have the appropriate licensure to practice in such a capacity; current state regulatory ordinances prevent these physicians, although limited, from distributing themselves in a more efficacious manner (Haffajee et al., 2018). To address this, New Mexico passed Senate

Bill 105 in 2016, expediting the licensing process of providers who are in good standing in other jurisdictions in the country (Altschul et al., 2018). State-level legislation can further incorporate other professionals into the general infrastructure of behavioral health care to expand its reach. For instance, with the passage of House Bill 54 in 2016, New Mexico made social workers and counselors eligible for rural practice state tax credits, with hopes of improving retention rates with the increased financial incentive (Altschul et al., 2018).

Efforts to expand the size and reach of the behavioral workforce should not be limited to behavioral health professionals. Extensive research supports the critical role of lay health workers such as community health workers (CHWs) and peer providers (also referred to as peer workers or certified peer specialists), in broadening and diversifying the behavioral healthcare workforce. CHWs work as liaisons between local health agencies and individuals and often share ethnic, linguistic, socioeconomic, and geographic similarities with those they serve (Daniels, Bergeson, & Myrick, 2017). Peer providers are individuals who use their lived experiences with behavioral health disorders and skills developed in formal training to deliver services in mental health and substance abuse treatment settings. Within these capacities, CHWs and peer providers are viable options to meet the needs of ethnic/racial and linguistic minority populations with limited access by providing outreach and education to underserved communities in a cost-effective manner. In scenarios of severe provider shortages, CHWs can also step into the role of primary providers of evidence based treatments (Barnett, Gonzalez, Miranda, Chavira, & Lau, 2018). Sustained financing of CHW and peer provider services must be developed to realize their potential in expanding the behavioral health care workforce and consequently addressing racial health disparities (Lapidos, Lapedis, & Heisler, 2019).

One potential avenue for financing and reimbursement may be through Medicaid and Medicare. In addition, the 2018 federal Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act stipulates that Medicare Advantage plans can offer nonmedical benefits to improve care for patients with chronic disorders; this act provides an opportunity for coverage of CHW services in Medicare Advantage plans that provide outreach to minority populations and address racial/ethnic mental health disparities (Lapidos et al., 2019). Medicaid has also proven to be an effective funding source for peer support services, with 36 states receiving Medicaid reimbursement for mental health peer services and 11 states for peer services in substance use disorder treatment (Gagne, Finch, Myrick, & Davis, 2018). Further expansion of Medicaid coverage for peer support and CHWs can help racial minorities navigate complex healthcare systems and thus improve behavioral healthcare access and outcomes (Cabassa, Camacho, Vélez-Grau, & Stefancic, 2017).

Conclusion

System-level barriers have impeded progress in addressing racial/ethnic disparities in behavioral health. Lack of political implementation, insufficient funding, systemic fragmentation, and a limited workforce delay improvements of behavioral health services and outcomes, with negative downstream effects for racial/ethnic minority and immigrant populations. In line with these challenges, systemic changes are needed to achieve equity in behavioral healthcare and health outcomes. Broad-scale system change is a challenging proposition, yet previous health movements successful in initiating system change indicate that the outcome is well worth the difficulty. For instance, AIDS activists in the 1970s and 80s initiated system change that improved care for HIV/AIDS patients in the US, first protesting the NIH and FDA and eventually "gaining a seat at the table" in government agencies, institutional review boards, and national advisory boards (Epstein, 1995). We can do the same. Only with system-level solutions, that address persistent behavioral health injustices and promise precedent for systematic change, can we eliminate behavioral health disparities and ensure services for all.

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Ethics Column: Considerations for Psychologists Using Mobile Apps in Clinical Care

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In recent years, there has been an explosion in the use of mental health-related mobile applications ("apps", also referred to as "smartphone apps"). Apps are broadly defined as applications clients/patients download, usually using a mobile device (such as a smartphone). Mobile apps vary in terms of their purpose and function. Certain apps can provide on-the-spot record keeping where clients/patients can record thoughts, feelings, behaviors, and experiences relevant for their clinical work. Other mobile apps can provide some clinical benefits in between sessions or for periods when a client/patient may not be able to see their provider. For example, some apps provide tailored problem-solving ideas and coping strategies. These are usually personalized and require active input from the user. Finally, some apps may facilitate experiences meant to reduce anxiety or improve mood but are not necessarily personalized to the individual, such as apps that provide brief guided meditation sessions.

There are several scientific, practical, ethical and legal questions that clinicians should consider before using an app in clinical practice, including whether: (1) there is data supporting the effectiveness of the app (2) there are adequate privacy safeguards for data entered by a client/patient, and (3) there is any oversight in terms of the use of the app or methods of protecting consumers from potential harms or misuse (Bush, Armstrong & Hoyt, 2016; National Institute of Mental Health, 2016).

The growth of mental health mobile applications in recent years has prompted interesting ethical questions for psychologists. Recently, the journal Psychological Services devoted a special issue (Volume 19, Issue 2) to the use of mobile clinical applications. Amanda Edwards-Stewart, Ph.D., a clinical and research psychologist with the Psychological Health Centers of Excellence (formerly with the National Center for Telehealth and Technology), and colleagues authored a helpful article in this special issue on ethical and legal topics related to the use of mobile clinical apps (Edwards-Stewart, Alexander, Armstrong, Hoyt & O'Donohue, 2019). Along with Dr. Edwards-Stewart, Erin Bonar, Ph.D., Associate Professor at the Addiction Center in the Department of Psychiatry at the University of Michigan, who researches the use of mobile health apps in interventions, has agreed to answer some questions for this quarter's Ethics Column about important considerations for psychologists who may be thinking about integrating apps into their practice.

Transmitting App Data

When considering using an app in clinical work, it's important to discuss with the client/patient their expectations with regard to app usage, how the provider sees the data, what data the provider can see, and how and when a provider will respond to data shared through the app (Edwards-Stewart et al., 2019; McGraw et al., 2013). One issue that Dr. Bonar says that providers need to think carefully about is about transmitting data from the app to the provider. "While apps have several advantages, psychologists need to understand issues pertaining to privacy and confidentiality. For example, patients will need to know that when they provide data to an app, that data is likely connected to Protected Health Information, such as their phone number and name." Transmitted data may become part of the clinical record and governed by federal laws (e.g., Health Insurance Portability and Accountability Act; 1996), state laws, and the APA Ethics Code (2017; see standards 6.01 Documentation of Professional and Scientific Work and Maintenance of Records and 6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work).

Dr. Edwards-Stewart agrees, highlighting not only the implications of transmitting data but also the method of transmission: "If a patient wants to send information from the app to their provider, the provider should let the patient know that electronic transmissions are subject to HIPAA, that emails or texts are not secure forms of communication, and patient sent electronic information will likely be included in their medical record." In addition to the method and security of transmitting data, providers may also need to consider the implications of the content of the data. For example, it is important to be aware of data that may trigger disclosures mandated or permitted by law, such as "duty-to-warn" or "duty-to-protect" laws.

Provider Responsibilities

Some clinicians may worry that the client/patient may erroneously believe that an app (especially one recommended by a clinician) may serve as a means of communication between client/patient and therapist, requiring the therapist to respond as soon as a client/patient enters data, but as Dr. Edwards-Stewart points out, these types of apps are not as common. That said, it may be useful to clarify with clients/patients policies in terms of contacting the provider as it relates to the app. "A provider needs to tell their patient that they cannot see the data entered into the app and will only be able to see it if the patient brings their phone to session." It may also be helpful to explain to clients/patients that with most apps, providers are not notified when they enter data and if the client/patient decides to share that data, such as through email, the policies in terms of method and timing for receiving a response

from the provider remain the same.

Dr. Bonar adds, "In a fast-paced, tech-driven society, humans have been getting used to 24/7, on demand access to everything from information and entertainment to food delivery. It may not be uncommon for patients to have similar expectations for receiving mental health care on demand. There will need to be clear communication between providers and patients about how and when the therapist would be available to communicate via the app, when the patient should seek emergency care versus using the app (during crisis an app should not be a substitute for seeking medical attention), and who might have access to the information contained in the app."

"Test-driving" Apps

Dr. Edwards-Stewart argues that it can be helpful for a provider to download and try an app (or "test-drive") before recommending it to clients/patients. "If a provider is going to recommend an app to a patient, it should be an app the provider is familiar with. The only way to become familiar with an app is to download it and use it. A provider should know what the benefits and possible risks of the app are, taking into consideration specific patient characteristics, and discuss those benefits and risks with their patient." It can also help to be able to anticipate the questions and concerns your clients/patients may have with the app and to increase "buy-in" by reviewing the app with them. As Dr. Edwards-Stewart explains, "It's more likely that patients will use an app outside of session if their provider takes the time, in session, to introduce it."

Many psychologists grapple with questions about how to choose a particular app. For example, it can sometimes be difficult to know whether an app is effective and whether there are potential negative effects. "Psychologists should be sure that they are choosing an app that complements or is rooted in evidence-based approaches, and they can be more certain of this by testing the app features. Most apps related to mental health have not been tested the way we have tested our gold standard therapies as research cannot keep pace with these rapid technology developments. Psychologists will want to make sure that they are still recommending approaches that are known to do no harm," Dr. Bonar says.

Privacy

"Patients have a lot of concerns about privacy, and rightly so," Dr. Edwards-Stewart says. Indeed, it may not always clear how data entered into an app may be used, how it is stored (for example, whether it is stored on the device or on a cloud-based server) and if and how the data may be shared with third parties (Edwards-Stewart et al., 2019; Hall & McGraw, 2014).

Dr. Edwards-Stewart explains, "App developers often don't inform users about how secure their information is. Organizations like the VA and DOD have strict policies around privacy and security for the apps they develop but not all developers do. Good questions for providers to ask about an app are: Does the app developer have privacy policy? Can you contact the developer to ask what their privacy standards are? Does the developer appear to be a legitimate organization? For providers recommending apps, is important to be able to answer these questions for patients with privacy concerns."

Dr. Edwards-Stewart also recommends trying to find out more about who developed the app and whether there is information about privacy policies. "Knowing who created the app will allow provider and patient alike to look up this organization and read about their mission, how they are funded, and if they have a privacy statement. A privacy statement is different than user agreement. Privacy policies aren't usually within the app, although some are. You can look up the name of the app developer and search for the privacy statement." This may be especially important in terms of understanding more about the "back-end," meaning how data are stored (if the app allows users to enter data).

Competence

One of the most pressing questions may be about how psychologists can gain the necessary training in mobile apps to feel confident using them in practice. Many (e.g., Bush, Armstrong & Hoyt, 2019) have advocated for the need for additional provider training (in graduate education, continuing education, and other programs) but these may not be readily available for clinicians who currently want to implement this technology in practice. While it can be hard for psychologists to gain competence in the area of mobile apps, Dr. Edwards-Stewart recommends that, "Psychologists should spend some time increasing their fluency in technology. If you don't understand something like permissions, look it up online, if you don't know an app developer privacy policy, contact that developer. Be willing to spend a little bit of time increasing your knowledge in this arena."

Dr. Bonar recommends consulting with local associations of psychologists or other clinicians. "Before integrating apps into your practice, it's probably a good idea to consult with other professionals through your state or local associations and learn any best practices they have agreed upon. In addition, if part of a larger organization such as a healthcare system there may be rules pertaining to app usage with patients given the possibility of the app containing HIPAA protected information for identified patients. Checking with your organization about any guidelines they have will help protect patients."

Conclusion

Clinically-oriented mobile apps appear to be an increasingly utilized tool that can facilitate a number of important mental health treatment goals. Many of these apps may be used in conjunction with specific mental health treatments and serve important functions in terms of tracking information, completing homework, and providing more accurate, temporal information. There are a number of clinical, ethical, and legal issues to consider before integrating mobile apps into clinical treatments. While this column focused on implementation considerations related to clinical care, it is important to note that mobile health (mHealth) applications are also growing in use in certain research settings and come with their own set of ethical considerations; a follow-up column will focus on some issues specific to human subjects research.

SOCIETY OF
CLINICAL PSYCHOLOGY

SCP Member Spotlight on Dr. Nick Grant

Dr. Nick Grant's research and program development experience has largely focused in the field of lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) psychology and more recently, has become more focused on LGBTQ veterans and service members. Currently, he is serving as a psychologist in the Navy and is in the process of getting board certified in clinical psychology through ABPP and certified in Emotionally Focused Therapy (EFT) through the International Center of Excellence in EFT. A recent graduate of Palo Alto University, Dr. Grant has had a busy and meaningful career. For example, he ran the only VA LGBTQ Veterans Mental Health Program while on postdoctoral Fellowship at the San Diego VA Medical Center and as an APA Congressional Fellow, he developed the first "Trans 101" training ever offered on Capitol Hill. In 2018, Dr. Grant received the Distinguished Alumni Award at PAU's June commencement ceremony for his significant career achievements and for making a difference in policies and practices to improve people's lives. Last year, he was also awarded the APA Citizen Psychologist Presidential Citation for his stellar leadership and service to LGBTQ communities. His commitment to improving the lives of all LGBTQ communities in which he lives is an exemplar of applying psychological science though sustained civic engagement. We had the opportunity to learn more about Dr. Grant through our Q&A correspondence. Read on to learn more!

Where did you complete your training (graduate school and area of emphasis, internship, post doc, etc.)?

I received my Ph.D. in Clinical Psychology from Palo Alto University (PAU) in 2015. While at PAU, I worked with Dr. Peter Goldblum at CLEAR, the Center for LGBTQ Evidence-based Applied Research, and focused my clinical training in health psychology. I completed an internship focused in behavioral medicine at Tulane University's School of Medicine. Following internship, I completed a postdoctoral fellowship focused in LGBTQ Mental Health at the San Diego VA Medical Center. From 2016 to 2017, I served as an APA William A. Bailey Health and Behavior Congressional Fellow in the Office of U.S. Senator Kirsten Gillibrand (D-NY) where I helped to support the senator's LGBTQ, healthcare and defense (e.g., military personnel, transgender military service, women in combat roles) portfolios. During my time as a Congressional Fellow, I put together a 4-hour "Trans 101" training for the staff, the first known training on this topic to ever be conducted in a U.S. Senate Office.

What is your current position/ occupation?

Nick Grant, Ph.D.

In May, I was commissioned into the U.S. Navy and have started my training to serve as a Navy psychologist. Until May 31, I worked as a government contractor with Salient CRGT (a leading technology company) serving as a clinical psychology subject matter expert supporting the Defense Health Agency's (DHA) Psychological Health Center of Excellence (PHCoE) where I worked on the Evidence-based Practice team of the Clinical Care Branch.

How long have you been a member of SCP?

2 years.

What roles have you had with APA or other organizations?

I have been very active in APA for many years. Since 2012, I have served as a Mentor of APAGS-CSOGD LGBT Graduate Student Mentoring Program. In 2015 I became a Health Equity Ambassador with APA's Health Disparities Initiative. In this role, I participated in the development and execution of dissemination activities related to program identified health disparities and best practices to improve health equity within underserved populations.

I am very active in APA Division 44, the Society for the Psychology of Sexual Orientation and Gender Diversity, where I've served in multiple roles since 2015. I am the co-chair of the public policy committee, where I provide responses to LGBTQ issues in the larger political sphere as they arise, including materials and consultations to government officials and psychologists in states that are facing anti-LGBTQ ballot issues, engaging in letter writing on a variety of matters. I am also a Health Equity Ambassador with the APA Health Disparities Initiative. As part of this role, I participated in the development and execution of dissemination activities related to program identified health disparities and best practices to improve health equity within underserved populations. I also serve as a member of the program committee, and as part of this role I assist in program development and review of

research proposals submitted through the Division for the annual APA Convention. Furthermore, I am member of the membership committee, providing strategic program development and outreach to strengthen the membership base and represent membership interests before the Executive Committee.

Since September 2018, I have been active in APA Division 9, Society for the Psychological Study of Social Issues (SPSSI). I serve as member of the James Marshall Public Policy Fellowship Selection Committee, assisting with application reviews, interviews and selection of fellows and also serve as a member of the Public Policy Committee, assisting with public policy initiatives focused on social issues set forth by the Division President and Policy Director.

Since November 2018, I have been active in APA Division 19, Society for Military Psychology. I serve as a member of the program committee assisting in program development and review of research proposals submitted through the Division for the annual APA convention and as a Student Participate of the Society Leadership Program.

Since February 2019, I have served as Chair of the Policy Resolution Writing Group, which is focused on opposing Discriminatory Legislation and Initiatives Aimed at Lesbian, Gay and Bisexual Persons. Since October 2018, I have been a Distinguished Faculty Member of the APA Online Leadership Academy. The APA Leadership Academy is a six-month leadership development program targeted to early career psychologists who are interested in strengthening their leadership skills and pursuing leadership roles. As part of this role, I helped develop and deliver an online class focused on skills, competencies, and opportunities for leadership in the field of psychology.

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

I have found it interesting how many early career psychologists are trying to brand themselves via the creation of websites, marketing, and media interactions. I think it is important for all of us, including myself as an ECP, to focus on striving towards excellence in our work and professional development. In that way, our reputation and work will speak for itself. This is one of the main reasons I am currently in the process of getting board certified. I entered the ABPP process via the Early Entry option while I was a student and just recently had my application approved to move into the second step of the process. I look forward to continuing to develop my skills while using my profession to help others. Palo Alto University's motto is "Engaging Minds, Improving Lives" and that has always stuck with me.

What's something nobody would know about you?

I am obsessed with The Golden Girls podcast entitled Out on the Linea and have been binging it daily for the past month.

What are your hobbies?

I enjoy running (lots of running), spending time with friends, volunteering, and self-reflection.

What led to your interest in clinical psychology?

As a first-generation college student, I had no idea what I was getting myself into when I entered college.

My path included attending community college for 1.5 years to obtain my AA, then a local Cal State University (Dominguez Hills) for another 1.5 years to complete my BA. I then went on to obtain an MA and then finally my MS and PhD from PAU. I decided within my first few months of my time in community college that psychology was going to be my major, and based on various life experiences and a dedicated continued interest in the field, I just kept going with it. I honestly can't imagine having another type of job because I love the work I do so much. I have been lucky to have so many diverse experiences as an ECP, including running the only VA LGBTQ Veterans Mental Health Program while on postdoc, working in the U.S. Senate on federal legislation as an APA Congressional Fellow, working at the DHA PHCOE to my new adventure as a Navy psychologist. I can't wait to see what lies ahead.

Diversity Spotlight: Choosing a Diversity Conscious Internship

Amanda L. Sanchez, M.S.
Mental Health Innovations and Technology (MINT) Lab, Center for Children and Families, Florida International University

Training to work with marginalized diverse families is imperative given the clear mental health disparities in access and quality of services received (Alegría, Green, McLaughlin, & Loder, 2015; Alegria, Vallas & Pumariega, 2010; Kataoka, Zang & Wells, 2002). One reason for these disparities may be providers' historical lack of cultural competence. Even now, many clinical psychology doctoral programs fail to provide sufficient cultural competency training in regard to clinical work and research with diverse populations. In considering my own goals during internship, the importance of seeking out programs that focus on training in cultural competency (i.e., multiculturalism, social justice, diversity) played a crucial role.

A little less than a year ago, I began my search for internship programs that focused not only on working with underserved families, but importantly valued cultural competency training. I mainly sought out such internship sites by asking colleagues and faculty mentors and searching key terms (e.g., diversity, multiculturalism, social justice, underserved) through APPIC. There are many factors one could prioritize when searching for a diversity-focused internship training program. I decided to focus on population served, explicit multiculturalism training, and faculty diversity. While doctoral students may have additional personal factors to consider when choosing an internship site, below are some considerations and specific steps for those looking for a diversity-focused internship program.

First, I read through the program brochures to determine the population served by each site. I wanted to find sites where interns could see patients on Medicaid or those without insurance, and where the population was racially and ethnically diverse. It is important to note that some tracks within the same program differ in the populations they serve, so look closely at each track of interest. Additionally, I found that at many sites, licensed clinicians treated Medicaid patients although interns could not. While most sites discuss the population served in their brochure, not all do, so this may be an important topic to discuss during interviews.

Next, when reading through the brochures, I carefully searched for an explicit focus on diversity beyond the mandatory APA requirements. Many sites will discuss diversity as one of their training goals, yet provide no other mention of how they conceptualize training in this area or how it is implemented. One important component that programs include is a seminar focused on topics of diversity; you may consider asking faculty and interns about seminars during your interviews as I found that the quality of seminars on topics of diversity varied greatly. For some, interns found their seminars to be unhelpful, while at other sites, students found the seminars to be thought provoking and inspiring. During my search process, I found the most impressive sites were those that discussed the framework of their training and how it included topics of diversity, such as multiculturalism and social justice. These sites expanded the training to not only the confined space of seminars, but integrated these concepts into their supervision and case conceptualization. I found it very helpful to ask interns about the ways in which topics of diversity were actually infused within their training, as this gave me a sense of the match between program intentions and training-in-action. For me, an important piece of this training was understanding how my own beliefs and values affect my work, so programs that discussed personal development as it related to cultural competency were high on my list.

The third factor I considered was faculty diversity. To me, faculty diversity shows that the program prioritizes representing their community. For example, I applied to one site where the majority of patients were Hispanic and Spanish-speaking, yet none of the faculty or supervisors spoke Spanish. However, many programs were more diverse and/or partnered with their local communities to provide culturally responsive care and had supervisors who spoke the languages of the people in their community. As a Spanish-speaking therapist, it was imperative for me to receive supervision in the language I deliver therapy to further develop my language skills and ensure that I am communicating effectively with my patients.

Together, the population diversity, explicit focus on cultural competency training, and faculty diversity helped me choose a set of internship sites that seem to truly provide quality training for graduate students looking to enrich their understanding of working with traditionally underserved families.

Humor Column: Insufferably Dilly-Dallying and Lazy Editorial (IDLE) Syndrome: Proposed Diagnostic Criteria for Identifying Slothful Journal Editors

Scott Lilienfeld, Ph.D.
Emory University
University of Melbourne

Robert D. Latzman, Ph.D.
Georgia State University

Numerous authors have bemoaned the myriad shortcomings of the journal peer review process (McCook, 2006; Peters & Ceci, 1982). Among the most frequently voiced complaints are the apparent arbitrariness of editorial decisions; biases of reviewers; unclear or inconsistent reviewer or editorial feedback; and unduly long delays between initial journal submissions and editorial decisions (Berquist, 2016; Stahel & Moore, 2014; Ware, 2007). Accumulating evidence suggests that much of the variance in author dissatisfaction with peer review stems from an underlying constellation of covarying editorial behaviors that have been variously characterized by aggrieved authors as idleness, indolence, slothfulness, dilatoriness, torpidity, languor, inertia, or more colloquially, laziness (see also Baumeister, 1992). Nevertheless, to our knowledge, no formal means of identifying this vexing syndrome of editorial behaviors is available in the published literature. The absence of standardized diagnostic criteria for this distinctive behavioral pattern is problematic given ample circumstantial evidence of its deleterious impact on author well-being, including intense distress, demoralization, and intermittent homicidal urges.

In response to this glaring gap, the authors (a psychology journal editor and psychology/psychiatry journal associate editor, respectively) hereby present a proposed new entry to the next edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM), which we tentatively term Insufferably Dilly-Dallying and Lazy Editorial (IDLE) syndrome. IDLE syndrome will of course require further investigation before it is enshrined in the formal psychiatric nomenclature, although we believe that it is ready for inclusion in Section III ("Emerging Measures and Models") of the DSM (American Psychiatric Association, 2013) as well for potential consideration in the forthcoming edition of the International Classification of Diseases (ICD-11). We believe that this provisional diagnostic criterion set should prove useful in facilitating research on this widely recognized yet surprisingly understudied (Dean & Forray, 2019) syndrome. The proposed criteria for IDLE syndrome, derived by the authors using a rigorous process of gossiping, griping, moaning-groaning, and kvetching with numerous academic colleagues across a two-decade span, supplemented by the time-honored statistical technique of "eyeball factor analysis" (McCall, 1994) conducted with the aid of an ample supply of ethyl alcohol, are presented below. We welcome suggested additions or revisions to this criterion set from interested or irate readers of The Clinical Psychologist.

Diagnostic Criteria for Insufferably Dilly-Dallying and Lazy Editorial (IDLE) Syndrome

A. Consistent pattern of indecisiveness or reluctance/unwillingness to provide with clear or informative feedback, as indicated by 4 or more of the following:

1. Recurrent failure to desk-reject (triage) manuscripts that are clearly inappropriate for the journal or inadequate in quality, leading authors to wait needlessly for several months for rejection letters

2. Repeatedly sitting on manuscripts for 1 month or more before finally desk-rejecting them, often with unclear or inadequate justification

3. Extremely brief (e.g., 1-2 sentence) action letters that provide authors with little or no guidance for how to address reviewer comments (e.g., "Please address the reviewers' comments below. We look forward to receiving your resubmission")

4. Recurrent failure to provide guidance to authors when reviewer comments are inconsistent or mutually exclusive (e.g., Reviewer 1 writes "The Discussion section is much too brief" and Reviewer 2 writes "The Discussion section is much too lengthy," and the editor writes "Please address the reviewers' concerns regarding the length of the Discussion section")

5. Repeatedly providing inconsistent feedback to authors (e.g., asking them to add an analysis and later asking them to remove it) across multiple rounds of revision, or repeatedly changing one's mind about whether the manuscript is publishable

6. Using identical "boilerplate" language for all action letters (e.g. "Although the current manuscript has a number of strengths, the reviewers noted a number

of weaknesses that preclude publication of the manuscript its current form")

7. Encouraging authors to repeatedly revise manuscripts even when the odds of acceptance are extremely low, resulting in numerous rejections of manuscripts that should have been rejected earlier

B. Consistent pattern of pathological dependency on reviewer input, reluctance/unwillingness to evaluate manuscripts independently, or failure to even inspect manuscripts before acting on them as indicated by 4 or more of the following:

1. Recurrent tendency to send manuscripts to reviewers who have little or no expertise in the subject matter of the paper, often based on a casual perusal of authors and co-authors listed in manuscript reference sections

2. Excessive reliance on reviewers' recommendations, as indicated by repeated editorial statements such as "Reviewer A is asking more changes," "Reviewer B is still not convinced by your arguments," or "I cannot accept the manuscript until all reviewers are satisfied with it"

3. Recurrent failure to read submitted manuscripts or to at best to skim them, as indicated by editorial comments that contradict statements in the manuscript (e.g., "Please address the limitations of your design" when the authors explicitly included a limitations section," "You did not conduct analysis X in your manuscript" when analysis X was reported in the submitted supplemental materials)

4. Recurrent tendency to send manuscripts back to reviewers over and over again even when requested changes are extremely minimal

5. Recurrent tendency to send revised manuscripts back to the same reviewers 2 or more times out of reluctance or unwillingness to appraise manuscripts independently

6. Recurrent failure to act on manuscripts for 1 or more months even when all reviewer recommendations have been submitted

7. Recurrent tendency to accept manuscripts only when all reviewer recommendations are positive, leading to rejection of almost or all controversial and/or innovative manuscripts

C. Not attributable to generalized laziness, indecisiveness, low motivation, inattentiveness, sleep disorders, or grandiose narcissism.

D. Produces clinically significant distress and/or impairment in submitting authors, as indicated by recurrent complaints to editors that their manuscripts have been handled ineptly; recurrent angry emails (which may be obscene) or threats of physical harm from authors; incessant whining and moaning to faculty colleagues, postdocs, and students; and marked increases in depressive, anxiety, insomnia, dissociative, substance use disorder, and anger-related symptoms.

E. Duration of at least 6 months or more. Journal editors exhibiting the features of IDLE syndrome for more than one week but less than 6 months should be diagnosed with Acute Insufferably Dilly-Dallying and Lazy Editorial Syndrome.

Diagnostic Specifiers: (a) With versus Without Email Non-responsiveness; (b) With versus Without Omniscient Delusions

Risk Factors, Associated Features, and Differential Diagnosis

Several studies suggest an elevated prevalence of IDLE syndrome in academic departments that provide few or no incentives for editorial activities, as well as among professional organizations and publishers that provide little guidance to or supervision of editors. IDLE syndrome is sometimes associated with excessive devotion to non-editorial activities, such as publishing 20 or more peer-reviewed papers per year or submitting 10 or more federal grant proposals per year. Anecdotal reports suggest that being extremely slow to return manuscripts reviews, as well as a tendency to turn down virtually all manuscripts review requests, are risk factors for IDLE syndrome among reviewers who later become journal editors. Although IDLE syndrome tends to generate intense distress among authors, some researchers maintain that this syndrome is associated with heightened levels of academic success among editors themselves, many of whom have considerably more time to devote to publication and grant activity than do other editors.

Circumstantial evidence indicates that IDLE syndrome is comorbid with several conditions, including generalized laziness, chronic self-absorption, absentmindedness, passive-aggressive personality disorder, sadistic personality disorder, and Editorial God Complex, but it should be distinguished from each of them. In rare circumstances, IDLE syndrome may co-exist with both sadistic personality disorder and Editorial God Complex (a constellation sometimes referred to by scholars as the Editor From Hell Dark Triad), in which cases it may pose a dire threat to author mental health, not to mention journal publication lags.

Prevalence and Demographic Differences

The precise prevalence of IDLE syndrome is unknown, although informal reports suggest that it afflicts between 5 and 10 percent of journal editors and

perhaps a comparable proportion of associate editors. IDLE syndrome appears to be especially prevalent among editors of journals that receive extremely high numbers of submissions. One study points to an elevated prevalence of IDLE syndrome among editors of predatory journals. There are no known gender, age, or race differences in IDLE syndrome; similarly, there are no published cross-cultural studies of IDLE syndrome.

Development and Course

IDLE syndrome tends to be associated with an early onset and usually emerges during the affected individuals' first journal editorship. One longitudinal study suggests that a history of early manuscript rejections is a risk factor for later IDLE syndrome, which may reflect a relatively advanced defense mechanism against the painful trauma associated with this early rejection. Although there are few systematic data on the course of IDLE syndrome, numerous reports strongly suggest that the condition is often chronic, even life-long. Full remission appears to be rare. In approximately 5 to 10 percent of cases, IDLE syndrome apparently worsens across successive journal editorships, occasionally resulting in Editorial Decision Paralysis Syndrome (marked by a complete breakdown in all vital, lower-level editorial functions, accompanied by a failure to make any editorial decisions at all). Editors diagnosed with IDLE syndrome for one journal typically meet criteria for IDLE syndrome for subsequent journals they edit.

Potential Consequences

The morbidity and mortality associated with IDLE syndrome are unknown, although an elevated frequency of emailed and phoned-in death threats sent to editors with IDLE syndrome compared with other editors has been reported in several studies. These death threats have almost always ceased promptly upon manuscript acceptance.

IDLE syndrome is associated with heightened levels of trichotillomania – not among journal editors themselves, that is, but among authors who have been observed to pull their hair out following multiple IDLE syndrome-related behaviors. Intermittent explosive disorder has also been reported as an occasional outcome among journal author victims. Scattered anecdotal reports further indicate that IDLE syndrome is associated with a variety of other symptoms among authors, including telephone scatologia; repeatedly muttering the journal name in vain under one's breath during faculty meetings; and marked increases in vocal tics and motor tics (especially coprolalia and copropraxia, respectively) whenever they encounter the journal name. Some investigators have also reported delusions of persecution among author victims of IDLE syndrome, although in many cases this apparent symptom may reflect accurate perceptions of persecution by sadistic journal editors.

Treatment

Observational studies suggest that IDLE syndrome is difficult or impossible to treat, at least using currently available interventions. In most cases, IDLE syndrome is associated with poor insight and low motivation for treatment. Although numerous authors have enthusiastically advocated prefrontal lobotomy or other forms of psychosurgery for editors with IDLE syndrome, there are no solid data, aside from subjective reports from authors of pleasurable fantasies (which may be highly cathartic; Personal Communication From Several Thousand Authors, 2019), supporting such practices. With regard to author victims of IDLE syndrome, data from several case studies raise the possibility that primal scream therapy can be an effective short-term intervention, as can extortion of journal editors (see "Potential Consequences").

Conclusions

IDLE syndrome is widely discussed by journal authors, especially when editors are not present in the room. Nevertheless, this disorder has been the subject of relatively little systematic research, largely because no formal method of diagnosing it has heretofore been available. We hope that these proposed diagnostic criteria for IDLE syndrome will provide a helpful impetus for future investigation regarding the pathophysiology of this poorly understood, presently untreatable, and enormously annoying condition. Promising approaches to the treatment and prevention of IDLE syndrome are urgently needed as a means of addressing the ailing mental health of the rapidly growing but underserved population of journal authors.

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Notes

1. Vehement assertions by some of their academic colleagues (and numerous authors who have been recipients of their action letters) notwithstanding, neither of the authors meets the diagnostic criteria for IDLE to the best of their knowledge. Then again, unpublished research by the first author suggests that between 95 and 100 percent of journal editors who meet criteria for IDLE are convinced that they do not have the disorder.

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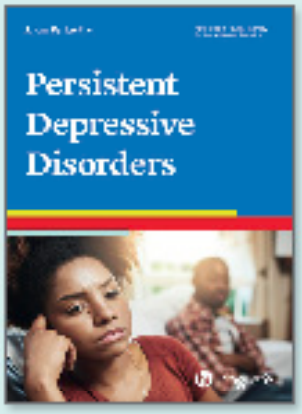

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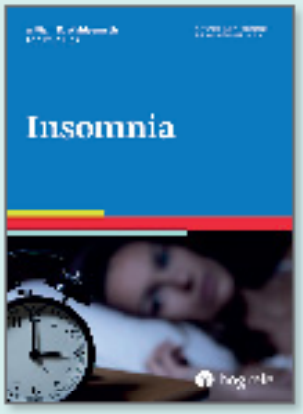

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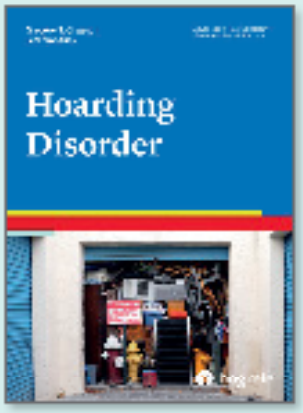

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- **Heart Disease** by J. A. Skala/K. E. Freedland/R. M. Carney (2005)

Forthcoming volumes

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- **Body Dysmorphic Disorder**
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- **Posttraumatic Stress Disorder**
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