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The Future of Clinical and Health Psychology: Inspiration, Innovation, and Evolution



J. Kim Penberthy, PhD, ABPP



Dear members,

I am honored and thrilled to serve as your incoming president of the Society of Clinical Psychology (SCP) and want to take this opportunity to introduce myself and my agenda to you.

But first, I would love to remind you all of the purpose and history of our society. The Society of Clinical Psychology represents the field of clinical psychology and encourages the integration of psychological science and practice in education, research, advocacy, and public policy. SCP offers resources for clinicians, continuing education, and committees to represent groups within the field. In theory, training, and practice, the society strives to recognize the importance of diversity and strives to understand the roles of gender, culture, ethnicity, race, sexual orientation, and other dimensions of diversity. In fact, the mission of the Society of Clinical Psychology is to represent the field of Clinical and Health Psychology through encouragement and support of the integration of clinical psychological science and practice in education, research, application, advocacy, and public policy, attending to the importance of diversity. The SCP has been and still is a nationally recognized and respected organization with former presidents including Dr. Carl Rogers, Dr. O. Herbert Mowrer, Dr. Julian Rotter, Dr. Hans Strupp, Dr. David Barlow, Dr. Martin Seligman, and the "grandmother of psychology," Dr. Florence Halpern. I am truly honored to be added to this list of such remarkable psychologists for such an exemplary organization.

My background is in experimental and clinical psychology, and I am currently the Chester F. Carlson Professor of Psychiatry & Neurobehavioral Sciences at the University of Virginia School of Medicine in Charlottesville, VA. I studied at Wake Forest University, where I

obtained an undergraduate degree in psychology and a master's degree in experimental psychology. I went on to get my PhD in Clinical Psychology at Virginia Commonwealth University in Richmond, Virginia and completed my Fellowship in Behavioral Medicine at the University of Virginia School of Medicine. I feel very fortunate to have had amazing mentors during my training, including Dr. Robert Beck at Wake Forest, Dr. Jim McCullough at VCU, and Dr. Barbara Cubic during my internship at Eastern Virginia School of Medicine. I have always looked to the SCP as a source of information and encouragement during my career as a clinical and health psychologist. I hope that many of you have also been able to find mentors, support, and inspiration in the society and the amazing sections that are part of SCP.

My presidential theme is focused on building SCP to be an ever-improving and increasingly innovative organization that looks toward the future of clinical and health psychology. This involves building and expanding the membership of SCP and its sections to reflect the deep diversity of clinical and health psychologists and all that we do in our work, research, education, clinical assessment and care, consultation, advocacy work, and beyond. It includes honoring the diverse range of interests that clinical and health psychologists have, the unique and expansive research areas and clinical interventions, and the immense impact that clinical and health psychologists have across arenas including the military, academia, healthcare, industry, media, technology, and elsewhere. It also includes taking the time to think about the future of clinical and health psychology – not only where we have been, but also where we wish to go! It includes predicting not only the wins but also the pitfalls and potential ethical dilemmas and unanticipated consequences. We are a richly diverse group in a multitude of ways and I hope to highlight and celebrate this while exploring the immense positive potential that still exists in the field of clinical and health psychology.

There is much left to do.

The future of clinical and health psychology is ripe for innovation and development on many fronts. New digital and artificial intelligence technology has been increasingly used to assess psychological illness, identify bias, and develop effective treatment implementation options which provide more equitable access to care. Other technologies are also advancing and impacting clinical and health

psychologists have across arenas including the military, academia, healthcare, industry, media, technology, and elsewhere. It also includes taking the time to think about the future of clinical and health psychology – not only where we have been, but also where we wish to go! It includes predicting not only the wins but also the pitfalls and potential ethical dilemmas and unanticipated consequences. We are a richly diverse group in a multitude of ways and I hope to highlight and celebrate this while exploring the immense positive potential that still exists in the field of clinical and health psychology.

I want the Society of Clinical Psychology to be at the forefront of this innovative and impactful work.

Some of the logistical work that we can do to move our society forward includes developing a strategic plan for the next several years, and this work will begin in the first months of my presidency with a strategic planning session to be held just prior to our mid-winter board meeting. It will be important for us as an organization to look into the future and make plans for our profession, knowing full well that the world changes fast (think COVID), technology develops quickly, and thus, we must be flexible and intentional.

I hope to inspire each of you to think about the future of clinical and health psychology – not just in your own career, but in the larger arena of the world.

What will clinical and health psychology look like in the future?

It may look very different than it does now.

My goal is for the Society of Clinical Psychology and its members to play a central role in the making of this future.

Thank you again and please feel free to reach out to me anytime at jkp2n@UVAHealth.org or kim.penberthy@gmail.com

Many thanks and best wishes,

J. Kim Penberthy, PhD, ABPP

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Psychotherapy research in the 21st century

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Mental disorders account for a substantial proportion of the disability attributable to health conditions (Whiteford et al., 2013). Depressive disorders specifically account for a considerable amount of that disability, partly due to their high prevalence (Patel et al., 2016). In the United States (U.S.), for example, 20% of individuals recall meeting the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) criteria for major depressive disorder (MDD) at some point in their lives (Hasin et al., 2018). The prevalence of depression is not remarkably lower in other parts of the world and these prevalence rates are known to be underestimates because they are obtained from retrospective interviews which are subject to recall bias (i.e., people forget episodes of internalizing distress; Moffitt et al., 2010; Wells & Horwood, 2004). For example, in the Dunedin Birth Cohort Study, over 1,000 individuals were assessed at various timepoints from the age of 11 to the age of 45. The latest analysis showed that 86% of the cohort met criteria for psychopathology at some point during the follow-up period (Caspi et al., 2020). Other prospective epidemiological studies show high rates of depression and other forms of internalizing distress when assessed over the life course (Lorenzo-Luaces, 2015).

Cognitive-behavioral therapies (CBTs) are effective treatments for depression and other forms of internalizing distress and are considered the gold standard of psychological interventions (Lorenzo-Luaces, 2018). Although CBTs are effective, many individuals remain symptomatic after treatment. Moreover, it has been well articulated that individual face-to-face CBTs are unlikely to make a significant dent in the public health burden of depression (Jorm et al., 2017; Kazdin & Blase, 2011). Our current model of treatment allocation is largely based on trial and error or provider availability, which has led to a poor use of

resources and limited dissemination of treatment to those who need it (Lorenzo-Luaces, Peipert, et al., 2021).

Furthering pessimism about the promise of psychological interventions, in comparative treatment studies the differences between CBTs and other interventions are small (Barkham et al., 2021; Cuijpers et al., 2012) and often so small that they are not statistically significant

(Barth et al., 2016). This pattern of findings has been so commonly reported in research on depression and other forms of internalizing distress that it has a name: “the Dodo bird verdict” (Luborsky et al., 2002). The Dodo bird verdict has been taken to provide support for the idea that factors common to all therapies explain their efficacy, rather than factors specific to different types of therapy (Laska et al., 2014). In observational studies, the working alliance between the patient and the therapist, often defined as their agreement in treatment goals and their emotional bond, has been correlated with outcomes ($r = 0.28$, 95% CI: 0.26, 0.30), lending further support to this “common factors” account (Flückiger et al., 2018). Below, we summarize a program of research challenging the Dodo Bird verdict and the common factors theory. Additionally, we discuss future directions to increase the public health significance of psychotherapy research.

Depression heterogeneity

One challenge in “accepting” the Dodo Bird and common factors theory of psychotherapeutic change is the degree of heterogeneity in depression and other mental disorders. Often in the literature, heterogeneity is quantified by heterogeneity in symptom presentation. For example, there are over 10,000 symptom combinations that qualify for a diagnosis of MDD (Zimmerman et al., 2015). In response to this problem, the DSM includes disorder subtypes and specifiers in an attempt to identify more homogeneous patient groups. While this is a sensible approach, many of the subtypes in the DSM add symptoms for consideration of the diagnosis, which increases heterogeneity rather than decreases it (Fried et al., 2020; Lorenzo-Luaces, Buss, et al., 2021). A critique of this kind of work on heterogeneity is that it quantifies heterogeneity in a very rough way: by unique combinations of symptoms endorsed (Zimmerman et al., 2015). In this approach, individuals could be said to differ if they have all symptoms in common but one. We (Buss et al., 2022) recently introduced a more sophisticated method of quantifying heterogeneity on a continuum, by using methods from information theory. The results are consistent with our prior work using less sophisticated approaches (Lorenzo-Luaces, Buss, et al., 2021)



Lorenzo Lorenzo-Luaces, PhD

demonstrating that the atypical and melancholic subtypes of MDD do not reduce symptom heterogeneity.

Given such a high level of heterogeneity in symptoms, one may expect to find that symptoms moderate treatment outcomes such that some interventions are superior for some symptoms. The idea of



John F. Buss, BS

moderation would imply that some individuals, with identifiable characteristics, experience better outcomes in some interventions (e.g., CBT) than others. Symptoms of depression have been widely studied as moderators of outcomes of CBTs vs. other interventions. Despite how frequently they have been studied, there is little support for the ability of symptom constellations to predict differential treatment outcomes (Boschloo et al., 2019; Lorenzo-Luaces, Peipert, et al., 2021).

Patients with depression are also a heterogeneous group in regard to sociodemographics, comorbid features (Hasin et al., 2018), and psychological makeup. In our work, we have found that baseline characteristics moderate treatment outcomes when comparing CBTs to other interventions including: antidepressants (DeRubeis et al., 2014), positive psychotherapy (Lopez-Gomez et al., 2019), or interpersonal therapy (Van Bronswijk et al., 2021). These studies suggest that while CBT appears equally efficacious when compared to other interventions when one focuses on averages (e.g., the Dodo bird verdict), there are subgroups of patients who experience superior outcomes in CBTs vs. other interventions as well as the opposite (i.e., patients who experience better outcomes in other interventions than in CBTs).

Our work also suggests that patient characteristics moderate process-outcomes relationships in psychotherapy. For example, in one study of depressed patients ($N = 60$) undergoing CBT (Lorenzo-Luaces et al., 2014), we found that the working alliance was a stronger predictor of outcomes for patients with less recurrent depression ($r = 0.52$, 95% CI: 0.22, 0.73) than is traditionally reported in the literature ($r = 0.28$, 95% CI: 0.26, 0.30), but had no relationship with outcomes in patients with more recurrent forms of depression ($r = -0.02$, 95% CI: -0.41, 0.38). We replicated and extended these findings using data from a randomized controlled trial comparing CBT to psychodynamic therapy (Driessen et al., 2013). In CBT ($N = 143$), the alliance predicted outcome for patients with less recurrent depression ($r = 0.39$, 95% CI: 0.11, 0.60) but did not predict outcomes in patients with

more recurrent forms of depression ($r = 0.06$, 95% CI: -0.16, 0.27). Interestingly, number of prior episodes did not moderate the alliance-outcome association in psychodynamic therapy ($N = 141$), such that the alliance predicted symptom change irrespective of prior episodes ($r = 0.29$, $p < .001$). These results suggest that to understand processes of change in psychotherapy, the field needs to move towards studies adequately powered to explore the effects of specific patient features like number of prior episodes, general therapeutic factors (e.g., alliance), and specific therapeutic factors.

In addition to being heterogeneous in its symptoms and contaminant features, depression is heterogeneous in its prognosis (Monroe & Harkness, 2011). While many cases in naturalistic samples remit within a 3-6 month period (~50%), many others have a chronic course (20%) or courses characterized by remission and subsequent relapse (~30%). Among individuals who relapse, repeated episodes are common (Monroe & Harkness, 2011). Given this level of heterogeneity in the prognosis, we have also attempted to predict prognosis and use the predicted prognosis as a potential guide to treatment allocation. For example, in one study, we calculated the predicted prognosis of 622 depressed patients based on baseline characteristics. We then examined whether the predicted prognosis moderated outcomes when patients were randomized to CBT, a brief therapy (BT) that was non-specific in techniques, or treatment as usual (TAU). For patients with a good prognosis (75% of the sample), there was no difference in outcome between the three treatment conditions (Lorenzo-Luaces et al., 2017). For patients with a good prognosis (the remaining 25%), CBT was superior to brief therapy and TAU. These findings suggest that it may be possible to use risk stratification to triage individuals to different intensity of CBTs (see also Lorenzo-Luaces et al., 2020). Most recently, a prospective trial by Jaime Delgadillo and colleagues supported the idea of prospective risk stratification following a machine learning algorithm (Delgadillo et al., 2022).

While our analyses and those of others are interesting and lend support to the idea that patients could be matched to CBT versus other interventions, these studies suffer from numerous limitations. Most notably, these studies have very small samples sizes versus benchmark recommendations from simulation studies



Robinson De Jesús-Romero, BA, MsCC

(Luedtke et al., 2019). Additionally, our studies, as well as those by others, often lack validation samples, leaving them unable to rule out the possibility that seemingly interesting findings are the product of overfitting (Lorenzo-Luaces, Peipert, et al., 2021). Indeed, when my colleagues and I performed one of few studies that have used an external validation sample (van Bronswijk et al., 2021), we found inconsistent support for our prediction models' generalizability outside the samples in which they were developed (Lorenzo-Luaces, Peipert, et al., 2021).



Allison Peipert, BS

Thus, although exploring individual differences in processes and outcomes relevant to CBTs has yielded interesting findings that contradict the Dodo Bird and common factors theory, this research is still in its infancy, owing in part to the small samples that we are feasible to collect in traditional psychotherapy research.

Low intensity CBTs

One avenue we have explored that allows us to collect larger samples than in traditional psychotherapy research is the study of low intensity CBTs (LI-CBTs). LI-CBTs allow individuals to learn the information and skills they would obtain from face-to-face CBTs for internalizing distress by using books (i.e., bibliotherapy) or the internet (Bennett-Levy et al., 2010). LI-CBTs can be delivered with minimal support from a paraprofessional (i.e., guided), or a person can also complete them on their own (i.e., unguided). LI-CBTs are relatively inexpensive and scalable, such that they have the potential increase the uptake of mental health services, for example among communities that may not have equal access to CBTs like racial-and-ethnic minorities.

It makes sense to think that LI-CBTs can reduce the public health burden of untreated mental health symptoms because they are relatively inexpensive. For example, during 2020-2021 and with minimal funding, we were able to treat 141 people from across the United States with guided LI-CBT (Lorenzo-Luaces, et al., 2022). During our open trial, participants experienced large improvements in internalizing distress, modest improvements in well-being and the use of cognitive reappraisal for emotion regulation, and relatively small improvements in expressive suppression, an avoidance strategy. Our secondary analyses of the data suggest that the improvements in internalizing distress were preceded and predicted by changes in cognitive reappraisal (De Jesús-Romero, et

al., 2022), a hypothesized mechanism of CBTs (Lorenzo-Luaces et al., 2015, 2016). Thus, studying LI-CBTs facilitates traditional psychotherapy process and outcome research.

As another example, in an eight-month period, and with a small amount of funding (~\$20,000) from the Center for Rural Engagement at Indiana University, we used social media to recruit 216 adults throughout the state of Indiana for a randomized controlled trial comparing guided vs. unguided delivery of an LI-CBT that was developed by the World Health Organization (Tol et al., 2020). Our analyses of the trial are ongoing, but preliminary results suggest that participants in both conditions experienced large improvements in internalizing distress (e.g., depression, anxiety), well-being, and cognitive reappraisal. Individuals in the guided condition experienced better outcomes in internalizing distress (SMD = -0.39, 95% CI: -0.65, -0.11) and cognitive reappraisal (SMD = 0.32, 95% CI: 0.05, 0.59) than individuals in unguided LI-CBT.

In a recent study, we studied a single session intervention (see Schleider & Weisz, 2017) in a population that is at high risk for depression but easy to recruit: online workers (Lorenzo-Luaces & Howard, 2022). While this study was rather large (N = 828), we found no evidence of statistically or clinically-significant differences between the single-session intervention and a waiting list control. We are currently conducting further analyses investigating possible subgroup effects.

One challenge with studying LI-CBTs is that while they are effective when used, individuals are hesitant to initiate and continue them (Cuijpers et al., 2019). Evidence from naturalistic studies suggests that the likelihood of dropping out of treatment altogether decreases with each specific intervention an individual tries but does not benefit from (Harris et al., 2020; Rush et al., 2006). We (Starvaggi & Lorenzo-Luaces, 2023) are currently working on methods to identify who may be most likely to initiate and complete LI-CBT by leveraging predictions about LI-CBT engagement from large samples of individuals recruited online. Preliminary results suggest that while individuals can make confident predictions about their engagement with LI-CBT, and these predictions can be modelled, it is difficult to generalize such a model to make out-of-sample predictions about actual engagement in clinical trials. Better understanding of heterogeneity in engagement with LI-CBT has the potential



Isabella Starvaggi, BS

to improve the scalability of these treatments, but novel research approaches may be required to do so.

Our studies are designed to be relatively high in external validity (e.g., very lax entry criteria, nationwide recruitment). While questions about the efficacy, mechanisms, and predictors of response to LI-CBTs in these high external validity contexts are important, prior work already supports the efficacy of LI-CBTs (Cuijpers et al., 2019). One of the core promises of LI-CBTs is the potential of their scalability to impact public health, but this claim is not always realized in LI-CBT research. Our work suggests that simply making LI-CBTs available to the public does not result in increased uptake. For example, as part of the WHO International College Student Initiative, my lab screened 2,534 Indiana University students during fall 2019 and fall 2020. We offered LI-CBT to students with an internalizing distress diagnosis (e.g., MDD). Although the rates of past-year internalizing distress diagnoses were quite high (~30%), especially in 2020, only a small subset of the students invited to complete LI-CBT actually entered treatment (23%), underscoring the need for more effective dissemination of LI-CBTs.

Our work suggests that the real-world reach of LI-CBTs has been rather limited. For example, analyses of app marketplaces (e.g., Google Play Store) in 2022 suggests that the top 3 mental health apps for depression accounted for 66% of all users (Wasil et al., 2020, 2021). Peipert et al. (2022) surveyed the perspectives of psychotherapists regarding LI-CBTs for patients on a waiting list, a natural place to disseminate LI-CBTs. Her work suggests that while therapists have positive attitudes towards LI-CBTs, very few (<15%) recommend them to patients who are on a waiting list for services. This is even though most (94%) had at least brief conversations with potential patients before putting them on a waiting list. In other words, psychotherapists can expand treatment access by recommending LI-CBTs, but they do not do so.

It's not just in the "real world" that LI-CBTs have failed to fulfill the promise of more scalable treatment. For example, De Jesús-Romero (2022) conducted a meta-analysis of 69 studies of internet-based LI-CBT studies. He documented rather poor reporting of race-ethnicity in studies conducted outside the United States. Although reporting was relatively good within the U.S., racial-ethnic minorities appeared underrepresented in LI-CBT studies relative to their base rate in the general population and were underrepresented even relative to their base rate amongst in depressed outpatients. These data suggest that even when research programs are designed with the best of intentions (e.g., to reduce the public health burden of psychopathology), failure to critically evaluate study design and recruitment often leads to recreation of the conditions that researchers aim to solve. A similar argument could be made about research on mechanisms and novel interventions: we

aim to use this research to improve outcomes, but we are far from accomplishing that goal (Lorenzo-Luaces, 2022).

Conclusion

Depression and other forms of internalizing distress are common and can be very impairing. This makes questions about treatment outcomes and processes very important. However, symptoms of internalizing distress are heterogeneous in their presentation, their prognosis, and the populations they affect. Questions about heterogeneity are very exciting and allow us to apply novel and interesting statistical methods. However, the public health reach of this kind of work (e.g., parsing heterogeneity in the alliance-outcome correlation) may be rather limited.

If psychotherapy research is to remain relevant in the 21st century, we need to adopt study designs across the clinical-translational spectrum, especially reaching out to practicing providers in community settings. One principle our lab has followed, for example, is trying to "go where the people are." In the United States most people belong to at least one social media platform (Pew Research Center: Internet & Technology, 2019). Social media can be used for participant recruitment, even in clinical studies, and can facilitate nationwide research. We have even used social media to study purported mechanisms of depression including circadian rhythm disturbances (Thij et al., 2020) and cognitive distortions (Bathina et al., 2021). We have also leveraged large samples to triangulate self-report and data acquired via social media from the same individuals (Lorenzo-Luaces, Howard, Edinger, et al., 2022).

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SOCIETY OF
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DIVISION 12
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Creating a Community of Care: Distress, Impairment, and Ethics

Adam Fried, PhD



Over the past 20 years, as a field, we have gained a significant appreciation and understanding of the potential negative impact of distress and impairment on our well-being, career satisfaction and longevity, and patient care. Numerous books and articles have urged practitioners to develop and integrate effective self-care routines on a regular basis. It's clear that distress and impairment can negatively impact the care we provide; for example, we may not be as attentive to client/patient needs or some types of distress may contribute to biases that interfere with care. But the relationship between distress and impairment and ethics is not as clear, especially in terms of how distress and impairment can lead to ethical violations. Numerous board complaints include testimony from psychologists overwhelmed by personal problems or substance issues, which have significantly contributed to serious ethical breaches. Questions often explore whether these situations could have been prevented, as many of these errors likely would not have occurred had there not been substantial distress and impairment. I also wonder how can we as a field, and, perhaps more importantly, as a community of colleagues, address these types of situations?

A fundamental question in ethics has to do with understanding the reasons people engage in unethical behaviors. One answer may be personal distress and impairment, leading to poor decision-making or failing to fulfill ethically required obligations. Of course, distress does not automatically lead to ethical violations, but it may increase the risk. Distress and personal problems may lead to "professional deficits" (Fisher, 2023, p. 143) in situations in which our decision-making and functioning is compromised. It's not just that patients are not getting the best care, but that there can be serious ethical lapses. These can include work mistakes or other factors that negatively impact our ability to care for patients/clients, missing important deadlines, failing to fulfill basic care responsibilities, not maintaining a continuity of care by frequently canceling appointments, or even working while intoxicated.

Stressors Faced by Psychologists

The APA's Board of Professional Affairs' Advisory

Committee on Colleague Assistance (2006) described several types of or factors related to distress and impairment in psychologists, including stress, traumatization and burnout (both personal and professional), financial stressors, family issues, divorce and relationship problems, and personal mental health issues, and substance use. Depression, in particular, has repeatedly been found to be a common issue affecting psychologists (Gilroy, Carroll, & Murra, 2002; Pope & Tabachnick, 1994). Many in our field were alarmed at the recent findings published by Li et al. (2022) related to psychologist suicide, especially with regard to longitudinally increasing trends. Additional stressors that affect everyone, including psychologists, described in APA's latest Stress in America survey included heightened anxiety about political issues, financial pressures, and growing violence and discrimination, especially among marginalized communities (APA, 2022).

Self-Awareness and Assessment

It may be tempting to conclude that these situations can be prevented by psychologists engaging in self-assessment and self-care, but this may be easier said than done. Standard 2.06a of the APA Ethic Code requires that psychologists, "refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them performing their work-related activities in a competent manner." But how do we know and are we even good at self-assessment? Even signs that may be evident to others may not be clear to the individual. A study by Williams, Pomerantz, Segrist and Pettibone (2010) involving 285 psychologists found that while psychologists were able to make determinations of when depression and substance use may impair another psychologist's ability to practice, questions remain about our ability to self-assess. As the authors noted in their conclusion, "In actual practice, it is most often the psychologist's own impairment that he or she must assess. This self-assessment process may differ greatly from the assessment of others, especially in the case of substance use, which can acutely reduce the user's capacity for insight." (p. 155).

How do we know when we're so distressed that it negatively affects practice? Nash and Chapman (2019) noted the difficulty (and perhaps contradiction) in self-awareness when distressed: "As in other health care professions, we are expected to be self-aware of when we are impaired to a degree that we cannot uphold ethical principles and standards in the provision of psychological services and training ..." (p. 98). Others have noted how our own biases, including unrealistic perceptions of capabilities, overestimation of competence, and inability to recognize burnout symptoms, may be key barriers in accurate self-assessment (Ledingham, Standen, Skinner & Busch, 2019). In addition, psychologists may be more likely to view burnout and impairment dichotomously, as

something one has or doesn't have, ignoring both the possibility that one's state can vary depending on circumstances, as well as the dangers of severe stress that may not yet be burnout (Good, Khairallah & Mintz, 2009; Ledingham, Standen, Skinner & Busch, 2019).

Barriers to Getting Help

Nash and Chapman (2019) uniquely and persuasively illustrated ways in which psychologists may be "... professionally and personally struggling behind masks of competence" (p. 98). How do we create a culture not just self-care but also one that removes the stigma, shame and the negative punitive consequences to encourage psychologists to seek help before significant ethical breach or even a negative impact to care may occur? Addressing these powerful barriers may allow a psychologist, as Nash and Chapman put it, to "be 'seen' as both a competent professional and person struggling through a significant life transition" (p. 105), which may be critically important in terms of seeking support.

Many psychologists may find it difficult to disclose to others due to shame and embarrassment, especially situations that are more societally stigmatizing (Charlemagne-Odle, Harmon, & Maltby, 2014). Other barriers include denial of problems, lack of time, financial concerns (especially among younger psychologists), difficulty finding resources, and concerns about confidentiality (including fears about reputation and professional status; Bearse, McMinn, Seegobin, & Free, 2013; Good, Khairallah, & Mintz, 2009). Finally, fear of being seen by others as incompetent may also prevent psychologists from confiding in other professionals and seeking necessary help (Vierthaler & Elliott, 2020).

Notwithstanding these barriers, many psychologists would agree that therapy would be helpful for them. In a study of 260 psychologists, Bearse et al. (2013) found that while most psychologists have participated in some therapy, the average amount of time since the respondents' last therapy session was almost 13 years. Moreover, almost 60% in this sample said that there were times when therapy would have been helpful but they did not pursue it.

Talking with Colleagues

Despite their area of expertise, psychologists may feel they are not in a position to intervene with colleagues (Smith & Moss, 2009) and may be more likely to report colleagues to governing bodies instead. Why is this the case and how do we facilitate professional outreach? As a profession and articulated in the APA Ethics Code (2017; Standard

1.04), we attempt to resolve issues informally when appropriate, which may include initiating a conversation, coming from a place of a concerned and caring colleague. Reasons that psychologists may not express concerns about a colleague's behavior may include concerns about whether they have enough evidence to raise concerns, questions about their role and obligation in discussing concerns, fear of adverse outcomes, including to themselves or their colleague, and beliefs that the concerning behaviors do not affect the colleague's professional practice (Johnson et al., 2008, 2011).

Conclusion

It goes without saying that we as a profession should encourage, normalize and facilitate accessible ways to seek help for personal problems. This is not just to help and support our fellow colleagues (although this reason alone is sufficient) but also to prevent perhaps avoidable ethical mistakes and potential harm to patients/clients, as well as more dire consequences, including those that may include severe impacts to one's career, such as license removal (Nash & Chapman, 2019). On this latter point, it's important to note that some licensing boards and state psychological associations have voluntary colleague assistance programs for psychologists who are experiencing distress in ways that may impact their practice, although some of the aforementioned barriers may impact use of these types of services (Barnett & Hillard, 2001; Munsey, 2006).

Honest conversations informally, through organized mechanisms such as peer consultation groups, and through publications, about our own struggles may help to normalize these experiences and start critical conversations [see Vierthaler and Elliot (2020) and Nash and Chapman (2019) for informative and powerful examples]. Removing barriers to having difficult conversations and admitting when there are times when personal issues may be having a significant impact on professional practice can allow for compassion, connection, and care, rather than judgment and isolation.

In their eloquent commentary, Good, Khallibrah, and Mintz (2009) highlighted the divide that often prevents us from reaching out to others or even being perceived as open to others seeking help from us. As they note, "...we are all fallible human beings doing the best we can on this journey through life ...We will all experience struggles and impairments over the course of our lives. Wellness and impairment is not an 'Us and Them' issue; rather, it should be viewed as an 'Us and When' issue." (pp. 22-23).

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SOCIETY OF CLINICAL PSYCHOLOGY



DIVISION 12

American Psychological Association

Winter 2023 Diversity Spotlight

Interviewer: Nandini Jhawar, MS

Interviewee: Nita Tewari, PhD



The current spotlight is on Dr. Nita Tewari whose work focuses on Indian American, South Asian, and Asian American mental health. Dr. Tewari received a B.A. in Psychology from the University of California, Irvine (UCI) in 1992. In 2000, she completed her doctoral degree in Counseling Psychology at Southern Illinois University.

Dr. Tewari is a Licensed Clinical Psychologist (CA) who provides psychological and consulting services to young adults, parents and diverse populations in her practice. She currently serves as a Board Member for the Dean's Leadership Council at UCI in the School of Biological Sciences (since 2018), is a Member of Beauty In Grace at Saddleback Memorial Care Hospital, a giving circle dedicated to women's health, and just completed her term as an appointee representing District 2 for the Orange County Mental Health Board. Dr. Tewari began her professional life at UCI, providing individual and group psychotherapy in the student counseling center and teaching Asian American Psychology. Based on her teaching curriculum, Dr. Tewari obtained a book contract and published *Asian American Psychology: Current Perspectives* in 2009.

Since then, she has gone on to contribute multiple book chapters dedicated to multicultural counseling with a focus on Asian Americans clients. One of her latest chapters, published in *Culturally responsive cognitive behavior therapy: Practice and supervision* (2019) highlights cultural and historical factors for South Asian Americans, such as the intersection of identities and cultural-specific concerns, acculturation, bicultural stress, and more. The chapter also provides clinical considerations, such as the therapeutic relationship, advantages and disadvantages of using CBT, and assessment with South Asian American clients.

Her clinical and consulting work with young adults and parents continues to use these culturally sensitive principles to help clients find solution-oriented strategies around specific goals such as choosing the right major or having a healthy relationship. Dr. Tewari has paid particular attention to the rising popularity and presence of social media in our lives and their role in the development of young adults.

She developed the SPACE model of wellbeing to help

teenagers and parents looking to make more intentional use of technology and combat its negative effects on sleep, academics, and social interactions. The model encourages people to examine the Social, Physical, Academic, Cognitive, and Emotional dimensions of how technology and social media affect them. For example, the Emotional dimension refers to using technology to enhance one's mood, resilience, and coping skills.



Nita Tewari, PhD

In light of her multifaceted professional life, and outstanding and needed service, I posed the following five questions to Dr. Tewari.

Given your expertise on race, ethnicity, and culture, with an emphasis on Asian American populations, what are two or three of the most important things that we, as psychologists and researchers, might be able to do to help reduce the mental health disparities that Asian Americans face in this country?

There are three primary methods we can use to reduce disparities: psychoeducation, training, and accessibility. First- and second-generation immigrants will benefit from culturally sensitive psychoeducation on what mental services are, where to receive them, and what to expect, because this is often unknown territory. We need to train more psychologists from every racial, ethnic, and cultural group to pursue research and clinical practice so that we can keep up with continually changing demographics. Lastly, mental health services need to become more accessible, both in terms of availability and affordability.

What led to the development of your wellness model, and how is it used today?

SPACE initially started with the challenges parents and students were facing with excessive use of technology that was permeating overall wellness. The changes were not necessarily reaching clinical levels, but enough such that there were negative changes in interaction, sleep, grades, etc. Parents wanted to know how to set boundaries around social media use, and teens and young adults wanted to talk about digital detoxing and digital impression management. This wellness model was created to help young adults be intentional about aligning their values with this stage of identity development. Considering the five dimensions encourages people to easily do self-assessments and create a personalized plan to use technology as a mind-enhancer, not a time waster.

After COVID-19, we have all become more comfortable using and relying on technology. Given your work with SPACE, what do you think is the future of technology

in psychology?

Technology is here to stay. We must continue to adapt to the ever-evolving digital age in our daily lives, educational system and workplace – mental health apps, ebooks, virtual therapy and so on. However, we must be aware of who are the beneficiaries of tech use given varied levels of knowledge, comfort levels in using technology and individual communication preferences in seeking support and learning. Resourceful communities may benefit through access to technology-based support, while others experiencing disparities may face challenges in using technology, whether access is the issue or whether the tech support is not seen as being user friendly. This is especially so in rural areas without reliable internet access or the lack of resources to purchase devices, computers or software needed to advance one's knowledge of psychology. There is also a huge gap and high frustration level among the aging population in navigating mental health apps to use live chats and seek support as well – so we as psychologists will continue to have opportunities to advance the intersection of technology and psychology. There have been positive technological advancements to enhance treatment outcomes in our field - like virtual reality to treat posttraumatic stress disorder among veterans or train military personnel for high risk and costly performance drills. Artificial Intelligence (AI) is also an emerging area in therapeutic technology. Software for emotion recognition has been developed and bots are being programmed to help minimize loneliness through chat features. I encourage trainees to keep up with technological advances because they will be a part of our future professional work.

You are such a productive clinician, author, and educator, and also find time to serve the community. What tools have you developed to balance so many demands?

Thank you. I have five tools that I have developed to manage my demands. First, I prioritize what I value the most at the developmental stage of my personal and professional life. You cannot do everything all at once, so prioritize what you need in this particular stage of life. I began my career in teaching and therapy in a university setting. Although I found this work to be incredibly fulfilling and rewarding, it did not give me the flexibility I needed as a parent. My second tool, be in control of my own schedule - I found the best way to remain engaged in the field was to be my own boss where I could determine my own projects, publications, and consulting work- not all at once, but over time. My third tool, I have believed in giving back to my community as a second-generation immigrant born in the United States when my parents immigrated from India 52 years ago. I sought out

people who cared about others and wanted to make a difference. I had incredible role models in higher education beginning with my writing professor, Jan Horn at my community college to Dr. Joseph White from the University of California, Irvine as an undergraduate. A fourth tool, staying connected to people; over the decades, I have maintained my educational, professional and social networks, both inside and outside psychology, where I can reach out to receive mentorship or guidance for my areas of interest, growth and development. Last, but not least, my most used tool is that I try to live my life intentionally with adjustment of my work-life balance, developing new goals and purpose each year professionally. Personally, I reevaluate healthy and unhealthy relationships with friends and family. An important driving force for me is to have an anti-stagnation way of life to keep my dopamine levels and desire for constant evolution to stay fired up

Finally, how do you like to spend your spare time?

I do something every week from my SPACE model. I can't do all of it daily, because life happens, but I try and live by my own model for my well-being whether it's spending time with my family, in nature, exercising or cooking farm-to-table gourmet meals

Written by Nandini Jhawar, M.S.

SOCIETY OF
CLINICAL PSYCHOLOGY



DIVISION 12
American Psychological Association

Assistance to Ukrainian psychologists

Marc Hillbrand, PhD



Section 7 of the Society of Clinical Psychology has become involved in providing assistance to Ukrainian psychologists regarding the management of the current mental health crisis in Ukraine. Alex Lupis, Ph.D., a Washington-area psychologist contacted Section 7. He is a US psychologist of Ukrainian descent who has been assisting the Ukrainian Psychological Association in identifying experts willing to provide trainings to Ukrainian psychologists. With the strong support of the executive committee of SCP, Section 7 has identified a number of speakers willing to give talks on a zoom platform to Ukrainian psychologists. US psychologist are following in the footsteps of European psychologists who have provided such trainings to their Ukrainian colleagues in the past year. The topics that have been identified by Ukrainian psychologists as areas in which they are in need of advanced training include the following.

Suicidality.
Bereavement.
Helping people whose loved ones are missing.
Moral injury.
Treating victims of sexual victimization.
Fear of death in the military.
Fear of military deployment.
Treating victims of torture.

The first training is scheduled for the beginning of next year on the topic of moral injury. Of greatest need at the present time are experts on these topics willing to give a one-hour zoom presentation to Ukrainian psychologists. The Ukrainian Psychological Association uses a zoom platform that accommodates an audience of 100 with simultaneous translation. SCP members who are interested in joining this initiative can contact Section 7 at marc.hillbrand@yale.edu.

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The Society of Clinical Psychology (Division 12) has eight sections. To learn more, visit Division 12's section web page:

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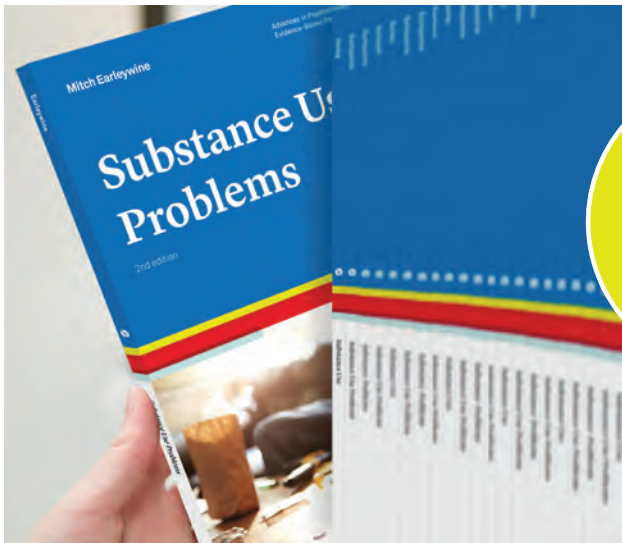
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Advances in Psychotherapy

Evidence-Based Practice

Developed and edited with the support of the Society of Clinical Psychology (APA Division 12), the series provides practical evidence-based guidance on the diagnosis and treatment of the most common disorders seen in clinical practice – and does so in a uniquely reader-friendly manner. A separate strand in the series looking at methods and approaches rather than specific disorders started with the volume on mindfulness. Each book is both a compact how-to reference for use by professional clinicians in their daily work, as well as an ideal educational resource for students and for practice-oriented continuing education.

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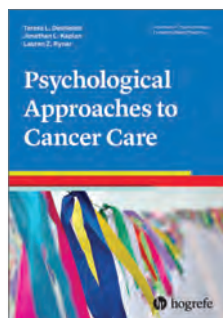


lore m. dickey / Jae A. Puckett

Affirmative Counseling for Transgender and Gender Diverse Clients

Vol. 45, 2023, vi + 104 pp.
ISBN 978-0-88937-513-0
Also available as eBook

This volume presents fundamental and evidence-based information on working with transgender and gender diverse people in mental health services. The authors outline the key qualities of affirming mental health services and explore strategies for improving inclusivity and evidence-based care with trans clients. Current topics, such as working with youth, the harmful and ill-advised approach known as rapid onset gender dysphoria, and whether and how autism might be a co-occurring diagnostic concern are also addressed.

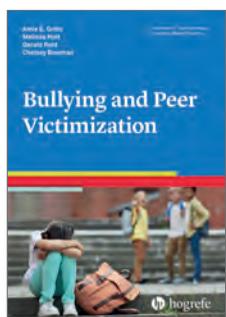


Teresa L. Deshields /
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Psychological Approaches to Cancer Care

Vol. 46, 2023, vi + 86 pp.
ISBN 978-0-88937-511-6
Also available as eBook

This volume provides psychologists, physicians, and other health care providers with practical and evidence-based guidance on the delivery of psychological interventions to patients with cancer. The authors succinctly present the key principles, history, and theoretical models of cancer-related distress, as well as explore clinical assessment and interventions in cancer care. In addition, they look at multidisciplinary care management and complementary supportive interventions.

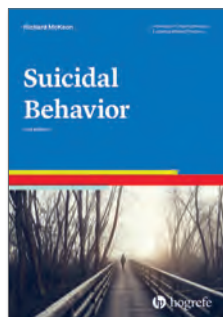


Amie E. Grills / Melissa Holt /
Gerald Reid / Chelsey Bowman

Bullying and Peer Victimization

Vol. 47, 2022, viii + 72 pp.
ISBN 978-0-88937-408-9
Also available as eBook

This volume provides clinicians with clear guidance on how to assess and treat this complex behavior. Practitioners learn about what bullying is, its prevalence, how cyberbullying differs from in-person bullying, and what models are available for understanding how bullying occurs. The reader is guided through the most effective school-based prevention programs that aim to reduce bullying. A clinical vignette gives hands-on insight into how a bullying case in a school is managed.



Richard McKeon

Suicidal Behavior

Vol. 14, 2nd ed. 2022,
viii + 120 pp.
ISBN 978-0-88937-506-2
Also available as eBook

With more than 800,000 deaths worldwide each year, suicide is still one of the leading causes of death throughout the lifespan. The second edition of this volume, incorporates the latest research, showing which empirically supported approaches to assessment, management, and treatment really help those at risk. This book aims to increase clinicians' access to empirically supported interventions for suicidal behavior, with the hope that these methods will become the standard in clinical practice.

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- measure changes in emotions during therapy/ counselling;
- and assist therapists in incorporating an emotional component into their formulations of psychological therapy.

The EPS provides the individual with a series of 25 statements to rate as to their applicability of how they felt or acted during the last week. The EPS uses five subscales (Suppression, Signs of unprocessed emotion, Controllability of emotion, Avoidance, and Emotional experience) to generate a total emotional processing score.

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