Fall is in full swing, and the holiday season is right around the corner (or has already arrived judging from many retail stores!). As we approach the holidays and reflect on the past year, this is the perfect time to ask: What are you grateful for?

Certainly, the COVID-19 pandemic has been a challenge for youth and adults. And it is still ongoing. Many have experienced the loss of a loved one or of economic, food, or housing security. All of us have encountered significant life disruption and uncertainty. Not surprisingly, data indicate that many youth and adults report elevated levels of stress and other mental health concerns, such as symptoms of anxiety and depression. In my previous column, I focused on prevention strategies that psychologists might use to address stress and mental health issues (resulting from disasters and also from the pandemic) that may be affecting so many individuals. Today, I’d like to focus on another beneficial concept – recognizing and expressing gratitude.

Gratitude is making a conscious effort to count one’s blessings – and to express appreciation for what one has. Gratitude is something that can be cultivated, and evidence indicates that practicing gratitude can increase happiness and promote better physical and mental health. Gratitude exercises might include keeping a diary in which one expresses gratitude for people and things in their lives and then shares these expressions of gratitude on a regular basis. For inspiration, there are various websites that provide examples of how to identify things to be grateful for.

In keeping with the gratitude spirit, I’d like to share a few things that I am grateful for this year. One is the opportunity I’ve had to serve as President of the Society of Clinical Psychology (SCP). It has been a privilege to work with and get to know the many, many individuals who work enthusiastically and diligently on behalf of SCP. This includes (but is not limited to) our current Officers (Elizabeth Yeater, Kalyani Gopal, Paul Arbisi, Chad Kelland); our Council Reps (Kim Penberthy, Michael Otto, Kathryn McHugh, Jonathan Weinand) and Member at Large (Randy Salekin) as well as the many Section Representatives to the SCP Board. It also includes the editors of our journal...
I am also grateful for the presence and support of my family and friends. Although it has not been possible to see those who live at a distance, the availability of Zoom, Facetime, and other online platforms has made it possible to have routine happy hours, movie nights, and even heart-to-heart chats with those I care about—including those who live on the other side of the world. The social connectedness that technology affords has been a life saver in this era of social distancing and restricted travel, generally helping to reduce loneliness and increase social support. (Relatedly, I’m grateful that I have the skills and equipment needed to engage in online social connections, which is not the case for many individuals.) Still, I do look forward to returning to more frequent in-person contacts.

Finally, I’m grateful that we are now making the seasonal transition to autumn. Since I’m living in South Florida, this doesn’t mean crisp days with spectacular fall foliage, like those that graced my childhood in New York and my graduate work in Indiana. Instead, it means that the weather is less incredibly humid and rainy; that overnight and in the morning it may “cool down” to 70 degrees, making outdoor activities more appealing; and that we are almost out of hurricane season (yeah!). And you can be grateful that I won’t remind you of this weather when you are experiencing snow and ice storms up north this winter!

Now that I shared some of my gratitude, perhaps you can do the same. What are you grateful for today? If you would like to get started on gratitude sharing, click on this link!

We will share your anonymous replies in 2022!
Early in my career the single most important advice I heard from community mentors in mental health advocacy was to “show up” and be present. Showing up includes attending community meetings, events, and celebrations that may have nothing to do with your specific research aim or data collection, but has everything to do with valuing community and building connections and relationships. It also includes asking and finding ways that you can contribute or assist in the execution, planning, or wrapping up post event. For me that has ranged from making “goodie bags” (e.g. with condoms, lubes, information), setting up tables, greeting attendees, and serving food to making handouts of mental health resources, giving requested presentations on mental health and HIV, and providing resources when called upon as a clinical psychologist and researcher. Being present also entails arriving as person (not just a psychologist or Dr. Dale) with a genuine interest to participate in the activities, help, engage with others, and listen. I recall an outreach event led by a department of public health and a few community partners that entailed packing and distributing condoms. There was no speech to be given or data to collect, just simply volunteer, but that day as we walked and distributed condoms to people walking or driving by I met someone who became one of my strongest community partners in this work.

In the context of research studies that are conducted in house (at clinical or academic settings) there is a need to ensure that procedures are being carried out in a manner consistent with valuing participants. Every study that I have led as a principal investigator (PI) thus far I have directly interfaced with participants ranging from calling to screen potential participants to welcoming participants and getting them situated for visits (e.g. offering coffee and snacks, no data, no research measures, facilitating intervention sessions, checking in with participants in-person or via phone if a need arises (e.g. participant disclose struggles with food, housing, or depression). While much of these tasks can and are also delegated to team members including research assistants/coordinates, graduate students, and postdoctoral fellows, helping to conduct these tasks results in participants learning that the PI is an individual with a vested interest in the participants and the research being done. I recall an interaction where I was facilitating a one-on-one behavioral medical intervention session and the lid to the participant’s coffee cup fell on the floor. I paused, picked up the lid, and offered to get her a new one. After that she said to me “you’re not doing this just for the money, you really care”. When participants have interactions with study leadership, they also feel empowered to reach out to leadership directly and provide feedback or address any issues that arise.

Centering Research Participants

Connected to the showing up and being present, centering the participant as human beings deserving of being welcomed, understood, and affirmed is essential. In the context of human subject’s research which often asks about personal topics, the human beings are key. Without our participants there would be no research, no research grants, no paid positions (PhDs, RAs, Postdocs), and no acquisition of knowledge to advance our field. As such we need to communicate that value in our interactions with participants. This can be accomplished through our contribution to research can be communicated through words (thank you), taking steps to minimize inconveniences and barriers (e.g. providing transportation), attending to their needs in the context of the study (e.g. refreshments, snacks), and providing information on resources for issues that arise (e.g. housing, accessing other care) that may be unrelated to the study. In addition, this may also include asking our participants to help others (several instances we had participants call and offer to meet the participant and speaking with the person).

Learning

This entails showing up and centering participant, they have shared invaluable information about their lived experiences both through qualitative interviews and quantitative surveys. As a result our team has been able to learn important information among Black individuals who arrive at the building looking to the moment they reach your team. For instance, on a couple of occasions we had participants call and inform us that they were being asked unnecessary questions by someone upon trying to enter the building to which we responded by immediately stopping to meet the participant and speaking with the person.

Weight of Intersectional Oppression

For instances, many women shared stories of sacrifice their self-care in roles they occupied as mothers, grandmothers, daughters, partners, and friends (Dale et al., 2018). Quantitatively we found that gendered racial microaggressions contribute uniquely to post-traumatic stress disorder symptoms, barriers to HIV care, and depressive symptoms, above the contribution of race- and HIV-related discrimination. Using daily text messages to capture microaggressions among BWLWH, we also found that microaggressions increased from a baseline of 52% at baseline/October, peaked at 70% during the holidays (November/December), declined to 55% in March when COVID-19 social distancing began, and then increased following the murder of George Floyd in May 2020 and peaked to 83% in June/July 2020 during widespread Black Lives Matters protests (Dale et al., 2021).

Strength and Resilience

However, in the midst of intersecting adversities BWLWH remind us of their strength, resilience, and adaptive coping strategies. For example, women shared that they coped with (past) trauma/violence by utilizing spirituality, social support, psychotherapy, enjoyable/adaptive activities, (b) racism through awareness, assertiveness, caution, and strategic avoidance of certain people and places, (c) disclosure of their HIV status, stigma, and other forms of selective non-disclosure of their HIV status, social support, gaining and sharing education/knowledge, and strategic avoidance, and (d) gender-related stressors through prioritizing the self, self-love, spirituality and self-care. The research conducted by our team a) identified psychosocial and structural factors including microaggressions, discrimination, and poverty b) developing effective prevention and intervention strategies to promote resilience and good health outcomes and c) engaging community members and stakeholders in research.

HIV discrimination/stigma, poverty, and trauma/violence is heavy and has negative consequences for their mental health and ability to access competent care, adhere to HIV mediation, and strive (Dale et al., 2018). BWLWH have experienced multiple traumatic experiences across their lifetime, experiencing race- and HIV-related discrimination and microaggressions at the interpersonal and institutional level, and gender-related stressors and oftentimes have to care for others while trying to care for themselves. This often leads to sacrifice their self-care in roles they occupied as mothers, grandmothers, daughters, partners, and friends (Dale et al., 2018). Quantitatively we found that gendered racial microaggressions contribute uniquely to post-traumatic stress disorder symptoms, barriers to HIV care, and depressive symptoms, above the contribution of race- and HIV-related discrimination. Using daily text messages to capture microaggressions among BWLWH, we also found that microaggressions increased from a baseline of 52% at baseline/October, peaked at 70% during the holidays (November/December), declined to 55% in March when COVID-19 social distancing began, and then increased following the murder of George Floyd in May 2020 and peaked to 83% in June/July 2020 during widespread Black Lives Matters protests (Dale et al., 2021).

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Social support also moderated the relationship between substance use disorder and HIV medication adherence in that substance use disorder predicted low HIV medication adherence in the past two weeks only for women low in social support from friends or overall (across relationship types) (Reid & Dale, 2021). We also found quantitatively that higher resilience (trait and coping) was associated with higher general self-efficacy, higher self-esteem, higher post-traumatic growth, lower post-traumatic stress cognitions, lower trauma symptoms, and lower depressive symptoms (Dale et al., 2019). Additional findings indicated that resilience was associated with higher HIV medication adherence and lower odds of having a detectable HIV viral load (negative indicator) and that resilience was especially important for higher medication adherence among women with histories of sexual or multiple abuse (Dale et al., 2014).

Developing Meaningful Interventions

Beyond broadening our understanding of adversities and resilience among BWLWH through intervention development studies, we have also learned that BWLWH and Black women placed at risk for HIV are eager for, appreciate, and respond well to HIV and mental health interventions that are culturally relevant, consist of content and approaches that honor their intersectional experiences, and are delivered by culturally competent clinicians. We have developed an open pilot trial and pilot RCT. MI-PrEP is a brief exposure Prophylaxis to prevent HIV (PrEP) via Interviewing to Increase Motivation for PrEP (Pre-exposure Prophylaxis for HIV) (MI-PrEP) via an open pilot trial (Dale & Safren, 2018), and a pilot randomized control trial (RCT) have indicated high acceptability, acceptability and feasibility and positive outcomes. We have seen similar evidence of acceptability, feasibility and outcomes. We have developed an open pilot trial and pilot RCT. MI-PrEP is a brief two-session intervention that combines information on PrEP, motivational interviewing techniques, and light case management (e.g. information on PrEP, facilities, programs covering the cost of PrEP) in a culturally-informed manner to promote PrEP uptake among Black women placed at high risk for HIV.

Context and Environments Matter

Our work has also reiterated the importance of understanding the impact of contextual, socioeconomic, and neighborhood factors on the lives of women living with HIV. For instance, recent findings using spatial analysis indicated that within-neighborhood characteristics and neighboring characteristics (employment, education, crime, income, number of religious organizations, low-income housing) significantly related to intersectional stigma/discrimination, mental health, HIV viral load, and medication adherence among BWLWH. For instance, within-neighborhood higher education was associated with lower HIV viral load and higher likelihood of HIV viral suppression (good health indicator) and lower income/subsidized rental housing within neighborhood was associated with lower HIV microaggressions. However, higher median income in neighboring areas was associated with higher gendered racial microaggression appraisal and higher trauma (Wright et al., 2021, under review). Another set of findings among BWLWH utilizing network analysis to assess the associations among discrimination (race- and HIV-related), microaggressions (gender and race), trauma, socioeconomic status (income, housing, education), mental health, and HIV outcomes indicated that the four most central factors in the network were, income, housing, and gendered racial microaggressions suggesting that these factors need to be addressed via policies and interventions to improve the wellbeing of BWLWH (Sharma, Dale, 2021, under review).

Partnering with Community Members to Effect Change

Moving beyond what we have learned about the key role of communities and the context of the lives of BWLWH, we have established strong community partnerships and launched a community engaged research effort in partnership with community consultants, businesses, and community-based health organizations that simultaneously has an impact and continue to advance our knowledge. Funded by Ending the HIV Epidemic supplements from NIMH, in 2019 we launched the Five Point Initiative which is currently in its third year (Dale, 2020). Over the course of this initiative our team has partnered with five venues (barbershops, hair/beauty salons, laundromats, corner stores/grocery, and mechanics/car wash/gas station) in Miami Dade zip codes with the highest number of Black individuals living with HIV (2) closely collaborated with community health organizations and (3) hosted outreach activities in which community members complete a brief electronic survey (on mental, sexual, and physical health) and HIV testing in exchange for a service/voucher (e.g. free laundry wash and dry) at a venue with the cost being covered for by the supplement and are offered condoms and information on Pre-exposure Prophylaxis (PrEP). The essence of our approach is to meet people in their communities and at venues that they frequent. Our approach has demonstrated acceptability and feasibility with praises from community residents, consultants, businesses, and health organizations. In the context of COVID-19 and in response to community needs our team has also offered COVID-19 testing and vaccine via our Five Point Initiative. Thus far we have conducted over 39 outreach events, partnered with 55 businesses, and engaged over 2000 residents.

Paying it Forward through Mentorship

I have stood on the shoulders of mentors in community and engaged over 2000 residents.

Jessica Henderson Daniel, would remind me to “pay it forward” when I expressed my gratitude for her mentorship. In addition, my experiences have proven time and again that the mental and sexual health needs of minoritized communities will not be adequately addressed without hiring, accepting into programs, training, and mentoring and sponsoring individuals with lived expertise of the conditions and inequities driving mental and physical health disparities and those with a demonstrated commitment to communities disproportionately impacted. Central to my research program is a commitment to facilitating access along the pipeline to minoritized scholars. The vast majority of mentees I attract are Black or otherwise racially/ethnically minoritized and coming from underserved communities. I mentor graduate students, undergraduate students, community members/partners, postdoctoral fellows, and sometimes high school students. Further, given the importance of research experience and publications to successfully get into doctorate programs, I mentor all my research staff with aspirations of pursing PhD/MD. Previous research assistants have been accepted to doctoral programs in clinical psychology, public health, and medicine. Given prior barriers to research exposure I often mentor my mentees on their first abstract/poster and first manuscript publication. For instance, I have mentored undergraduate mentees on first-authored publications. In addition, I actively work to sponsor and elevate community members with lived...
LeAD Article: Conducting Impactful Research in HIV and Mental Health

Members of the SHINE Research Program

experiences through consultancy roles, staff positions, paid speaking engagements, and writing/publishing (Phillips, under review). Similarly, I also mentor junior faculty (physician and PhDs) as they submit their first grants or develop research ideas around HIV, mental health, and marginalization. Beyond the mentees who are members of SHINE, I am a multiple principle investigator (MPI) and Co-Director of an NIMH funded training grant (T32) entitled CHANGE (Culturally-focused HIV Advancements through the Next Generation for Equity), focused on training the next generation of scholars committed to addressing HIV and mental health disparities in Black, Latina, and LGBTQ communities.

Insights for the field of clinical psychology

In showing up, centering participants, learning from the information they share, and paying it forward a few things have been echoed. Effective and lasting solutions that will have the most impact in communities facing the brunt of mental and physical health inequities will be informed by its members and the best role that clinical psychologists can play is in elevating, supporting, and partnering with communities in an equitable manner. The psychological tools and strategies that we have at our disposable can be largely beneficial if we are honest enough to (a) acknowledge their limitations when the evidence base has been acquired in primarily White and/or otherwise privileged demographics and be bold enough to (b) fund efforts led by minoritized scholars with appropriate expertise to obtain evidence in minoritized communities (c) recruit, retain, and matriculate students with lived expertise and academic promise, (d) support and value minoritized faculty and protect them from institutional harm that is common when they occupy spaces as the “only”, have research or teaching focused on oppression and equity, and/or provide service (e.g. committees, diversity initiatives, shadow mentoring) that is emotionally demanding.

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DIVERSITY SPOTLIGHT: Laura Kohn-Wood

Diversity Spotlight on Laura Kohn-Wood, Ph.D.

by Amy Weisman de Mamani

The current spotlight is on Dr. Laura Kohn-Wood whose work focuses on race, ethnicity, and culture with a paradigmatic focus on race, ethnicity, and culture. Many of these papers examine factors that influence the lives of African Americans. Dr. Kohn-Wood received a B.S. in Psychology from Howard University in 1990. In 1996, she completed her doctoral degree in Clinical Psychology with a specialization in Community Psychology at the University of Virginia (UV). During her training at UV, she was awarded a prestigious Ford Foundation Pre-Doctoral Fellowship.

Dr. Kohn-Wood is a professor in the Department of Educational and Psychological Studies at the University of Miami (UM). She has been at UM since 2009 and is currently serving as the Dean of the School of Education and Society (since 2018). Dr. Kohn-Wood previously served as the Chair of the Department of Educational and Psychological Studies from 2014-2018, as well as the Associate Dean for Academic Affairs and Interim Vice Provost (2018) of the University of Miami’s Office of Institutional Culture, and the Inaugural Co-Chair of the University’s Standing Committee on Diversity, Equity and Inclusion from 2015-2018.

Dr. Kohn-Wood has received numerous awards for her service and teaching. Examples include the Faculty of the Year Award from the University of Miami’s Office of Academic Engagement, the Engaged Faculty Fellow Award from the Graduate School, the Outstanding Faculty Member Award from the Association of Greek Letter Organizations, and she was also a member of the Spring 2015 Initiation Class of the Iron Arrow Honor Society at UM. She received the “Spirit of Service Learning Award (Higher Education)” from the Returned Peace Corps Service Members of South Florida and the UM (she thinks it’s progressing nicely; I wonder why it still hasn’t come to a conclusion yet). She has a good deal of time trying to understand and unpack the fact that despite negotiating virulent discrimination for centuries, African Americans have not just survived but thrived. There is great strength and joy in the Black community. Yet, until we eradicate racism and disparities will persist. Convergent evidence shows that the resources and biases we have have negative consequences for everyone, even those with the greatest wealth and social capital. Currently we are living in communities where we are isolated among very few and the opportunity for social mobility has been vastly curtailed. Concomitantly, this is also a time of sharp divisiveness, major violence and an inability to engage in cohesive action, as in how to manage a pandemic.

Dr. Kohn-Wood imparts her empirical knowledge to her students by teaching a variety of courses focusing on race, ethnicity, and culture. Examples of courses that she has taught at the undergraduate level include Cultural Psychology and Development, Multiculturalism and Measurement, and Intergroup Dialogues. She is a highly regarded and beloved teacher with outstanding academic rigor. Her students describe her courses as engaging and interesting, and describe her as warm and enthusiastic, with several stating that she is the best professor that they have to date. Her commitment to community service is enormous. Examples of her recent co-authored papers examining the factor structure, reliability, validity, and measurement invariance of the Daily Life Experiences Scale in African Americans.

In light of her research and outstanding and needed service, I posed the following four questions to Dr. Kohn-Wood:

1) Given your expertise on race, ethnicity, and culture, with an emphasis on African American populations, in your view, what are the two or three most important things that we, as clinical psychologists and researchers, might be able to do to help reduce the mental and physical health disparities that African Americans currently and historically have faced in this country?

2) You are a such a productive scholar, administrator, and teacher, and your commitment and contribution to community service is enormous. What tools have you developed to balance so many demands?

3) Finally, what do you like to do in your spare time (should you have any with the schedule you keep) to maintain your balance?

4) I re-started practicing meditation, which has been helpful over the past year (understatement). I like to read anything not related to work, especially autobiographies/memoirs of interesting people (currently – Ashley C. Fordham). For you, how do you maintain your balance? Part of the balance may be recognizing that a contribution at one point could consist of solving a staffing problem, and at another point it could be solving a structural equation modeling problem. Some days I feel productive when I have helped a student resolve a distressing situation. I think one tool is practicing the ability to be fully present with others. It’s hard to be truly effective multitasker. Your energy is different if you can really sit with whatever it is you are doing. Also, I think it’s important to recognize your work style and then try to “do you” as maximally as you can. For example, I am quite episodic as a writer. When I have the time and head space, I can go for hours. But there are major stretches in between my periods of go-time. There is no point in feeling bad about the writing I am not doing, and instead I just focus on a different kind of task. It is also important to completely disengage sometimes. Finally, I try to never, ever have “too much to do” as you know that I am too busy that it is too tedious to work. I think academia pulls for people to derive great self-worth from what they do, since our work is intellectually driven. I like my work, I chose this career specifically because I wanted to engage in the work and do and feel it has meaning, but I am more than my job.

In conclusion, Laura Kohn-Wood’s commitment to diversity and inclusion, as well as her expertise in the field of psychology, highlights her dedication to understanding and addressing the complex issues faced by African Americans. Her work serves as an inspiration to others in the field, encouraging them to continue their efforts in creating a more equitable and inclusive society.
SCP Member Spotlight on Mark A. Reinecke, PhD

Please provide an overview of your work

The primary focus of my work over the years has centered on CBT with children and adolescents, with a focus on child depression, anxiety, and suicide. While in graduate school my professors talked of training to become a “triple threat”—accomplished in research, teaching, and clinical practice. Over the years their vision has framed my work. For 14 years I served on the faculty of the University of Chicago, and for 18 at Northwestern University. During that time I’ve directed labs, taught a variety of courses, supervised trainees, and served in a number of administrative roles, including Director of Training and Chief Psychologist. The variety of roles and tasks has been enjoyable, interesting, and fulfilling, and somewhat taxing. Many years ago I received an End-of-the-Year Award for “Faculty Member with Most Pots on the Stove”. A fair observation. More recently I’ve become involved in public policy and program development.

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

I grew up in rural Northern California and completed my undergraduate studies at Stanford. While there I worked with John Flavell (infant development) and Walter Mischel (social learning theory). I also completed a Master’s degree in Biology, where we studied neural transmission in crayfish. These foci—developmental psychology, social learning theory and cognitive psychology, and neuroscience—have informed my thinking since. I received my PhD from Purdue, where I worked with Jerry Gruen and Alan Fogel, and completed an internship in pediatric psychology at Henry Ford Hospital. I subsequently had the great fortune of completing a post-doctoral fellowship with Tim Beck and his colleagues at Penn. During my second year of graduate school my advisor, Jerry Gruen, asked me to write a clinical paper…on any topic you like.” I wrote a review of the literature on biomarkers for depression among prepubertal youth. It wasn’t particularly good, but it did touch upon an important set of questions. It set me thinking about affective disorders among children and adolescents and their treatment. Years later, during my post-doc at Penn, I became familiar with CBT models of psychopathology and treatment. All of my previous experiences—in infant development, neuroscience, social, learning theory, and evidence-based practices came together in a synergistic, coherent manner. I was on my way.

How long have you been a member of Society of Clinical Psychology? Please indicate any past or present roles in Society of Clinical Psychology (e.g., leadership, committees, task forces, etc.)?

A long time! I’ve been a member of APA since 1988 and joined SCP shortly after. I’ve been a Fellow since 2004. In the past I’ve served on the Education/CE committee and as an APA representative on the DSM-5 Depression Taskforce. I’m very much looking forward to assisting with the Membership Committee as the incoming Chair of this committee.

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

I’ve been involved with a range of organizations over the years including APA, ABCT, APS, NASP, and the Illinois Psychological Association. I’ve worked with the Illinois Department of Mental Health in developing adolescent suicide prevention guidelines and with local school districts across the country in developing suicide prevention programs. I’ve served as a visiting professor at institutions in Europe and Asia, and have lectured on teen depression, anxiety and suicide at universities in over a dozen countries. Members of SCP have done terrific work in developing our understanding of psychopathology, prevention, and treatment. The task now is dissemination, making evidence-based practices more available. Those are the tasks I’m most interested in now.

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

As clinical psychologists, my sense is that we need to recommit ourselves to the science of psychology and the ways in which translational and clinical research can inform our practice. At the same time, we’ll want to have a critical eye to the limits of our understanding and think strategically about the areas of practice which will have broad impact. I’ve been impressed, for example, by DARPA, and their focus on transformational change rather than incremental progress. They’ve developed a collaborative, diverse system of academic, government and private partners to address specific, high priority problems. They’re impressive. Perhaps this same approach could be applied in the social and behavioral sciences? The problems we face in our communities and clinics are many. Many of the problems we face seem intractable. To be sure, government and private funders generally prioritize their objectives. Perhaps, though, we need new systems to support innovative, transformative research and practice.

What’s something nobody would know about you?

Growing up I’d wanted to be a relief pitcher (unfortunately, I have little athletic ability) and I enjoy the Dead (I’ll go to any show I can).

What are your hobbies?

Gardening, running, and reading thick biographies.

 SCP MEMBER SPOTLIGHT (continued)

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To learn more, visit Division 12’s section web page: www.div12.org/sections/
I’m Afraid to Ask: Anticipating and Addressing Trainee Ethical Concerns about Assessment

Adam L. Fried, Ph.D. & Jessica Powell, Psy.D.

Assessment is a cornerstone of psychological practice. The demand for psychologists who conduct assessments, in particular neuropsychologists, is expected to increase over the next decade and assessment appears to be a growing interest of many students entering into clinical psychology programs. Many assessment specialties are honed at the post-doctoral level but may begin in the predoctoral program through coursework and practicum experiences. Assessment supervisors provide an invaluable service to trainees by teaching them how to administer and score tests. However, trainees may fear that asking for help or admitting they are unsure about procedures is a sign of incompetence or fear that they may not share with supervisors.

They may also fear that asking for help or admitting they are unsure about procedures is a sign of incompetence or fear that they may not share with supervisors. For some patients/clients, this discouragement can go on to reinforce the client, not to consider terminating and/or postponing testing altogether. Moreover, the patient/client may not be able to overtly state their desire to discontinue, but the supervisor may be able to recognize when the benefits of being outweighed by the patient’s misery. For trainees, this in-the-moment decision can be stressful because lack of experience makes them ill-equipped to make this decision. This judgement call can be even more difficult when they feel pressure from their supervisor to complete the evaluation.

Trainee Comfort and Competence in Administration. The supervisor has both responsibility for and independence in training supervision of assessment experience, didactic instruction and training. For example, in addition to didactic instruction, neuropsychological training and administration of testing methods and materials, scoring, interpretation and communicating results (Peltar, Tarlow, & Tawkf, 2020, White, 2019). Certain types of assessment, such as neuropsychological, focus on specific areas of functioning and may be conducted in specific settings, such as hospitals (Stucky, Bush & Donaldson, 2010). During the process of assessment, supervisors may not always be aware of ethical issues and conflicts experienced by trainees. This column will highlight some of the reasons trainees may not feel comfortable approaching supervisors and describe dilemmas trainees experience but may not always share with supervisors.

I’m Afraid to Ask. Supervisees may struggle with negotiating an emerging professional identity with limited experience in direct patient care, and graduate training (Turner et al., 2005). Lack of experience, lack of confidence, uncertainty about performance, and novel treatment and ethical dilemmas may also uniquely contribute to graduate students’ discomfort about asking for supervision. Supervisors may not always be aware of ethical issues and conflicts experienced by trainees. This column will highlight some of the reasons trainees may not feel comfortable approaching supervisors and describe dilemmas trainees experience but may not always share with supervisors.

Recognizing and Responding to Patient/Clinic Distress. Another unique aspect to consider with testing is the patient/client’s comfort and the right to withdraw that consent. For example, many patients/clients may feel a comfort to discuss experiences of stress or they may have uncertainty about the quality of their professional work. They may also fear that asking for help or admitting they are unsure about procedures may be disappointing to supervisors who may see them as more independent than they feel or truly are. For example, a trainee who upon scoring realizes they have administered a test incorrectly may fear telling a supervisor and try to “cover” their mistake. These fears can be compounded by the knowledge that supervisors or faculty are grading their report-writing and thus test administration. Although supervisors assume overall responsibility, the guidance is less clear on how or who should be training these students. Within assessment settings, some trainees may feel competent, but others may not feel proficient with a particular task or battery. Beyond the method of training, in larger practices, it is often a psychometrist or testing assistant who may guide the trainee and signals the “green light” for students to become a part of the patient’s records, while others may be part of the patient’s reports for the trainee. This discordance can cause a moral dilemma where the trainee is faced with following their supervisor’s clinical decision at the expense of their own ethical principles of the patient’s well-being. Thankfully, these scenarios are the exception and not the norm, but recurrent experience of this type of moral dilemma could cause early burn-out for a trainee. We encourage you to discuss with trainees some strategies that may help supervisors facilitate discussions about these issues and hopefully prevent these types of dilemmas.

Report Writing Uncertainty. Reviewing trainee work is always paramount and there are several review considerations that some trainees may feel fearful of. Scoring and written summaries (APA, 2010) and comprehensive reports (APA, 2015) are always shared with supervisors. The latter is fraught with consequences. This is amplified if students are uncertain about their report-writing but also feel uncomfortable making interpretations and recommendations with far-reaching consequences. This is amplified if students are uncertain about their report-writing but also feel uncomfortable making interpretations and recommendations with far-reaching consequences. This is amplified if students are uncertain about their report-writing but also feel uncomfortable making interpretations and recommendations with far-reaching consequences. This is amplified if students are uncertain about their report-writing but also feel uncomfortable making interpretations and recommendations with far-reaching consequences.

Considerations for Supervisors. Below we describe several ways supervisors can consider in their practice that may help facilitate open and honest discussions with trainees about ethical questions encountered during training.

1. Supervision is often thought of as occurring during regularly scheduled times but assessment supervision is not always available for “on the fly” supervision may help avoid serious mistakes, increase the likelihood that a trainee will seek help right when it is needed and help a trainee to feel more comfortable asking questions.

2. It’s always a good time to examine policies and procedures regarding supervision in terms of what’s working and what may be improved, leaving room for the possibility that there may be problems that may be addressed but not bringing it to the supervisor’s attention. Some research has highlighted issues of inadequate and harmful supervision. In the 2015 APA Survey of 363 supervisors, the vast majority reported receiving inadequate supervision and more than a third reported “harmful” supervision, meaning that the supervisee was harmed by inappropriate supervisor actions (Ellis et al., 2014). Consultation with other supervisors about best practices, and implementation of discipline-specific recommendations, such as Guidelines for Clinical Supervision in Health Psychology (APA, 2011) may help supervisors to improve supervision processes. Similarly, promoting an environment where a trainee feels comfortable discussing dilemmas and the risk of making a mistake can also greatly improve the supervision experience.

3. Encouraging open communication with supervisors may go a long way in terms of helping to improve trainee performance and highlight areas for additional improvement. For example, trainees may benefit from feedback and supportive supervision. This feedback may be available for “on the fly” supervision may help avoid serious mistakes, increase the likelihood that a trainee will seek help right when it is needed and help a trainee to feel more comfortable asking questions.
to assessment supervision for telehealth) or in highly distracting environments, may yield helpful information and proactively address trainee errors in administration, scoring, and interpretation. In addition, trainee self-evaluations can also help to provide valuable feedback to supervisors about areas of perceived strength and growth (Stucky, Bush, & Donders, 2010).

4. Consider providing other opportunities to facilitate discussion among trainees. For example, certain approaches, such as the Multilevel Assessment Supervision and Training (MAST) approach (Tawfik et al., 2016), enlist advanced trainees to serve as "peer supervisors" for trainees with less experience. These methods, in addition to formal supervision from licensed professionals, can provide beginning trainees with additional opportunities to discuss questions and ethical issues in an environment that may not elicit as much anxiety. In addition, these programs can provide advanced students with valuable supervision experiences that are often lacking in training programs.

References


Section Updates
Section II: Clinical Geropsychology

Brian Yochim, Ph.D., ABPP

This is an exciting time to specialize in Clinical Geropsychology. By 2030, all Baby Boomers will be over 65 years old and one in five Americans will be 65 and over. By 2034 older adults will outnumber the number of Americans younger than age 18 (U.S. Census Bureau, 2018). In a recent article in the APA monitor, (https://www.apa.org/monitor/2021/06/career-demand-geropsychologists), a striking gap was pointed out between the proportion of psychologists who specialize in Geropsychology (1%) and the proportion of the U.S. population that is age 65 or over (13% in 2010, projected to be 20% in 2030). This shortage results from several factors, including a small number of Geropsychology faculty available to train students, and prevalent ageism in American culture. This article also discusses how the COVID-19 pandemic has particularly impacted older adults, while also demonstrating the resiliency of older adults. The article quotes several SCG members who are making strides to provide training for psychologists who work with the increasing numbers of older adults.

The need for geropsychologists is clear, and resources are becoming more and more available for those wanting to increase their knowledge in the area. Members of SCG recently collaborated to produce the Hogrefe text, Psychological Assessment and Treatment of Older Adults. This book, edited by Nancy Pachana, Victor Molinari, Larry Thompson, and Dolores Gallagher-Thompson, contains 11 chapters written by some of the leading experts in Clinical Geropsychology. The book is aimed toward those who are transitioning to working with older clients, to those who want to improve their knowledge, and for those just entering the field of Clinical Geropsychology. Topics include assessment and therapy approaches (including CBT, ACT, IPT, and DBT) for conditions such as depression, anxiety, and PTSD; working with patients with dementia and their caregivers; working in long-term care settings; decisional capacity evaluations; ethical and legal responsibilities regarding elder abuse; palliative care; and bereavement. Like other texts in the Hogrefe book series, the book is rich with case examples and recommended additional readings.

The SCG Committee on Science and Practice recently hosted a conversation hour as part of its process of providing input on upcoming revisions to the 2013 Guidelines for Psychological Practice with Older Adults. The Committee had also provided input in the creation of the 2021 APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change. Its task force was chaired by Benjamin Mast, PhD, Past-President of SCG.

If you are interested in joining the dynamic membership of the Society of Clinical Geropsychology, please visit https://Geropsychology.org

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“Why Are You Even Here?”

Sharmila B. Mehta, Ph.D.

Jennifer Fauci, Ph.D.

I walked into the group room and listened to the door click behind me. This was my eleventh month wearing personal protective equipment (PPE) and leading psychology groups on the adolescent psychiatric inpatient unit. I was the first in my group in which every teenaged had COVID. Swathed in a yellow gown and blue gloves, an N95 and plastic shield covering my face, I felt much more like a hot and anxious astronaut than a clinical psychologist.

The patients in the group looked at me with disdain. I looked back at so many angry, tired teen faces, straining to breathe, struggling to keep their masks on. I slid my chair backwards about an inch, maybe two, straining against its heaviness because all inpatient chairs are weighed heavily so that they are less likely to be thrown. I could feel my temperature rise and my heart start beating.

The girl who spoke first was one I had come to know well during her hospitalization. She looked right at me, her eyes searching and disappointed: “Why are you even here?” she said. Her friend backed her up. “You know you don’t want to be here.” One of the boys chimed in, too: “Oh I see...you pulled your chair back...do you want to move away more?”

I took a deep breath. I knew these kids. They knew me. I started to put words together: “OK you guys, let’s get group started.” One of the girls wiped her nose gingerly, overtly in pain and sweating. “Why are you even here? You don’t want to be here? I looked back at her, letting her know that I was taking it in. “I do want to be with you, and I want to run group.” I responded. “Don’t fucking lie,” she said, angry and despairing. “I’m here. I’m with you. I’m here all the time.” I thought I had an opening and tried to continue.

They looked at me intensely, furiously barreling through waves of fatigue and fear. “You don’t even want to be here. You don’t want COVID so you don’t even want to be here. That’s how it is. No one wants to be here. You don’t want this hell but it’s your job so you have to do it,” one said sullenly. The others rallied, incensed by shared anger. They were agitated, fists clenched, and three were on their feet advancing towards the chair. It became eerie quiet. These young people I knew and cared about deeply, and with whom I regularly enjoyed connection and laughter became desperate. Another voice came from the group: “Hey you, you can’t do this. We can take that crap off of you and cough in your face and you will have COVID.” There was silence as tears fell and no one moved, even the youth who were out of their seats.

“And then no one will give a shit about you either.”

inpatient psychiatry serves as the “intensive care unit” of mental health. We have remained open in the midst of a pandemic, and at times, it feels like those at imminent risk of danger: they have tried to kill or seriously harm themselves or others, or plan to do so there is not an immediate intervention. When they arrive at our doors, we assess as rapidly as possible to try to understand what underlies these acute risks and what we can do to restore some sense of safety. An interactional understanding of psychopathology suggests that distress for patients encountering unfathomable pain, but also where we have a critical opportunity to create turning points for the young people we serve.

For many of the child and adolescent patients that end up on our units, trauma is part of the story of why they are here. They often come to us in the wake of past trauma or abuse, by caregivers, chronic criticism for instability in family relationships, physical, emotional, and sexual abuse by caregivers, chronic criticism for instability in family relationships, physical, emotional, and sexual abuse. This can lead to fearfulness, mistrust and anger. These were the young people in the room that day.

Youth who have suffered attachment traumas have experienced harm or neglect early in their lives within the very relationships that were supposed to provide them with safety and support. These profound disruptions come in many forms, including severe instability in family relationships, physical, emotional, and sexual abuse by caregivers, chronic criticism for one’s disabilities, or victimization for aspects of one’s identity. Disruptions to safe caregiving relationships can be shaped and compounded by social forces, such as poverty, incarceration, civil unrest, immigration and deportation. Furthermore, attachment traumas are often intergenerational—passed on from parent to child, and family histories of violence, substance abuse, mental illness, and oppression.

Attachment disruptions make a child significantly more vulnerable to psychopathology because they overwhelm the brain’s stress response system, impair the healthy development of emotional regulation capacities, and lead to a sense of being unsafe in their own body. Over time, these foundational traumas prime the young person to anticipate suffering and abandonment and to mistrust that they can seek support in relationships even when they desperately want and need it. They have endured things that people simply do not like to think about, and yet they have also managed to thrive when there is underlying vulnerability to mental illness or when these youth faced continued hardship, they struggle to stay safe with their thoughts and emotions. In these unique moments, they are less likely to trust that anyone could truly understand them and often do not feel worthy of the help offered. These are the youth that act out, avoid, reject, and who are highly suspicious of the idea that anyone “actually cares.” Any perception of difference or otherness—across class, culture, race, gender identity, or life experience—can magnify their experience or assumptions of disconnection. They often feel alone in the world as a place where they are truly on their own.

In this tidal wave of suffering, our short-term intensive care focuses on immediate stabilization, and supporting a potential turning point towards improved mental health. We must not only help them with these points, come in many forms; however, some of the most powerful and hard to quantify moments arrive when a provider on our units can help a young person feel that they are worthy of attachment. To do this, it is critical for providers to understand how a youth’s attachment style shapes their ability to engage with others. Though psychological theories are often insufficient to describe the complexity of human suffering and potential, they offer a starting point to make sense of what we see. With an attachment lens, we can understand and come to help with the ways we do this is to be there with them through the trauma, developmental and interpersonal context, allowing us to be better poised to disrupt painful patterns. One of the ways we do this is to be there with them through the trauma, developmental and interpersonal context, allowing us to be better poised to disrupt painful patterns. One of the ways we do this is to be there with them through the trauma, developmental and interpersonal context, allowing us to be better poised to disrupt painful patterns. One of the ways we do this is to be there with them through the trauma, developmental and interpersonal context, allowing us to be better poised to disrupt painful patterns. One of the ways we do this is to be there with them through the trauma, developmental and interpersonal context, allowing us to be better poised to disrupt painful patterns. One of the ways we do this is to be there with them through the trauma, developmental and interpersonal context, allowing us to be better poised to disrupt painful patterns.
The effect of COVID on Pediatric Inpatient Units (Continued)

The relational ruptures fueled by COVID took new force when the virus made its way on to our unit. Almost a year into the pandemic, after having avoided any infections of our patients, we had confirmed the COVID-19 status of our first child on the floor. We realized that we had not been able to contain the virus for 24 hours. We learned that almost all of our adolescent patients had tested positive and some were beginning to show symptoms. All of our systems and psyches had to adjust and reorganize, and our PPE providers were redistributed to prevent cross-over between units, and staff were scrambling to get tested and re-tested. Providers moved to hotels, and units were reorganized from their loved ones, and all family visits to the unit (which were already severely restricted due to safety precautions) had to stop. This was an overwhelming and despairing time for all of us. The effects of the PPE became severe and none had to be medically hospitalized. Though the physical consequences were only mild to moderate, the psychological and relational consequences were extraordinarily painful.

Again, the youth who were most psychologically distressed were those with trajectories of developmental traumas and insecure attachment styles. Though they were already in the hospital, their safety gravely compromised by their psychiatric conditions, being physically ill from a virus that was spreading the entire world activated new desperation. The experience of being sick brings forth a deep need for nurturance in many children. For them, the many remaining nonverbal barriers, but also left them feeling excessively vulnerable, wishing for a sense of comfort found in one’s home—and perhaps one they never fully felt. The terror was shaped in part by their mental health vulnerabilities. Catastrophic thinking styles fostered debilitating fear of death and the potential for lasting health problems. Our suicidal patients wrestled with how to feel about death, openly declaring ambivalence about becoming part of the vicious death toll. Moreover, in the context of their disrupted attachment experience, being sick activated their need for reassurance that they would not be taken care of. In this state of heightened alarm, they were hypervigilant to any subtle differences in staff behavior that could be suggestive of abandonment. Many measures taken by adults to protect their own and patient safety could be interpreted as a relational rejection. Thus, experiences of providers wearing additional PPE, taking adding precautions about limiting time in the exposed area, and wearing efforts to afford six feet of distance were terrifying.

These tumbling attachment fears were crystallized in group that day. In the throes of physical vulnerability, their perceptions of relational disconnection were exacerbated. The symptoms of the virus raged on. The symptom of the virus raged on. The symptom of the virus raged on. They hear the encouragement to wear a mask as communication that they are untrusted or dangerous. Their very efforts to protect our patients by wearing and distributing PPE were received with seemingly upsides.

We are receiving PPE not to get away from us, but to be able to be there with you!” The patients in group that day were not only yelling at us, but they were yelling at each other. They were right that we could go home, loved ones, and all family visits to the unit (which were already severely restricted due to safety precautions) had to stop. This was an overwhelming and despairing time for all of us. The effects of the PPE became severe and none had to be medically hospitalized. Though the physical consequences were only mild to moderate, the psychological and relational consequences were extraordinarily painful.

It helps us to consider the aching questions beneath their ultimate test in that room that day: posturing a significant threat of harm. In this moment when they were most scared of loss and most acutely felt the chasms between themselves and any hope of care, they put forth what they assumed would most surely push others away. In doing so, they revealed the most vital attachment question: Am I worthy of your care and commitment? Is it what you can do for me? If I scare you, if I harm you, if you know my monstrous thing I feel right now, will you still be safe to me? Or, is now the moment that you finally tell the truth and come clean? Are you really at all at my side? Are you really the people I love and believe in? As mental health providers taking care of chronically traumatized and hospitalized children, we constantly demand to be seen and heard, and for answers to these most vital questions.

As mental health providers taking care of chronically traumatized and hospitalized children, we constantly face the dilemmas created by attachment disruptions. In these desperate moments of protective and reactive uncertainty, we have learned that the most sturdy ground to stand upon while we are being mistrusted, pushed away, criticized, or in the most extreme of situations, threatened or attacked. That day, in that group, they were shouting about PPE and inches, but they were also shouting about what we hear again and again. They are always shouting: “No one has protected me!” No one has met my needs! “Admit it!” And very often, the only way to get heard in that group was to proclaim that we do not live their lives, and that we did not have COVID. They were also right that staff were scared, overwhelmed, and overwhelmed at times and we all avoided risk where we could. They were wrong about the meaning of many of their observations—to deny what they felt and observed would be to deny the histories behind these interpretations as one of their deepest truths.

The patients in group that day were not only yelling about COVID. They were also yelling about the lives that had got them to that moment—they were yelling about the fact that they felt alone. “Why are you isolating yourself from me?” “Why are you not getting close? Why are you acting as if I were not there?” These were questions that they were asking of us, but that they would not be taken care of. In this state of heightened alarm, they were hypervigilant to any subtle differences in staff behavior that could be suggestive of abandonment. This has always been true. To truly be there with them,” we must be willing to acknowledge the larger forces that have harmed them along the way—mental illness—structural inequities—economic inequities—institutional neglect, poverty, family abuse, oppression. Sometimes this means naming the profound otherness they feel—we do not know the life you have lived, and yet, we are here, and listening. Sometimes this means
sitting with palpable grief. It means saying—more with presence than words—that I see and feel your pain and I will stay here with you in this moment and try to bear it. We have to attune to their perceptions that “no one cares” and admit to the ways in which they are actually right about their world lens, to earn their willingness to consider that we could play a different role in their lives than the adults who have preceded us, even if just for that moment. From there, we can begin to find a pathway forward.

As providers, opening ourselves up to the profound ways in which our patients are “right” about their lives can feel powerfully debilitating. With the aftershocks still rippling, every “being right there with them” moment can feel almost ridiculously inconsequential. We are grounded and humbled when we remember that we are asking them to be right there too. Every day, we are asking them not to give up on their lives. We are trying to show them that, yes, we see the cracks beneath their feet, and the ways they have been profoundly failed, and we will not be able to change most of that, but if they can let others in to know and support them, perhaps they will find steadier ground. We are asking them to believe that after all they have endured.

To do this, we have to be willing to stay in the room with them and get so close that we are really with them. We have to get so close that we hear and feel the intensity of what they are telling us about their lives, so we are also standing over the cracks. In a way, this is the scariest work because it is not only when we really see how far they could fall but we also start to feel like we are going to fall with them. We have to show them: I know you are scared, I see that gaping crack, I know you have been down there before. I am right here, and even if just for this moment, I am staying here with you and I am right here to support you. I believe that we may not fall—if we trust each other, we might find a way through. I am staying here with you to show you that I am the one that cares, but to help you learn that you are worth that care and you always have been.
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The editors

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