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## PRESIDENT'S COLUMN



### Clinical Psychology Meets Today's Top Stories: Pursuing our Work in the Fierce Urgency of Now

Jonathan S. Comer, Ph.D.

 Throughout history, many of psychology's greatest advances and contributions have sprung from strategic efforts to make sense of, and remedy, the most extraordinary and seemingly inconceivable world events of their time. For example, Stanley Milgram initiated his series of obedience experiments just a few months after the start of Adolf Eichmann's war crimes trial. In order to understand the atrocities of the Holocaust and how they could have come to be, Milgram questioned whether it was too simplistic and naïve to adopt a "pure evil" causal explanation. Milgram, instead, wondered whether a more mundane and insidious explanation was at play—that Eichmann and millions of accomplices in the Holocaust might have just been following orders. The classic Milgram experiments went on to help clarify for the field, and for the world, the circumstances under which individuals can feel the most distance from their actions (no matter how heinous those actions may be) and the specific conditions that yield the most fertile ground for harmful coercion.

These days, we live in interesting times, to say the least. Strange days indeed. Recent years have witnessed rapid changes in public policy, societal norms, geopolitical alliances, and acceptable public discourse and rhetoric. Moreover, across the past decade, we've seen dramatic changes, fluctuations, and uncertainty in health care law, widening disparities in access to services and quality education, increasing rates of opioid use and opioid-related fatalities, broadening resource inequity, a worsening immigration crisis, vast disagreements about how to address climate change, an under-resourced veterans health system in need of improvement, expanding concerns about our privacy in the information age, rising rates of death by suicide, and a seeming uptick in mass casualty incidents. These are, of course, just a handful of the modern challenges affecting our world today, but suffice it to say, the problems of our time are heavy and they require the focused input and innovation of experts in human functioning, well-being, dysfunction, and resilience. Indeed, these times call upon us as clinical psychologists to meaningfully participate in cross-disciplinary efforts to address the very human causes and consequences of our transforming world.

Against this backdrop, we have seen a compelling flurry of very timely activity in clinical science, scholarship, practice, and activism focused on understanding and improving the human condition in these extraordinary times. I hope you will join us in Chicago this August for the Annual APA Convention, because, among other topics, our Division 12 Program is specifically showcasing leading activities that are leveraging clinical science and practice to address the psychological toll our modern challenges are taking, particularly on society's most disadvantaged, marginalized, and disenfranchised. For example, Dr. Margaret Sheridan will be presenting a Division 12 invited keynote presentation on what psychological science can tell us about the impact of child separation on mental health, based on her research with Dr. Charles Nelson studying Romanian orphans placed in foster homes versus orphanages. This fascinating work on the placement of children in government institutions versus with families has been increasingly applied in many circles to inform our national conversation about immigration policy and child separations at the border. Other Division 12 invited keynotes at the convention will include Dr. Rosaura Orengo-Aguayo's presentation on her trauma-focused work promoting psychological recovery in Puerto Rico after Hurricane Maria, and Dr. Marc Atkins' presentation on his innovative work engaging with paraprofessionals to better support parenting in underserved communities. Moreover, digital health formats, passive sensors, and remote technologies have been championed as offering key opportunities to improve the reach and scope of mental health care, overcome barriers to service utilization and disparities in treatment access, and offer more ecologically valid assessment and treatment. Dr. David Mohr, a leader in the field of behavioral intervention technologies, will present this year's final Division 12 invited keynote—a thoughtful presentation encouraging us to rethink our approach to digital mental health.

Beyond these four invited keynote presentations, the Division 12 Program at the APA Convention will include expert presentations on a range of other critical topics reflecting many of the unique challenges of our time—including symposium presentations on preventing suicide, moving from anxiety to action on climate issues, socio-contextual factors underlying mental health problems in ethnic, racial, and gender minority populations, improving the quality of mental health assessment in the Veterans Health Administration, recruiting and retaining a more diverse mental health workforce, and navigating difficult dilemmas in global mental health.

Although the seriousness of our modern challenges is daunting, our field's most important developments and paradigm shifts have often arisen in efforts to remedy the significant challenges we face. This year's Division 12 Program at the 2019 APA Convention suggests that our field—as it has in response to so many challenging times before—has already firmly positioned itself as an indispensable part of the solution. It's certainly an extraordinary time to be a clinical psychologist.

I hope you can join us in Chicago this August!



Jonathan S. Comer, Ph.D.  
President, Society of Clinical Psychology



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## Lead Article: Increasing access to evidence-based care in serious mental illness: Embracing mobile technology while minding the digital divide

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 Digital interventions in clinical psychology include a variety of approaches to supplementing or guiding mental health care through web-based or mobile delivery. Advances in functionality of mobile technologies have supported the reach of evidence-based mental health care into people's daily lives. There are hundreds of smartphone apps readily available to help you track your mood, improve your sleep, reduce your anxiety, or connect you to a counselor in your area. Soon, you may even be able to ask Alexa, Amazon's virtual assistant, to find you a therapist in the comfort of your own home (<https://thedifference.co/>). One of the more exciting consequences of these advancements is the opportunity to increase access to care. Many of the leaders in our field, including former APA President Alan Kazdin (Kazdin & Rabbitt, 2013), have made calls to capitalize on cutting edge technologies to achieve this aim. This is clearly a watershed moment for broadening the reach of mental health care.

One population with a lot to gain from increased access to care is people with serious mental illness (SMI), including those with schizophrenia, bipolar disorder, and recurrent major depression. In the US, it is much easier for people with SMI to receive pharmacological interventions than evidence-based behavioral interventions, such as CBT; the majority of people with SMI fail to receive these interventions (Drake, Bond, & Essock, 2009; Mueser et al., 2003). Outside of the systemic obstacles that reduce access to evidence-based treatments broadly, people with SMI face additional challenges related to limited resources (e.g., financial, insurance coverage, transportation) and illness-based factors (e.g., cognitive impairment and reduced motivation/goal-directed behavior), among others. Reduced access to care is problematic given significant evidence that pharmacological interventions

are far from a panacea—ongoing symptoms and rehospitalization are the norm, even when psychotropic medications are taken at recommended dosages (Moeller, Shireman, & Liskow, 2006; Weiden & Olfson, 1995). Most evidence-based behavioral interventions are designed to directly target psychosocial functioning outcomes (e.g., social skills, work/educational support), which are reported as most critical to the clients themselves, while psychotropic medications are most focused on symptom reduction (Kern, Glynn, Horan, & Marder, 2009). It is clear that we can and should be doing a better job of providing adequate care for people with SMI.



**Daniel Fulford, Ph.D.**

Digital interventions may provide an opportunity to increase access to evidence-based care. Smartphone apps (e.g., Ben-Zeev et al., 2014), text messaging (e.g., Granholm et al., 2011), and web-based (e.g., Gottlieb et al., 2013) approaches have all been examined as adjunctive treatments for people with SMI. The typical focus of these interventions is in supporting the implementation of cognitive and behavioral strategies to reduce the impact of distressing symptoms (e.g., hallucinations) in daily life. A review of smartphone app-based approaches in schizophrenia suggests high acceptability and feasibility (Firth & Torous, 2015), though there remains much to be learned given the limited number of existing studies.



**Jasmine Mote, Ph.D.**

There are a few key points we should consider as we move forward in implementation of digital interventions for SMI. One is that we may be violating several assumptions that form the requisite foundation for the success of digital interventions—namely, that our clients will exhibit levels of intrinsic drive and motivation required to repeatedly interact with these often remotely-delivered approaches. A second key point is that limited resources greatly impact access to the technologies themselves. And third: we cannot

ignore the critical need for supportive human interaction when considering the use of these approaches. These three considerations form the foundation of a “digital divide” that may further reduce the potential benefit of such approaches to care. Here we provide a critical assessment of our assumptions when it comes to the promise of digital interventions for people with SMI, as well as considerations for addressing these concerns.

### **Will people with SMI be motivated to use the technology over sustained periods of time?**

Most evidence-based interventions require clients to have sufficient internal drive to follow through with collaboratively identified goals and activities. Homework, for example, is a key activity in any cognitive-behavioral approach to treatment (Kazantis et al., 2016). Without assigning between-session experiential exercises, self-monitoring, or thought challenging, these interventions would be limited to activities addressed in session, typically no more than 45-50 minutes of the week. Further, recall for therapy content is often poor, even one week following the previous therapy session (Gumpert, Williams, & Harvey, 2015; Lee & Harvey, 2015). Any clinician who has implemented cognitive-behavioral interventions knows well that beneficial outcomes are limited when homework is ignored and material from prior sessions is not reviewed or summarized.

The excitement around translation of evidence-based behavioral treatments into digital formats is at least partly derived from the idea that moving instruction for behavioral practice and coping strategies into a device that can be readily accessed will facilitate practice of skills in daily life, when and where they are needed most. For instance, we are more likely to see benefits of practicing good sleep hygiene when clients have access to strategies on their phones or tablets right before bed time. We translate these approaches into the digital domain under the assumption that simply having the exercises and supports available in a user-friendly, aesthetically pleasing format will make them attractive enough for regular use. We all know in practice, however, that is a tenuous assumption at best. This is not only based on evidence suggesting that homework completion rates remain low in traditional, in-person CBT (Helbig & Fehm, 2004), but also based on limited evidence that mobile devices meant to change behavior by themselves create long-term changes without in-person supports (Patel, Ash, & Volpp, 2015). Further, as digital interventions continue to grow in popularity, they also grow in number; one study identified over 1,000 smartphone apps that putatively addressed “depression” based on their description, with less than 25% of those apps classifiable as a mental health app (i.e., addressing self-assessment, symptom monitoring, psychoeducation, psychological therapy, or psychotherapeutic skills training) (Shen et al., 2015). Further, sustained smartphone app usage

in general is low; in the US, approximately 20% of apps that were downloaded in 2015 were only used once (Fried, 2015). Thus, even finding a suitable app that one wants to use over time to address specific mental health needs is a barrier to sustained use.

In SMI in particular, the assumption of sustained, autonomous use may be even more tenuous. Reduced motivation critically limits engagement in daily activities (Foussias & Remington, 2010; Silverstein, 2010). These impairments are present prior to illness onset (Fulford et al., 2013; Schlosser et al., 2014) and persist despite adequate pharmacological intervention (Fervaha, Goussias, Agid, & Remington, 2015). In fact, antipsychotic medications contribute to the subjective experience of worsening drive and motivation for people with schizophrenia (Read & Williams, in press). With this reduced drive come cognitive difficulties, such as problems in working memory and executive function, which result in further challenges to engage in independent goal-directed activities. Cognitive and motivational impairments work reciprocally in SMI to set up additional barriers to engaging in activities that digital interventions necessitate (Gard, Fisher, Garrett, Genevsky, & Vinogradov, 2009). While these difficulties are not insurmountable, people with SMI may require additional support to facilitate engagement that current digital interventions are lacking or not accounting for. Further, these challenges are often most effectively addressed through what can be provided with an in-person intervention, such as encouragement that incentivizes behavior change, teaching skills that improve self-efficacy, or moderating the pace of the intervention (Mote, Grant, & Silverstein, 2018).

It is important to note here that digital intervention research studies always incorporate direct support, typically from research staff who are highly invested in study outcomes. From check-ins by phone or email, to additional in-person meetings, regular contact ensures that participants use the technology and connect its use to meaningful outcomes. Indeed, this support is critical to the success of any digital intervention. That is why it is rather surprising that details of how this support is delivered are rarely provided. Given the well-known impact of non-specific factors on psychotherapy outcomes (e.g., therapeutic alliance; Martin, Garske, & Davis, 2000), it is fair to venture that variability in how human support is provided during a digital intervention may have a significant impact on outcomes. Even when this support is not provided, emotional connection to digital interventions themselves may influence engagement. Indeed, in a recent study of digitally-delivered CBT for people with mood and anxiety symptoms, ratings of emotional connection with the program were associated with logins, frequency of self-monitoring, and number of modules completed (Clarke et al., 2016).

For a population that reports high levels of loneliness

and social isolation, those with SMI may be even more sensitive to this variability in human support. While the evidence is sparse, recent research suggests that not only is a strong therapeutic alliance beneficial for symptom outcomes in people with SMI, but a poor alliance could result in significantly worse outcomes (Goldsmith, Lewis, Dunn, & Bentall, 2015). In consideration of the available evidence, the assumption that people with SMI will show sustained engagement in standalone digital interventions should be carefully examined.

### **Do people with SMI have equal access to digital technology?**

Digital technology is ubiquitous in daily life across the globe. There are roughly three billion smartphone users on earth, with 71.5% penetration in the US (Statista, 2018). Access to the internet (through personal computers or other devices) tops four billion people worldwide. We are a wired world.

But there are clear discrepancies in access to devices and data plans, largely driven by available infrastructure and financial resources. It is important to take a closer look at these discrepancies as we start to consider the utility of digital interventions for people with SMI, who on the whole have limited resources. An encouraging finding is that when people with SMI have access to digital technology, they report finding it useful (Gay, Torous, Joseph, Pandya, & Duckworth, 2016). There is also reported interest in using smartphones to help monitor mental health among people with SMI (Torous et al., 2014). Existing studies, however, may overestimate prevalence of technology use. For example, the Gay et al. (2016) study included a sample of people who self-identified with SMI, and was conducted exclusively online, making access to technology a requirement for participation. This sample was also predominately white, young, and highly engaged in treatment, factors not representative of the majority of people with SMI. A recent study of mobile phone ownership paints a different picture (Torous, Wisniewski, Liu, & Keshavan, 2018). Two groups of participants were surveyed: one from a private clinic, made up mostly of clients with depression and anxiety, and another from a state ran department of mental health, the majority of whom had SMI. In this study, mobile phone ownership was 98% in the private clinic and 85% in the state setting; however, while smartphone ownership was 90% in the private clinic, it was only 67% in the state setting. Another consideration is that these studies may not be representative of people with SMI who are not actively engaged in treatment, a subgroup that one would hope to reach in any endeavor meant to improve access to evidence-based care.

Reduced ownership of, and engagement with, smartphones and other digital technologies may be due to challenges unique to people with SMI. As discussed

above, these could include cognitive impairments, which may pose challenges to smartphone navigation, and negative symptoms such as low motivation, which could reduce engagement and interest in digital technologies. Nonetheless, as mentioned above, there are likely more systemic contributors to reduced technology use among people with SMI. For example, while smartphones are becoming more affordable over time, phone and data plans pose financial barriers to people who do not earn a living wage, of whom those with SMI constitute a considerable proportion. Indeed, a recent study of emergency department users sheds light on the impact of socioeconomic status on mobile device ownership (Kim et al., 2019). In this study, only 24% of those with public insurance owned a smartphone or tablet. Data from the Medical Expenditures Panel Survey showed that 85% of people with schizophrenia were publicly insured (Khaykin, Eaton, Ford, Anthony, & Daumit, 2010). Indeed, a study of 210 veterans with SMI (a population supported by government-funded healthcare) reported smartphone ownership at 30%, a rate well below those reported in other settings (Klee, Stacy, Rosenheck, Harkness, & Tsai, 2016). In concert with the evidence above suggesting people with SMI in public healthcare settings show significantly lower ownership rates, it is becoming clearer that the ubiquity of digital technology has yet to permeate all populations evenly, with limited resources greatly impacting ownership.

The existing data are limited; epidemiological studies should provide more accurate data on ownership of mobile technologies across demographic strata. Additionally, there is currently little-to-no discussion of the support required to train people with SMI on how to use smartphones and other technologies effectively, a topic that becomes increasingly important as these technologies become more affordable over time. Nonetheless, it's clear that a digital divide exists: a substantial proportion of people with SMI do not own smartphones or other devices, and thus have lower access to digital mental health care than other populations in need.

### **Can digital technology circumvent the need for costly face-to-face therapist contact?**

It's safe to say that most practicing clinical psychologists would agree that human interaction is a requirement for effective mental health care. In-person treatment, including manualized protocols, allows for reciprocal communication and individualized adaptations to cater to the specific needs of the client. Current digital interventions do not allow for this level of flexibility in content delivery. And the data, at least to date, would support this assertion—while digital interventions show promise for reducing symptoms such as depression and anxiety, there is limited support for the idea that these are effective as standalone, unguided approaches. Indeed, in a recent network meta-analysis allowing for

direct comparison of multiple treatment approaches simultaneously, Cuijpers and colleagues (2019) showed that while individual, group, telephone, and guided self-help CBT were all equally effective for treating depression, unguided CBT was no better than usual care. Additionally, both guided and unguided self-help CBT had the highest dropout rates, suggesting limited acceptability of these approaches relative to those involving more human interaction. These findings suggest that human support confers benefits for mental health care that self-help approaches (viz. independent engagement with digital therapies) cannot.

We are unaware of any studies that have looked at the relative benefit of human interaction in the context of digital interventions for SMI specifically. One recent study examined clinic-based service use for three months before, during, and after exposure to a smartphone intervention for schizophrenia (Ben-Zeev, Buck, Hallgren, & Drake, 2019). Those who responded to the smartphone intervention (i.e., showed improved recovery outcomes) reduced their in-person service use more so than those who did not respond. While these findings might suggest that digital interventions could reduce the need for costly face-to-face services, they cannot rule out the strong possibility that those who are more engaged in digital interventions also require less face-to-face support. The findings also do not suggest that digital interventions can replace in-person services for SMI—those in the smartphone intervention as a whole continued to use such services roughly two hours per week in the three months post-intervention.

A critical consideration regarding the importance of human contact in the context of digital interventions is that people with SMI are often lonely and isolated. People with schizophrenia report significantly higher levels of loneliness than the general population (Eglist, Palmer, A'verria, Tu, & Jeste, 2018). They also list improving relationships as a critical treatment goal (Auslander & Jeste, 2002). Given the relatively limited social experiences of people with SMI, human interaction may confer even more benefit to outcomes in this population than for those with other diagnoses. While digital interventions can promote social engagement online, other strategies not involving direct intervention (e.g., providing people with smartphones and/or internet access) may also provide forms of social support (e.g., access to social media, web forums dedicated to connecting people with mutual interests). Nonetheless, online social engagement may not be sufficient for reducing loneliness in people with SMI. For example, a dating app or a social media platform may provide opportunities for a person with SMI to make new social contacts, but in-person support may still be necessary to help that person engage with those forums in a sustained and productive manner.

In addition to the above considerations, an important

question remains regarding the extent to which digital interventions can reduce costs associated with face-to-face services. The field of mobile and electronic health as a whole is still mostly comprised of small studies in specialized areas, with limited methodological rigor (i.e., few randomized-controlled trials). Only a handful of cost-effectiveness studies have been completed. Recent reviews of cost-effectiveness of telehealth, mobile health, and other approaches, across a variety of health conditions, were mostly inconclusive, primarily given a dearth of available studies (Iribarren, Cato, Falzon, & Stone, 2017; Marcolino et al., 2018). More critically, we could not identify any available studies examining the cost-effectiveness of mobile and electronic approaches to care for people with SMI. In the study reported above showing a reduction in in-person service use related to engagement in a smartphone intervention in SMI, impacts on healthcare costs were not reported (Ben-Zeev et al., 2019). Nonetheless, even a small reduction in in-person services, when applied across a large group of people, could have a significant impact on healthcare expenditures. As such, the jury is still out as to whether digital interventions actually reduce healthcare costs, especially when it comes to treatment for SMI.

In sum, the available evidence does not support advocating for the replacement of trained clinicians with smartphone apps or other digital approaches to care for people with SMI (or any other condition, for that matter). Furthermore, while evidence for the benefit of digital interventions in SMI is accumulating, we firmly believe that such approaches will never replace the benefit of training clinicians in evidence-based interventions for the majority of people with SMI, given the needs of this population.

### **Acknowledging assumptions and moving forward: Embracing digital technology as a bridge to human-supported evidence-based care in SMI**

Research on digital interventions in SMI is growing at a rapid pace, yet remains in its infancy. There is so much promise—pocket-sized smartphones have more computing power than massive machines did a very short time ago, allowing us to deliver active ingredients of evidence-based interventions at the palm of one's hand. While the promise is evident, we hope our commentary will serve to draw attention to some key considerations when evaluating the extent to which digital interventions can close the research-practice gap in mental health care for SMI. We have focused on illness characteristics that might serve as barriers to engagement, issues of access due to limited resources, and the pitfalls of relying solely on digital approaches to provide evidence-based care. Now that we have acknowledged the importance of such considerations, we can shift focus to the exciting ways digital technology can make a difference in the lives of people with SMI.



As we discussed above, motivational impairments and others illness features that could limit engagement in digital interventions pose a challenge to most approaches to mental health care in SMI. However, exciting advances in virtual reality, augmented reality, and other “gamification” of evidence-based care could help increase engagement by making digital interventions more dynamic, personalized, and rewarding (Khazaal, Favrod, Sort, Borgeat, & Bouchard, 2018; Rus-Calafell, Garety, Sason, Craig, & Valmaggia, 2017). Targeting self-efficacy through the use of “missions” to achieve, or challenges to overcome, in the context of a gaming environment could serve to enhance intrinsic motivation for care. These approaches have been used to address social skills (e.g., Adery et al., 2018), improve physical activity (e.g., Leutwyler, Hubbard, Cooper, & Dowling, 2015), promote vocational rehabilitation (e.g., Bell, Laws, Pittman, & Johannesen, 2018), and increase engagement in cognitive remediation (e.g., Mahncke et al., 2019) in people with SMI. Despite this promise, the majority of these approaches are developed and tested in controlled environments. Implementation of these and other paradigms using mobile devices is an exciting direction to help promote engagement with digital interventions that can address an array of concerns for people with SMI.

As with developing any psychosocial intervention or smartphone app, an evidence-based approach that incorporates consumer input is integral to success. As digital health interventions remain novel, there remains a paucity of evidence not only for their effectiveness, but in evidence-based approaches towards their development, implementation, and dissemination (Kumar et al., 2013). Eliciting user feedback at various stages of digital intervention development (e.g., prior to design, usability testing) can help address potential motivational facilitators and barriers. For example, consumers with SMI may suggest that a simplified user interface with large text may promote more use of an app than one that is more aesthetically pleasing, but harder to read or comprehend. Researchers should continue to develop, test, and use evidence-based frameworks to design and evaluate new interventions with consumer (and other stakeholder, e.g., family member) input. The creation of a strong evidence base for digital interventions should be prioritized over the constant churning out of newer, “fancier” apps that compete with previous iterations.

While there appears to be a current digital divide when it comes to accessing certain technologies among those with SMI, there is growing evidence that simple digital approaches can have impact. For example, telehealth—the remote delivery of care through telecommunications technologies (viz. audio and/or video)—can address reduced access that occurs from transportation barriers, or limitations in trained

providers in geographic regions. Common applications include delivery of care at rural clinics with access to an internet-enabled computer, or delivery by phone call and/or video in the home for those with such access. The Veterans Affairs has implemented telehealth services for mental health care for several years, with documented evidence of success. Recent examples include the positive impact of telehealth programs on hospitalization for veterans with schizophrenia (Flaherty, Daniels, Luther, Haas, & Kasckow, 2017; Pratt, Naslund, Wolfe, Santos, & Bartels, 2015).

Another successful approach has been to use text messaging as an adjunct to evidence-based care. Granholm and colleagues (2011) reported on the impact of a text-messaging intervention for reducing symptoms and improving sociability in people with schizophrenia. In this study, social interactions increased, while the severity of hallucinations was reduced. Text messages do not require smartphone capability, and thus circumvent problems of reduced access due to financial requirements of costly data plans. Further, for those with smartphone access and/or as technology advances, text message support can become increasingly individualized. For example, if a person responds to an online survey that they are experiencing symptoms of paranoia, an automated text message could be generated including a list of coping strategies that have worked for that person in the past.

Focus on digital interventions should not divert attention away from policies that can address the multiple systemic obstacles of obtaining evidence-based care (homelessness, incarceration, affordability of health care, differences in urban versus rural access to care). As the writer and activist Soraya Chemaly said, “Self-help, different from self-efficacy, is frequently what you do when you aren’t getting the help you need from your society” (Chemaly, 2018, p. xxiii); however, as long as these systemic issues remain a reality, digital health initiatives remain an important treatment modality.

From a public health perspective, we could improve access to digital devices through other means. For example, waivers for smartphones with data plans and/or vouchers for internet access would provide the necessary methods to disseminate important digital interventions to those in need. Additionally, publicly available technology literacy courses or resources, possibly provided in traditional mental health care settings or through mental health advocacy groups by volunteers, would improve the efficacy of digital interventions not just for people with SMI, but for anyone who has difficulty keeping up with the rapid pace of evolving technologies (e.g., the aging population, those with cognitive difficulties). Currently, people experiencing incarceration are provided little-to-no access to digital technology and the quality of evidence-

based mental health care administered in these settings is universally poor (Roth, 2018). Providing such access in a safe, strategic, and supervised manner could vastly improve mental health care to arguably the largest and most vulnerable population of people with SMI in the US. However, these proposed initiatives should be included in larger policies that address the systemic barriers to access to all evidence-based mental health treatment. It should not be the goal to create a future where digital interventions are broadly accessible, while only the privileged and wealthy retain the ability to seek in-person care (Bowles, 2019).

There are also in-person/digital hybrid interventions that can meet some of the needs described above and improve access to evidence-based care. For example, computer-based CBT for psychosis, facilitated by clinical helpers (i.e., nonprofessionals), can be delivered in the context of regular care. Gottlieb and colleagues (2013) developed a self-paced, web-based CBT program to address positive symptoms of psychosis. This program was delivered in a clinical setting and facilitated by a non-clinician proctor who was available to help set up the program, check in on progress/provide technical support, and review exercises completed between sessions. In the randomized controlled trial of this program (Gottlieb et al., 2017), people receiving web-based CBT showed larger improvements in social functioning than those in usual care alone. Another example of this hybrid approach involves a study of coordinated technology-delivered treatment for people with SMI (Brunette et al., 2016). In this program, consumers were offered a variety of options for relapse prevention, including a smartphone intervention, a daily support website, a medication decision support system, and a web-based CBT for psychosis program in the context of ongoing clinical care. Outcomes of this program have

yet to be published. Nonetheless, implementation of the program supports the potential feasibility for such an approach to integrating digital interventions into the usual care context, potentially supplementing the delivery of evidence-based approaches to care for people with SMI.

While we do not believe that digital interventions can or should be used as one-size-fits-all replacements to traditional in-person treatment, training clinicians on how to incorporate these technologies in their practice is necessary in our increasingly wired world. While clinicians with full caseloads should not be responsible for knowing every single available smartphone app that addresses psychological concerns, some baseline knowledge would help support clients to address multiple barriers they may face in accessing or using these technologies. For example, a therapist who wants to incorporate mindfulness meditation in her practice may find it useful to introduce and show clients how to use apps that can remind and monitor meditation use outside of session. Alternatively, if a client with SMI wants help dating or making new friends, it would be useful for a therapist to be familiar with social connection and dating apps, including potential barriers of use for a particular client. Similar to previous calls for an increased focus on training future clinical psychologists to work with people with SMI (Mueser et al., 2013), trainees should also have access to information on the use and evaluation of digital interventions in addressing concerns for in this population.

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# Ethics Column: Uncertainty and Avoidance: Practical and Ethical Challenges in Clinical Record-keeping

Adam Fried, Ph.D.

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 Record-keeping, including maintaining client/patient records, is an essential yet often overlooked aspect of clinical practice. Record-keeping can have enormous legal and ethical implications, both for practitioners and for clients/patients. Aside from privacy and security<sup>1</sup>, there are other aspects of client/patient record-keeping that can be a source of confusion that can create difficult ethical situations. For example, confusion among clinicians about what to include in records can create avoidance behaviors, resulting in either failing to maintain adequate records, resulting in potentially serious ethical and legal consequences. This column will focus on practical challenges experienced by psychologists, tips about creating practical and ethical processes, and feature an interview with Maelisa Hall, Psy.D., Licensed Psychologist and Owner of QA Prep, who works with clinicians on creating effective practices surrounding record-keeping.

## Challenges Related to Note Keeping

Record keeping is informed by multiple entities, including professional organizations (e.g., APA Ethics Code, 2017), state laws and federal regulations such as HIPAA, and organizational rules (Fisher, 2012). Although the APA Ethics Code (2017) includes some guidance as to some of the goals of record-keeping in its standards (e.g., 6.01 Documentation of Professional and Scientific Work and Maintenance of Records; 6.02 Maintenance, Dissemination and Disposal of Confidential Records of Professional and Scientific Work), such as facilitating continuity of care, it does not necessarily dictate the exact contents of what should be in clinical notes<sup>2</sup>. As such, the psychologist makes a final determination as to what is important to include.

As Hall explains, record-keeping and note-taking are not usually covered in graduate school and, therefore, clinicians are not taught how to write a note or what purpose they serve, leading to confusion about what information is necessary or even recommended to include in our notes. “Our ethical guidelines outline reasons for documentation (such as facilitating provision of services later by ourselves or other professionals) but don’t give specifics about what to put in a note. Therefore, many of us are left to our own devices, relying on trainings we received early in our career at an agency or on templates from our first supervisors.”

The consequence of this uncertainty, Hall argues, is that many people end up avoiding writing notes, which can lead to potentially serious ethical and legal breaches. “Many mental health clinicians tell me they avoid writing notes because they are not sure what to write and so the task of writing notes for a day’s worth of clients takes them hours. They agonize over how to explain something that happened in session and whether or not they are writing the ‘correct’ information.”

Another challenge Hall finds commonly reported by therapists has to do with failing to adequately schedule time for record-keeping. She explained that this seemingly minor time management issue can snowball into a potentially serious situation. “While this is more of an administrative issue, it can quickly become a clinical issue when a psychologist gets weeks or months behind in notes. Many clinicians are ashamed of dealing with this issue which makes reaching out for help difficult. However, it is a very common issue in our profession.”

## Practical Solutions

Despite the significant challenges of record-keeping, Hall has some recommendations for clinicians who struggle with the content and process of note-writing and record-keeping:

1. **Create Meaningful Notes.** Specific recommendations about records and note-taking for practitioners may be found in a number of sources, including APA Record Keeping Guidelines (2007), journal articles (e.g., Drogin, Connell, Foote, & Sturm, 2010), and on Hall’s website ([www.qaprep.com](http://www.qaprep.com)). The main goal for notes, Hall argues, is that they be purposeful. “Meaningful does not equal long or short notes. Meaningful notes are those that are individualized to your client. For example, you list the interventions you did in a session but also how they applied to this specific client, how the client responded to the intervention, and why you chose to use that intervention.” Maintaining records serves a number of purposes, including compliance with laws and regulations and facilitating care with other professionals. In addition, Hall argues that creating meaningful records can improve the services we provide and help our clients/patients, especially when treatment may not be progressing as planned. “Going back and reading through notes from the beginning of treatment is one of the best ways to identify patterns we may have missed week by week, or to provide concrete examples of progress to our clients when they are feeling discouraged about treatment.”

2. **Create a Process and Schedule for Writing.** Aside from content, the other major impediment to record-keeping is time management. Therefore, it is important to find a process and schedule that works best for you. Hall argues that there isn’t necessarily a “right” way to do this; for some, writing a note immediately after an

encounter may work best, but for others, completing notes at the end of a work day may be more effective. She suggests that clinicians “play around with what time of day works best for you. Everyone will need a slightly different schedule, and it is unlikely that most clinicians can write their notes between sessions. Very few people are able to do this, so create a plan that is realistic rather than idealistic.”

3. Avoid the Trap of “Quick Notes”. In her work, Hall has found that instead of completing a full note after an encounter or at the end of the day, some clinicians will jot down some salient details of the encounter to serve as a reminder for when the clinician completes the full note at a later date. She argues that this practice, which she calls “quick notes,” can create later difficulties. “The problem is that these notes quickly become a crutch and provide a false sense of security. Clinicians are less likely to make writing the note a priority because they feel confident they can do it any time with the help of their quick notes. However, they are relying on these ‘quick notes’ more and more with each day because their memory is fading much more than they anticipate. Most clinicians look at their quick notes weeks or months later and realize they do not have the information they need to write a sufficient note.” In addition, Hall argues that these “quick notes” can quickly build and create avoidance due to the overwhelming nature of the work. “This process can also act as a de-motivator, because the clinician looks at the notes in the notepad piling up and feels like catching up will be too time consuming. Therefore, they never begin the task and catching up starts to feel overwhelming.”

4. Consider Incorporating Collaborative Documentation Practices. Collaborative note-taking practices usually include summarizing with the client at the end of an encounter the important points covered in the session, documenting progress and discussing immediate and long-term goals. Hall suggests that collaborative note-taking has several benefits, including increasing involvement of the client/patient, increasing transparency, and can help providers change how they think about notes; rather than a task that consumes valuable time and is seen solely as a requirement of our licensing board, these notes can facilitate treatment progress. Hall explains, “Collaborative documentation is a great way to save time on writing notes, but more importantly, it is a great way to ensure you and your client are on the same page with how treatment is progressing.” Some may incorrectly believe that collaborative implies that the client is dictating the note or has the final say on what goes into the record. It’s important to remember that the clinician retains the responsibility for the notes. Hall provides some clarification on this point: “In this process the clinician asks the client for input, but the clinician is still the one determining what goes in the note.” While this may not be appropriate for all clients,

Hall argues that there are many reasons to consider implementing this practice. “There is a lot of research showing that collaborative documentation enhances therapeutic rapport and motivates clients to be more involved in therapy. Many clients also note that it feels empowering to have access and increased knowledge about their documentation, so the process usually has very positive outcomes for both client and clinician.”

### Documentation of Significant Events and Interactions

As a final note on record-keeping, it’s important to remember that documentation is not just for service encounters, but can be critically important for noting unusual interactions and significant events (Knapp & VandeCreek, 2012), including:

- If a client/patient has made a sexual advance or an inappropriate sexual comment
- Unanticipated out-of-office encounters that may have involved a questionable interaction (such as a potential breach of confidentiality)
- Rationales for sessions that occur on off-times, such as late at night or on the weekends
- Repeated non-compliance with recommendations
- Dangerous behaviors
- Unusual phone or email correspondence

Documentation may be an important defense against claims of malfeasance, especially against claims of multiple relationships (Fisher, 2017).



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## SCP Member Spotlight on Dr. Marvin Goldfried

 Dr. Marvin (Marv) Goldfried is Past President of SCP and distinguished member whose career has been dedicated to helping close the science-practice gap.

Dr. Goldfried's remarkable work exemplifies the integration of research and practice, and his leadership in SCP, Division 29, and beyond have led to advancements in clinical psychology. Dr. Goldfried was recognized for his remarkable achievements when he was awarded the 2018 APA/APF Gold Medal Award for Life Achievement in the Application of Psychology. We had the opportunity to learn more about Dr. Goldfried through our Q&A correspondence. Read on to learn more!

### Could you provide an overview of your work in Clinical Psychology?

Ever since graduate school, I had been concerned about the gap between research and practice. Many of the readings on projective techniques and psychotherapy were based on impression, not evidence. Consequently, some of my early research involved the investigation of whether conclusions drawn from projective techniques had any empirical validity. When I arrived at Stony Brook University in 1964 to assist in developing our behavior therapy program, the outlook of the program fit very nicely with my interest in evidence-based clinical work. We developed a postdoctoral program in behavior therapy, and then developed our graduate program. Although starting with behavior therapy, it soon became apparent that cognition played an important role in intervention, and my research moved in that direction.

My research program over the years has involved the following: (1) Outcome research on the use of behavior therapy and cognitive behavior therapy (CBT) in treating anxiety disorders; (2) Psychotherapy process research to determine the common and unique processes associated with change in CBT and psychodynamic-interpersonal interventions; (3) Research and reviews on psychotherapy integration; and (4) Research on mediators and moderators associated with psychological problems among sexual minorities.

Having been trained in a psychodynamic approach during graduate school, my teaching and research on CBT soon led me to become interested in common principles of change. This has been a theme in my research, teaching, supervision and clinical work since the 1980s. As an extension of this, and together

with several other colleagues (i.e., James Boswell, Louis Castonguay, Mike Constantino, Catherine Eubanks, Jessica Schleider, and Alex Vaz), I am currently devoting my efforts to having the field of psychotherapy work on developing a consensus. After more than 100 years of psychotherapy, the clinical and research question I believe we now need to ask is: "On what can we--both clinicians and researchers--agree, despite our varying theoretical orientations?"



**Marvin Goldfried, Ph.D.**

### Where did you complete your training?

I received my doctorate from the University of Buffalo in the 1950s, at a point in which behavior therapy had not quite emerged on the professional scene. I was interested in closing the gap between research and practice even as a graduate student, and a summer internship at the VA hospital in Palo Alto California was transformative. At the time, behavior therapy was just developing in the U.S., and work was also being conducted on the development of family therapy. This all occurred in the psychology building, where I had my office. Being a graduate student witnessing these emerging approaches most likely helped me to think outside the box.

### What is your current position/occupation?

I am a Distinguished Professor of Psychology, working within the clinical area, and I have been at Stony Brook for over 50 years. I was there even before there was a "there" there. Most of my teaching has been at the graduate level, and I am both fortunate and proud to have had many of the current leaders in clinical psychology as students in my therapy classes, and as clinical supervisees in our clinic. In addition to my teaching, writing, research, and supervision, I have also maintained a limited practice of therapy in New York City.

### How long have you been a member of SCP? What roles have you held in SCP?

I've been a member of SCP for over 50 years and in my early days, was fortunate to serve as a Contributing Editor to the SCP newsletter. Much of what I wrote



about centered around the need to close the gap between research and practice.

I have also served as President of SCP and in collaboration with the Society for the Advancement of Psychotherapy (Division 29), my presidential initiative for both societies involved developing a collaboration, with the goal of closing the research–practice gap. It was The Two-Way Bridge Between Research and Practice initiative, in which the goal was to have practicing therapists disseminate their clinical observations to researchers in instances where empirically supported treatments did not always work. The goal of this initiative was to present clinical practice as the context of the discovery, so that researchers could investigate clinical issues that improve clinical intervention and meet the needs of practitioners. More about this can be found at: <https://www.stonybrook.edu/two-way-bridge/>

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

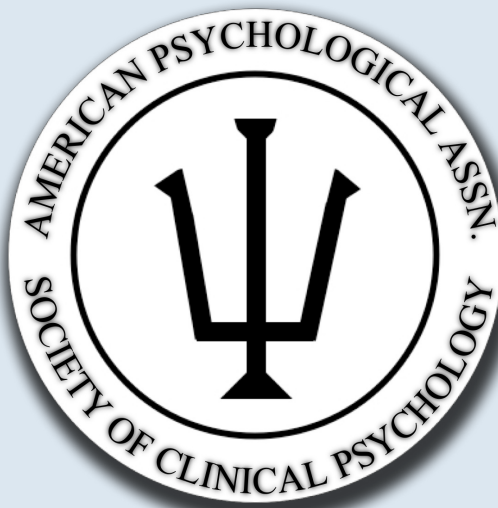
In addition to serving as SCP President, I have served as President of Division 29 (the Society for the Advancement of Psychotherapy) and President of the Society for Psychotherapy Research (SPR). I am also a Co-Founder of the Society for the Exploration of Psychotherapy Integration (SEPI), Founder of AFFIRM: Psychologists Affirming their LGBT family, and Founder of the Journal of Clinical Psychology: In Session, a journal that bridges the divide between researchers and practice, as well as the gap that existed across different therapeutic orientations, by including clinical guidelines, case illustrations, and summaries of relevant research findings that were written specifically

for practicing therapists. .

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

The field of psychotherapy has been in existence for over 100 years, and we have yet to reach the point of being what sociologists of science have called a “mature” science. There are numerous problems that keep us from moving forward, including the gap between research and practice, competing schools of thought, and the failure to build upon past research. We very much need to stop spinning our wheels and get our act together, especially since the emphasis on research funding has moved toward biological psychiatry rather than funding for psychotherapy. What holds us back and how we need to overcome these obstacles is spelled out in a forthcoming article to appear in the American Psychologist entitled “Obtaining Consensus in Psychotherapy: What Holds Us Back?” [https://www.stonybrook.edu/commcms/psychology/\\_pdfs/clinical/Goldfried%20AP%20Consensus.pdf](https://www.stonybrook.edu/commcms/psychology/_pdfs/clinical/Goldfried%20AP%20Consensus.pdf)

With some apprehension, I have also just begun to use Twitter to describe the obstacles toward obtaining a consensus in psychotherapy, and to communicate what we need to do to become a more mature science. More information can be found at @GoldfriedMarvin.



## Diversity Spotlight

**Randy Salekin, Ph.D.**  
*University of Alabama*



This Diversity Spotlight is dedicated to honoring Dr. Kalyani Gopal for her grassroots efforts to raise awareness about human trafficking and change the way people who are exploited by human traffickers are treated. At present, Dr. Gopal is President-Elect of the Illinois Psychological Association and Member of the National Register of Health Service Providers in Psychology. She is also on the Board of Directors for APA, Society for Clinical Psychology, and Past President of Section IV, D12, APA, and Clinical Psychology of Women. Furthermore, Dr. Gopal is, of course, founder and CEO of the SAFE Coalition for Human Rights, which has its Headquarters in Indiana. Most recently Dr. Gopal is the recipient of the Top 20 Woman of Global Excellence.

People are missing all over the world, including 800,000 missing children in the USA. Human trafficking is a multi-billion dollar industry that may account for these missing individuals, and Dr. Gopal is working to alleviate this problem. Indeed, she is a leader in bringing awareness to the global problem of human trafficking and has written two books on this issue. Dr. Gopal became interested in understanding human and sex trafficking through her work with children in foster care; she learned of high rates of missing children and, like many people (including psychologists) at the time, assumed they were running away from home. She described her increasing concern that these children may be disappearing, rather than running away, as stemming from a call she received from a Chicago payphone late at night. The call gave her pause and she later reflected that “if only we had known more about trafficking at the time,” we might not have assumed that these kids were running away. Dr. Gopal became more concerned that society was not noticing these children and that something needed to be done; she believed that she could do more personally to help children who might be disappearing into a human trafficking ring. For her efforts, Dr. Gopal received the distinguished honor of being named one of the Top 20 Global Women of Excellence on International Women’s Day by the United States Congress and Multiethnic Task Force.

Psychologists and other mental health professionals, including Dr. Gopal in earlier days, often feel most comfortable within their own clinics. However, Dr. Gopal stresses that it is important for clinicians to get out onto the streets and into community settings in order to affect change. Dr. Gopal first became well known through her clinical work with foster children in her community and then the word spread. Her work with a few children, led to others learning about her clinical work and referring additional children and families.

Eventually, people became aware that Dr. Gopal was helping children who had been sex-trafficked.

Part of Dr. Gopal’s dedicated work is aimed at better understanding children who have been traumatized in order to more effectively provide care. Many of the kids that Dr. Gopal (and others) works with are diagnosed with Bipolar Disorder and other types of mood conditions; however, their symptoms are usually better characterized as a reaction to what has happened to them and the psychological problems and syndromes are often not recognized in context. Dr. Gopal is attempting to educate clinicians about the ways in which these conditions can be more accurately and properly assessed. She states “there needs to be more information on the psychology of girls and boys who are trafficked and what they will have to face as they try to recover.” When Dr. Gopal was starting out with her efforts she recalls bringing four girls to a conference where they were to speak for the first time in an academic setting about being exposed to trafficking. Only six people showed up to the symposium. Dr. Gopal reflects that this was surprising for them - the girls had all gone out and bought outfits and prepared for the symposium. However, because of the steady work of Dr. Gopal and others like her, so much has changed since then. There is less marginalization and greater inclusion of survivors. There is now a conference called SAFE COALITION Global Conference on Human Trafficking, which was the first to broadcast in 10 countries; presenters from 73 countries were represented at last year’s conference. Dr. Gopal and her colleagues are currently planning for their 4th conference (November 3-6th, in Chicago) and the United Nations, the roundtable of Consulate Generals, Ministers of Interior and Gender, Directors of Anti-Trafficking, and Heads of anti-trafficking police are all slated to attend.

On March 5, 2014, Dr. Gopal, with little-to-no knowledge about nonprofits, set out to start her own nonprofit organization called the “Safe Coalition for Human Rights (SAFECHR);” in December of 2014, she and her group achieved this goal. Dr. Gopal has a strong mission to protect these victims, primarily girls, from having to keep re-telling their stories; instead, she believes that people should be putting forth an effort to help those who have been caught up in sex trafficking. She believes in a community approach, but also that we need science and an infrastructure to help. And, also that the victims are the experts and that we need to have an interchange rather than assuming that the psychologists know everything – survivors are the “experienced (experiential) experts.” In 2014, Dr. Gopal started the APA symposium conference topic on human trafficking, where this issue is discussed and there is an opportunity for the voices of victims to be heard. From her grassroots efforts, Dr. Gopal is now training people all over the globe in evidence-based

practice for youth and adults who have been trafficked or exposed in some way to human trade. That Dr. Gopal was one of the individuals chosen for The Top 20 Global Women of Excellence is of no surprise. The women who receive this award are referred to as “trail blazers in their respective fields.” They are also women who “through indignation, passion, emotion, and anger spark real change in the world around them.” All these descriptors define Dr. Gopal and her amazing work with children in need. The award was delivered on International Women’s Day for Dr. Gopal’s “accelerated and exceptional efforts.” Division 12 is very honored and impressed to have Dr. Gopal.

In closing, Dr. Gopal is building a village for holistic and evidence-based residential trauma treatment for kids who have been trafficked. She is hoping to be able to house 100 children and trafficked women. Dr. Gopal will need to raise 7 million dollars to build the facility, but she plans to do this and is moving forward at full speed. This initiative may have been sparked from her work on internship at New York’s Children’s Village, the oldest in the USA, where she developed some of her first treatment manuals for children who had been sexually abused. Dr. Gopal is continuing to work on and develop treatment manuals and trainer curriculum to set standards to disseminate and implement. She

has already disseminated some of the trainings to 9 countries (e.g., UK, Myanmar, Nigeria, Kenya, Uganda, Germany, Tunisia, India, and the US). It is clear that Dr. Gopal is a TRUE trail blazer whose passion, indignation, and exceptional efforts will undoubtedly continue to fuel her important work.



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- 1.1 Terminology
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- 1.3 Epidemiology
- 1.4 Course and Prognosis
- 1.5 Differential Diagnosis
- 1.6 Comorbidities
- 1.7 Diagnostic Procedures and Documentation

### 2 Theories and Models of the Disorder

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### 5 Case Vignette; Further Reading; References

### 6 Appendix: Tools and Resources

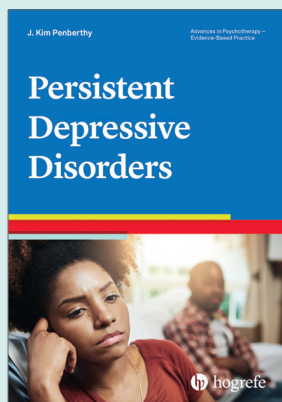
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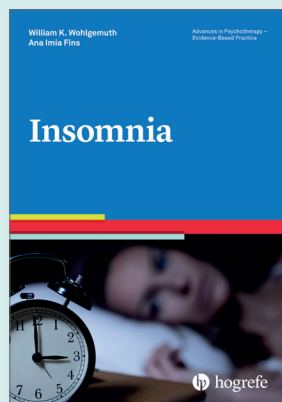
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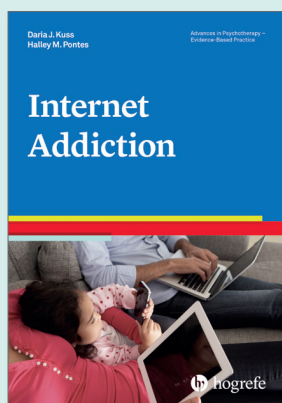
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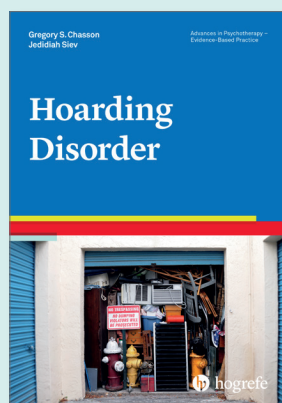
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