

**PETITION FOR THE RECOGNITION OF A  
SPECIALTY IN PROFESSIONAL PSYCHOLOGY**

Name of Proposed Specialty: **Clinical Health Psychology**

Please check one:

☐

Petition for Initial Recognition

☒

Petition for Renewal of Recognition

# Clinical Health Psychology Specialty Renewal Petition 2025

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**Criterion I. Administrative Organizations.** The proposed specialty is represented by a specialty council or one or more organizations that provide systems and structures sufficient to assure the organized development of the specialty.

*Commentary: The evolution of a specialty generally proceeds from networks of psychologists interested in the area to the eventual establishment of organized administrative bodies which carry out specific responsibilities for the specialty and its practitioners. These responsibilities include governance structures which meet regularly to review and further describe the specialty and appropriate policies for education and training in the specialty*

**1. Please provide the following information for the organization or specialty council submitting the petition:**

Name of organization or specialty council:

This specialty petition is being submitted by the **Clinical Health Psychology Specialty Council (CHPSC)**, which is composed of key stakeholders representing the educational, training and practice aspects of the clinical health psychology specialty. The Chair of the CHPSC and representatives from all core CHPSC member organizations participated in the preparation of this application.

This renewal petition was drafted by a team coordinated by the **Society for Health Psychology**, with the approval and participation of CHPSC.

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**2. Please provide the following information for the President, Chair, or representative of the organization or specialty council submitting the petition:**

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**3. Please provide the following information for the organization or specialty council submitting the petition:**

Year founded? 2014

Incorporated? No

State incorporated: n/a

Describe the **purpose and objectives** of the administrative organization or specialty council submitting the petition.

This specialty petition is being submitted by the Clinical Health Psychology Specialty Council (CHPSC). The CHPSC is composed of key stakeholders representing the educational, training and practice aspects of the CHP specialty. The purpose of the Specialty Council is:

1. To represent all major stakeholders of the specialty of clinical health psychology and facilitate communication with the Council of Specialties in Professional Psychology (CoS), APA Commission on Accreditation, other professional organizations, and to the general public;
2. To promote quality assurance of education, training, credentialing, and practice in clinical health psychology;
3. To assure education and training guidelines relevant to the specialty of clinical health psychology are maintained;
4. To assure that clinical health psychology specialty recognition is maintained; and
5. To provide a bi-annual report to CoS about activities of the Clinical Health Psychology Specialty Council.

Member organizations of the CHPSC include the following: **Society for Health Psychology** (SfHP; APA Division 38), the **Council of Clinical Health Psychology Training Programs** (CCHPTP), the **American Board of Clinical Health Psychology** (ABCHP), the **American Academy of Clinical Health Psychology** (AACHP), the **Association of Psychologists in Academic Health Centers** (APAHC) and **Section of Health Psychology** (Society of Counseling Psychology, APA Division 17). Member organizations appoint representatives to serve on the specialty council for a three-year term and may serve a maximum of two consecutive three-year terms. The CHPSC chair is elected for a three-year term by member organization representatives and may be re-elected for a second three-year term.

Further information about each of the Specialty Council's core member organizations is

given below:

- The **Society for Health Psychology** seeks to improve the lives of individuals and society by promoting health, preventing illness, and improving health care through research, practice, education, training, and advocacy. The mission of SfHP is to: a) Advance psychology's role in understanding health and illness through research and integrating biomedical and psychological knowledge; b) Promote education and services in health psychology; and c) Inform the psychological, biomedical, and general communities about current research and service activities.
  - Additional SfHP purpose and objectives available at: [About - Society for Health Psychology](#)
  - SfHP Bylaws available at: [2024-SfHP Bylaws\(Shared\) - Adobe cloud storage](#)
- The **Council of Clinical Health Psychology Training Programs** is a training council that represents doctoral, internship, and post-doctoral training programs in Clinical Health Psychology. Initially established at the Arden House National Working Conference on Education and Training in Health Psychology in 1983, CCHPTP became recommissioned in 2007 with the Tempe Executive Summit on Education and Training in Clinical Health Psychology. CCHPTP has played an active role in defining the professional competencies and addressing training issues in clinical health psychology. It is important to note that CCHPTP represents doctoral, internship, and post-doctoral programs in health psychology, thus ensuring that education and training at all levels are included.
  - Additional CCHPTP purpose and objectives available at: [Home | CCHPTP](#)
  - CCHPTP Bylaws available at: [About Us | CCHPTP](#)
- The goal of the **American Board of Clinical Health Psychology** is to serve the public and the profession by ensuring that psychologists certified by ABPP in clinical health psychology have completed the appropriate education, training, and experience required of this specialty, maintain ethical standards, and demonstrate core and cross-cutting competencies required to provide quality clinical health psychology services.
  - Additional ABCHP purpose and objectives available at: [Clinical Health Psychology – ABPP](#)
  - ABCHP Bylaws are attached in Appendix I
- The mission of the **American Academy of Clinical Health Psychology** is to support the professional interests of board-certified specialists in clinical health psychology, recruit and mentor candidates eligible for board certification in clinical health psychology and promote the value and recognition of ABPP board certification. The Academy is closely affiliated with the American Board of Clinical Health Psychology.
  - Additional AACHP purpose and objectives available at:

[American Academy of Clinical Health Psychology – ABPP](#)

- AACHP Bylaws available at:
  - [AACHP Bylaws – ABPP](#)
- The purpose of the **Association of Psychologists in Academic Health Centers**, Section 8 of the Society of Clinical Psychology (APA Division 12) is to: a) Promote the discipline and profession of psychology in academic health centers and affiliated units (e.g., schools of medicine, nursing, public health, dentistry, pharmacy, health professions, Veterans Affairs Medical Centers, teaching hospitals and other similar entities); and b) To encourage and support psychologists’ participation in institutional governance, research, educational programs, administration, leadership and policy development.
  - Additional APAHC purpose and objectives available at:  
[Association of Psychologists in Academic Health Centers \(ahcpsychologists.org\)](#)
  - APAHC Bylaws available at:  
[APAHC Bylaws 2017.docx \(squarespace.com\)](#)
- The **Health Psychology Section of the Society of Counseling Psychology** (APA Division 17) is dedicated to the science, practice and advocacy of counseling psychology in health-related contexts. This is conducted through: a) Research with medical, rehabilitation or other health-related populations; b) Direct service to individuals across their lifespan (e.g., prevention, adjustment to and recuperation from illness, healthy lifestyle changes, psychological concomitants of medical illnesses); c) Teaching and training of graduate students or the education of other health care professionals; and d) Development of culturally informed health policy.
  - Additional Health Psychology Section purpose and objectives available at:  
[Health Psychology - Home \(div17.org\)](#)
  - Health Psychology Section Bylaws available at:  
[Health Psychology-About-Bylaws \(div17.org\)](#)

Please append the **Bylaws** for the petitioning organization or specialty council if bylaws are not provided on the website.

Bylaws for the Clinical Health Psychology Specialty Council (current version as of November 19, 2020) are available on the Council of Specialties in Professional Psychology website:

- [Clinical Health Psychology | cospp-2](#)

Outline the **structure and functions of the administrative organization** or specialty council (frequency of meetings, number of meetings per year, membership size, functions performed, how decisions are made, types of committees, dues structure, publications, etc.) using the table below. Provide samples of newsletters, journals, and other publications, etc.

Name of Organization	<b>Clinical Health Psychology Specialty Council (CHPSC)</b>
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Frequency of Meetings	One spring meeting and one annual meeting coinciding with the APA annual convention.
Number of Meetings per Year	Two: Virtual format in the spring and hybrid format during the time of the APA annual convention.
Membership Size	CHPSC members include one Chair and one representative from each of the six participating organizations, as well as an Early Career Psychology representative. Of these constituent organizations, the largest is the Society for Health Psychology, with 2700 members.
Functions Performed	<p>Represent major stakeholders and facilitate communication with APA offices, other organizations, and the general public;</p> <p>Promote quality assurance in specialty training, credentialing, and practice;</p> <p>Assure maintenance of education and training guidelines relevant to the specialty;</p> <p>Maintain clinical health psychology specialty recognition; and</p> <p>Report to the Council of Specialties regarding activities of the Specialty Council.</p>
How are Decisions Made	Decisions are subject to a majority vote of a quorum of representatives. Voting may be conducted by email, telephone or in person. The Chair abstains from voting except in the case of a tie vote.
Types of Committees	<p>The CHPSC itself does not have standing committees. The Society for Health Psychology maintains a number of councils and interest groups, the details of which may be found at:</p> <p><a href="#">Get Involved - Society for Health Psychology</a></p>
Dues Structure	Each CHPSC member organization pays \$350 in annual dues, with the exception of ABCHP, which pays \$700 annually to cover dues for AACHP, which is not a dues-collecting organization. Dues payments are collected by the CHPSC Treasurer and forwarded to the CoS Treasurer, who is authorized to manage the CHPSC banking account.
Names of Publications	Not applicable. Peer-reviewed publications representing the specialty that are managed by CHPSC member organizations include <i>Health Psychology</i> (SfHP peer-reviewed journal) and the <i>Journal of Clinical Psychology in Medical Settings</i> (APAHC



	peer-reviewed journal).
Website	CHPSC does not maintain a website.

**Present a rationale that describes how your organization or specialty council provides systems and structures which make a significant contribution to the organized development of the specialty.**

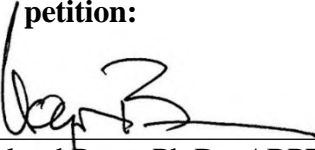
The Clinical Health Psychology Specialty Council (CHPSC) assures that the appropriate stakeholders of the specialty are collaborating and communicating and that the interests of the specialty are represented on the Council of Specialties in Professional Psychology (CoS). CHPSC actively participated in the 2021 CoS Taxonomy Initiative and conducted a thorough and systematic update of its Clinical Health Psychology Education and Training Taxonomy to ensure consistency in language and definitions across specialties. CHPSC also provided public comment on Committee on Accreditation (CoA)'s revised Level 3 – Specialty for clinical health psychology postdoctoral residency programs (IR C-9 P) in 2021 (see Appendix V). The CoA incorporated all CHPSC recommendations.

In January 2024, the President of the Society for Health Psychology (SfHP), Division 38 of the American Psychological Association, and the Chair of CHPSC convened a Clinical Health Psychology Education and Training Summit in New Orleans, Louisiana, the fourth held since 1983. This working conference brought together 20 invited leaders in the field of clinical health psychology to examine the key challenges facing education and training of Clinical Health Psychologists and promote visionary thinking about educational opportunities and pathways toward the specialty. During the summit, the definition of Clinical Health Psychology, last updated by SfHP Executive Board in 2015, was reaffirmed and the revised 2021 Clinical Health Psychology Education and Training Taxonomy was endorsed (see Appendix IV).

CHPSC member organizations are actively involved in initiatives of the American Psychological Association and collaborate with other organizations engaged in research and intervention related to health issues as they relate to enhancing public welfare. For example, in the area of practice, SfHP is an active participant in the Interdivisional Health Care Committee and works diligently with APA on issues of reimbursement and coding for health psychological services, efforts that have benefited the profession as a whole. The Council of Clinical Health Psychology Training Programs (CCHPTP) provides information on the health psychology perspective to major committees, task forces, and boards of the APA. CCHPTP is a member of the Council of Chairs of Training Councils, through which it interfaces with the APA Board of Education Affairs (BEA), the Committee on Accreditation (CoA) and other APA Boards and Committees on relevant issues. The Association of Psychologists in Academic Health Centers (APAHC) has a seat at the table for the Council of Faculty and Academic Societies (CFAS) of the Association of American Medical Colleges (AAMC). Finally, the American Board of Clinical Health Psychology (ABCHP) and the American Academy of Clinical Health Psychology (AACHP) represent

clinical health psychology's needs and interests in the board certification functions provided as an affiliated specialty board of the American Board of Professional Psychology.


**4. Signature of officials representing the organization or specialty council submitting the petition:**



\_\_\_\_\_  
Lloyd Berg, Ph.D., ABPP  
Chair, Clinical Health Psychology Specialty Council  
Chair, Society for Health Psychology 2024  
CRSSPP Renewal Petition Task Force

12/13/2024

Date



\_\_\_\_\_  
Mark E. Vogel, Ph.D., ABPP  
Past-President, Society for Health Psychology

12/13/2024

Date

**Criterion II. Public Need for Specialty Practice. The services of the specialty are responsive to identifiable public needs**

*Commentary: Specialties may evolve from the professions' recognition that there is a particular public need for applications of psychology. Specialties may also develop from advances in scientific psychology from which applications to serve the public may be derived.*

**1. Describe the public needs that this specialty fulfills with relevant references. Under each need specify the populations served and relevant references.**

Prevalent and burdensome medical conditions are linked to behavioral and psychological factors

According to the most recent Centers for Disease Control and Prevention data, the leading cause of death in the U.S. in 2022 were heart disease, cancer, accidents (unintentional injuries), COVID-19, and stroke (National Center for Health Statistics, 2022).

Approximately half of all premature deaths are attributable to modifiable behavioral risk factors such as tobacco smoking, sedentary lifestyle, diet and alcohol misuse (McGinnis & Foege, 1993). Moreover, chronic disease and mental disorder comorbidity is associated with health care expenditures (Sporinova et al., 2019). There is evidence that: 1) behavioral factors precipitate and contribute to the leading causes of illness and death in the U.S.; 2) behavioral and psychosocial factors can increase biological risk factors for disease; and 3) behavioral and psychological interventions are important avenues for the prevention and treatment of chronic diseases and medical conditions (Fisher et al., 2011). The clinical health psychology specialty addresses these public needs through multiple avenues, including research, evidence-based practice, advocacy and education.

Clinical health psychologists' scientific knowledge and expertise in the inter-relationships among behavioral, emotional, cognitive, social and biological components in health and disease make them well suited to improve the health and well-being of individuals, groups and populations. Reliable and valid screening and assessment methods of behavioral risk factors are necessary for resource allocation and treatment planning. Clinical health psychologists are able to design primary, secondary and tertiary prevention interventions to reduce the frequency, morbidity and mortality associated with chronic illness. Finally, the scientific basis of clinical health psychologists' training enables them to develop and apply rigorous evaluation methods to ensure that clinical programs and interventions have the intended effects on population health.

Examples of the impact of health psychology interventions on physical health outcomes are numerous; specific examples are described in detail in Criterion IX Effectiveness.

The burden of medical illness includes declines in psychosocial and emotional functioning

Living with a chronic medical condition is associated with behavioral risk factors, including sedentary lifestyle that in turn may exacerbate the chronic medical condition (Linardakis et al., 2015). Mental health conditions are associated with many medical

diseases (e.g., Scott et al., 2013). A large national survey demonstrated that persons with chronic health conditions had high rates of scoring positive or at-risk for mental health conditions, including cancer (73%), heart disease (75%), chronic pain (79%), diabetes (74%) and chronic obstructive pulmonary disease (80%) (Mental Health America, n.d.) Depression can lead to decreased self-care, poorer functional outcomes and increased mortality. Patients with diabetes and comorbid depression, for example, have a 46% increased risk of all-cause mortality than diabetic patients without depression (van Dooren et al., 2013). Major depression has been identified as a risk factor for several medical diseases, including cancer, cardiovascular and metabolic disorders and dementia, with evidence suggesting a bidirectional relationship (Berk et al., 2023). Chronic pain, which afflicts one-in-five Americans and is a main reason why people seek medical treatment, represents another public health issue that falls within the purview of clinical health psychology (Centers for Disease Control and Prevention, 2020). Studies have shown chronic pain to be highly comorbid with a number of mental disorders, including depression, anxiety, PTSD and substance use disorders, including tobacco (Hooten, 2016).

Disordered mental health may persist even after stabilization or remission of a primary medical condition. For instance, adult survivors of childhood cancer are at risk for elevated rates of depression and anxiety, particularly if they have experienced long-term side effects from treatment (Nathan et al., 2018). Moreover, the psychological impact of disease extends beyond the patient to the entire family system. For example, research has documented the psychological impact of being a caregiver (George et al., 2020). As the burden of chronic disease in the U.S. increases, there is unprecedented need for effective strategies to reduce the burden of illness.

A comprehensive outlook on health outcome measurement must include quality of life, adherence, and psychosocial functioning

The Society for Health Psychology upholds the World Health Organization principle of health as a state of complete physical, psychological and social well-being and not merely the absence of illness or disability (WHO, n.d.). The ultimate goals of clinical health psychology assessments and interventions are to improve patients' health, functioning, quality of life and treatment outcomes. As new technologies and interventions become available to cure disease and extend life, we must always be sure that the benefits of these treatments are weighed carefully against their risks and impact on quality of life. For example, new drug treatments for cancer are evaluated for Food and Drug Administration approval chiefly on the basis of their ability to extend survival time, even if they have negligible impact on quality of life or functioning (e.g., Samuel et al., 2022). Similarly, even when commonly used treatments for chronic pain, e.g., spinal surgery or chronic opioid use, result in apparent objective success, we must be alert to the possibility that this does not necessarily improve quality of life, prevent disability or ensure patient satisfaction with care. Inclusion of health psychologists in interprofessional treatment and research teams, to bring expertise in measurement of these factors, is critical if we are to improve public health and not simply extend longevity. Integration of measurement-based psychological interventions can have additional implications for optimizing medical management and reducing service utilization and healthcare costs. Health Psychology, the scientific journal

of the Society for Health Psychology, dedicated a special issue in 2019 featuring outcomes research and applications of universal health-related quality of life measures produced under the Patient-Reported Outcomes Measurement Information System® (PROMIS®) initiative (Yount et al., 2019).

Health psychology knowledge and interventions have the potential to help reduce health disparities across diverse populations

Health outcomes can vary considerably within and between different population groups, and clinical research is needed to better understand why some health care structures, processes, and interventions may result in different health outcomes depending on factors such as race/ethnicity, gender, socioeconomic status, sexual orientation, and other population characteristics. The evidence base informing the specialty's efforts to address health disparities is described in greater detail in Criterion III. Both the Society for Health Psychology and the Association of Psychologists in Academic Health Centers have standing committees devoted to issues of diversity and health disparities and incorporate diversity issues into their conference programming, continuing education, and other activities.

Health Psychology has an important role in mitigating national health crises

*The Opioid Crisis.* The National Institute of Health has identified addiction to opioids as a national crisis and has prioritized the tandem issue of finding safe, effective, non-addictive strategies to manage chronic pain, including behavioral therapies (NIH, 2023). Chronic pain, a primary reason for seeking health care, is one of the most prevalent and disabling conditions in the United States (Nahin et al., 2023). Significant evidence points to the negative impact pain-related fears, cognitions, and behaviors have on functional impairment (Martinez-Calderon et al., 2020), while psychological interventions such as cognitive behavioral therapy have been shown to be beneficial in patients with conditions such as chronic lower back pain for improving pain, disability, fear avoidance and self-efficacy (Yang et al., 2022). Members of the Society for Health Psychology's Pain Psychology Interest Group (PPIG) were instrumental in developing the *APA Clinical Practice Guideline for Psychological and Other Nonpharmacological Treatment of Chronic Musculoskeletal Pain in Adults* (APA, 2024).

*The COVID-19 Pandemic.* Between January 2020 and May 2023, the United States experienced significant social, economic and public health disruption as a result of the COVID-19 pandemic. Over 6 million people were hospitalized and 1.1 million people died as a result of being infected by the COVID-19 virus during this public health emergency period. From March 2020 to October 2021, COVID-19 accounted for 1 in 8 deaths in the US and was a top 5 cause of death in every age group aged 15 years and older, exceeded only by heart disease and cancer (Shiels et al., 2022). While the COVID-19 pandemic affected the entire U.S. health care system, a 2022 literature review revealed that social determinants of health, including race and ethnicity, poverty, housing, health care access, education, and transportation access, affected the rates of infection and mortality from COVID-19 (Brakefield et al., 2022). Efforts to contain the spread of the virus were

complicated by public divisiveness over prevention strategies such as mask wearing, social distancing and vaccine uptake, with studies showing Black and Hispanic respondents to be significantly less likely to report intending to be vaccinated, as were respondents who were females, younger, and those who were more politically conservative. (Larkin et al, 2021). Findings such as these highlighted the need for clinical health psychology expertise in designing education, policy and intervention strategies to address these concerns. Clinical health psychology was represented in the development of the *APA Consensus Statement on Using Psychological Science to Understand and Fight Health Misinformation* (APA, 2023), while the Society for Health Psychology's journal, *Health Psychology*, published a special issue on the topic of vaccine hesitancy (Bednarczyk et al., 2023).

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## **2. Describe what procedures this petitioning organization and/or other associations associated with this specialty utilize to assess changes in public needs.**

The need for health psychology services is well documented in major epidemiological surveys and health monitoring efforts conducted by numerous federal and state agencies and authorities. Examples within the U.S. include: *Healthy People 2020 and 2030*, collated and reported by the National Center for Health Statistics, which is part of the Centers for Disease Control and Prevention (CDC) (National Center for Health Statistics, 2024); the *National Health and Nutrition Examination Survey (NHANES)*, also conducted by the National Center for Health Statistics (National Center for Health Statistics, 2023); the *California Health Information Survey*, a health survey conducted by UCLA in California that oversamples members of underrepresented groups (UCLA Center for Health Policy Research, n.d.); and the *Behavioral Risk Factor Surveillance Survey* (conducted by the



Centers for Disease Control) (Center for Disease Control and Prevention, 2024). On a global level, the World Health Organization monitors and tracks the health status of countries around the world, including diseases that involve behavioral components (e.g., chronic pain, HIV/AIDS, lung disease, cancer) (WHO, n.d.). On a more local level, community engagement/community based participatory research has been conducted to document the needs of communities, cities, and geographical areas. Findings of these studies can be communicated through national sources and peer-reviewed professional journals, as well as through meetings and conventions of other groups that also have a health psychology focus and/or relevant to health psychology. These groups, in addition to the member organizations of the Clinical Health Psychology Specialty Council, also include the Society of Behavioral Medicine, the Association of Psychological Science, the International Society of Behavioral Medicine, the American Public Health Association, the American Medical Association and an array of specialty organizations that can include health psychology data and interventions (e.g., the American Association of Cancer Research, American Association of Pain Psychology, American Psychosomatic Society). Formal and informal liaisons between member organizations of the Clinical Health Psychology Specialty Council and various entities representing public health and healthcare systems help ensure that clinical health psychologists stay abreast of emerging needs and trends relevant to practice in the specialty.

Clinical health psychology organizations have worked together to monitor and respond to changes in public needs. The APA Interdivisional Healthcare Committee, for example, is made up of representatives from the following APA Divisions that share interest in health issues: Division 17 (Society of Counseling Psychology), Division 22 (Rehabilitation Psychology), Division 38 (Society for Health Psychology), Division 40 (Clinical Neuropsychology) and Division 54 (Society of Pediatric Psychology). This has led, for example, to a committee charged with reviewing and developing health policy to shape the organization and delivery of behavioral health services (Health Policy Council of the Society for Health Psychology). This supports health psychology practitioners to provide the most up-to-date interventions available when they render consumers services.

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### **3. Describe how the specialty attends to public need.**

Specialists in clinical health psychology attend to the need for specialized expertise in health and behavior through a variety of activities. Whereas many of these activities are initiated at the level of the individual or within local communities or systems, the specialty provides a robust organizational structure with which to coordinate efforts at the regional and national levels:

- a) Direct provision, administration and/or supervision of clinical services. Clinical health psychologists work in a variety of settings including primary care and specialty medical and surgical practices, academic settings, general and specialty hospitals including Veterans Affairs (VA) health care facilities and private practice settings. The Society for Health Psychology's (SfHP) Clinical Health Services Council is devoted to reviewing and acting on emerging issues in the practice of clinical health psychology. Examples of issues relevant to the Clinical Health Services Council include laws and policies pertaining to the practice of health psychology, billing for health psychology services, the integration of psychology practice into medical settings and the development and endorsement of guidelines pertaining to treatment, assessment and practice matters. The Council also oversees other committees, most notably the Integrated Primary Care Committee, and may create ad hoc working groups as needed. SfHP's Health and Advocacy & Policy Council (HAPC) collaborates with staff from APA central office on impactful advocacy & policy issues as they relate to the field of health psychology. A major focus of the HAPC is to identify approaches to broaden the access of care for a diverse population of patients who would benefit from health psychology services, and to diversify the workforce delivering these services. Relevant SfHP Special Interest Groups (SIG) attending to public health needs of specific populations include the Adolescent and Young Adult SIG, Lifestyle Medicine SIG, Pain Psychology SIG and Women's Health SIG.

The Association of Psychologists in Academic Health Centers (APAHC) is also dedicated to the unique roles, needs and interests of psychologists who work in academic health centers and medical schools, many of whom provide, supervise or administer clinical services. APAHC's Committee on Health Disparities and Diversity specifically works to increase the provision of research-informed care that reflects the needs and concerns of diverse populations to help eliminate disparities and promote behavioral and emotional health among different groups. Finally, the American Board of Clinical Health Psychology (ABCHP) serves to define and standardize skills/competencies for specialty practice in clinical health psychology.

- b) Training and education. Clinical health psychologists are often involved in mentoring and training psychology students and/or trainees, but may also be involved in designing, delivering and supervising educational and training programs for other health professionals and multidisciplinary teams. Clinical health psychologists can also play a role in providing education to the general public. This is especially

relevant in terms of potential misinformation and use of artificial intelligence. The Council of Clinical Health Psychology Training Programs (CCHPTP) leads the specialty's efforts to advance doctoral and postdoctoral education and training in clinical health psychology. Other entities, such as the Education and Training Council of the Society for Health Psychology, are tasked with providing and promoting resources to enhance education and training in the specialty.

- c) Research. Clinical health psychologists are expected to be competent in performing and evaluating research. Clinical health psychologists are regularly involved in research activities that contribute to a growing knowledge base regarding the role of psychological factors in the predisposition, perpetuation, treatment and prevention of physical illness. The emphasis that health psychologists place on the biopsychosocial model assists in the research and effective implementation of health interventions for health conditions such as tobacco cessation in cancer centers (Paul et al., 2021) and weight management (Damschroder & Lowery, 2013). Funded investigators in clinical health psychology have had a successful track record of responding to areas of public need as announced by the National Institutes of Health, Agency for Healthcare Research and Quality, the U.S. Department of Veterans Affairs and other federal entities.

Health psychologists also participate on review panels for major funding sources, including the National Institutes of Health. The current editor-in-chief of *Health Psychology*, the official journal of the Society for Health Psychology, is a member of the U.S. Preventive Services Task Force and the Association of Psychologists in Academic Health Settings (APAHC) maintains links to academic leaders in other health care disciplines, particularly through membership as an academic society in the Council of Faculty and Academic Societies (CFAS) of the Association of American Medical Colleges (AAMC).

- d) Advocacy and policy development. Health psychologists have contributed to both broad-based advocacy efforts in the scientific community (e.g., to advocate for research funding and the welfare of international trainees subject to immigration policy changes) and to advocacy for discipline- and specialty-specific issues (e.g., integrated care delivery models). Emmons & Gandelman (2019) points out while there is substantial research on prevention, the translation of this research is vital in impacting policy. Health psychology can play a vital role in communicating research findings to the public, and in turn impacting potential policy changes. Several committees and councils in the Society for Health Psychology and other specialty council member organizations have engaged in targeted advocacy efforts. The Health and Advocacy & Policy Council within the Society for Health Psychology has responded to requests from within and outside of APA to review and provide feedback on various policy-related matters. External organizations, particularly the Society of Behavioral Medicine, have also been active in advocacy and policy development by issuing position statements on health-related topics such as smoking cessation, physical activity programming, and care of people with chronic pain (Society of Behavioral Medicine, n.d.)

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**Criterion III. Diversity. The specialty demonstrates recognition of the importance of cultural and individual differences and diversity.**

*Commentary: The specialty provides trainees with relevant knowledge and experiences about the role of cultural and individual differences and diversity in psychological phenomena as it relates to the science and practice of the specialty in each of the following areas: i) development of specialty-specific scientific and theoretical knowledge; ii) preparation for practice; iii) education and training; iv) continuing education and professional development; and v) evaluation of effectiveness*

Because the population is diverse:

**1. Describe the specialty-specific scientific and theoretical knowledge required for culturally competent practice in the specialty, how it is acquired and what processes are in place for assessment and continued development of such knowledge.**

Culturally competent practice is a foundational clinical health psychology competency. Attitudes of respect, curiosity and empathy are integral to practicing across the range of sociodemographic diversity. Additionally, there is a shift to adding cultural humility as a necessary component of clinical practice. The development of cultural humility and cultural competence entails the acquisition of specific scientific, theoretical knowledge and supervised clinical experience over the course of one's doctoral, internship and postdoctoral training, as well as a commitment to continuous post-licensure education in cultural and individual differences, in order to work effectively with persons across the range of sociodemographic diversity and ensure equitable treatment. It is now well established that specific racial/ethnic and cultural groups are disproportionately burdened with negative physical health outcomes and the degree to which practitioners demonstrate cultural competence and humility can result in cultural, racial/ethnic, socioeconomic and individual differences in health outcomes (APA, 2019). Much of the work on culturally competent practice in clinical health psychology is interrelated with the concept of health disparities, defined by the U.S. Centers for Disease Control and Prevention as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations." According to the NIH, populations that experience health disparities include: 1) racial and ethnic minority groups, 2) people with lower socioeconomic status, 3) underserved rural communities, 4) sexual and gender minority groups and 5) people with disabilities (National Institute on Minority Health and Health Disparities, n.d.). On a broader level, Social Determinants of Health (SDOH) - the conditions in which people are born, grow, live, work, and age that influence health - helps to explain some of the health inequities and is a critical area of understanding and influence for health psychologists.

Health disparities are attributed to a confluence of biopsychosocial factors that include the intersection of perceived racial identity and social experiences and environments and the interplay between these factors. Key psychosocial risk factors include, but are not limited to, socioeconomic disadvantages, access to healthcare, health literacy, bias and discrimination at all levels of social experience, acculturation and health behavior. As such, research, education, assessment and intervention may focus not only on individual

behavior but also on group-level and systemic factors underlying health disparities. Clinical health psychology recognizes that social and structural determinants broadly impact public health (Llabre & Goodman, 2024). Examples include disparities in pain management (Kapos et. al., 2024), mortality (Atherton, 2024) and birthweight (Evans et. al., 2023). Conversely, some scholars have identified cultural practices and beliefs that are health assets (Lightfoot et. al., 2016).

Specialty education and training in clinical health psychology, including the development of cultural competence and humility, begins during doctoral studies, continues with experiential training during internship and is most often completed during postdoctoral training. All accredited doctoral and internship programs in health service psychology ensure coverage of discipline-specific knowledge and acquisition of profession-wide skills/competencies, including competencies in individual and cultural diversity, that are required by the *Standards of Accreditation for Health Service Psychology* (APA, 2015). Postdoctoral fellowships seeking accreditation as clinical health psychology training programs also must demonstrate that residents have achieved these skills/competencies upon completion. By the conclusion of postdoctoral training, entry-level clinical health psychologists are expected to possess a set of core skills/competencies in the specialty, including culturally competent practice. Individual and cultural diversity is one of the eight foundational competencies that must be demonstrated by all candidates pursuing board certification in clinical health psychology through the American Board of Professional Psychology (American Board of Clinical Health Psychology, 2018). Through a rigorous peer review process, a recognized quality assurance mechanism to ensure professional standards, board examiners solicit evidence that the candidate:

- Conveys an awareness of one's own diversity variables and how these influence the people with whom, and contexts within which, one functions as a clinical health psychologist.
- Appreciates the individual and cultural diversity of beliefs and attitudes toward health and wellness held by patients and healthcare providers.
- Demonstrates knowledge of sociodemographic factors that influence healthcare and access to healthcare.
- Uses culturally inclusive measures and procedures when conducting Clinical Health Psychology services.
- Ensures appropriate accommodations to enable effective delivery of Clinical Health Psychology services.
- Pursues professional development opportunities related to individual and cultural diversity.

Entry-level clinical health psychologists are expected to be knowledgeable about, and adherent to, the *APA Ethical Principles of Psychologists and Code of Conduct*, including Section 2.01 Boundaries of Competence, subsection b. pertaining to the obligation to obtain training, experience, consultation, or supervision necessary to ensure the competence of their services with respect to factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 2017). Furthermore, all clinical health

psychologists are also expected to abide by the *APA Guidelines on Race and Ethnicity in Psychology: Promoting Responsiveness and Equity* (APA, 2019), which aim to address inequities among people of different races, ethnicities and cultural backgrounds in the U.S. The guidelines call on all psychologists to maintain a scholarly knowledge of race and ethnicity and view racial and cultural responsiveness as a lifelong endeavor. More specifically, they encourage psychologists to explore their own “positionality,” or one’s status within society’s sociocultural hierarchy, in order to more fully appreciate what values, assumptions and biases shape one’s beliefs. The guideline authors note that this type of reflection, an important method to promote culturally competent practice, can be facilitated through group activities focused on race and ethnicity, including workshop attendance or participation in society interest groups.

Many opportunities exist for clinical health psychologists to attend continuing education trainings and professional development workshops designed to enhance cultural competencies and responsiveness to the health disparity challenges experienced by members of historically marginalized communities, including offerings by the 60 APA-affiliated state, provisional and territorial psychological associations (SPTAs). The APA annual convention remains a major resource for continuing education programs promoting cultural competence. The Society for Health Psychology (SfHP) regularly provides programming on cultural competency and health disparity topics at the APA conventions. The Society of Pediatric Psychology, the Society of Behavioral Medicine, the Association of Psychologists in Academic Health Centers and the Council of Clinical Health Psychology Training Programs all host their own separate conferences, with a strong emphasis on content relevant to clinical health psychology, including topics involving provision of culturally sensitive psychological services to historically marginalized groups. SfHP also continuously lists a number of free webinars on cultural competence and health disparities on its website, with recent titles including *Brave Spaces: A Forum to Advance Diversity, Equity and Inclusion*; *Repository of Health Disparity-Related Literature*; *Health Equity and Power: Misogynoir and Black Women’s Health*; and *Why Asking About Race Matters in Healthcare*. APA Books also offers books for CE credit on topics related to cultural competence in healthcare provision, including *Occupational Health Disparities*; *Eliminating Inequities for Women with Disabilities*; *Emotion, Aging and Health*; and *Rural Behavioral Health Care: An Interdisciplinary Guide*.

All clinical health psychologists are also expected to remain up to date in the empirical literature pertaining to the specialty. Of all the specialties recognized by the American Board of Professional Psychology, clinical health psychology was found to have the shortest half-life of knowledge durability (Neimeyer et al., 2014). The importance of cultural and individual differences in health and health disparities is evidenced not only by the inclusion of articles that cover these topics in mainstream journals (e.g., *Health Psychology*, *Journal of Behavioral Medicine*, *American Journal of Public Health*) but also by the proliferation of journals devoted specifically to these topics (e.g., *Journal of Healthcare for the Poor and Underserved*, *Ethnicity and Disease*, *International Journal for Equity in Health*, *Social Science and Medicine*, *The Lancet Public Health*). In recent years, prominent health psychology journals such as *Health Psychology* and the *Journal of Clinical Psychology in Medical Settings* as well as broader APA journals such as *Journal*

of Consulting and Clinical Psychology and Journal of Latina/o Psychology have devoted special issues to the topic of health disparities (see examples below).

Beyond self-directed practice and reflection, the *APA Guidelines on Race and Ethnicity in Psychology: Promoting Responsiveness and Equity* (APA, 2019) provide a blueprint for further development of cultural competencies that are relevant for clinical health psychologists in the areas of clinical practice, research, and training and education:

Clinical Practice: The guidelines implore all psychologists to consider issues of race, ethnicity and culture in assessment formulations and treatment planning. This is especially relevant for clinical health psychologists, as research indicates the value of understanding the person's perspective in order to improve communication and overall health and well-being. Health disparities account for significant variances in health outcomes, including morbidity and mortality. They also call for psychologists to recognize and challenge structural dynamics in our society that perpetuate health disparities.

Training and Education: Psychology educators are urged to develop curricula that are inclusive, address systemic biases and take a strengths-based approach to issues facing historically marginalized groups, in addition to promoting cultural humility and a commitment to ongoing examination of one's own implicit and explicit biases about culture, race and ethnicity. A special issue of the Journal of Psychologists in Medical Settings spotlighted how psychologists practicing in academic health settings are working with their interprofessional colleagues to address the intent and impact of diversity, equity and inclusion issues and initiatives (Lemanek et al., 2023).

Research: All psychologists are encouraged to strive to conduct and disseminate research that benefits historically marginalized populations and decrease health disparities, as well as reduce the impacts of cultural biases in research. As a major funder of health psychology research, the National Institutes of Health (NIH) has several policies and programs supporting the continued development of scientific knowledge to support culturally competent knowledge and practice:

- The NIH requires both grant applicants and recipients in annual reports to provide data on the race, ethnicity and gender of individuals who participate in clinical research.
- The National Center on Minority Health and Health Disparities, an NIH subsidiary, invests in research and fosters collaborations and partnerships to promote and support evidence-based science and designing interventions to improve health outcomes to reduce and ultimately lead to the elimination of health disparities.
- NIH has issued a number of funding requests for research on health disparities. Through its loan repayment program, NIH offers financial assistance for researchers focusing on health disparities.
- NIH supports the development of health-related research careers for individuals from underrepresented minority groups through a variety of mechanisms. For example, the National Heart, Lung, and Blood Institute (NHLBI) sponsors the



Programs to Increase Diversity among Individuals Engaged in Health-Related Research (PRIDE), an all- expense-paid summer research institute for junior scientists and transitioning postdoctoral scientists who have disabilities and/or are from underrepresented backgrounds. Psychologists serve among site investigators and administrators for the PRIDE program.

- NIH also offers loan repayment assistance for researchers from disadvantaged backgrounds and funds administrative supplements to project, center and program grants to further diversify the biomedical research workforce via support of investigators from diverse & underrepresented groups at various career stages.

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## **KEY CLINICAL HEALTH PSYCHOLOGY AREAS AND PAPERS**

The following list provides representative examples of peer-reviewed literature published in the past 7 years on the psychosocial and behavioral aspects of cultural and individual differences in health and health disparities:

### Recent APA Special Issues

Else-Quest, N. M. (Editor). (2023). Intersectionality in stigma and health research [Special issue]. *Stigma and Health*, 8(3).

Kaholokula, J. K., Okamoto, S. K. & Yee, B. W. K. (Guest Editors). (2019). Advancing native Hawaiian and other Pacific Islander health [Special issue]. *Asian American Journal of Psychology*, 10(3).

Thurston, I. B., Alegria, M., Hood, K. B., Miller, G. E., Wilton, L. & Holden, K. (Guest Editors). (2023). How Psychologists can help achieve equity in health care: Advancing innovative partnerships and models of care delivery [Special issue]. *American Psychologist*, 78(2).

Lemanek, K. L., Bignall, W. J. R., King, J. D. (Guest Editors). (2023). Diversity, equity and inclusion in academic medical centers [Special issue]. *Journal of Clinical Psychology in Medical Settings*, 30(2).

Lu, Q., Fang, C. Y. & Kim, J. H. J. (Editors). (2024). Expanding the frontier of Asian American cancer control and survivorship research [Special issue]. *Asian American Journal of Psychology*, 15(3). <https://doi.org/10.1037/aap0000339>

Marceau, K., Conradt, E. & Roubinov, D. (Special Issue Editors). (2024). Prenatal influences across the life course: Biobehavioral mechanisms of development [Special issue]. *Developmental Psychology*, 60(9).

Tucker, C. M. (Guest Editor). (2019). Psychological science to reduce and prevent health disparities. *Translational Issues in Psychological Science*, 5(4). <https://doi.org/10.1037/tps0000215>

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### Access to Care

Clark, T. L., Savin, K. L., Perez-Ramirez, P., Valdez, T., Toba, G., & Gallo, L. C. (2023). eHealth weight loss interventions for adults with low income: A systematic review. *Health Psychology, 42*(6), 353–367. <https://doi.org/10.1037/hea0001278>

Pierce, B. S., Perrin, P. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2021). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in U.S. mental health care delivery. *American Psychologist, 76*(1), 14–25. <https://doi.org/10.1037/amp0000722>

### Advocacy

Cullinan, C. C., Harrison, R. R., & Hughes-Reid, C. (2024). Meeting the moment: Centering cultural humility and antiracism in health service psychology internship training. *Training and Education in Professional Psychology, 18*(3), 213–220. <https://doi.org/10.1037/tep0000473>

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Kelly, J. F. (2022). Building a more equitable society: Psychology's role in achieving health equity. *American Psychologist, 77*(5), 633–645. <https://doi.org/10.1037/amp0001019>

### Cancer

Aspiras, O., Lucas, T., Thompson, H. S., Manning, M. A., Blessman, J., Dawadi, A., Hirko, K. A., & Penner, L. A. (2023). Culturally targeted message framing and colorectal cancer screening preferences among African Americans. *Health Psychology, 42*(1), 1–4. <https://doi.org/10.1037/hea0001246>

Blashill, A. J., Nogg, K., Aguilar, R. A. C., Roesch, S., Brady, J., Corliss, H. L., Pagoto, S., & Wells, K. J. (2024). Skin cancer risk behaviors in sexual minority men: A mixed methods approach. *Health Psychology, 43*(6), 462–475. <https://doi.org/10.1037/hea0001371>

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### Cardiovascular Health

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**2. Describe how the specialty prepares psychologists for practice with people from diverse cultural and individual backgrounds (e.g., through coursework, supervised practice, continued professional development, etc.) and how competence is demonstrated.**

Education and training in cultural and individual differences and the promotion of cultural humility in clinical health psychology occurs at all points in the sequence of training and is part of practitioners' lifelong continuing education experiences. For clinical health psychologists, foundational cultural competence skills are initially developed at the doctoral level and then further elaborated, expanded and defined at the internship, postdoctoral fellowship and professional practice levels. Professional psychology doctoral programs provide specific coursework and initial practica experiences that integrate a focus on individual differences and diversity into courses, didactic experiences, clinical training and research activities. These competencies and skills are further defined during internship, with postdoctoral residency programs providing the refinement of these competencies within a clinical health specialty framework, allowing for the integration of issues of individual and cultural differences and diversity with a biopsychosocial health model that informs clinical practice and research.

Because training in areas related to sociodemographic diversity is part of the *Standards of Accreditation* used in the accreditation of doctoral, internship and post-doctoral training programs, all accredited programs must provide education and experience in this core area (APA, 2015). The evaluation of student, intern, and trainee competence in emerging cultural competence is typically left to individual programs, with a range of methods used to demonstrate and evaluate these skills. At the doctoral level, these include but are not limited to performance in classes that cover the topic; comprehensive/qualifying examination results; completion of scholarly work in the area; and supervisor ratings of work with diverse clients in practica. At the internship and post-doctoral levels, this evaluation includes supervisor ratings of work with patients and an assessment of the trainee's ability to integrate and apply knowledge about these topics to clinical and research activities. It is important to note that evaluation of the understanding of individual and cultural differences is often integrated into other core evaluations as well, in part because it is considered central to the work of a clinical health psychologist.

Clinical training opportunities affording the opportunity to develop cultural competencies in



in working with historically marginalized populations at the doctoral, internship and postdoctoral level have significantly expanded since the last specialty renewal petition in 2018 due to expanded funding from the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. HRSA is the primary Federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable. HRSA funds the Graduate Psychology Education Program (GPE), which has received over \$176 million in funding since 2002 (APA, n.d.). GPE provides three-year grants to accredited doctoral, internship and postdoctoral psychology education and training programs to support the interprofessional training of graduate students, interns and postdoctoral fellows in underserved rural and urban communities. HRSA's Behavioral Health Workforce Education and Training (BHWET) and Opioid Workforce Expansion Program (OWEP) also provide funding to interprofessional training programs to increase the supply of behavioral health professionals, including psychology practicum, internship and postdoctoral trainees, working in medical underserved areas.

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### **3. Describe how the specialty is monitoring developments and has moved to meet identified emergent needs and changing demographics in training, research, and practice (e.g., through research, needs assessment, or market surveys).**

Several seismic events in the United States in recent years have had broad impacts on the field of psychology and the specialty of clinical health psychology. The COVID-19 pandemic and the murder of George Floyd brought about what many termed as a racial reckoning. Many articles documented the disparate impact of COVID-19 on communities of color (e.g., Masterson, 2023). In 2020, APA's Society for the Psychological Study of Culture, Ethnicity and Race assembled The Warrior's Path Presidential Task Force of 2020 and in 2021 published a seminal article asserting that the COVID-19 pandemic exposed the pervasive consequences of colonialism, defined as entrenched societal policies that impose dominant cultural and sociopolitical practices that lead to inequities in marginalized racial communities, including health disparities, in America and throughout the world (Aiello et al., 2021). A board-certified clinical health psychologist, Dr. Marie Weil, served on this task force. The task force implored psychologists to be Warriors to protect and advocate for people who are not currently served by psychological science and challenged APA to adopt proactive decolonization policies and practices in order to diversify, cultivate a culture of inclusion and better serve its members and the public. The task exacted a number of calls to this effect, including a call for thorough representation in the field of psychology across all areas of research, teaching, clinical practice,

supervision, mentorship and publications.

The specialty of clinical health psychology in many areas has improved representation and engaged in committed action to adopt decolonization practices. The Society for Health Psychology (SfHP) utilized APA's Equity, Diversity, and Inclusion framework, including APA's *Inclusive Language Guide* (APA, 2023) in adopting inclusive language that raises awareness and supports the use of culturally sensitive terms and phrases throughout the organization. Those changes were immediately adopted in the SfHP flagship journal, *Health Psychology*, which is now available in Spanish translation, as well as other journals in the specialty. Other affiliated groups have created affinity groups to provide inclusive spaces (e.g., Society for Behavioral Medicine affinity groups, various meet and greets, mentoring activities) and many of the professional associations for clinical health psychologists have created diversity and equity related positions, in addition to active committees or working groups tasked with identifying, assessing and implementing changes to improve health related outcomes based upon the current understanding of the value of diversity, equity, and inclusion. For example,

- The Society for Health Psychology governing board includes a Diversity and Inclusion Officer and counts a Diversity Council among its standing committees.
- The Association of Psychologists in Academic Health Centers (APAHC) maintains an active standing committee, the Health Disparities and Diversity Committee, which promotes diversity as central to the mission of APAHC. The mission of the committee is to support APAHC in maintaining an equitable environment for diverse psychologists in academic health centers and ensure issues of diversity in race, gender, sexual orientation and ability status remain central to the mission of APAHC.
- Clinical health psychologists also contribute to diversity and health equity initiatives throughout APA. Former APA President Jennifer Kelly, PhD, ABPP, for example, is a board-certified clinical health psychologist who in 2020 appointed the APA Presidential Task Force on Psychology and Health Equity. The editor of SfHP's *Health Psychology* journal participated in this endeavor, which produced the APA Report of the 2021 American Psychological Association Presidential Task Force on Psychology and Health Equity (APA, 2022). The current chair of the APA Public Interest Directorate's Ad Hoc Committee on Health Equity, which focuses on addressing the systems, policies, regulations and institutions that promote and maintain inequities and the resulting adverse health conditions and outcomes among marginalized communities and populations, also is a clinical health psychologist. Clinical health psychology is also represented within other relevant offices and committees throughout APA, including the National Steering Committee on Health Disparities and Committee on Socioeconomic Status.

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**4. Describe how the education and training and practice guidelines for the specialty reflect the specialty’s recognition of the importance of cultural and individual differences and diversity.**

The Standards of Accreditation for Health Service Psychology (SoA) outline training requirements for programs at the doctoral, doctoral internship, and postdoctoral levels. Correspondent to the SoA are the Implementing Regulations (IRs), which are official policy documents that operationally define the Commission on Accreditation’s (CoA) policies and procedures. The CoA requires all trainees who complete accredited training programs develop certain competencies as part of their preparation for practice in health service psychology (HSP). According to the most recently updated CoA *IR C-9 P. Postdoctoral Residency Competencies* (2021), individual and cultural diversity is recognized as a profession-wide competency, regardless of practice specialty. All postdoctoral residents, including clinical health psychology trainees, are expected to demonstrate:

- an understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from themselves;
- knowledge of the current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities related to the accredited area including research, training, supervision/consultation, and service
- the ability to integrate awareness and knowledge of individual and cultural differences in the conduct of professional roles (e.g., research, services, and other professional activities). This includes the ability to apply a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their careers. Also included is the ability to work effectively with individuals whose group membership, demographic characteristics, or worldviews create conflict with their own.
- the ability to independently apply their knowledge and demonstrate effectiveness in working with the range of diverse individuals and groups encountered during residency, tailored to the learning needs and opportunities consistent with the program’s aim(s).

The central importance of cultural and individual differences and diversity training within the specialty of clinical health psychology is further reflected in the mission statement of the Council of Clinical Health Psychology Training Programs (CCHPTP):

“The mission of CCHPTP is to promote the advancement of graduate and post-graduate training in clinical health psychology with a commitment to multiculturalism, social justice, and integrated-care training that prepares health psychologists to deliver state-of-the-art-science and culturally-responsive services in a variety of research and clinical health care settings to meet the needs of diverse cultural and linguistic communities across the nation.” (Council of Clinical Health Psychology Training Programs, n.d.)

CCHPTP is a member council of the Council of Chairs of Training Councils (CCTC), which, at their CCTC 2020 Conference, developed a consensus statement calling on the Health Service Psychology (HSP) training community to act on long-standing concerns about health-related inequities, social injustice, systemic racism and the role of unrecognized privilege. The resulting *CCTC 2020: Social Responsiveness in Health Service Psychology Education and Training Toolkit* (2021) includes recommendations on diversifying HSP pipelines, social justice and advocacy, and socially responsive community engagement.

A professional practice guideline that clearly informs clinical health psychology practice is the *APA Guidelines on Evidence-Based Psychological Practice in Health Care* (APA, 2021). Guideline 6 states that “Psychologists endeavor to adapt their clinical approach to patient characteristics, culture, and preferences in ways that increase effectiveness.” The *APA Guidelines for Prevention in Psychology* (APA, 2014) are another pertinent clinical health psychology reference, with several sections highlighting the importance of attending to cultural diversity and health disparities, including Guideline 2 (“Psychologists are encouraged to use socially and culturally relevant preventive practices adapted to the specific context in which they are implemented”), Guideline 6 (“Psychologists are encouraged to attend to contextual issues of social disparity that may inform prevention practice and research”) and Guideline 8 (“Psychologists are encouraged to engage in systemic and institutional change interventions that strengthen the health of individuals, families, and communities and prevent psychological and physical distress and disability”).

Clinical health psychologists also have participated in the development of APA guidelines that include guidance on culturally competent practice with several groups at risk for negative health outcomes. Although the scope of these guidelines is broad, the guidelines include specific material pertinent to physical health outcomes, health disparities and experiences of health care. Examples include:

- The *Guidelines for Psychological Practice with Older Adults* (APA, 2024), which includes Guideline 6 (“Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as sex, gender identity, race, ethnicity, socioeconomic status, immigration status, sexual orientation, disability status, religion, spirituality, employment status, and urban/ rural

- residence may influence the experience and expression of health and of psychological problems in later life.”).
- The *APA Guidelines for Assessment and Intervention with Persons with Disabilities* includes Guideline 6 (“Psychologists strive to use appropriate language and respectful behavior toward individuals with disabilities”) and Guideline 7 (“Psychologists strive to recognize the intersectional identities of persons with disabilities.”)

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**Criterion IV. Distinctiveness.** A specialty differs from other recognized specialties in its body of specialized scientific knowledge and professional application.

*Commentary: While it is recognized that there will be overlap in the knowledge and skill among various specialties in psychology, the petitioning organizations must describe the specialty in detail to demonstrate that it is distinct from other recognized specialties in the knowledge and skills required, the need or population served, problems addressed, and procedures and techniques used.*

Clinical health psychologists have knowledge, experiences and a unique set of skills that enable them to positively impact the health outcomes of individuals and populations. However, trends in health care delivery prompted by the Affordable Care Act have prompted many other psychologists, including those whose training and experience fall predominantly within the scope of traditional mental health services, to expand their practices into health-related areas and medical populations. Thus, the distinction between a clinical health psychologist and other health service psychologists warrants elaboration.

One straightforward distinction between clinical health psychologists and other health service psychologists lies in the types of presenting problems or referral questions they address. For instance, clinical psychologists typically focus on the mental health needs of individuals. While those individuals also may have medical conditions, the primary focus of assessment and intervention is on patients' mental health. Clinical health psychologists have as their primary focus the physical well-being of individuals and groups. While those patients may have mental health issues, the primary focus of the clinical health psychologist is the degree to which the mental health issues directly or indirectly impact the physical well-being of the patient. The *primary* focus on medical conditions or health risk factors affects both the conceptualization of the client or target population and the set of assessment tools, interventions and other strategies used in the clinical health psychologist's practice.

Clinicians outside of psychology (e.g., social work) may also incorporate behavioral health or health and wellness into their practice domains. The distinction between a clinical health psychologist and these other behavioral health professions centers on the knowledge and skills acquired in both general and specialty-specific training in psychology, including:

1. The ability of the clinical health psychologist to use the best available evidence to generate new and better hypotheses about the problem in question;
2. Expertise in the scientific method to help clinicians of all specialties better assess and evaluate the outcomes of their work;
3. Use of clinical assessment measures and evaluations to guide treatment;
4. Skills to develop new interventions when previous ones do not appear to benefit the patient or population; and
5. The ability to use research skills to develop program evaluation methods and processes.

The specialty recognizes that there are several areas of focus in training and practice that represent the wide range of educational, clinical and scientific work in clinical health psychology. Each of these focus areas has a robust scientific literature supporting them as

empirically based activities within clinical health psychology (see representative examples cited in the subsections below). These educational and practice opportunities include a focus on a number of health-related topics and areas of practice, including pain psychology, psycho-oncology, cardiac psychology, obesity, primary care, public health and health disparities, disease prevention and health promotion, tobacco control and work across a wide range of acute and chronic illnesses. Future developments may lead to the establishment of specialty or subspecialty recognition of these areas of practice, within or in conjunction with clinical health psychology.

**1. Identify how the following parameters differentiate and where they might overlap with other specialties. Describe how these parameters define professional practice in the specialty.**

**a. Populations**

The populations served by health psychologists include any individual of any age with a disease or health-related condition that could be prevented, treated or rehabilitated with specialized psychological techniques or procedures. The primary focus is on problems that present as physical concerns, as opposed to issues that are restricted to emotional or mental health. Clinical health psychologists deal with modifiable lifestyle behaviors such as smoking, poor diet, lack of exercise, drug and alcohol misuse and coping with stress. They provide treatment for chronic pain, side effects caused by medication and other therapies (e.g., nausea and vomiting associated with cancer chemotherapy), treatment nonadherence, preparation for stressful medical procedures (e.g., bone marrow aspirations), stress-related diseases and disorders and an array of movement and other problems (e.g., Tourette's syndrome). They facilitate primary, secondary and tertiary prevention efforts in a variety of medical areas, including, but not limited to, cardiovascular disease, diabetes, cancer, HIV/AIDS and gynecological problems.

Existing specialties that assess and treat similar populations include:

Rehabilitation psychology. According to the CRSPPP public definition of the specialty, rehabilitation psychologists work with individuals “with an injury or illness, which may be chronic, traumatic and/or congenital, including the family, in achieving optimal physical, psychological and interpersonal functioning.” Although clinical health psychologists and rehabilitation psychologists may work with the same populations (e.g., people with neurological disorders), two key distinctions are noteworthy. First, rehabilitation psychologists chiefly focus on *adaptation to disability*, regardless of the source of disability (including disabilities not related to disease). In contrast, clinical health psychologists provide interventions that directly affects the course of illness, from primary through tertiary care contributions, rather than focusing primarily on adaptation to existing illness or injury. Secondly, clinical health psychologists’ range of expertise extends into areas of health maintenance, health promotion and prevention of illness. They therefore may work in part or exclusively with healthy or at-risk populations, rather than solely working with people who have existing diseases, conditions or disability.

Geropsychology. Geropsychology, according to its public description, “is a specialty in professional psychology that applies the knowledge and methods of psychology to understanding and helping older persons and their families to maintain well-being, overcome problems and achieve maximum potential during later life.” Age is a risk factor for many medical conditions, and as such clinical health psychologists often work with older adults. However, geropsychologists work across the spectrum of later life psychological conditions and phenomena, neither primarily focused on nor limited to the areas of health promotion and medical illness. Geropsychologists focus on aspects of functioning among older adults, including activities of daily living, cognitive capacities and broad mental health conditions. Clinical health psychologists working with older adults are more focused on the intersection of functioning, behavioral health and medical conditions. Moreover, the work of clinical health psychologists covers the entire lifespan and some clinical health psychologists focus exclusively on other specific age groups (e.g., pediatrics, women of childbearing age, etc.).

Clinical child and adolescent psychology. The public definition of clinical child psychology emphasizes specialized knowledge in “The research and practices [that] are focused on understanding, preventing, diagnosing, and treating psychological, cognitive, emotional, developmental, behavioral, and family problems of children.” Many clinical child and adolescent psychologists (i.e., pediatric psychologists) work at least a portion of the time in medical settings or with patients who have medical conditions. Here again, however, the focus of the clinical child and adolescent psychology specialty is the broad spectrum of psychological functioning and problems specific to developmental stage and is not particularly limited to the areas of health promotion and medical illness. Furthermore, clinical health psychologists may be trained to work with pediatric populations and have as their focus work with children and adolescents with medical conditions. Indeed, a significant number of pediatric psychologists identify as clinical health psychologists and pursue board certification through the American Board of Clinical Health Psychology.

- b. Problems (psychological, biological, and/or social that are specific to this specialty):

In general, referrals to clinical health psychologists are appropriate when psychological issues are related to the prevention, diagnosis and treatment of acute or chronic medical conditions. Common reasons for referral include psychological distress secondary to diagnosis or distress that interferes with treatment, problems with treatment adherence, maladaptive coping, pain management, stress management, sleep difficulties and lifestyle interventions. In medical settings, referral sources include departments of oncology, anesthesiology, cardiology, endocrinology, gastroenterology and other medical/surgical specialties. A non-exhaustive list of specific referral examples includes: psychological conditions secondary to diseases, injury and disability (e.g., post myocardial infarction depression and fear of engaging in sexual activities; alteration of body image secondary to burns, amputation, surgery, menopause); somatic presentations of psychological dysfunction (e.g., chest pain in



panic attack, somatization disorders); psychophysiological disorders (e.g., tension and migraine headache, spastic colitis); physical symptoms responsive to behavioral interventions (e.g., vasospasms, enuresis, fecal incontinence, anticipatory nausea); medical complications associated with behavioral factors (e.g., mismanagement of diabetes, failure to comply with hypertensive medication); psychological presentations of organic disease (e.g., hypothyroidism presenting as depression, steroid-induced psychosis); and psychological and behavioral aspects of stressful medical procedures (e.g., pain, lumbar puncture, debriding of wounds, cardiac catheterization, surgery).

Clinical neuropsychology is another specialty where there is overlap with regard to presenting problems, in addition to the specialties delineated in the above section. While clinical health psychologists may see individuals with neurological problems or symptoms, the focus is on coping with or ameliorating a specific physical health problem or decreasing a potential health risk. In contrast, while a neuropsychologist may conduct assessments and even provide cognitive rehabilitation with patients with neuromuscular disorders, the focus is on problems that arise from abnormal central nervous system functioning. Clinical health psychologists working with the same patient might focus on stress associated with the disorder, comorbid illnesses or on the impact of caring for the person on his/her family and significant others.

Finally, clinical health psychologists are also involved at levels other than the individual patient. This can include interventions and work with health care providers and health care systems (e.g., physician-patient relationships, staff delivery systems) as well as efforts designed to bring about health-related policy change. Primary employment settings include hospital-medical centers, independent practice and a combination of these.

#### c. Procedures and techniques

Many of the assessment and intervention techniques and procedures overlap with those that are part of clinical and/or counseling psychology. Specialized health psychology assessment techniques include the following:

- Interviews, particularly structured interviews, that focus on health-related concerns (e.g., Psychosocial Adjustment to Illness-PAIS, 24 hour Recall Interview);
- For illnesses and/or symptoms that vary as a function of time, diaries are often part of the assessment process (e.g., pain diaries);
- Objective assessment instruments that have demonstrated utility for use with medical surgical populations (e.g., Minnesota Multiphasic Personality Inventory, Millon Behavioral Health Inventory);
- General stress, anxiety, or depression instruments that have been demonstrated to be useful with medical-surgical patients (e.g., Center for Epidemiological Studies Depression, State-Trait Anxiety Inventory, various NIH PROMIS

scales; Activities of Daily Living, Family Environment Scale, Schedule of Racist Events);

- Instruments that have been developed for specific health or medical disorders (e.g., Arthritis Impact Measurement Scale, McGill Pain Questionnaire, Cornell Medical Index, Dental Anxiety Scale, Eating Disorder Inventory, Cancer Inventory of Problem Situations, Multidimensional Pain Inventory, Battery for Health Improvement-2);
- Behavioral observation of patients undergoing specific procedures (e.g., response to burn debridement, cold stress challenges for Raynaud's, self-administration of insulin);
- Psychophysiological measures (e.g., muscle tension, skin temperature, blood pressure heart rate, respiratory activity);
- Medical charts, records, and other legal and quasi-legal documents including hospital policies, disability laws, and health-related policies;
- Biological measures that are associated with specific illnesses (e.g., glycosylated hemoglobin levels for assessing diabetic control, spirometric measures of pulmonary functioning, skinfold thickness);
- Health outcome measures (e.g., quality of life, disease-related symptoms or disability).

In addition to the standard psychotherapeutic interventions (including evidence-based practices such as cognitive-behavior therapy), a clinical health psychologist may be called upon to provide the following interventions:

- Supportive individual, family or group counseling related to treating or coping with a disease, injury, disability or bereavement;
- Education and health-related information about a range of health, well-being, disease, disability and illness management issues;
- Intervention with patients and their families at critical times, including the time of diagnosis, when medical intervention is required, if/when there is a change in health status and if the treatment is not successful;
- Relaxation and imagery training procedures designed to control or modify physiological responses (e.g., diaphragmatic breathing, progressive muscle relaxation, autogenic training);
- Psychophysiological training procedures (e.g., biofeedback) designed to improve physiological responding and reduce symptoms;
- Techniques designed to increase likelihood of making lifestyle changes (e.g., motivational interviewing and mindfulness training);
- Modeling, skills training and behavioral rehearsal to facilitate successful coping with the disease/injury/disability and/or to improve health and well-being;
- Contingency and behavioral management to improve symptoms related to disease, injury, or disability management and daily care;
- Interventions designed to reduce health risk factors and prevent disease (e.g., smoking cessation, exercise and diet interventions) including environmental engineering to promote health and well-being;

- Consultation-liaison skills involving interventions with other health care professionals in the medical-surgical hospital setting.

**2. In addition to the professional practice domains described above, describe the theoretical and scientific knowledge required for the specialty and provide references for each domain as described below. For each of the following core professional practice domains, provide a brief description of the specialized knowledge that is required and provide the most current available published references in each area (e.g., books, chapters, articles in refereed journals, etc.) While reliance on some classic references is acceptable, the majority of references provided should be from the last five years and should provide scientific evidence for the theoretical and psychological knowledge required for the specialty.**

a. Assessment:

Assessment in health care settings differs from assessment as conducted in a private clinical practice or counseling center. In particular, the assessment is likely to be carried out in an environment where results will be integrated into medical treatment and a medical record that may be part of a larger health care system. These assessments are sometimes provided prior to medical treatment for candidate selection and to advise the medical team of the most appropriate course of action (e.g. bariatric presurgical evaluations, pre-transplant evaluations). Assessment approaches often include cognitive and behavioral assessment, psychophysiological assessment, clinical interviews, demographic surveys, objective and projective personality assessment and various other clinical and research-oriented protocols. Facets of assessment include referral question clarification, interview of the patient and relevant health care professionals, administration of assessment instruments, interpretation of results and communication of results to those with a need to know. Finally, a best practices approach to assessment includes a broad understanding of multiple methods of assessment and application of strategies for making choices that balance the often competing demands presented by the particular situation and context of each patient. Thus, clinical decision making, critical analysis and understanding of practical contingencies are considered essential.

#### Assessing adherence to self-care and medication regimens

Fan, Y., Shen, B. J., & Ho, M. R. (2024). Loneliness, perceived social support, and their changes predict medical adherence over 12 months among patients with coronary heart disease. *British Journal of Health Psychology*, 29(3), 814–832.  
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### Assessing appropriateness for various medical procedures

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### Assessing quality of life

Danielsen, J. T., Strøm, L., Knutzen, S. M., Schmidt, H., Amidi, A., Wu, L. M., & Zachariae, R. (2023). Psychological and behavioral symptoms in patients with melanoma: A systematic review and meta-analysis. *Psycho-oncology*, 32(8), 1208–1222. <https://doi.org/10.1002/pon.6184>

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### Cultural factors in health

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Wang, K. T., Kim, S. H., Wang, J. K., Wang, K. J., Jun, H. H., & Lee, D. D. (2024). FOBism Unveiled: Quantifying assimilative racism within Asians in the United States. *European Journal of Investigation in Health, Psychology and Education*, 14(10), 2800–2818. <https://doi.org/10.3390/ejihpe14100184>

### Knowledge and perceptions of illness

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b. Intervention:

In addition to possessing the knowledge, attitudes and values required to conduct traditional psychotherapeutic interventions, clinical health psychologists require unique foundational skills/competencies including: 1) a dynamic knowledge base and skill set necessary for working with individuals and families with physical health concerns, 2) the ability to access and evaluate the best available biopsychosocial evidence, 3) awareness of the unique nature of interdisciplinary collaboration in health care and the importance of patient-practitioner relationships; and 4) an understanding of the particular ethical-legal standards involved in the healthcare system. In addition, specific functional skills/competencies include knowledge of physiological, psychological and social-environmental factors associated with health behavior, illness, and disease and their implications for the delivery of biopsychosocial treatments. Specific interventions often include stress management, relaxation therapies, biofeedback, psychoeducation about normal and pathophysiological processes, ways to cope with disease and cognitive-behavioral and other psychotherapeutic interventions. Healthy people are taught preventive health behaviors. Both individual and group interventions are utilized. Frequently, clinical health psychology interventions focus upon buffering the effect of stress on health by promoting enhanced coping or improved social support utilization.

Adjustment to chronic disease

Fogarty, J. J., Fertig, M. R., Gulbicki, L., Ashar, D., O'Cleirigh, C., & Stanton, A. M. (2024). Identifying the ways in which tobacco cessation interventions have been tailored for sexual and gender minority individuals: A systematic review. *Journal of Health Psychology*, 13591053241284083. Advance online publication. <https://doi.org/10.1177/13591053241284083>

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Kenny, E., Coyne, R., McEvoy, J. W., McSharry, J., Taylor, R. S., & Byrne, M. (2024). Behaviour change techniques and intervention characteristics in digital cardiac rehabilitation: a systematic review and meta-analysis of randomised controlled trials. *Health Psychology Review*, 18(1), 189–228. <https://doi.org/10.1080/17437199.2023.2185653>

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### Diet and obesity

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### Digestive diseases

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Epton, T., Ghio, D., Ballard, L. M., Allen, S. F., Kassianos, A. P., Hewitt, R., Swainston, K., Fynn, W. I., Rowland, V., Westbrook, J., Jenkinson, E., Morrow, A., McGeechan, G. J., Stanescu, S., Yousuf, A. A., Sharma, N., Begum, S., Karasouli, E., Scanlan, D., Shorter, G. W., ... Drury, J. (2022). Interventions to promote physical distancing behaviour during infectious disease pandemics or epidemics: A systematic review. *Social Science & Medicine (1982)*, 303, 114946. <https://doi.org/10.1016/j.socscimed.2022.114946>

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### Lung diseases

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## Pain

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## Tobacco use

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## Women's health

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c. Consultation:

Clinical health psychologists must possess an ability to collaborate effectively with various healthcare providers and across disciplines in the optimal service of the patient. This requires knowledge of professional roles and expectations within the context of intra- and inter-disciplinary consultation in the healthcare setting. Further, clinical health psychologists must be able to: 1) conceptualize referral questions that bear on human behavior; 2) communicate about and cultivate mutual understandings regarding problems among individuals from diverse disciplines (e.g., medicine, nursing, physical therapy, social work, etc.); 3) translate and communicate relevant scientific findings as they bear on the healthcare consultation/liaison questions; 4) work with other disciplines to increase the likelihood of early referral for consultation, as opposed to “last resort” referrals; and 5) interact with fellow healthcare professionals in ways that facilitate improved treatment implementation, based on the unique contributions that clinical health psychology can make.

Consultation in primary care

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Consultation in subspecialty care

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academic center. *Journal of Clinical Sleep Medicine*, 20(11), 1793–1806.  
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McCrone, P., Patel, M., Hotopf, M., Moss-Morris, R., Ashworth, M., David, A. S., Husain, M., James, K., Landau, S., & Chalder, T. (2024). Cost-utility analysis of transdiagnostic cognitive behavioural therapy for people with persistent physical symptoms in contact with specialist services evaluated in the PRINCE secondary trial. *Journal of Psychosomatic Research*, 187, 111960.  
<https://doi.org/10.1016/j.jpsychores.2024.111960>

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<https://doi.org/10.1007/s10880-024-10006-8>

Toole, J., Vartak, N., Vransy, E., Vaidean, G., Goschin, S., Kogan, J., Rosen, S., & Gianos, E. (2024). Integration of psychological services with preventive cardiology consults: A feasibility study. *American Journal of Lifestyle Medicine*, 15598276241286011. Advance online publication.  
<https://doi.org/10.1177/15598276241286011>

d. Supervision:

The supervision and teaching role of the clinical health psychologist requires attention to the interdisciplinary nature of the health care setting and the different roles, identities, standards and health-related beliefs of other health care professions within the setting. Specifically, supervision must foster the trainees' ability to: 1) deal effectively with issues and challenges that may be unique to working in health care settings (e.g., death and dying, infection control); 2) utilize technology to obtain both the basics and the latest information about disease pathophysiology; 3) appreciate the unique knowledge base, skill sets and roles in the health care team, and limitations and boundaries of the professions that provide services to the population being treated; 4) take into account individual and cultural differences of both consumers and other members of the health care team; and 5) assert professional autonomy and identity. In addition, clinical health psychologists may be involved in the teaching and supervision of psychology trainees and trainees from other disciplines (e.g., medicine, nursing, physical therapy).

Boutry, C., Rathbone, J., Gibbons, F., Brooks, D., Moghaddam, N., Mays, C., Patel, P., & Malins, S. (2024). Experiences of deliberate practice orientated psychological skills training for cancer care staff: Barriers and facilitators to learning and implementation in practice. *Journal of Health Psychology*, 29(5), 467–480.  
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Mathis, M., & Lamparyk, K. (2024). Navigating supervision and interprofessional relationships in health psychology. *Journal of Clinical Psychology in Medical Settings*,

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<https://doi.org/10.1007/s10880-024-10021-9>

e. Research and inquiry:

The distinct focus of clinical health psychology research is on physical health problems and is dedicated to the scientific development of knowledge regarding the interface between behavior and health and to the delivery of high quality services based on that knowledge to individuals, families and health care systems. Broadly speaking, clinical health psychologists are actively involved in clinical and basic research related to the promotion of health and the prevention, treatment and rehabilitation of illness and disability. More specifically, clinical health psychology researchers are on the leading edge of research focusing on the biopsychosocial model in areas such as HIV, oncology, psychosomatic illness, treatment adherence with medical regimens, health promotion and the effect of psychological, social and cultural factors on numerous specific disease processes (e.g., diabetes, cancer, hypertension and coronary artery disease, chronic pain and sleep disorders).

Randomized trials

Crawshaw, J., Meyer, C., Antonopoulou, V., Antony, J., Grimshaw, J. M., Ivers, N., Konnyu, K., Lacroix, M., Presseau, J., Simeoni, M., Yogasingam, S., & Lorencatto, F. (2023). Identifying behaviour change techniques in 287 randomized controlled trials of audit and feedback interventions targeting practice change among healthcare professionals. *Implementation Science : IS*, 18(1), 63. <https://doi.org/10.1186/s13012-023-01318-8>

Hsu, T. C., Whelan, P., Gandrup, J., Armitage, C. J., Cordingley, L., & McBeth, J. (2024). Personalized interventions for behaviour change: A scoping review of just-in-time adaptive interventions. *British Journal of Health Psychology*, 10.1111/bjhp.12766. Advance online publication. <https://doi.org/10.1111/bjhp.12766>

Translational research

Rabin, B. A., Smith, J. D., Dressler, E. V., Cohen, D. J., Lee, R. M., Goodman, M. S., D'Angelo, H., Norton, W. E., & Oh, A. Y. (2024). Designing for data sharing: Considerations for advancing health equity in data management and dissemination. *Translational Behavioral Medicine*, 14(11), 637–642. <https://doi.org/10.1093/tbm/ibae049>

Simoun, A., Fleet, A., Scharf, D., Pope, L., Spaeth-Rublee, B., Goldman, M. L., & Pincus, H. A. (2024). Technology for advancing behavioral health integration: implications for behavioral health practice and policy. *Translational Behavioral Medicine*, ibae043. Advance online publication. <https://doi.org/10.1093/tbm/ibae043>

### Community-based participatory research

Pedersen, M., Harris, K. J., Lewis, J., Grant, M., Kleinmeyer, C., Glass, A., Graham, N., Brown, B., & King, D. (2021). Uplifting the voices of rural American Indian older adults to improve understanding of physical activity behavior. *Translational Behavioral Medicine*, 11(9), 1655–1664. <https://doi.org/10.1093/tbm/ibab107>

Persad-Clem, R., Ventura, L. M., Lyons, T., Keinath, C., Graves, K. D., Schneider, M. L., Shelton, R. C., & Rosas, L. G. (2023). Community engagement in behavioral medicine: A scoping review. *International Journal of Behavioral Medicine*, 10.1007/s12529-023-10242-6. Advance online publication. <https://doi.org/10.1007/s12529-023-10242-6>

Windsor, L. C., Benoit, E., Pinto, R. M., Gwadz, M., & Thompson, W. (2021). Enhancing behavioral intervention science: using community-based participatory research principles with the multiphase optimization strategy. *Translational Behavioral Medicine*, 11(8), 1596–1605. <https://doi.org/10.1093/tbm/ibab032>

### Theoretical models in health and behavior change

O'Rourke, L., Fisher, P. L., Campbell, S., Wright, A., & Cherry, M. G. (2021). Factors associated with fear of cancer recurrence in family caregivers of cancer survivors: A systematic review. *Frontiers in Psychology*, 12, 625654. <https://doi.org/10.3389/fpsyg.2021.625654>

Petrova, D., Okan, Y., Salamanca-Fernández, E., Domínguez-López, S., Sánchez, M. J., & Rodríguez-Barranco, M. (2020). Psychological factors related to time to help-seeking for cancer symptoms: a meta-analysis across cancer sites. *Health Psychology Review*, 14(2), 245–268. <https://doi.org/10.1080/17437199.2019.1641425>

#### f. Public interest:

Clinical health psychologists are well suited to develop and advocate for programs and policies that improve physical health outcomes and quality of life. They are also knowledgeable about healthcare delivery systems and models and are able to assume positions of leadership in multidisciplinary healthcare teams and healthcare institutions.

Grunberg, V. A., & Vranceanu, A. M. (2023). Integrating mind, body, and technology: Building virtual psychosocial programs for medical populations. *Health Policy and Technology*, 12(1), 100700. <https://doi.org/10.1016/j.hlpt.2022.100700>

Hughes, L. D., Gamarel, K. E., King, W. M., Goldenberg, T., Jaccard, J., & Geronimus, A. T. (2022). State-level policy stigma and non-prescribed hormones use among trans populations in the United States: A mediational analysis of insurance and anticipated stigma. *Annals of Behavioral Medicine*, 56(6), 592–604. <https://doi.org/10.1093/abm/kaab063>

g. Continuing professional development:

Ongoing continuing education opportunities are provided by major health psychology organizations at international, national and state levels (e.g., Society for Health Psychology; Division of Health Psychology of the British Psychological Society; European Health Psychology Society; Health Section of the Canadian Psychological Association). These opportunities exist in the form of clinical, research and ethics programming at annual conferences, published resources (e.g., specialty journals, books and book series, treatment manuals, etc.), and online continuing education offerings.

MacIntyre, E., Pinto, E., Mouatt, B., Henry, M. L., Lamb, C., Braithwaite, F. A., Meulders, A., & Stanton, T. R. (2024). The influence of threat on visuospatial perception, affordances, and protective behaviour: A systematic review and meta-analysis. *Clinical Psychology Review*, 112, 102449. <https://doi.org/10.1016/j.cpr.2024.102449>

Voisard, B., Dragomir, A. I., Boucher, V. G., Szczepanik, G., Bacon, S. L., & Lavoie, K. L. (2024). Training physicians in motivational communication: An integrated knowledge transfer study protocol. *Health Psychology*, 43(11), 842–852. <https://doi.org/10.1037/hea0001395>

Textbook resources

Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2024). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention* (3rd ed.). American Psychological Association. <https://doi.org/10.1037/0000380-000>

Labott, S. M. (2019). *Health psychology consultation in the inpatient medical setting*. American Psychological Association. <https://doi.org/10.1037/0000108-000>

Taylor, S. E. (2020). *Health psychology* (11th ed.). McGraw-Hill Education.

Wachholtz, A. (2020). *Clinical health psychology: Integrating medical information for improved treatment outcomes*. Cognella.

**3. Identify professional practice activities associated with the specialty in each of the following domains and how they differentiate and where they might overlap with other specialties.**

Practitioners in clinical health psychology are required to receive training and to demonstrate the same profession-wide skills/competencies of all other health service psychologists. Although clinical health psychologists possess competencies to engage in these activities, and many overlap with those of psychologists in other specialty areas (e.g.,

traditional psychological and intellectual assessment; therapeutic interventions aimed at mental health problems), the types of activities they perform as clinical health psychologists are distinctive in their focus and content as follows:

a. Assessment:

- Demonstrate knowledge and understanding of biological, psychological and social and environmental assessment strategies and their results used in health care settings.
- Evaluate the presenting problem and select and administer empirically supported biopsychosocial assessments appropriate for the patient's physical illness, injury or disability.
- Conduct a comprehensive biopsychosocial interview and evaluate objective biological and psychosocial findings related to physical health or illness, injury or disability.
- Assess biopsychosocial and behavioral risk factors for the development of physical illness, injury or disability.
- Assess environmental factors that facilitate or inhibit patient knowledge, values, attitudes and/or behaviors affecting health functioning and health care utilization.
- Assess biopsychosocial factors affecting adherence to recommendations for medical and psychological care.
- Assess the biopsychosocial impact of medical procedures (including screening, diagnostic and intervention/prevention procedures).
- Solicit input of significant others in the assessment process as indicated.
- Communicate the results of assessments to both professional and lay audiences in the health care setting.

b. Intervention:

- Access, evaluate, and utilize information in designing and implementing treatment, health promotion, and prevention intervention using new and emerging health technologies.
- Implement individual- or family-level treatment interventions that are evidence-based to treat health- and mental health-related issues.
- Implement evidence-based interventions for individuals and populations along a continuum, from acute clinical need to subclinical problems to prevention and wellness.
- Evaluate, select and administer appropriate assessments for the purpose of monitoring and evaluating the process and outcomes of treatment and rehabilitative services.

c. Consultation:

- Demonstrate knowledge of own and others' professional roles and expectations within the context of intradisciplinary and interdisciplinary consultation in the health care setting.

- Conceptualize referral questions that bear on human behavior (including an understanding of the patient's, other providers' or health systems' role).
- Translate and communicate relevant scientific findings as they bear on the health care consultation/liaison questions.
- Work with professionals from other disciplines to increase the likelihood of appropriate early referral for consultation with clinical health psychologists, as opposed to "last resort" referrals.

d. Supervision:

- Supervise clinical health psychology skills, conceptualization and interventions for psychologists, psychology trainees and behavioral health providers from other health professions.
- Demonstrate awareness of the conflicts between training and service in health care settings and negotiate for optimal integration and reimbursement of these activities.
- Be proactive and anticipate the scope of problems and issues that might be encountered.
- Deal effectively with the kinds of issues and challenges that may be unique to working in health care settings (e.g., death and dying, infection control).
- Utilize informatics and other technology-based methods to obtain both the basics and the latest information about a disease being addressed.
- Demonstrate awareness of and appreciation for the unique knowledge base, skill sets, roles in the health care team and limitations and boundaries of the professions that provide services to the population being treated.
- Train students to assert their professional autonomy and identity.
- Provide supervision that considers individual and cultural differences of both patients, families and members of the health care team.
- Encourage behavior that appropriately respects the professional autonomy of other professions.
- Provide effective instruction and supervision in psychology both to psychology trainees and across disciplines and across levels of training.
- Provide effective instruction and supervise the conduct of health related research across disciplines.

e. Research and inquiry:

- Apply diverse methodologies to scientifically examine psychosocial and biological processes as they relate to health promotion, illness prevention and disease progression.
- Select, apply and interpret quantitative and qualitative data analytic strategies that are best suited to the diverse research questions and levels of analysis characteristic of health psychology.
- Formulate and implement health-related research using interdisciplinary research teams.



- Accurately and efficiently communicate research findings in ways that can be understood by fellow psychologists, professionals from other disciplines and lay audiences.
- Use research skills to evaluate the effectiveness and quality of clinical health psychology services within health care settings, including participation in quality improvement efforts.

f. Public interest:

- Seek to meet performance criteria for becoming credentialed by the American Board of Professional Psychology in clinical health psychology.
- Apply applicable APA ethical principles and state and federal laws that apply to medical patients (e.g. American with Disabilities Act, advance directives, capacity for medical decision making, etc.)
- Conduct the “business” of health psychology practice and research management (e.g., electronic coding and records management; personnel recruitment, evaluation, and retention; development of policy and procedures manuals) in an ethical and appropriate manner.
- Develop clinical health psychology services and evaluate their effectiveness and quality.
- Provide leadership within an interdisciplinary team or organization (e.g., demonstrate skill/competence in seeking consultation when appropriate; managing the ethical dilemmas in the context of an interdisciplinary professional setting) to ensure consumer needs are met.
- Integrate the talents and skills of professionals from different disciplines and different levels of training (e.g., masters, doctoral) to optimize treatment.
- Participate in activities to educate the community (general public, legislators, patients) about the impact of behavioral factors on health and available clinical services.
- Demonstrate recognition that advocacy to improve population health involves interacting with a number of systems (e.g., the health care system, local funders, federal funders, etc.).
- Advocate for increased resources for research and training in clinical health psychology at local, state and federal levels.

g. Continuing professional development:

- Seek to meet performance criteria for becoming credentialed by the American Board of Professional Psychology in clinical health psychology.
- Affiliate with scientific/professional organizations whose mission it is to advance knowledge and practice in health psychology.
- Engage in continuing education and life-long learning activities to strengthen existing skills/competencies and add new competencies.
- Participate in local, national or international organizational activities in health psychology (e.g., elected office, committee membership, program development, task forces).

- Establish mentoring relationships in the specialty in practice, research, public interest or educational endeavors.

h. Any relevant additional core professional practice domains:

- Demonstrate knowledge of mission and organizational structure, relevant historical factors and position of psychology in the health care organization and system.
- Demonstrate knowledge of appropriate methods to develop a clinical health psychology practice, educational program and/or program of research.
- Demonstrate leadership within an interprofessional team or organization in the health care setting.

As conveyed in the preceding sections, clinical health psychology is distinctive from other specialty areas in its *primary* focus on medical conditions or health risk factors that can be prevented, treated, managed and/or recovered. In the area of assessment, clinical health psychology employs biopsychosocial measures to assess current functioning and use this information to guide the medical team. While both clinical health and clinical neuropsychology might assess cognitive functioning, the clinical health psychology assessment is distinctive in helping to make immediate care decisions, whereas clinical neuropsychology might conduct a more comprehensive assessment of cognitive functioning to make more long-term treatment and rehabilitation planning. The interventions provided by a clinical health psychology would similarly focus on disease prevention, prevention, management, and recovery. Whereas rehabilitation psychology would focus more on adaption and accommodation to illness/injury, clinical health psychology would provide interventions over the course of illness and extends into areas of health maintenance, health promotion and the prevention of illness. Consultation practice activities might be shared with other specialties (e.g. pediatric, rehabilitation) but would tend to be focused on the broad medical team involved in the care of patients. Supervision practice activities would be largely shared with other specialties but tends to be more distinctive in the focus on direct observation as a teaching method with content focused on the larger medical team interactions. Research activities are distinctive in terms of the subject matter investigated but would share research methodology common to other specialties. Public interest practice activities would be shared with other specialties (e.g. ethics, coding and billing, advance directives, etc.) but would be distinctive in their advocacy for systemic health improvement changes (i.e. population health), quality improvement activities and interdisciplinary team development. Continuing professional development professional activities would share common methods but would be distinctive in the content of study (e.g. clinical health psychology topics and interdisciplinary team development skills). Health psychologists are uniquely trained to apply health psychology research to individuals, families, groups and systems for the promotion of health and well-being or to address health-related concerns.<sup>1</sup>

<sup>1</sup> Eyer, JC, et al. (2015). APA Division 38 Task Force on Branding: Public Definitions. Archives: admin@societyforhealthpsychology.org

**Criterion V. Advanced Scientific and Theoretical Preparation.** In addition to a shared core of knowledge, skills and professional attitudes required of all practitioners, a specialty requires advanced, specialty-specific scientific knowledge.

*Commentary: Petitions demonstrate how advanced scientific and theoretical knowledge is acquired and how the basic preparation is extended.*

**1. Specialty education and training may occur at the doctoral (including internship), postdoctoral or post-licensure levels. State the level of training of the proposed specialty.**

Specialty education and training in clinical health psychology begins at the doctoral level, continues with experiential training during internship and is most often completed during postdoctoral training. During doctoral training, future clinical health psychologists acquire general health service psychology skills and competencies that are typically augmented by academic coursework and some practicum experiences specifically related to health. Based upon our *Clinical Health Psychology Specialty Education and Training Taxonomy* (see Appendix IV; also posted at <https://societyforhealthpsychology.org/articles-resources/education-training/clinical-health-psychology-taxonomy/>), doctoral and internship programs provide content distinctive to the specialty of clinical health psychology characterized as an *Exposure*, *Experience*, *Emphasis* or *Major Area of Study*, using the terminology used to describe levels of specialty training outlined in *Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Services Specialties* (APA, 2012; Rozensky et al., 2015). The *Clinical Health Psychology Specialty Education and Training Taxonomy* outlines didactic, research, and clinical training experiences in the specialty that comprise doctoral, internship, postdoctoral and post-licensure training programs in clinical health psychology.

Although all accredited doctoral programs in health service psychology ensure coverage of discipline-specific knowledge and acquisition of profession-wide skills/competencies that are required according to the *Standards of Accreditation for Health Service Psychology* (APA, 2015), programs differ in the breadth and depth of specialty-specific training activities. For instance, many doctoral programs offer specialty training at the *Exposure* or *Experience* level (e.g., one course in health psychology and/or one clinical health psychology practicum). In these types of programs, the *Exposure* or *Experience* level of training specific to clinical health psychology is not sufficient for acquiring the full set of skills/competencies required for entry into practice as a clinical health psychologist. For trainees completing these programs, supplemental courses are needed to provide basic introduction to the medical and public health issues that are considered essential competency areas of clinical health psychology. Not all faculty in these types of programs have training in health psychology. By contrast, programs that offer an *Emphasis* or a *Major Area of Study* in clinical health psychology provide a “structured, in-depth opportunity for knowledge acquisition, practical experience, and scientific study in our given specialty area.”

Regardless of the sequence or level of coverage of specialty training at any given time point, it is expected by completion of training that entry level clinical health

psychologists will share a common set of core skills/competencies in the specialty. These competencies exist in harmony with the broader set of profession-wide competencies for health service psychology, as developed by the Health Service Psychology Education Collaborative (HSPEC) and subsequently adopted by the Commission on Accreditation for doctoral programs in health service psychology (APA, 2015; HSPEC, 2013; Larkin & Klonoff, 2014).

2. **Training at the doctoral level is assumed to be primarily broad and general. If specialty training occurs in whole or in part at the doctoral level, describe that training. If there is specialty specific scientific knowledge that is typically integrated with aspects of the broad and general psych curriculum (e.g., biological bases of behavior, cognitive-affective bases of behavior, individual bases of behavior, ethics (science and practice) rather than taught as a freestanding course or clinical experience, specify how this integration occurs.**

The balance of training in broad and general skills/competencies and specialty-specific skills/competencies at the doctoral program depends upon the level of training the program espouses to employ. For example, programs that provide *Exposure* or *Experience* in clinical health psychology will consist of content primarily covering broad and general skills/competencies (i.e., discipline-specific knowledge and profession-wide competencies), whereas programs that provide an *Emphasis* or *Major Area of Study* cover much more content in the specialty area. Regardless of the level of education and training opportunities in the specialty in the doctoral training program, all doctoral programs ensure the acquisition of broad and general skills/competencies of health service psychology.

3. **If specialty training occurs in full or in part during a formal postdoctoral program describe the required education and training and other experiences during the postdoctoral residency. Are there any doctoral level prerequisites beyond an APA-accredited degree in professional psychology required for postdoctoral training?**

In general, training in clinical health psychology occurs at all levels: doctoral, internship and postdoctoral. Congruent with the eligibility requirements for board certification in clinical health psychology, the paradigmatic sequence of training consists of one of the following post-doctoral pathways:

- a. The applicant can apply for certification upon successful completion of at least one year of an APA/CPA accredited clinical health psychology postdoctoral fellowship or a clinical child psychology postdoctoral fellowship with a major area of study (80%) in pediatric health psychology **OR**
- b. If the applicant completed an APA/CPA accredited postdoctoral fellowship before October 29, 2021, in an area other than clinical health psychology, but at least 50% of the training was in clinical health psychology, the applicant can apply for certification after one additional year of clinical health psychology experience following the fellowship **OR**

- c. If the applicant completed a non-accredited postdoctoral fellowship with 80% supervised training in clinical health psychology, the applicant could apply for certification after one additional postdoctoral year of supervised clinical health psychology experience<sup>1</sup> **OR**
- d. The applicant can apply for certification after three post-licensure years with evidence of continued education including one-year post-licensure supervised experience in clinical health psychology and two additional years of post-licensure clinical health psychology experience. To qualify for this option the applicant must demonstrate a major area of study in clinical health psychology by attesting to either at least  $\geq 45$  continued education credits in clinical health psychology **AND/OR**  $\geq$  three clinical health psychology courses.<sup>2</sup>

Regardless of training sequence, entry-level clinical health psychologists by the conclusion of postdoctoral training are expected to possess a set of core skills/competencies in the specialty. Postdoctoral fellowships seeking accreditation as clinical health psychology training programs must demonstrate that residents have achieved these skills/competencies upon completion. Since our last application for specialty recognition, the Clinical Health Psychology Specialty Council was asked to articulate the outcome competencies required for evaluating post-doctoral training programs in our specialty area by APA's Commission on Accreditation. The Commission sought input from the specialty area as they developed criteria for evaluating programs providing post-doctoral training in clinical health psychology for purposes of accreditation. The Specialty area commissioned a task force, chaired by Dr. Rick Seime, to define skills/competencies for entry level practice in clinical health psychology. The task force's initial draft was sent for comment to all member organizations comprising the Clinical Health Psychology Specialty Council and sent to the Commission in July 2017. The draft was posted for public comment and eventually approved by APA in September of 2021 (see Appendix V; also posted at: <https://www.cospp.org/copy-of-education-and-training-guid>). In brief, the document outlines entry level competencies in the following areas (see Appendix V for detailed description of each of these competency areas):

- Research
- Professional Values, Attitudes, and Behaviors
- Communication and Interpersonal Skills
- Assessment
- Intervention
- Teaching/Supervision
- Consultation and Interprofessional/Interdisciplinary Skills
- Leadership

<sup>1</sup> Supervised clinical health psychology experience defined as supervision being provided by persons with competencies in clinical health psychology demonstrated by appropriate training, qualifications, or credentials (e.g., ABPP, HSP) as clinical health psychologists. The supervisor attests to have provided supervision for at least 1000 hours of supervised clinical health psychology experience.

<sup>2</sup> Clinical Health Psychology course: Must have content congruent with *Clinical Health Psychology 2018 Education and Training Guidelines* (available on Council of Specialties in Professional Psychology website <https://cospp.org/education-and-training-guidelines-1>).

**4. If specialty training occurs in full or in part post-licensure, describe the required education and training during this training. Are there any doctoral level prerequisites beyond an APA- accredited degree in professional psychology required for post-licensure training?**

Specialty training in clinical health psychology is received wholly or predominantly prior to licensure. However, generalist/health service psychology training is necessary but not sufficient for competence in the specialty; as noted by Larkin and Klonoff (2014), “most [health service psychologists] will not acquire the full range of skills needed for the competent practice of clinical health psychology.”

At present, there are no formal programs that prepare licensed psychologists to specialize in clinical health psychology. However, the process of board certification in clinical health psychology allows for a pathway that includes supervised practice and experience in the specialty and demonstration of specialty-specific skills/competencies, which may be developed through consultation, continuing education, and other mechanisms.

References:

American Psychological Association. (2012). *Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties*. Washington, DC: Author.

American Psychological Association. (2015). *Standards of Accreditation for Health Service Psychology*. Washington, DC: Author.

Health Service Psychology Education Collaborative (2013). Professional psychology in health care services: A blueprint for education and training. *American Psychologist*, 68(6), 411-426.

Larkin, K. T., & Klonoff, E. A. (2014). *Specialty competencies in clinical health psychology*. New York: Oxford University Press.

Rozenky, R. H., Grus, C. L., Nutt, R. L., Carlson, C. I., Eisman, E. J., & Nelson, P. D. (2015). A taxonomy for education and training in professional psychology health service specialties: Evolution and implementation of new guidelines for a common language. *American Psychologist*, 70(1), 21-32.

**Criterion VI. Advanced Preparation in the Parameters of Practice.** A specialty requires the advanced didactic and experiential preparation that provide the basis for services with respect to the essential parameters of practice. The parameters to be considered include a) populations, b) psychological, biological, and/or social problems, and c) procedures and techniques. These parameters should be described in the context of the range of settings or organizational arrangements in which practice occurs and at each level that specialty training occurs.

***Commentary:***

***A) Populations.*** This parameter focuses on the populations served by the specialty, encompassing both individuals and groups. Examples of persons representing diversity include but are not limited to the following: children, youth and families; older adults; workforce participants and those who seek employment; men; women; persons of color, members of racial and ethnic communities, and persons speaking English as a second or subsequent language; gay, lesbian, bisexual and transgender individuals; persons of various socioeconomic status groups; religious communities; and those with physical and/or mental disabilities.

***B) Psychological, Biological, and/or Social Problems.*** This parameter focuses on symptoms, problem behaviors, rehabilitation, prevention, health promotion and enhancement of psychological well-being addressed by the specialty. It also includes attention to physical and mental health, organizational, educational, vocational, and developmental problems.

***C) Procedures and Techniques.*** This parameter consists of the procedures and techniques utilized in the specialty. This includes assessment techniques, intervention strategies, consultative methods, diagnostic procedures, ecological strategies, and applications from the psychological laboratory to serve a public need for psychological assistance.

**1. Describe the advanced didactic and experiential preparation for specialty practice in each of the following parameters of practice:**

**a. populations (target groups, other specifications):**

As noted earlier, the populations served by clinical health psychologists include any individual of any age with a disease or medical condition that could be prevented, treated or rehabilitated through the use of psychological techniques or procedures. The primary focus is on problems that present as physical complaints or behavioral factors impacting physical health, as opposed to issues that are restricted to emotional or mental health. Health psychologists deal with modifiable lifestyle behaviors such as smoking, poor diet, lack of exercise, drug and alcohol misuse and coping with stress. Thus, at all levels of training, clinical health psychologists must have supervised experience working directly in a medical setting alongside other health professionals. This includes working with a diverse range of patients of all ages and characteristics, seen in settings that include academic health science centers and associated teaching hospitals, community hospitals and clinics, rehabilitation

settings, military hospitals, VA hospitals, schools, medical and surgical private practices, dental clinics, nursing facilities and pediatric hospitals. Clinical health psychologists often work closely with medical practitioners inside or outside of medical settings in providing treatment for chronic pain, medication and therapy side effects (e.g. nausea and vomiting associated with cancer chemotherapy), failure to adhere to treatment regimens, preparation for stressful medical procedures (e.g., bone marrow aspirations), stress-related diseases and disorders and an array of movement and other problems (e.g., Tourette's syndrome). They facilitate primary, secondary and tertiary prevention efforts in a variety of medical areas, including, but not limited to, cardiovascular disease, diabetes, cancer, HIV/AIDS and gynecological problems.

b. problems (psychological, biological, and/or social (including symptoms, problems behaviors, prevention, etc.):

Clinical health psychology focuses on the interplay between behavior and physical health. Patients with physical problems often have psychological reactions that can affect the illness, physical problems can present as if they were solely psychological issues, and some physical problems are successfully treated by psychological interventions. In addition, many illnesses are caused by psychological stress or exacerbated by lifestyle concerns (e.g., smoking, poor diet, lack of exercise), and interventions for these issues are typically behavioral. Because clinical health psychologists are trained in the biological, social, affective, cognitive and psychological aspects of physical health and illness, they are able to assess, treat, conduct research and design programs related to the prevention, treatment and rehabilitation of disease, as well as the promotion of health. Educational programs are usually based in universities, medical schools or hospitals and typically housed in a clinical psychology program with an *Emphasis* or *Major Area of Study* in clinical health psychology.

c. procedures and techniques (for assessment, diagnosis, intervention, prevention, etc.):

Procedures and techniques required of clinical health psychologists have been described above. Although they possess the competencies to assess, diagnose and treat or prevent a broad range of presenting problems commonly seen by health service psychologists, there are unique procedures and techniques that clinical health psychologists deploy in their practices. Regarding assessment procedures, clinical health psychologists are trained to understand and utilize assessment strategies commonly used in the modern health care environment, including those obtained during regular clinic visits (e.g., blood pressure, heart rate, BMI), blood or urine assays (e.g., HbA1C, blood lipids, cortisol), and through contemporary scanning technologies (e.g., fMRI, echocardiography). They are equally facile in interpreting results of psychometric assessments of medical symptoms (e.g., chronic pain inventories; measures of patient adherence, symptom severity, and quality-of-life) and assessing environmental factors that affect health outcomes (e.g., living in a food desert; having limited access to health care; social determinants of health). Their competency in assessment makes them natural leaders, as health care facilities gather outcomes data crucial for survival in the healthcare environment.



Regarding diagnosis, clinical health psychologists lend their expertise in diagnosing psychological symptoms that may interfere with management of numerous conditions treated in health care settings. It is a routine practice for clinical health psychologists to conduct evaluations of patients being considered for bariatric surgery, blood and organ transplantation and a range of pain-control interventions, including the prescription of opioid medications.

Congruent with their broad competencies in the area of assessment, clinical health psychologists possess the knowledge and skill to conduct psychological interventions with patients seeking medical care that no other members of treatment teams can provide. Based upon their expertise in the science of behavior, they devise and carry out intervention or prevention programs that facilitate smooth operations of treatment teams (e.g., preparing patients for painful medical procedures, working with patients to improve adherence to treatment plans, implementing behavior change interventions to decrease tobacco use or increase physical activity).

In sum, clinical health psychologists possess specialized competencies in assessment, diagnosis, intervention and prevention that complement the traditional competencies of health service psychologists. By adding their expertise in the biological and social determinants of health, the presence of a clinical health psychologist ensures that the provision of health care is fully based on the biopsychosocial model of health.

All of these skills and competencies are developed through experience, modeling and supervision, with supervised postdoctoral experience being the time for more focused development (Larkin & Klonoff, 2014; also see Criterion V for a review of recently developed competencies for postdoctoral residency training in clinical health psychology). The final step in demonstrating skill/competence should be specialty board certification as a clinical health psychologist.

It should be noted that clinical health psychologists frequently develop sub-specializations based upon their work environment and the nature of the medical problems treated in their location of practice. This is a natural outcome when clinical health psychologists with sub-specialty competencies are in great demand in most health care settings, in addition to private/independent practice settings. Consequently, clinical health psychologists have begun to identify themselves as cardiac psychologists, pain psychologists, pediatric psychologists, transplant psychologists, oncology psychologists, women's health psychologists or primary care psychologists.

## References

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Larkin, K. T., & Klonoff, E. A. (2014). *Specialty competencies in clinical health psychology*. New York: Oxford University Press.

## **Criterion VII. Structures and Models of Education and Training in the Specialty.**

The specialty has structures and models to implement the education and training sequence of the specialty that reference and employ the American Psychological Association's *Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties and Subspecialties* (APA, 2020). The structures are stable, sufficient in number, and geographically distributed and may be found at the doctoral, doctoral internship, postdoctoral, and/or post-licensure level.

### ***Commentary:***

**A) *Sequence of Training.*** A petition describes a typical sequence of training, including curriculum, research, and supervision.

**B) *History and Geographic Distribution.*** A specialty has at least four identifiable psychology programs providing education and training in the specialty in more than one region of the country and which have produced an identifiable body of graduates over a period of years.

**C) *Psychology Faculty.*** Specialty programs have an identifiable psychology faculty responsible for the education and training of students and their socialization into the specialty. The faculty has expertise relevant to the education and training offered. Faculty may include individuals from other disciplines as appropriate. Specialty programs also have a designated psychologist who is clearly responsible for the integrity and quality of the program and who has administrative authority commensurate with those responsibilities. This psychologist has an advanced credential from a recognized board certification organization attesting to their specialty knowledge and skills and a record of scholarly productivity as well as other clear evidence of professional competence and leadership like fellow status in the American Psychological Association or the Canadian Psychological Association, or other evidence of equivalent professional recognition.

**D) *Procedures for Evaluation.*** Specialty programs regularly monitor the progress of trainees to ensure the relevance and adequacy of the curriculum and integration of the various training components. Attention focuses on the continuing development of the trainee's knowledge, skills, attitudes, and values. Formal performance-based feedback is provided to trainees in the program.

**E) *Admission to the Program.*** Program descriptions specify the nature and content of the program and whether they are designed to satisfy current licensing and certification requirements for psychologists as well as whether or not graduates can satisfy the education and training requirements for advanced recognition in the specialty. Postdoctoral programs have procedures that take into account the trainees' prior academic and professional record. These programs design an education and training experience that builds upon the doctoral program and doctoral internship and the professional experiences of the postdoctoral residents as they prepare for meeting the guidelines of preparation for the specialty.

**F) *Post-licensure Training.*** A petition describes acceptable post-

*licensure specialty training that may go beyond any state or providence licensing requirements for psychologists. This may include re-acquaintance with recommended specialty topics after certain time periods (e.g., recommending X hours of CEs in Evidence Based Practices every X number of years), additional contact hours treating clients within that specialty, and additional supervision hours by appropriately identified specialty supervisors. Specialties may give broad guidelines for maintaining competency in the specialty through continuing education and/or give detailed guidelines for Specialty sponsored credentialing programs.*

*Post-licensure certificate programs are designed to allow psychologists to expand their areas of expertise throughout their careers. When programs offer different levels of competency training (e.g., Exposure, Experience, Emphasis and/or Major Area of Study each level has clearly stated criteria for CE hours, required contact hours with clients being treated within that specialty, and required supervision hours with a supervisor that the program has vetted for expertise in that specialty area. Post-licensure programs may choose to give certificates at any or all levels of exposure.*

**1. How are education and training programs in the specialty recognized? How many programs exist in the specialty?**

Education and training programs in Clinical Health Psychology are recognized in part by the **Council of Clinical Health Psychology Training Programs (CCHPTP)**. CCHPTP promotes the advancement of graduate and postgraduate education and training within the field of clinical health psychology, with a commitment to multiculturalism, social justice and integrated-care training that prepares health psychologists to deliver state-of-the-science and culturally-responsive services in a variety of research and clinical health care settings to meet the needs of diverse cultural and linguistic communities across the nation. Consistent with this purpose, CCHPTP member programs strive to educate and train future clinical health psychologists to promote human welfare and to advance the growth of health psychology science and practice. CCHPTP espouses graduate and postdoctoral education and training that produces a clinical health psychologist capable of functioning as a scientific investigator and as a practitioner, consistent with the highest standards of clinical health psychology.

The primary objectives of CCHPTP are to promote:

- a. The scientific basis of clinical health psychology.
- b. Education and training in and use of assessment and intervention procedures in clinical health psychology that are empirically supported.
- c. Education and training in evidence-based practice, which is a process of clinical decision making that involves the integration of best available research evidence with clinical expertise and patient preference and characteristics.
- d. Research regarding the validation of assessment and treatment techniques as well

- as any other research of interest to clinical health psychologists.
- e. Education and training in the research methodology for developing and evaluating new assessment and intervention procedures in clinical health psychology.
- f. Dissemination of information, exchange of views, collection of data, and facilitation of communication concerning education and training in clinical health psychology.
- g. Participation in the formulation of policies concerning clinical health psychology education and training.
- h. Representation of CCHPTP programs within organizations relevant to graduate and postgraduate education in clinical health psychology.
- i. Consultation in clinical health psychology education and training to other scientific and professional organizations.
- j. Cooperation with other organizations concerned with clinical health psychology.

Full membership in CCHPTP is offered to doctoral, internship, and postdoctoral programs that meet all of the following criteria:

- a. Accredited by the APA or Canadian Psychological Association.
- b. Programs that train health service psychology students with skills/competencies in the science and practice of clinical health psychology.
- c. Programs that provide training at the *Major Area of Study* or *Emphasis* levels of the Taxonomy (APA, 2024; see Criterion IV and Appendix IV for further details).

CCHPTP also offers Associate membership to accredited programs in health service psychology that demonstrate commitment to training students in the specialty and offer training at the *Experience* or *Exposure* levels of the Taxonomy. Individual membership is open to psychologists who are interested in the education and training of clinical health psychologists but who are unaffiliated with a CCHPTP member program. Finally, Student membership is open to students/trainees enrolled in graduate, internship and postdoctoral training programs that provide clinical health psychology training. Membership criteria are further elaborated in the applications for program and individual membership (see Appendix VI).

As of this writing, CCHPTP has a total of 69 active member programs, including 29 doctoral and 40 internship and/or postdoctoral training programs.

## **2. Describe the qualifications necessary for faculty who teach in these programs. Describe the qualifications required for the director of such programs.**

Faculty members who teach in doctoral programs that offer training in clinical health psychology at the *Major Area of Study* or *Emphasis* levels are expected to engage in research, teaching, mentoring and clinical activities that relate to the specialty. It is important to note that many researchers in health psychology are not trained as health

service psychologists (e.g., are trained in social or some other area of psychology), and so it is acceptable at all levels for research to be supervised by someone who does not have practice training. However, trainees' clinical work must be supervised by clinical health psychologists during their training. Individuals who lead training programs in clinical health psychology are expected to be more senior level clinical health psychologists who have advanced specialty level knowledge and skills.

Faculty members who teach and supervise in internship and postdoctoral programs are expected to have expertise and demonstrate substantial competence and have credentials in the specialty of health psychology. Because these individuals must serve as professional role models for postdoctoral fellows, it is expected that the majority will hold board certification in clinical health psychology. The training director should be a more senior level professional with credentials and expertise in the specialty, including supervised practice and, if appropriate, research experience.

**3. If programs are doctoral level, what are the requirements for admission? Provide sample evaluation forms.**

At the doctoral level, the specific qualifications for student admissions vary from program to program, based on the individualized goals of the program in question. Student credentials for admission are reviewed and applicants are admitted based on a range of factors. These typically include: undergraduate preparation, including completion of prerequisites, if any; research experience, including publications and presentations if appropriate; clinical and research interests, including match with mentors who may be taking students; prior academic achievement, including grades and GRE scores; and letters of recommendation. Typically, a specific match with the program offerings in health psychology is assessed as part of the selection process. Candidate evaluation criteria and rating forms are provided in Appendix VIII.

**4. If programs are postdoctoral, what are the requirements for admission? Provide sample evaluation forms.**

In general, post-doctoral programs require graduation from an APA/CPA accredited program, including completion of an APA/CPA accredited internship. Following is the description of the admissions requirements and process for the postdoctoral fellowship in clinical health psychology at Virginia Commonwealth University Health/School of Medicine, Richmond, VA:

“We seek qualified applicants who are excited by the opportunity to develop advanced clinical skills and obtain research experience in a selection of areas that include organ transplantation, mechanical circulatory support, obesity and weight loss surgery, trauma surgery and burn surgery, primary care, smoking cessation, pain management and other areas. Versatility, the ability to interact effectively with others and the ability to develop liaison relationships in more than one area of health care are necessary. Applicants must have completed or be nearing completion of an APA-accredited doctoral program including

an APA-accredited internship, preferably within a medical setting. Previous clinical and research experience in health psychology and behavioral medicine is highly desirable.

Versatility, the ability to interact effectively with others and the ability to develop liaison relationships in more than one area of health care are necessary. Applicants must have completed or be nearing completion of an APA-accredited doctoral program including an APA-accredited internship, preferably within a medical setting. Previous clinical and research experience in health psychology and behavioral medicine is highly desirable.”

Candidate evaluation rating forms from exemplar programs are provided in Appendix VIII.

**5. Include or attach education and training guidelines for this specialty as appropriate for doctoral training, doctoral internship, postdoctoral training, post-licensure, or all four. (In this context, education and training guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)**

The following bibliography summarizes guidelines and best practices for doctoral and postdoctoral training in clinical health psychology. This list is maintained by the Council of Clinical Health Psychology Training Programs (CCHPTP):

Belar, C. D. (2008). Clinical health psychology: A health care specialty in professional psychology. *Professional Psychology: Research and Practice*, 39(2), 229-233.

Condie, L., Grossman, L., Robinson, J., & Condie, D. (2014). Ethics, standards of practice and HIPAA in academic medical centers. In C. Hunter & C. Hunter (Eds.), *Handbook of Clinical Health Psychology in Medical Settings*.

France, C. R., Masters, K. S., Belar, C. D., Kerns, R. D., Klonoff, E. A., Larkin, K. T., Smith, T. W., Suchday, S., & Thorn, B. E. (2008). Application of the competency model to clinical health psychology. *Professional Psychology: Research and Practice*, 39(6), 573-580.

Health Service Psychology Education Collaborative (2013). Professional psychology in health care services: A blueprint for education and training. *American Psychologist*, 68(6), 411-426.

Kerns, R. D., Berry, S., Frantsve, L. M. E., & Linton, J. C. (2009). Life-long competency development in clinical health psychology. *Training and Education in Professional Psychology*, 3(4), 212-217.

Larkin, K. T. (2009). Variations of doctoral training programs in clinical health psychology: Lessons learned at the boxoffice. *Training and Education in Professional Psychology*, 3(4), 202-211.

Larkin, K. T., Bridges, A., Fields, S., & Vogel, M. (2016). Acquiring competencies in integrated behavioral health care in doctoral, internship, and post-doctoral programs. *Training and Education in Professional Psychology*, 10(1), 14-23.

Larkin, K. T., & Klonoff, E. A. (2014). *Specialty competencies in clinical health psychology*. New York: Oxford University Press.

Masters, K. S., France, C. R., & Thorn, B. E. (2009). Enhancing preparation among entry-level clinical health psychologists: Recommendations for "best practices" from the first meeting of the Council of Clinical Health Psychology Training Programs (CCHPTP). *Training and Education in Professional Psychology*, 3(4), 193-201.

McDaniel, S. H., Grus, C. L., Cubic, B. A., Hunter, C. L., Kearney, L. K., Schuman, C. C., Karel, M. J., Kessler, R. S., Larkin, K. T., McCutcheon, S., Miller, B. F., Nash, J., Qualls, S. H., Connolly, K. S., Stancin, T., Stanton, A. L., Sturm, L. A., & Bennett Johnson, S. (2014). Competencies for psychology practice in primary care. *American Psychologist*, 69, 409-429.

Nash, J. M., & Larkin, K. T. (2012). Geometric models of competency development in specialty areas of professional psychology. *Training and Education in Professional Psychology*, 6(1), 37-46.

Nicholas, D. R., & Stern, M. (2011). Counseling psychology in clinical health psychology: The impact of specialty perspective. *Professional Psychology: Research and Practice*, 42(4), 331-337.

Rutledge T, Gould H, Hsu A, Beizai K. (2020). Consultation-liaison psychology: training and research recommendations for this emerging interprofessional practice. *Professional Psychology: Research and Practice*, 51(4):383–389.

## **6. Provide sample curriculum expected of model programs.**

The exemplar programs listed below (item 7) have developed model curricula for training at the doctoral, internship and postdoctoral levels. Curricula from these programs are attached in Appendix VII.

## **7. Select four exemplary doctoral and/or postdoctoral level geographically distributed, and publicly identified programs in psychology in this specialty and provide the requested contact information. If no example programs that are APA accredited are available, please complete the appropriate Attachment (A or B) for the level of the program. If the specialty education and training occurs at both the doctoral and postdoctoral level provide examples of both and not from the same institution.**

Program One:      X Doctoral                      Postdoctoral                      Internship

Name of University, School, or Institution offering Program: University of Colorado Denver



Name of Program: Clinical Health Psychology PhD Program

Address: Dept of Psychology, Campus Box #173, PO Box 173364

City/State/Zip: Denver, CO 80217-3364

Contact Person: Amy Wachholtz, PhD, MDiv, MS, ABPP

Telephone Number: 303-315-7051

Email address: [amy.wachholtz@ucdenver.edu](mailto:amy.wachholtz@ucdenver.edu)

Website: <https://clas.ucdenver.edu/psychology/clinical-health-psychology-phd-program>

APA Accreditation:

Initial Accreditation: We were initially accredited in September, 2014 for the full allowed time.

Current Accreditation: We received our reaccreditation in August 2024 for 10 years

Next site visit: 2034

Program Two:      Doctoral                      Postdoctoral                      X Internship

Name of University Offering Program: Harvard Medical School/Boston Children's Hospital

Name of Program: Internship in Health Service Psychology

Address: 300 Longwood Avenue, Mailstop 3022

City/State/Zip: Boston, MA 02115

Contact Person: Erica Lee, PhD

Telephone Number: 617-355-6680

Email Address: [Erica.lee@childrens.harvard.edu](mailto:Erica.lee@childrens.harvard.edu)

Website:

<https://dme.childrenshospital.org/graduate-medical-education/trainings-programs/psychology-internship/>

APA Accreditation: :

Initial accreditation date: 6-1-1956

Current accreditation status: This program was last reviewed and accredited for 10 years. The decision is based on the CoA's professional judgment of compliance or substantial compliance with all domains of the Guidelines and Principles.

Program Three:     Doctoral             X Postdoctoral             Internship

Name of University, School, or Institution offering Program: San Antonio Uniformed Services Health Education Consortium – Wilford Hall Ambulatory Surgical Center

Name of Program: Military Readiness Psychology Postdoctoral Fellowship

Address: 59 MDOS/SGOWM; 1100 Wilford Hall Loop, Bldg 4550

City/State/Zip: Joint Base San Antonio—Lackland, TX 78236-9908

Contact Person: Maj Ryan Kalpinski, Ph.D., ABPP

Telephone Number: 210-292-7361

Email address: [dha.jbsa.brooke-amc.list.saushec-afchp@health.mil](mailto:dha.jbsa.brooke-amc.list.saushec-afchp@health.mil)

Website: Air Force Clinical Health/Military Readiness Psychology | Health.mil Military Readiness Psychology | safp (usafpsychologists.com) <https://www.health.mil/Military-Health-Topics/DHA-GME/Institutions/SAUSHEC/GAHE-Programs/afchmrp>

APA Accreditation:

Original Accreditation: 2000

Current Status: This program was last reviewed and accredited for 10 years. The decision is based on the CoA's professional judgment of compliance or substantial compliance with all domains of the Guidelines and Principles for Accreditation (G&P). No serious deficiencies.

Next site visit date: 2029

Program Four:     Doctoral             X Postdoctoral             Internship

Name of University, School, or Institution offering Program: Virginia Commonwealth University Health/School of Medicine

Name of Program: Clinical Health Psychology Postdoctoral Fellowship

Address: The Jackson Center, PO Box 980380, 501 N. 2<sup>nd</sup> Street

City/State/Zip: Richmond, VA 23219

Contact Person: Leila Islam, Ph.D.

Telephone Number: 804-628-6752

Email address: [Leila.Islam@vcuhealth.org](mailto:Leila.Islam@vcuhealth.org)

Website: <https://psych.vcu.edu/education/postdoctoral-fellowship-in-clinical-health-psychology/>

APA Accreditation:

- Initial accreditation date: 2007 (Site visit was February 20-21, 2007)
- Current accreditation status: Active; Last site visit was May 30-31, 2024, with post-visit responses submitted to CoA on August 12, 2024
- Next site visit date: TBD, anticipated 2031

**Criterion VIII. Continuing Professional Development and Continuing Education.** A specialty provides its practitioners a broad range of regularly scheduled opportunities for continuing professional development in the specialty practice and assesses the acquisition of knowledge and skills.

*Commentary: With rapidly developing knowledge and professional applications in psychology, it is increasingly difficult for professionals to deliver high quality services unless they update themselves regularly throughout their professional lives through continuing education mechanisms. A variety of mechanisms may be used to achieve these goals.*

**1. Describe the opportunities for continuing professional development and education in the specialty practice. Provide detailed examples, such as CE offerings that are available.**

Since the last version of this petition, remote learning using videoconferencing platforms has been widely adopted, enabling unprecedented access to live and asynchronous continuing education (CE) and professional development activities. Numerous continuing professional development and CE offerings in clinical health psychology are available through the Society for Health Psychology (SfHP) and related professional societies, psychology-specific and multidisciplinary conferences, structured training and short courses, and self-directed study.

Live Continuing Education Webinars for Society Members

SfHP has been an APA-approved continuing education (CE) sponsor in the past. A CE Committee was formed in 1998 and discontinued in 2013. One initiative of the original CE Committee was to offer article-based CE credits for readers of *Health Psychology*, but response was lower than anticipated and this was eventually discontinued. Several in-person CE offerings were developed, but these were difficult to sustain due to modest attendance and high costs.

With the increasing uptake of webinars (teleconferences) for delivery of CE, SfHP members expressed renewed interest in CE offerings for health psychologists. In 2019, an *ad hoc* task force in SfHP was created to consider options for providing CE. Ultimately, the decision of this task force, with approval of the SfHP executive committee, was to partner with an existing CE sponsor (Society of Clinical Psychology, APA Division 12) to offer free webinars for CE credit to SfHP members. To evaluate this initiative, a survey was distributed to attendees of the first 4 CE webinars offered by SfHP (n = 124). >90% of evaluations were favorable (“Agree” or “Strongly Agree”) for questions addressing appropriateness of content, appropriateness of instruction, instructor effectiveness, and the extent to which stated learning objectives were met. Of note, 37% of respondents indicated that it they were “Very unlikely” or “Somewhat unlikely” to be able to find health psychology-related CE elsewhere. Furthermore, 23% of respondents indicated that the lack of access to health psychology-specific CE was a reason for attending the program. Based on the success of the initial program evaluation, SfHP has continued to offer webinars for CE credit through its partnership with the Society of Clinical Psychology (see Appendix X).

Other related psychology organizations (e.g., Society of Pediatric Psychology, Association of Psychologists in Academic Health Centers, Council of Clinical Health Psychology Training Programs) also offer regular CE webinars, providing health psychology-related CE credit at nominal or no cost to their members. All three of these organizations hold both in-person conferences and live webinars that offer APA-approved CE. In addition, the Association of Psychologists in Academic Health Centers offers a pre-conference “boot camp” focused on early career and mid-career professional development.

#### Live Non-CE Eligible Professional Development Webinars

In addition to webinars offered for CE credit, SfHP has continued to host non-CE eligible programming focused on professional development and other special topics of interest to the specialty. Recent topics/titles include “Ethics in Integrated Primary Care” (2/28/2024), “Promoting Health and Wellness in Women across the Life Span: Individual and Population Health Considerations” (10/17/2023), and “Brave Spaces: A Forum to Advance Diversity, Equity, and Inclusion” (9/21/2023).

#### Conferences

The APA Annual Convention continues to be a major outlet for continuing education programs offered by leading clinicians and researchers in the field. Both formal symposia and paper sessions and more informal poster sessions give practitioners the ability to learn about cutting edge interventions, diagnostic procedures and prevention efforts. State and regional psychological association meetings provide additional training locations. The programs represent a broad range of topics and levels. Appendix X provides examples of health psychology programming from recent APA Annual Conventions.

The Society of Pediatric Psychology, the Society of Behavioral Medicine, the Association of Psychologists in Academic Health Centers, and the Council of Clinical Health Psychology Training Programs host their own separate conferences with a strong emphasis on content relevant to clinical health psychology. In addition, the Association of Psychologists in Academic Health Centers offers a pre-conference “boot camp” focused on early career and mid-career professional development.

In addition to these discipline-specific meetings, clinical health psychologists are regular invited speakers at specialized multidisciplinary meetings and conventions, including ObesityWeek, American Psychosocial Oncology Society, Society of Pediatric Psychology, American Pain Society, PAINWeek, Digestive Disease Week, American Society of Reproductive Medicine, Society of Behavioral Medicine, the Collaborative Family Healthcare Association’s Integrated Care Conference, and the Academy of Behavioral Medicine Research. These forums provide educational opportunities for colleagues from within health psychology and, reflecting the field’s multidisciplinary focus, colleagues from other related disciplines such as medicine, nursing, physical therapy and public health.

#### Structured trainings and short courses for post-licensure professionals

Increased recognition of the potential benefits and value of integrated care has increased demand for training and education resources for licensed professionals who wish to increase their knowledge and skills in this growing specialty area. Postgraduate short courses, designed and implemented by clinical health psychologists, have been developed to meet this need. Often, these programs train psychologists as well as other professionals from fields such as social work, medicine and counseling.

The following examples are short courses or certificate programs that are directed by clinical health psychologists or include clinical health psychologists among the planners and program faculty. Most, but not all, offer APA-approved CE credits:

#### Primary Care Psychology

- Certificate in Primary Care Behavioral Health Leadership (Collaborative Family Healthcare Association): <https://integratedcareconsultation.com/certificate-program-in-primary-care-behavioral-health-leadership/>
- Short courses in integrated primary care (Center for Integrated Primary Care at the University of Massachusetts Chan Medical School certificate program: <https://www.umassmed.edu/cipc/webinars-short-courses/short-courses/pcbh-short-courses/>
- Behavioral Health Consultant Certificate Course (Rice University in partnership with Mental Health American of Greater Houston): <https://glasscock.rice.edu/offering/behavioral-health-consultant-certification>

#### Pain Psychology

- Empowered Relief Clinical Certification Workshops (Stanford University): <https://empoweredrelief.stanford.edu/clinician-training>
- Emotional Awareness and Expression Therapy for Chronic Pain course (Wayne State University): <https://unleashyourpain.com/product/emotional-awareness-and-expression-therapy/>

#### Psycho-oncology

- Meaning-Centered Psychotherapy Training Program for Cancer Care Providers (Psycho-oncology Education & Training Institute, Memorial Sloan Kettering Cancer Center; funded by National Cancer Institute grant R25 CA 190169): <https://mskcc.org/departments/psychiatry-behavioral-sciences/psycho-oncology-education-training-institute/course-meaning-centered-psychotherapy-cancer-patients>
- Hypnosis for Cancer Pain (Center for Behavioral Oncology, Icahn School of Medicine at Mount Sinai; funded by National Cancer Institute grant R25 CA 248462): <https://www.hypnosis-for-cancer-pain.com/>

#### Self-directed study

Many books and journals offer opportunities for learning in the field (for examples of the breadth and depth of recent publications in the field, see the reference list in Criterion

IV). APA offers the opportunity for psychologists to earn CE credits by completing book-based and article-based exams and accessing on-demand video courses. At the time of this writing, 61 book-, article-, and video-based CE opportunities in health psychology are available through APA's Continuing Education web page ([www.apa.org/Education/ce](http://www.apa.org/Education/ce)), an increase of 49% since the last petition in 2017.

The Society for Health Psychology also offers a self-paced modular curriculum entitled Integrated Primary Care: An Introductory Curriculum, available through SfHP's web site at: <https://societyforhealthpsychology.org/articles-resources/education-training/integrated-primary-care-an-introductory-curriculum/>. In addition, on-demand CE courses and other educational resources are distributed free of charge to practitioners through APA's Integrated Health Alliance (<https://www.apa.org/ihca>).

In addition to resources available through APA and SfHP, clinical health psychologists have also created professional development resources offered through external organizations. For example, clinical health psychologists have contributed to the development of the National Register of Health Service Psychologists' integrated healthcare training series, available as a video series to psychologists holding National Register credentials (<https://ce.nationalregister.org/>). Although not specific to clinical health psychology, topics include practices for consultation and collaboration in healthcare settings and issues specific to certain chronic medical conditions. In addition, several specialized organizations offer on-demand APA-approved CE webinars for clinical health psychologists and related disciplines. Examples of these specialized CE providers include the American Psychosocial Oncology Society (cancer care), Rome Foundation (digestive diseases) and the American Society for Reproductive Medicine (reproductive health).

## **2. Describe the formal requirements, if any, for continuing professional development and education to maintain competence in the specialty**

Clinical health psychologists are licensed as psychologists for independent practice and thus must meet the requirements for licensure and for maintaining licensure in each state or province in which they practice. These requirements include state- or provincial-continuing education requirements. Most often, these specify a number of APA-approved continuing education hours required within a given interval of time. Certain states/provinces mandate a specific number of continuing education hours in ethics, cross-cultural applications and/or other content areas per cycle.

Currently, there are no formal postgraduate specialization programs for licensed psychologists who wish to specialize or re-specialize in clinical health psychology. However, the American Board of Clinical Health Psychology specifies a path by which psychologists who have not completed a doctoral or postdoctoral training program in clinical health psychology can become board certified after one year of supervised postdoctoral experience and two additional years of postdoctoral experience in clinical health psychology (see Criterion V).

**3. Describe the minimum expectations, if any, for continuing professional development and education to maintain competence in the specialty.**

After initial board certification by ABPP, specialists in clinical health psychology are expected to participate in ongoing continuing professional development activities within each the following categories:

- Collaborative consultation (e.g., case consultations, research groups)
- Teaching and training (e.g., teaching students or other trainees, participating in thesis/dissertation committees)
- Ongoing education (e.g., attending conferences, reading professional materials)
- Development and application of research and innovative methodologies/programs (e.g., publishing peer reviewed journal articles, engaging in practice outcome monitoring)
- Professional leadership (e.g., holding an office or other leadership position within professional psychology, participating in grant review)

For practitioners who were board certified in clinical health psychology after January 1, 2015, the American Board of Professional Psychology requires participation in the maintenance of certification (MOC) process every ten years. Specialists who boarded prior to 2015 may choose to either pursue MOC or opt out. Briefly, the MOC process entails a self-examination and documentation of continuing education and professional development since the last examination or credentials review. This is accomplished using a Specialty Continuing Professional Development Grid combined with a professional narrative of no more than 750 words (e.g., a summary of professional activities that demonstrate engagement in specialty practice and continuing professional development). Completed materials are then rated using standardized criteria, resulting in a “pass” or “fail” recommendation for renewal of certification.

Specialists who are applying for MOC are required to have 40 hours/credits of continuing professional development across these five categories in the past two years. Furthermore, their activities must demonstrate evidence of continued professional development in each of the 8 Foundational Competencies (Relationships, Individual and Cultural Diversity, Ethical and Legal Standards/Policy, Professionalism, Reflective Practice/Self-Assessment/Self-Care, Scientific Knowledge & Methods, Interdisciplinary Systems and Evidence-based Practice) and at least two Core/Functional Competencies as specified by the American Board of Clinical Health Psychology (Assessment, Intervention, Consultation and Program Development). Applicants are encouraged to document professional development in other functional competencies (Supervision, Teaching, Management-Administration, and Advocacy), although these are not credited toward MOC in Clinical Health Psychology



**Criterion IX. Effectiveness.** A specialty demonstrates the effectiveness of the services provided by its specialist practitioners with research evidence that is consistent with the APA 2005 Policy on Evidence-based Practice.

*Commentary: A body of evidence is to be presented that demonstrates the effectiveness of the specialty in serving specific populations, addressing certain types of psychological, biological and social behaviors, or in the types of settings where the specialty is practiced.*

- 1. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of clients or populations (including groups with a diverse range of characteristics and human endeavors) usually served by this specialty. Summarize and discuss the relevance of the findings of the studies, specify populations, interventions, and outcomes in relation to the specialty practice.**

Note: The references in this section are from the U.S. Preventive Services Task Force (USPSTF). John Ruiz, Ph.D., the editor-in-chief of *Health Psychology*, the Society for Health Psychology journal, is one of the 16 USPSTF members.

a. Weight Management

US Preventive Services Task Force, Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Cughey, A. B., Davidson, K. W., Doubeni, C. A., Epling, J. W., Jr, Grossman, D. C., Kemper, A. R., Kubik, M., Landefeld, C. S., Mangione, C. M., Phipps, M. G., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2018). Behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults: US Preventive Services Task Force recommendation statement. *JAMA*, 320(11), 1163–1171. <https://doi.org/10.1001/jama.2018.13022>

Over 35% of men and 40% of women in the United States are obese. Obesity is associated with many health problems and is a risk factor for coronary heart disease, type 2 diabetes, various types of cancer, disability and premature mortality. The USPSTF reviewed the evidence on behavioral and pharmacotherapy interventions for weight loss or weight loss maintenance that can be provided in or referred from a primary care setting. They found adequate evidence that intensive, multicomponent behavioral interventions in adults with obesity can lead to clinically significant improvements in weight status and reduce the incidence of type 2 diabetes among adults with obesity and hyperglycemia; these interventions were found to be of moderate benefit. The USPSTF found adequate evidence that behavior-based weight loss maintenance interventions also are of moderate benefit. The USPSTF also noted that the harms of intensive, multicomponent behavioral interventions (including weight loss maintenance interventions) in adults with obesity are small to none. Based on these findings, the USPSTF concluded with moderate certainty that offering or referring adults with obesity to intensive behavioral interventions or behavior-based weight loss maintenance interventions has a moderate net benefit and recommends that clinicians offer or refer adults with a body mass index of 30 or higher to intensive,

multicomponent behavioral interventions. (B recommendation).

b. Smoking/Tobacco Use Prevention

US Preventive Services Task Force, Owens, D. K., Davidson, K. W., Krist, A. H., Barry, M. J., Cabana, M., Caughey, A. B., Curry, S. J., Donahue, K., Doubeni, C. A., Epling, J. W., Jr, Kubik, M., Ogedegbe, G., Pbert, L., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2020). Primary care interventions for prevention and cessation of tobacco use in children and adolescents: US Preventive Services Task Force recommendation statement. *JAMA*, 323(16), 1590–1598.  
<https://doi.org/10.1001/jama.2020.4679>

Tobacco use is the leading cause of preventable death in the US. An estimated annual 480,000 deaths are attributable to tobacco use in adults, including from secondhand smoke. Although conventional cigarette use has gradually declined among children in the US since the late 1990s, tobacco use via electronic cigarettes (e-cigarettes) is quickly rising and is now more common among youth than cigarette smoking. e-Cigarette products usually contain nicotine, which is addictive, raising concerns about e-cigarette use and nicotine addiction in children. The USPSTF commissioned a systematic review of the evidence on the benefits and harms of primary care interventions for tobacco use prevention and cessation in children and adolescents, including e-cigarettes. The USPSTF concluded with moderate certainty that primary care-feasible behavioral interventions, including education or brief counseling, to prevent tobacco use in school-aged children and adolescents have a moderate net benefit. They recommend that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents. (B recommendation). They found insufficient evidence to assess the balance of benefit and harms of these primary care interventions.

c. Alcohol Use Prevention

US Preventive Services Task Force, Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., Doubeni, C. A., Epling, J. W., Jr, Kemper, A. R., Kubik, M., Landefeld, C. S., Mangione, C. M., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2018). Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*, 320(18), 1899–1909.  
<https://doi.org/10.1001/jama.2018.16789>

Excessive alcohol use is one of the most common causes of premature mortality in the United States. Alcohol use during pregnancy is also one of the major preventable causes of birth defects and developmental disabilities. The USPSTF commissioned a systemic review of the evidence on the effectiveness of screening to reduce unhealthy alcohol use. They found the net benefit of screening and brief behavioral counseling interventions for unhealthy alcohol use in adults, including pregnant women, was moderate. The evidence was insufficient, however, to adequately assess the balance of

risks and benefits of screening and brief behavioral counseling interventions for alcohol misuse in adolescents. Based on these findings, the USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. (B recommendation).

d. Behavioral Counseling to Prevent Sexually Transmitted Infections

US Preventive Services Task Force, Krist, A. H., Davidson, K. W., Mangione, C. M., Barry, M. J., Cabana, M., Caughey, A. B., Donahue, K., Doubeni, C. A., Epling, J. W., Jr, Kubik, M., Ogedegbe, G., Pbert, L., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2020). Behavioral counseling interventions to prevent sexually transmitted infections: US Preventive Services Task Force recommendation statement. *JAMA*, 324(7), 674–681. <https://doi.org/10.1001/jama.2020.13095>

Approximately 20 million new cases of sexually transmitted infections (STIs) are reported each year, with approximately half occurring in adolescents and transition age youth. STIs are often asymptomatic, which can lead to delayed diagnosis, treatment and unknowing transmission. STIs are associated with pelvic inflammatory disease, infertility, cancer and HIV/AIDS. The USPSTF commissioned a systemic review of the evidence on the benefits and harms of behavioral counseling interventions aimed at STI prevention. They concluded with moderate certainty that behavioral counseling was beneficial in reducing the likelihood of STI acquisition in sexually active adolescents and at-risk adults. The USPSTF recommends behavioral counseling for all sexually active adolescents and at-risk adults (B recommendation).

e. Behavioral Counseling and Cardiovascular Disease Prevention

US Preventive Services Task Force, Krist, A. H., Davidson, K. W., Mangione, C. M., Barry, M. J., Cabana, M., Caughey, A. B., Donahue, K., Doubeni, C. A., Epling, J. W., Jr, Kubik, M., Landefeld, S., Ogedegbe, G., Pbert, L., Silverstein, M., Simon, M. A., Tseng, C. W., & Wong, J. B. (2020). Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: US Preventive Services Task Force recommendation statement. *JAMA*, 324(20), 2069–2075. <https://doi.org/10.1001/jama.2020.21749>

Cardiovascular disease (CVD) is one of the leading causes of death in the US. Studies have shown that adults who adhere to national guidelines for a healthy diet and physical activity have lower incidences of cardiovascular morbidity and mortality compared with those who do not. The USPSTF commissioned a systemic review of the evidence on behavioral counseling to promote a healthy diet and physical activity for CVD prevention in adults with cardiovascular risk factors, including hypertension, elevated cholesterol or metabolic syndrome. They concluded with moderate certainty that behavioral counseling interventions have a moderate net benefit on decreasing CVD risk in at-risk adults. Based on these findings, the USPSTS recommends offering

or referring adults at risk for developing CVD to behavioral counseling interventions to promote a healthy diet and physical activity. (B recommendation).

2. **Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of psychological, biological, and/or social problems usually confronted and addressed by this specialty. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results.**

a) Acceptance-Based Interventions for Migraine Headache – A Meta-Analysis

Polk, A.N. & Smitherman, T.A. (2023). Meta-analytic review of acceptance-based interventions for migraine. *Headache*, 63(9), 1271-1284. doi:10.1111/head.14614

Acceptance-based approaches for treating disability related to chronic pain and migraine have been growing in popularity in recent years. Even though there is a nascent, and growing, body of research investigating the effects of acceptance-based interventions—including Acceptance and Commitment Therapy (ACT) and mindfulness-based interventions (MBIs)—there hasn't been a meta-analytic review of ACT for headache, and the two meta-analytic reviews of MBIs for migraine had conflicting results. In this meta-analytic review, Polk and Smitherman investigate the effects of ACT and MBIs on headache-related disability, medication use, and headache frequency. Important findings: 1. Acceptance-based interventions had small-medium effect sizes on improvement of disability compared to control. 2. There was no significant difference between acceptance and control groups on medication use or headache frequency. 3. Reduction in pain-related disability mediated by living a values-consistent lifestyle, increased acceptance of negative internal states, increased headache acceptance, and decrease headache-related avoidance. 4. Patients with chronic migraine benefit more from acceptance-based interventions, though both populations benefit. Although there has been a lot of evidence in support of acceptance-based practices to treat patients with chronic pain, it is less clear whether these findings would map onto patients with headache conditions, who have distinct pathophysiology and illness course. [This article was chosen] because acceptance-based practices, often in the form of mindfulness smartphone apps, have become ubiquitous... This article demonstrates that psychological flexibility and pain acceptance may be key mechanisms of change in reducing headache-related disability. From a clinical perspective, providers of patients with both chronic and episodic headache conditions may find that interventions aimed at increasing these outcomes could benefit their patients. *Reviewed by Toby Dresdner, M.A., doctoral candidate at Ferkauf Graduate School of Psychology for the SfHP Health Research Council.*

b. Mindfulness-based Interventions Decrease Mood Symptoms and Increase Immune Function in Women with Breast Cancer

Sarenmalm, E. K., Martensson, L. B., Andersson, B. A., Karlsson, P., & Bergh, I. (2017). Mindfulness and its efficacy for psychological and biological responses in

women with breast cancer. *Cancer Medicine*, 6, 1108-1122. <https://doi.org/10.1002/cam4.1052>

[This study] is a longitudinal, randomized, controlled trial that assessed the efficacy of a mindfulness-based stress reduction (MBSR) intervention for women with breast cancer to reduce mood symptoms and improve immune functioning. RCTs are widely considered the most rigorous form of research to assess effectiveness of interventions, particularly over time. [In this study], the authors do more than acknowledge the impact of psychological distress on overall health, they utilized medical and psychological measurement to showcase the impact of mindfulness-based interventions on markers of immune system function. MBSR is a well-established program originally created to support people living with chronic health concerns; it incorporates mindfulness training in the form of meditation, yoga, and other stress-reduction techniques. The researchers compared mood symptoms (e.g., anxiety and depression scores, coping skills, post-traumatic growth) and markers of immune functioning via blood samples (e.g., NK-cell activity, lymphocyte distribution) across 3 groups: those who participated in an 8-week MBSR program with access to weekly instruction, active controls (self-instruction only), and true control (no intervention). They found benefit of the 8-week MBSR intervention on mindfulness-based coping, posttraumatic growth, as well as immune functioning in breast cancer patients. During and after cancer treatment, many individuals find themselves monitoring their body's functioning in maladaptive ways due to the anxiety about cancer recurrence. These works show that psychological interventions that incorporate mindfulness-based skill building during cancer treatment may benefit patients in a variety of ways including reducing stress, reducing the burden of depressive symptoms, enhancing post-traumatic growth, and improving immune functioning which would improve overall health and reduce risks of future health concerns, including cancer recurrence. *Reviewed by Alex Nobel Murray, PhD for the SfHP Health Research Council.*

c. Ecological Momentary Assessment of Physical Activity Effects on Blood Pressure

Thomas, M.C., Kamarck, T.W., Li, X., Erickson, K.I. & Manuck, S.B. (2019). Physical activity moderates the effects of daily psychosocial stressors on ambulatory blood pressure. *Health Psychology*, 38(10), 925-35. <https://doi.apa.org/doiLanding?doi=10.1037%2Fhea0000755>

The research methods involved the use of ambulatory blood pressure monitoring along with ecological momentary assessment and actigraphy. Participants completed four days of monitoring, wearing the blood pressure cuff during the daytime, and with the cuff inflating and taking a blood pressure reading hourly. They also completed an electronic diary entry with each cuff inflation (to capture the stress experiences) and wore an armband monitor (for 7 days) to capture physical activity. This methodology allowed the investigators to capture blood pressure hourly throughout the four days and relate these to psychosocial stresses the participant was experiencing (e.g., work related stress, social conflict stress) and to physical activity the participant was

engaging in; physical activity in the period surrounding the blood pressure measurements along with average weekly physical activity were used in analyses. Thus, the methodology provided for a ‘real world’ examination of stress to blood pressure relationships vs. a laboratory based ‘reactivity’ protocol. [The} findings are also very informative and consequential. The investigators found that weekly physical activity moderated the effect of stress on blood pressure whereby less active participants overall showed a more robust blood pressure response to stress. Similarly, though with a smaller effect, physical activity near the time of blood pressure measurement also reduced the effect of the stress on blood pressure. Thus, this study highlights the importance of regular physical activity as one strategy for stress management, to reduce the impact of daily life stress on blood pressure. *Reviewed by Matthew M. Burg, PhD for the SfHP Health Research Council.*

d. Emotional Reaction Mediates Response to Pictorial Cigarette Smoking Warning Labels

Peters, E., Shoots-Reinhard, B., Evans, A. et al. (2019). Pictorial warning labels and memory for cigarette health-risk information over time. *Annals of Behavioral Medicine*, 53, 358-371.  
doi:10.1093/abm/kay050<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6289901/>

A primary focus of tobacco control policy in the U.S. is to communicate and educate about the harms of tobacco products via warnings on packaging and advertisements. The U.S. Food and Drug Administration (FDA), which regulates tobacco products, is mandated to develop pictorial warnings on cigarette packaging and advertisements and recently published a rule for new cigarette pictorial warnings. [This study is included] as it is timely and exemplifies ongoing work identifying characteristics of warnings that best educate the public about the harms of smoking. This article describes an experimental test of the impact of negative emotional reactions to cigarette warnings on short and longer-term memory for the health risks identified in the warning. U.S. adult and teen smokers and Appalachian adult smokers were exposed to either high-emotion pictorial, low-emotion pictorial, or text-only warnings and then reported label risk information, smoking risk perceptions, and quit intentions either immediately after exposure or six weeks after exposure. Immediate recall was highest for low-emotion pictorial warnings and lowest for high-emotional pictorial warnings. However, six-month recall was lowest for low-emotional pictorial warnings, and similar for high-emotion pictorial and text-only warnings. Additionally, emotional reaction mediated the effect of warning label type on memory outcomes and memory outcomes were directly or indirectly associated with greater risk perceptions and quit intentions. Further, indirect effects of label type on risk perceptions and quit intentions also occurred through negative emotional reaction independent of memory, suggesting an advantage of high-emotion pictorial warnings over text-only warnings. These findings suggest that cigarette warnings eliciting stronger emotional responses are more likely to be recalled over time and thus more likely to educate the public about the health risks of smoking. This work adds to a growing body of work emphasizing the importance of emotional response elicited by cigarette warnings on their effectiveness.

These findings could also have implications for developing communications about other forms of tobacco (e.g., e-cigarettes) which are growing in popularity. *Reviewed by Renee Magnan, Ph.D. for the SfHP Health Research Council.*

e. Self-Efficacious Pain Communication Moderates Relationship Between Emotional Expression Ambivalence and Pain Catastrophizing

Van Denburg, A.N., Shelby, R.A., Caldwell, D.S., O’Sullivan, M.L., and Keefe, F.J. (2018). Self-efficacy for pain communication moderates the relation between ambivalence over emotional expression and pain catastrophizing among patients with osteoarthritis. *Journal of Pain*, 19, 1006-1014.  
<https://www.ncbi.nlm.nih.gov/pubmed/29631037>

Pain catastrophizing is a potent predictor of patients’ pain experience. The goal of this article was to improve understanding of the social context of pain catastrophizing. The study examined the degree to which patient ambivalence over emotional expression and negative network orientation were related to pain catastrophizing and whether patient self-efficacy for pain communication functioned as a moderator of these relations. Sixty patients with osteoarthritis who were married or partnered participated in the study. Results showed that greater ambivalence over emotional expression was associated with increased pain catastrophizing. In addition, self-efficacy for pain communication moderated the relationship between ambivalence over emotional expression and pain catastrophizing. Specifically, the association between ambivalence over emotional expression and pain catastrophizing weakened as self-efficacy for pain communication increased. [This article was chosen] because it makes an important contribution to health psychology research and clinical practice. It is increasingly recognized that patients’ pain experience does not unfold in a vacuum but is instead strongly linked to their social network and interpersonal context. This study highlights the role of the social context in patients’ pain catastrophizing. It further addresses ambivalence over emotional expression, a salient construct for many patients with chronic pain. The results of this study can inform future research on pain communication and patient expression of emotional experiences. *Reviewed by Doerte U. Junghaenel, Ph.D. for the SfHP Health Research Council.*

f. Mindfulness Intervention Reduces Body Weight, Food Craving and Emotional Eating

Schnepper, R., Richard, A., Wilhelm, F. H., & Blechert, J. (2019). A combined mindfulness–prolonged chewing intervention reduces body weight, food craving, and emotional eating. *Journal of Consulting and Clinical Psychology*, 87(1), 106–111.  
<https://doi.org/10.1037/ccp0000361>

Conventional weight-loss programs emphasizing caloric restriction are largely unsuccessful in maintaining in long-term weight reduction or changing unhealthy eating habits. Mindfulness interventions redirect attention from the weight-loss goal and toward the process of eating itself. By employing mindfulness-informed eating

strategies, participants were hypothesized to reduce their daily calorie intake and experience less food cravings and stress driven eating. Participants were randomized to either intervention (n = 23) or waitlist group (n = 23) to investigate the effectiveness of a 4-session mindfulness and prolonged chewing intervention. Dependent variables were body mass index, food craving and emotional, external, and intuitive eating. Across the 8 weeks of intervention, decreases in body mass index and disadvantageous eating styles (food cravings, emotional and external eating) and an increase in intuitive eating were found in the intervention group. Weight loss in the intervention group was maintained after a 4-week follow up. The results suggest a combination of mindfulness and a specific chewing training that increases awareness of satiety strongly impacted energy intake and related eating styles.

This study was selected for several reasons: 1) it studies a timely topic given the high level of obesity in the United States, as well as more recent emphasis on medical management of weight through injections such as semaglutides; 2) it recognizes that “diets” most often fail and result in weight gain; 3) it focuses on how to eat by developing healthy eating styles through mindfulness interventions such as prolonged chewing; 4) the results show that both disadvantageous eating styles such as food cravings and emotional eating were reduced in the experimental condition in addition to body mass index; and 5) it points to the importance of including variables of mindfulness in managing weight instead of simply focusing on calorie deficits.

**3. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's procedures and techniques when compared with services rendered by other specialties or practice modalities. Summarize and discuss the relevance of the findings of these studies, particularly their measures and outcome results and the comparisons to other specialties or modalities.**

- a. Shaping Illness-Specific Perceptions Improves Health Behavior, Return to Work, and Anxiety Post-Myocardial Infarction Over Standard of Care

Broadbent, E., Ellis, C. J., Thomas, J., Gamble, G., & Petrie, K. J. (2009). Further development of an illness perception intervention for myocardial infarction patients: a randomized controlled trial. *Journal of Psychosomatic Research*, 67(1), 17-23. DOI:10.1016/j.jpsychores.2008.12.001

Moss-Morris, R., Weinman, J., Petrie, K., Horne, R., Cameron, L., & Buick, D. (2002). The revised illness perception questionnaire (IPQ-R). *Psychology and Health*, 17(1), 1-16. doi: 10.1080/08870440290001494

Broadbent and colleagues (2009) conducted a randomized control trial of a brief in-hospital illness perception intervention for myocardial infarction (MI) patients. This intervention fostered a coherent illness model with causal attributions for the MI to high cholesterol and lack of exercise. The Brief Illness Perception Questionnaire (IPQ; Moss-Morris, 2002) was used to assess patients' perceptions of their illness in several



dimensions (i.e., identity, timeline, consequences, personal/treatment control, concern, understanding, emotional response). This brief illness perception intervention consisted of four 30 minute in-hospital sessions with a health psychologist, with material tailored using the patient's responses on the IPQ. At the time of discharge, patients in the intervention group had a better understanding of the information they had received in the hospital and felt more prepared to leave the hospital compared to the control group. Patients in the intervention group had become less anxious about resuming work after the intervention. Conversely, anxiety had increased in the control group and was associated with more phone calls to their GP or hospital with questions related to their heart condition at the 3-month follow-up than those in the intervention group. Participants who received the intervention returned to work faster than the control group with a greater proportion of the intervention group being back in full-time work after 3 months compared to the control group. Patients in the intervention group endorsed an illness model with internal and modifiable causal factors on which to base their recovery, resulting in improvements to exercise behaviors not seen in the control group. In sum, this psychological intervention targeted patient beliefs about the cause of a specific medical event (MI), resulting in improved anxiety, return to work, and exercise behaviors. *Reviewed by Dr. Elise McKelvey for the SfHP Health Research Council.*

b. Phenotype-Tailored Behavioral Obesity Treatment Results in Greater Weight Loss Vs. Standard Behavioral Intervention Alone

Cifuentes, L., Ghush, W., Feris, F., Campos, A., Sacoto, D., De la Rosa, A., McRae, A., Rieck, T., Mansfield, S., Ewoldt, J., Friend, J., Grothe, K., Lennon, R. J., Hurtado, M. D., Clark, M. M., Camilleri, M., Hensrud, D. D., & Acosta, A. (2023). Phenotype tailored lifestyle intervention on weight loss and cardiometabolic risk factors in adults with obesity: a single-centre, non-randomised, proof-of-concept study. *EClinicalMedicine*, 58, 101923. <https://doi.org/10.1016/j.eclinm.2023.101923>

Cifuentes and colleagues (2023) conducted a proof-of-concept study exploring the effects of 12-week phenotype-tailored lifestyle intervention on weight loss in adults with obesity. In this study, 165 participants were assigned to one of two treatment groups: standard lifestyle intervention (SLI; control) or phenotype lifestyle intervention (PLI; intervention). The SLI group intervention included behavioral modification strategies such as goal setting, self-monitoring, and stimulus control. The PLI group built upon SLI by adding targeted behavioral interventions for participants' individual physiological and metabolic characteristics; 4 phenotypes were identified *a priori*: 1) Hungry Gut participants were instructed to restrict timing of meals with modifications in fiber intake, 2) Hungry Brain: participants were instructed to eat consistently and include a pre-meal protein supplement, 3) Emotional Hunger: participants engaged in intensive behavior therapy and wellness coaching to address emotional eating, and 4) Slow Burn: participants were instructed on activity modification and advised on post-activity protein supplement. Mean total body weight loss from baseline was -7.4 kg (95%CI -8.8, -6.0) for PLI vs. -4.3 (95%CI -5.8, -2.7) for SLI (difference, -3.1 kg [95%CI -5.1, -1.1];  $P = 0.004$ ). The authors

concluded that phenotype-tailored behavioral weight management intervention may result in more weight loss than SLI. *Reviewed by Dr. Afton Koball for the SfHP Health Research Council.*

c. Psychological Pain Interventions Combined with Physiotherapy Improve Chronic Low Back Pain Vs. Physiotherapy Alone

Ho, E. K., Chen, L., Simic, M., Ashton-James, C. E., Comachio, J., Wang, D. X. M., Hayden, J. A., Ferreira, M. L., & Ferreira, P. H. (2022). Psychological interventions for chronic, non-specific low back pain: systematic review with network meta-analysis. *BMJ (Clinical research ed.)*, 376, e067718. <https://doi.org/10.1136/bmj-2021-067718>

Ho and colleagues (2022) conducted a systematic review with network meta-analysis to examine the comparative effectiveness and safety of psychological interventions for chronic non-specific low back pain. The examined interventions were cognitive behavior therapy, behavior therapy, pain education, and physiotherapy. Physiotherapy care was the reference comparison intervention. Primary outcomes were physical function and pain intensity. 97 randomized controlled trials of 13 136 participants were included. Timepoints were post-intervention (from the end of treatment to <2 months post-intervention), short term ( $\geq 2$  to <6 months post-intervention), mid-term ( $\geq 6$  to <12 months post-intervention), and long-term follow-up ( $\geq 12$  months post-intervention). For physical function, cognitive behavioral therapy (standardized mean difference 1.01, 95% confidence interval 0.58 to 1.44), and pain education (0.62, 0.08 to 1.17) delivered with physiotherapy care, resulted in clinically important improvements at post-intervention. The most sustainable effects of treatment for improving physical function were reported with pain education delivered with physiotherapy care, at least until mid-term follow-up (0.63, 0.25 to 1.00). For pain intensity, behavior therapy (1.08, 0.22 to 1.94), cognitive behavior therapy (0.92, 0.43 to 1.42), and pain education (0.91, 0.37 to 1.45) delivered with physiotherapy care, resulted in clinically important effects at post-intervention. Behavior therapy delivered with physiotherapy care maintained clinically important effects on reducing pain intensity until mid-term follow-up (1.01, 0.41 to 1.60). The authors concluded that psychological intervention combined with physiotherapy care enhanced patient outcomes on physical function and pain intensity. *Reviewed by Dr. Elechia Morrison for the SfHP Health Research Council.*

d. Diabetes Prevention Program Sustains Reduced Incidence of Diabetes for 10 Years Vs. Standard of Care

Knowler, W. C., Barrett-Connor, E., Fowler, S. E., Hamman, R. F., Lachin, J. M., Walker, E. A., Nathan, D. M., & Diabetes Prevention Program Research Group (2002). Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. *The New England Journal of Medicine*, 346(6), 393–403. <https://doi.org/10.1056/NEJMoa012512>

Diabetes Prevention Program Research Group, Knowler, W. C., Fowler, S. E., Hamman, R. F., Christophi, C. A., Hoffman, H. J., Brenneman, A. T., Brown-Friday, J. O., Goldberg, R., Venditti, E., & Nathan, D. M. (2009). 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. *Lancet*, 374(9702), 1677–1686. [https://doi.org/10.1016/S0140-6736\(09\)61457-4](https://doi.org/10.1016/S0140-6736(09)61457-4)

Whittemore R. (2011). A systematic review of the translational research on the Diabetes Prevention Program. *Translational Behavioral Medicine*, 1(3), 480–491. <https://doi.org/10.1007/s13142-011-0062-y>

The Diabetes Prevention Program is a lifestyle intervention targeting diet and physical activity to support weight loss among individuals at increased risk for Type 2 Diabetes (i.e., prediabetes). This lifestyle intervention was developed to facilitate a minimum weight loss of 7% by applying the science of behavior change to eating and exercise behaviors. Cognitive behavioral strategies are a core feature of the program to support adherence to the caloric goal and to increase physical activity to 150 minutes per week. In the pioneering multisite randomized clinical trial (Knowler et al., 2002), 3234 adults (including 45% who identified with a minoritized racial/ethnic identity) were randomly assigned to the lifestyle intervention, to a metformin condition, or a control condition. At an average follow-up of 2.8 years, the incidence of diabetes was 11.0 in the control condition, 7.8 in the metformin condition, and 4.8 in the lifestyle group, representing a 58% reduction in risk in the lifestyle condition. Despite partially regaining weight, diabetes incidence was reduced by 34% during a 10-year follow-up period for individuals in the lifestyle intervention and by 18% in the metformin group compared to the control (DPP Research Group et al., 2009). Findings demonstrate a lasting impact of lifestyle intervention for delaying or preventing transition to Type 2 Diabetes and led to the American Diabetes Association recommending it as a first line treatment (Whittemore, 2011). *Reviewed by Dr. KayLoni Olson for the SfHP Health Research Council.*

e. Effect of Computer-Assisted Cognitive Behavior Therapy vs Usual Care on Depression Among Adults in Primary Care

Wright, J. H., Owen, J., Eells, T. D., Antle, B., Bishop, L. B., Girdler, R., . . . Ali, S. (2022). Effect of computer-assisted cognitive behavior therapy vs usual care on depression among adults in primary care: A randomized clinical trial. *JAMA Network Open*, 5(2), 1-13. e2146716-e2146716. doi:10.1001/jamanetworkopen.2021.46716 <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788926>

This article tested the efficacy of a randomized clinical trial comparing computerized cognitive behavioral therapy (CCBT) with brief clinician support versus treatment as usual (TAU) in the primary care setting. Of the 175 participants, the majority were female (84.5%), a large portion identified as non-white (40%), a significant number had less than a college education (74.6%), and 61.5% reported an income of less than

\$30,000 annually. Participants who reported no computer or internet access were given loaner laptops. CCBT was presented over 12 weeks with nine specific sessions using a program entitled “Good Days Ahead” (GDA). Participants also had up to 12 telephone sessions for a maximum to 20 minutes with a master’s level mental health clinician. Text and email with the clinician were also permitted. Participants who completed 6 of the 9 sessions and 9 of the 12 telephone sessions were counted as completing the intervention. PHQ-9 scores decreased in both groups, however, there were larger decreases in the CCBT group compared to the TAU group (mean difference -2.5 at end of treatment, -2.3 at 3 months post-treatment, and -3.2 at 6 months post-treatment). Decreases were also seen in secondary measures assessing anxiety, life satisfaction, and automatic thoughts, with better outcomes for patients in the CCBT group compared to the TAU group. This study is interesting because it uses a primary care population with limited education, income, and internet access, areas that are not well represented in other CCBT studies. *Reviewed by Lynne H. Unikel, PhD for the SfHP Health Research Council.*

**4. Provide at least five psychological manuscripts published in refereed journals (or equivalent) that demonstrate the efficacy of the specialty's services for dealing with the types of settings or organizational arrangements where this specialty is practiced. Summarize and discuss the relevance of the findings of these studies in relation to the specialty practice.**

a. Improving the Patient Experience through Consultation-Liaison Psychology

Bullock, A. J., Sorbello, A., Gilrain, K. L., Fizur, P., & Aplin, K. S. (2022). Patient Satisfaction with a Psychology Consultation-Liaison Service at an Academic Medical Center. *Journal of Clinical Psychology in Medical Settings*, 29(4), 717-726.  
<https://doi.org/10.1007/s10880-021-09829-6>

Bullock and colleagues (2022) evaluated the benefits of consultation-liaison (CL) psychology services amongst adults (n=220) admitted to an academic teaching hospital. Eighty-three percent of participants rated the CL psychology service as helpful or very helpful to their overall medical care (M = 3.09, SD = .90), and 62% noted a moderate or major impact on their overall hospitalization satisfaction (M = 2.64, SD = 1.23). The authors highlight the relationship between patient satisfaction, improved clinical outcomes, and hospital reimbursement. Additionally, 75.6% of participants reported that the CL psychology service engaged in effective communication. Most participants (80%) found that the CL psychology service helped them to understand their emotional/behavioral reactions to their medical illness and how they may better manage these reactions (e.g., using coping skills). The results suggest that CL psychology services may contribute to improving overall patient experience.

b. Improving Healthy Behavior Change in the Primary Care Setting

Nyman, S. J., Vogel, M. E., Heller, G. M., Hella, J. R., Illes, R. A., & Kirkpatrick, H. A. (2023). Development and evaluation of a health behavior change clinic in primary

care: an interdisciplinary partnership. *Journal of Clinical Psychology in Medical Settings*, 30(4), 909–923. <https://doi.org/10.1007/s10880-023-09945-5>

This study describes the development, implementation, and preliminary outcomes of a PCBH psychologist—physician interdisciplinary health behavior change clinic within a Family Medicine residency program. Outcomes included measurements of smoking cessation and weight loss and resident physician perceptions of the program’s educational value. Retrospective chart review data and resident evaluations were collected on 249 patients who attended 451 in-person clinical appointments over a 50-month period. Data gathered included demographics, specific health behavior(s) to be addressed (e.g., weight loss, smoking cessation, or both), total number of appointments during the data collection period, pertinent medical data at each appointment, including weight, BMI and blood pressure and daily cigarette consumption. The resident physician evaluation response rate was 58%. Patient outcomes revealed significant reductions ( $p < .01$ ) in weight, BMI, and tobacco use. These findings provide preliminary support for the efficacy of PCBH-based psychologist – physician interdisciplinary clinical partnership models within underserved, lower SES communities for smoking cessation and weight loss goals.

c. Benefits and Challenges of Implementing a Randomized Control Trial for Depression and Obesity in Primary Care

Ronneberg, C. R., Lv, N., Ajilore, O. A., Gerber, B. S., Venditti, E. M., Snowden, M. B., Steinman, L. E., Wittels, N. E., Barve, A., Dosala, S., Rosas, L. G., Kringle, E. A. & Ma, J. (2022). Integrated collaborative care intervention for depression and obesity in primary care: translation from research to practice. *Health Education Research*, 37(4), 227-241. <https://doi.org/10.1093/her/cyac017>

[This] article examined the benefits and difficulties of implementing a randomized control trial for depression and obesity in the primary care setting. A racially and ethnically diverse sample participated in an integrated collaborative care intervention using problem-solving therapy, plus as needed antidepressant medication, and behavioral weight loss treatment. The intervention included nine coaching sessions plus nine videos over the course of six months. A mixed-methods approach using surveys, open-ended questions, and intervention participation was used to better understand intervention delivery. Increased length of time between intervention sessions may be an early warning sign of withdrawal and a place to intervene early for participant retention. Participants preferred weekly contact and believed it helped keep them on track with their goals. A combination of in-person and Zoom sessions was preferred. Compared with standard care, this intervention improved depression and anxiety symptoms although there was minimal effect on weight loss. The intervention began in-person and moved to Zoom and telephone due to the COVID-19 pandemic which may have affected outcomes. Although further work is needed, integrated collaborative care interventions show potential for being efficacious and acceptable to patients in the IPC setting. [The study demonstrates] the unique needs of implementing evidence-based interventions in integrated primary care settings. This is a growing area for health

psychologist clinicians and researchers and has the potential to impact many people seeking behavioral health treatment. There is an enhanced need for efficacious and acceptable interventions tailored to the unique needs of professionals and patients in IPC. *Reviewed by Lynne Havsy Unikel, PhD for the SfHP Health Research Council.*

d. Promoting Engagement in Mobile Health

Nahum-Shani, I., Rabbi, M., Yap, J., Philyaw-Kotov, M. L., Klasnja, P., Bonar, E. E., Cunningham, R. M., Murphy, S. A. & Walton, M. A. (2021). Translating strategies for promoting engagement in mobile health: A proof-of-concept microrandomized trial. *Health Psychology*, 40(12), 974–987. <http://dx.doi.org/10.1037/hea0001101>

Mobile health (mHealth) strategies occupy an increasingly important role as behavioral interventions in health psychology and behavioral medicine. But researchers who have sought to evaluate interventions with mHealth components know that interest, enthusiasm, and level of use usually wanes dramatically with time. Various approaches have been applied to stem the loss of engagement. User-centered design, for example, provides a critical means of incorporating stakeholder perceptions of what they want and need in a particular mHealth application. This type of front-end developmental work can result in mHealth applications that future users will find to be relevant and helpful. mHealth interventions have also been developed that rely on specific types of strategies to heighten sustained engagement, including gamification and financial inducements. However, across the various types of strategies employed, enduring engagement continues to be difficult to achieve. The new publication by Nahum-Shani and colleagues is unique in taking a different tack to the engagement problem. Rather than focusing on any single engagement strategy, their work focuses on incorporating multiple strategies that derive from theory-based approaches to engagement in the fields of behavioral intervention research and behavioral economics. They report on a novel, proof-of-concept study to provide the foundation for incorporating and testing these strategies. As a vehicle for their work, they examined a mobile app that facilitates self-reporting of substance use in adolescents and young adults. Similar to many areas of study where behavior change is the goal, sustained engagement and willingness to engage in self-reporting of substance use is fundamental to research and clinical activity that seeks to change substance use behavior. Adding to the innovation of their work, the authors used a microrandomized study design in which study participants were randomized multiple times daily to receive the various engagement strategies under consideration (e.g., strategies to promote new self-reports and strategies to reinforce reports that participants made). The results, perhaps not surprisingly, suggested that some strategies were more effective than others, and that continued work to refine the strategies is needed. Such conclusions are entirely reasonable for an early-phase, proof-of-concept investigation. Arguably, however, the specific results are less important than steps that the authors describe to assemble, deploy, and evaluate their engagement strategies. Their approach seems highly feasible for use in other contexts and populations with other types of mHealth interventions. In short, the authors' work provides a "road map" to mHealth intervention researchers for how to develop and evaluate theory-based engagement strategies. We know that sustained engagement is a

prerequisite for effective mHealth interventions. The authors' work helps us to think about how to achieve the necessary engagement and thereby ensure that the interventions themselves receive a fair test of their potential value. *Reviewed by Mary Amanda Dew for the SfHP Health Research Council.*

e. Online Patient-Provider Communication Improves Quality of Life

Liu, P. L., & Yeo, T. (2021). How online patient-provider communication impacts quality of life: Examining the role of patient-centered care and health competence. *Health Communication*, 38(3), 562–567.  
<https://doi.org/10.1080/10410236.2021.1961971>

Most of the research surrounding the recent upswing of digital platforms for health services has focused on comparing digital modalities to traditional face-to-face interactions. Telehealth has also been analyzed from the perspective of costs and benefits to larger systems. Liu and Yeo (2021) emphasized that wider health implications, particularly patient overall well-being, continue to be under-researched. Mediation variables, health competence and patient-centered care, were placed in a model examining both the direct and indirect effects of patient-provider online communication on quality of life. This selection of variables was supported by previous research; however, a theoretical orientation was less clear. A similar model, therefore, could be crafted in relation to a specific population or concern. The potential to alleviate disparities with the utilization of digital platforms is promising. Researchers found positive and significant relationships among all variables in their model. Quality of life (e.g., sleep, exercise, social activity, and psychological well-being) increased with patient-provider online communication, both directly and indirectly (via health competence and perceived patient-centered care). These findings support the potential for empowering patients underserved in the healthcare system. The researchers noted that online communication with a physician increases involvement and affords more time for a patient to express their concerns and formulate questions. Since patient-provider online communication was found to relate positively to sleep, exercise and psychosocial well-being, they discuss how self-care enhancement potentially increases health competence as well. This orientation to patient empowerment is noteworthy and ought to be replicated. *Reviewed by Amanda L. Almond, PhD for the SfHP Health Research Council.*

**Criterion X. Quality Improvement.** A specialty promotes ongoing investigations and procedures to develop further the quality and utility of its knowledge, skills, and services.

*Commentary: The public interest requires that a specialty provides the best services possible to consumers. A specialty, therefore, continues to seek ways to improve the quality and usefulness of its practitioners' services beyond its original determination of effectiveness. Such investigations may take many forms. Specialties promote and participate in the process of accreditation to enhance the quality of specialty education and training. Petitions describe how research and practice literatures are regularly reviewed for developments which are relevant to the specialty's skills and services, and how this information is publicly disseminated.*

- 1. Provide a description of the types of investigations that are designed to evaluate and increase the usefulness of the skills and services in this specialty. Estimate the number of researchers conducting these types of studies, the scope of their efforts, and how your organization and/or other organizations associated with the specialty will act to foster and communicate these developments to specialty providers. Provide evidence of current efforts in these areas including examples of needs assessed and changed that resulted.**

Health psychology is reflected in an extensive empirical literature addressing the usefulness of specialized skills, assessment methods and services in a wide variety of domains. Some examples include: the utilization of general psychological assessment methods in physically ill populations; the development and validation of disease-specific psychological assessment procedures; the evaluation and use of psychological intervention strategies to manage both acute and chronic pain; the evaluation and use of behavioral intervention methods to improve medication and treatment regimen adherence in acutely and chronically ill patients; the evaluation of the impact of disease, injury, or disability diagnosis and its management, treatment, and rehabilitation on patients and their families; the identification of stresses associated with disease, injury, and disability onset and management; development and utilization of methods to reduce the impact of stress, improve successful coping and enhance quality of life in physically compromised individuals; the examination of patient-provider communication and methods to improve the quality of these interactions; health promotion and disease prevention program development and evaluation; the impact of changes in health policy on patients, providers, families and the general public; and the examination of bio- behavioral relationships underlying disease onset and the course and exacerbation of disease in acutely and chronically ill populations.

Although exact estimates of the number of investigators conducting research related to the broad area of health psychology is not available, the sheer volume of journal articles, journals, book chapters, books, and undergraduate and graduate courses dedicated to the topic attests to the numerous individuals making research contributions to the field. Because the scientist-practitioner is the most prominent



model characterizing training in clinical health psychology, it is perhaps not surprising that basic and applied research is a hallmark of the field. The Society for Health Psychology, whose membership has ranged between 2,700-3,000 over the past several years, estimates about 30% of its members identify as researchers and as many as 60% have dual academic/research or clinical/research responsibilities. The Society of Behavioral Medicine (SBM), with a membership of over 2,294 members in 2023, including a considerable number of psychologists, is another home to both scientists and practitioners.

Health psychology organizations have consistently fostered basic and applied research through their journals (e.g., *Health Psychology* published by the Society for Health Psychology (SfHP), *Annals of Behavioral Medicine* published by the Society of Behavioral Medicine and *Journal of Clinical Psychology in Medical Settings* published by the Association of Psychologists in Academic Health Centers), their newsletters (e.g., *The Health Psychologist* published by the Division 38), and their books series. The SfHP Health Research Council disseminates new and surging areas of research in health psychology monthly through the SfHP listservs. These organizations regularly give small research grants to students in the field and acknowledge the contributions of both junior and senior researchers through annual scientific contribution awards. SBM, for example, has a *Proven Science-Better Health Giving* Campaign that to date has donated over \$90,000 to support the next generation of behavioral medicine researchers and support postdoctoral member research.

One example of an impactful quality improvement study involves a pilot study of behavioral health integration within the US Air Force facilities (Landoll et al., 2019), exploring how shifting the access point for behavioral from specialty mental health clinics to primary care can improve a range of health outcomes. Retrospective data analysis was conducted on an Air Force quality improvement project implemented at three military treatment facilities over a one-year period. Positive preliminary support was found in terms of expanded patient populations, decreased time to first appointment, increased patient encounters increased patient satisfaction and decreased purchased community care compared with non-participating sites.

## References

Landoll, R. R., Nielsen, M. K., Waggoner, K. K., & Najera, E. (2019). Innovations in primary care behavioral health: a pilot study across the U.S. Air Force. *Translational Behavioral Medicine*, 9(2), 266–273. <https://doi.org/10.1093/tbm/iby046>

## **2. Describe how the specialty seeks ways to improve the quality and usefulness of its practitioners' services beyond its original determinations of effectiveness.**

Continuing education and professional development. The APA Annual Convention is one of the major venues for disseminating research and best practices in clinical health psychology; each year the subject index of the APA Convention program lists

numerous entries under health psychology (see Appendix X for recent annual convention programs). In addition, the Council of Clinical Health Psychology Training Programs (CCHPTP) holds two meetings a year, a mid-winter meeting held in conjunction with the annual mid-winter meeting of the Council of University Directors of Clinical Psychology meeting and a business meeting held in conjunction with the APA Annual Convention. The Society of Behavioral Medicine hosts an annual conference, and the Association of Psychologists in Academic Health Centers hosts a conference every two years. These are but a few examples of the wide variety of continuing education opportunities made available to practitioners in the field. Other continuing education and professional development opportunities are described in Criterion VIII.

Encouraging mentoring and development of early career professionals. The Society for Health Psychology and the Association of Psychologists in Academic Health Centers provide members with opportunities for one-on-one peer mentoring and peer consultation at no cost. In addition, the Society for Health Psychology includes an Early Career Professionals Council, one goal of which is to ensure early career professional representation on each of the Society's major committees and councils. These initiatives have helped ensure opportunities for professional development among clinical health psychologists who represent the next generation of leaders in the field.

Promoting collaborative care and interprofessional education. Because clinical health psychologists often work in close collaboration with other health care professionals, the specialty has developed and maintained liaisons with organizations representing other health professions. A prominent example is the affiliation of the Association of Psychologists in Academic Health Centers (APAHC) and the Association of American Medical Colleges (AAMC) through representation on the AAMC's Council of Faculty and Academic Societies.

Encouraging participation in the board certification process. In recent years, the Society for Health Psychology has sponsored webinars and APA Convention programming dedicated to educating practitioners about the process and benefits of board certification in clinical health psychology. Members who are newly board certified are recognized at the Society's annual business meeting at the APA Convention and honored in the Society's newsletter.

Public service and outreach. In addition to their clinical roles, health psychologists participate actively in programs geared to public education at the local, regional and national levels. The Society for Behavioral Medicine's *Healthy Living* website (<http://www.sbm.org/healthy-living>), for example, includes 21 public-facing articles educating readers on how to improve health through behavioral change. Topics include:

- How to Help Someone You Love Quit Vaping
- Helping Kids Get the Sleep They Need
- The 7 Components of a Successful Weight-Loss Plan

- Tips for Beating Burnout in Graduate School
- How to Manage Stress Naturally During Pregnancy

Clinical health psychologists also participate in a number of committees and task forces designed to educate the public about health-related lifestyle issues and to help develop health policy in the future. The Society for Health Psychology's Health Policy Council routinely reviews and provides substantive comment on policy proposals from a variety of sources.

Clinical health psychologists also serve as administrators in a number of federal agencies, including the National Cancer Institute and the Office of Behavioral Science Research. Clinical health psychologists often participate in the federal government's efforts to review, summarize and disseminate health-related information. For example, health psychologists currently serve as advisors to the Centers for Medicare & Medicaid Services and on a federal panel to address opioid misuse and overprescribing in chronic pain.

**3. Describe how the research and practice literature are regularly reviewed for developments which are relevant to the specialty's skills and services, and how this information is publicly disseminated. Give examples of recent changes in specialty practice and/or training based upon this literature review.**

Reviews of basic and applied research in health psychology regularly appear in peer-reviewed journals, books, and other publications. Topical reviews of the literature are published in journals such as *Health Psychology*, *Annals of Behavioral Medicine*, *Psychosomatic Medicine*, and *Journal of Clinical Psychology in Medical Settings*. In addition, a number of scholarly and practice-oriented volumes have been published or revised in recent years, covering topics such as integrated primary care, pre-surgical psychological assessment, psychology of women's health and biopsychosocial assessment in clinical health psychology (see Criterion IV, References). Many of these recent articles and books have been adopted as course materials in clinical health psychology training programs. APA Books maintains a *Clinical Health Psychology* series, a set of practice-oriented books for clinicians who are new to specific medical settings and populations. To date, the series has covered psychological treatment of patients with various medical presentations in primary care, oncology and cardiology settings.

In addition to traditional publications, the APA Center for Psychology and Health maintains an up-to-date web site ([www.apa.org/health](http://www.apa.org/health)) that serves as a centralized source of information on health psychology training and CE programs, practice guidelines, videos, links to publications, briefing sheets and white papers on the role of psychology in various health care settings and populations.

In an effort to promote further dissemination of current research published in the journal *Health Psychology*, the Society of Health Psychology's Health Research Council uses the Society for Health Psychology's listserv to publish brief summaries

of interesting current research. Research council members represent a broad cross-section of interests and expertise, and they select research to disseminate that is of particular interest to members' specializations and that may be of interest to other Society members. Summaries are also available on the Society's website.

4. **This criterion includes two components: one focusing on past activities around accreditation (X.4.a), and the other on future activities around accreditation (X.4.b).**

**For X.4.a, describe how the specialty has promoted and participated in the process of accreditation to enhance the quality of specialty education and training. Also, indicate how many programs in this specialty have been accredited at the doctoral and/or postdoctoral level.**

Clinical health psychology is recognized as a specialty with completion of training at the postdoctoral level. Accreditation is available for postdoctoral programs in clinical health psychology by the Commission on Accreditation (CoA) of the American Psychological Association. As of December 2024, there are 11 accredited postdoctoral programs in clinical health psychology and 18 clinical health psychology postdoctoral programs listed through the Association of Psychology Postdoctoral and Internship Centers (APPIC). The Council of Clinical Health Psychology Training Programs (CCHPTP) provides a forum for training directors at all levels (pre-doctoral, internship and post-doctoral) to meet on a regular basis and discuss issue relevant to training in the specialty, including minimal training standards. Clinical health psychologists also participate in quality assurance, serving as site visitors and serving on the Commission on Accreditation.

The Clinical Health Psychology Specialty Council (CHPSC), which represents the specialty on the Council of Specialties in Professional Psychology, and the Society for Health Psychology (SfHP) both participated in CoA's most recent solicitation for public comment between March and June, 2021 regarding revisions to the Implementing Regulations (IR) relevant to acquisition and demonstration of advanced competencies required at the post-doctoral level (i.e., C-9.c P. Clinical Health Psychology Level 3 – Specialty Competencies). CoA adopted all of the proffered CHPSC and SfHP recommendations without revision, which are reflected in the most recent September 2021 CoA Implementing Regulations (see Appendix V).

**For X.4.b, describe how the specialty will promote and participate in the process of accreditation in the future to enhance the quality and sustainability of specialty education and training. Also, explain how the future accreditation support activities will be consistent with the Education and Training Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties and Subspecialties (see: <http://www.apa.org/ed/graduate/specialize/taxonomy.pdf>) and will be sustained (e.g., training CoA site reviewers with specialty expertise, sponsoring CoA self-**

**study workshops, fostering the development or ongoing operation of a specialty training council, administrative agreements and protections, financial support, etc.). Explain how these activities will result in an increase in the number of specialty programs that are accredited at the doctoral and/or postdoctoral level.**

In 2021, the Clinical Health Psychology Specialty Council, a member of the Council of Specialties in Professional Psychology (CoS), participated in the CoS Taxonomy Initiative to improve upon all specialty education and training taxonomies and promulgate them across affiliated specialty councils and other organizations. The initiative was developed in collaboration with the Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (CRSSPP) and a Workgroup from the Interorganizational Summit 4.0 on Specialty, Specialization, and Board Certification. The main purpose of this initiative was to facilitate clear and consistent communication (i.e., “truth in advertising”) in the use of terminology for training programs, students, professional organizations and members of the public. Thus, these CoS-approved taxonomies provide clarification about the type and intensity of specialized training opportunities offered by individual education and training programs at the doctoral, doctoral internship, postdoctoral and post-licensure stages for each recognized specialty. The revised Clinical Health Psychology Education and Training Taxonomy was approved by CoS Board of Directors on October 29, 2021. A subsequent revised version was approved by the CoS Taxonomy Review Committee on October 10, 2024, as a requirement for submission of this specialty renewal petition to CRSSPP (See Appendix III).

The Council of Clinical Health Psychology Training Programs (CCHPTP) was instrumental in the revising our specialty’s educational and training taxonomy and continues to lead efforts to advance education and training in clinical health psychology. Two clinical health psychologists who currently serve as CCHPTP Leadership Officers also serve as our clinical health psychology “taxonomy champions” who are tasked with identifying and advising clinical health psychology programs across the continuum of doctoral, internship, postdoctoral and post-licensure training in adopting updated taxonomy language in their promotional and curricular materials. The four doctoral, internship and postdoctoral training programs in clinical health psychology listed in Appendix VIII are exemplar programs that offer a *Major Area of Study* in clinical health psychology and have incorporated updated education and training taxonomy language in their program descriptions.

It is expected that CCHPTP, as well as the other member organizations of the Clinical Health Psychology Specialty Council, will continue to closely monitor and contribute to updates involved in updating CoA as skills/competencies are refined or emerge in new areas (e.g., telehealth). CCHPTP meetings continue to serve as the primary vehicle for staying abreast of the changing accreditation landscape. CCHPTP is a member of the Clinical Health Specialty Council and sends a representative to the Council of Chairs of Training Councils, and this body stays in close contact with issues that affect accreditation and other training-related issues.

**Criterion XI. Guidelines for Specialty Service Delivery.** The specialty has developed and disseminated guidelines for practice in the specialty that expand on the profession's general practice guidelines and ethical principles.

*Commentary: Such guidelines are readily available to specialty practitioners and to members of the public and describe the characteristic ways in which specialty practitioners make decisions about specialty services and about how such services are delivered to the public.*

- 1. Describe the specialty-specific practice guidelines for this specialty. Please attach. How do such guidelines differ from general practice guidelines and ethics guidelines? (In this context, professional specialty guidelines refer to modes of conceptualization, identification and assessment of issues, and intervention planning and execution common to those trained and experienced in the practice of the specialty. Such professional guidelines may be found in documents or websites including, but not limited to, those bearing such a title or as described in a variety of published textbooks, chapters, and/or articles focused on such contents.)**

APA's professional practice guidelines, though broad in scope, address certain practices that are especially relevant to clinical health psychology. The *Guidelines on Evidence-Based Psychological Practice in Health Care* (APA, 2021), while broadly applicable, are useful to the practice of clinical health psychology, given that it is by definition connected with health care. The *Guidelines for Practice in Health Care Delivery Systems* (APA, 2013) are highly relevant to clinical health psychology and address issues of multidisciplinary collaboration, professionalism and advanced competencies that are consistent with the advanced skills and competencies necessary for the practice of clinical health psychology. The *Guidelines for Prevention in Psychology* (APA, 2014) refer not only to prevention of psychological and behavioral problems but also prevention of physical health problems such as obesity and associated health risks (see Appendix IX for a copy of these guidelines). In addition, APA has published clinical practice guidelines relevant to clinical health psychology, including the *Clinical Practice Guideline for the Treatment of Obesity and Overweight in Children and Adolescents* (APA, 2018). Members of the Society for Health Psychology and other societies participated as members of the obesity guidelines panel and the SfHP Health Policy Council provided extensive feedback as well. Clinical health psychologists have also been leaders in other health subspecialty areas such as pain management. Expert clinical health psychologists have been involved in developing core competencies and interdisciplinary practice guidelines through engagement in APA task forces and committees to reform healthcare policies, thus promoting evidence-based practice across disciplines treating chronic pain (APA, 2024).

A number of other guidelines developed by external organizations are used to inform the work of clinical health psychologists. These guides frequently cite research in clinical health psychology, and some represent the input of health psychologists on expert consensus and review panels. Prominent recent examples of such policies

include:

### Intervention guidelines

- Behavioral intervention as standard of care for diabetes management by the American Diabetes Association (ADA, 2021).
- Clinical practice guidelines for the perioperative nutritional, metabolic and nonsurgical support of the bariatric surgery patient, cosponsored by American Association of Clinical Endocrinologists/American College of Endocrinology, The Obesity Society, American Society for Metabolic & Bariatric Surgery, Obesity Medicine Association and American Society of Anesthesiologists (Mechanick et al., 2020).
- Survivorship care guidelines for breast, prostate, head and neck and colorectal cancer by the American Cancer Society (Cohen et al, 2016).
- Palliative care for adults guideline from the National Coalition for Hospice and Palliative Care ( National Consensus Project for Quality Palliative Care, 2018).
- Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women from the US Preventive Services Task Force (Patnode, Henderson, Coppola, Melnikow, Durbin & Thomas, 2021).
- Primary care interventions for prevention and cessation of tobacco use in children and adolescents, also from the US Preventive Services Task Force (Owens et al, 2020).
- National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology for Smoking Cessation (Shields et al, 2023).
- The American College of Physicians clinical practice guidelines on noninvasive treatments for acute, subacute and chronic low back pain (Qaseem et al., 2017).
- Clinical practice guidelines for the treatment of chronic insomnia, American Academy of Sleep Medicine (Sateia et al., 2017).
- Behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults from the US Preventive Services Task Force (USPSTF et al., 2018).

### Screening guidelines

- American Diabetes Association Standard of Care in Diabetes (ADA, 2023).
- National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology for Distress Management (Riba et al., 2019).
- Guidelines from American College of Surgeons regarding screening and intervention of mental health symptoms in patients who have experienced an acute injury - released March 2022, updated December 2023 (ACS, 2023).
- USPSTF alcohol use screening guidelines (USPSTF et al., 2018b)
- USPSTF guidelines on behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors (USPSTF et al., 2020).

### System-level guidelines

- The National Committee for Quality Assurance's Patient Centered Medical Home Recognition Standards and Guidelines and Distinction for Behavioral Health Integration (NCQA, n.d.)
- Behavioral health and primary care integration from the Agency for Healthcare Research and Quality (Cohen, et al., 2015).

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## **2. How does the specialty encourage the continued development and review of practice guidelines?**

As noted previously, clinical health psychologists have long participated as content experts on various panels and committees tasked with reviewing and endorsing policies related to health behavior and disease management. One key example is the recent update to the American Medical Association’s *Guides to the Evaluation of Permanent Impairment, Sixth Edition* (AMA, 2024). Dan Bruns, PsyD, a noted clinical health psychology leader, chaired a task force that included over 30 senior and early career psychologists who reviewed a massive amount of literature on this topic. After four years of work, the 2024 edition of *The Guides* was recently published, which includes a 60-page review of psychometric outcome measures which physicians can use to scientifically assess the patient perspective when performing these evaluations (D. Bruns, personal communication, October 14, 2024). These changes ensure that physicians are using evidence-based assessment tools and include patients’ perspectives when evaluating impairment.

The Society for Health Psychology’s Health Policy Task Force was re-designated in 2017 as a standing council devoted to health policy. The purpose of the SfHP Health Advocacy and Policy Council is to collaborate with staff from APA Central Office on impactful advocacy & policy issues as they relate to the field of health psychology. The Council serves SfHP by coordinating requests from APA or external organizations to create, collaborate or review statements and briefs related to health psychology advocacy and national policy, including practice guidelines. One of the top priorities of the Council is addressing the limited options for billing reimbursement codes for the full range of clinical health psychology and behavioral medicine services offered in specialty healthcare settings. The Council has recruited a team of motivated colleagues to help advocate for a broader framework of billing reimbursement for health psychology services in healthcare specialty settings and to develop scenarios for value-

based care models. Another major focus of the Council is to identify approaches to broaden the access of care for a diverse population of patients who would benefit from health psychology services and to diversify the workforce delivering these services.

Looking forward, the SfHP Health Advocacy and Policy Council will continue to develop relationships with APA Government Relations Office, APA Practice Organization, Center for Psychology and Health as well as other national organizations (e.g., American Heart Association, American Diabetes Association, Consortium of Social Science Associations) around addressing important initiatives, including the opioid crisis, federal funding cuts, and threats to the Affordable Care Act, as well as advocating for policy statements, briefs, op-eds, etc. to increase the visibility of our evidence-based science for practice. Through the Council, SfHP will also continue its collaboration with the Society of Behavioral Medicine, which has a well-established policy and advocacy arm.

In the future, we anticipate APA may adopt a policy to affirm practice guidelines created by external organizations. Should this occur, the Society for Health Psychology and other organizations representing the specialty stand well positioned to review third-party guidelines and provide recommendations.

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### **3. Describe how the specialty's practitioners assure effective and ongoing communication to members of the discipline and the public as to the specialty's practices, practice enhancements, and/or new applications.**

Clinical health psychologists and organizations representing health psychology are committed to improving the overall health of the U.S. and, where appropriate, the world. There is active communication and exchange of views and treatment recommendations among members on the listservs of the various organizations and at professional meetings. An array of committees representing training from many disciplines addresses research, practice, teaching and consumer issues. Workshops and meetings that focus on topics related to health psychology are well-attended, as are specialty meetings of the medical societies that also utilize health psychology methods.

The continuing education committees and journal editors representing major journals of the specialty of clinical health psychology monitor the needs of the populace and foster dissemination of knowledge and new developments affecting practice. In particular, Society for Health Psychology's peer-reviewed journal, *Health Psychology*, promotes high quality, inclusive research in the field and disseminates findings to a broad audience. In order to promote inclusive readership, the journal provides Spanish language abstracts of every paper published since 2023. The specialty also disseminates research, policy developments and relevant practice guidelines through its organizations' newsletters, e-zines and websites, and through the web site of the

APA Center for Psychology and Health.

A recent example of clinical health psychologists providing updates about specialty practice to the field of psychology is release of a seven-hour curriculum, *The Role of Psychology in Addressing Pain and Related Opioid Dependence*, provided by APA's Office of Continuing Education Credit. This course, released in 2024 and authored by three prominent clinical health psychologists, provides comprehensive education in assessment and intervention for chronic pain in both clinical health and other settings.

#### **4. How does the specialty communicate its identity and services to the public?**

- At the individual and organizational level, clinical health psychologists frequently provide education and outreach to the general public, the mass media, multidisciplinary professional audiences and other members of the psychology profession. Examples include presenting at Grand Rounds within a healthcare system, writing brief articles on health psychology topics to share with the public and engaging through social media to share research findings. Clinical health psychologists also engage with the public through social media outlets that include Instagram, LinkedIn and podcasts.
- The Society for Health Psychology website has been updated as of 2024. The newly redesigned website is more easily navigated to provide information about the education, research and practice of clinical health psychology. The web site provides clear public definitions relevant to the specialty (see Criterion XII) and serves as a primary source of information about the roles of health psychologists in research, practice, education, advocacy and other activities. The Society for Health Psychology is also working to further expand its online presence.
- The web page of the American Board of Professional Psychology includes a section for the public to provide education about board certification and specialization in professional psychology, including clinical health psychology. The web site also includes a search feature to allow members of the public to locate a specialist.
- The APA Center for Psychology and Health maintains a web site ([www.apa.org/health](http://www.apa.org/health)) containing videos, briefing sheets, white papers and links to publications on topics relevant to health psychology and integrated care.
- Society for Behavioral Medicine hosts a web page entitled "Healthy Living," which provides brief, public-facing articles on various topics related to health and wellness. These articles make evidence-based strategies accessible to the lay public, increasing access to self-management tools for everyone.

**Criterion XII. Provider Identification and Evaluation.** A specialty recognizes the public benefits of developing sound methods for permitting individual practitioners to secure an evaluation of their knowledge and skill to be identified as meeting the qualifications for competent practice in the specialty.

*Commentary: Identifying psychologists who are competent to practice the specialty provides a significant service to the public. Assessing the knowledge and skill levels of these professionals helps increase the ability to improve the quality of the services provided. Initially practitioners competent to practice in the specialty may simply be identified by their successful completion of an organized sequence of education and training. As the specialty matures it is expected that the specialty will develop more formal structures for the recognition of competency in practitioners.*

**1. Describe the formal peer review-based examination process of board certification including its use of a review and verification of the individual's training, licensure, ethical conduct status, and a peer assessment of specialty competence.**

A clinical health psychologist is a member of the professionally recognized specialty that focuses on the clinical application of health psychology research to individuals, families, groups and systems for the promotion of health and well-being or to address health-related concerns. Clinical health psychologists are educated and trained at the doctoral level with supervised postdoctoral training and experience, in accordance with the standards set forth by American Board of Professional Psychology certification. They work in diverse settings and contexts, often as part of interprofessional teams, demonstrating expertise in professional functions such as assessment, intervention, health promotion, consultation, research, supervision, education and training, advocacy and administration.

Continuing education alone is not sufficient for the development of skill/competence in the practice of clinical health psychology. No enforcement mechanisms prevent use of the title by those who are unqualified, and compliance is therefore voluntary. However, for those interested in demonstrating their qualifications to do so, the American Board of Clinical Health Psychology (ABCHP) offers board certification in the area of Clinical Health Psychology under the auspices of the American Board of Professional Psychology (ABPP).

To obtain board certification, an individual must pass a credentials review by ABPP and ABCHP regarding education and training in both professional psychology and in health psychology to be admitted to candidacy for board certification. The credentials review covers both generic requirements for board certification and specialty-specific requirements as follows:

- Doctoral degree from an APA/CPA accredited program or from a program otherwise designated as equivalent by the ABCHP;

- Completion of a one-year full time or two-year half-time internship that is accredited by the APA or CPA or listed in the Association of Psychology Postdoctoral and Internship Centers Directory for the year the internship was completed. The internship criterion can also be met if the candidate holds the Certificate of Professional Qualification through the Association of State and Provincial Psychology Boards, is listed in the National Register of Health Service Psychologists or the Canadian Register of Health Service Psychologists;
- Once they have completed their doctorate:
  - a. The applicant can apply for certification upon successful completion of at least one year of an APA/CPA accredited clinical health psychology postdoctoral fellowship or a clinical child psychology postdoctoral fellowship with a major area of study (80%) in pediatric health psychology **OR**
  - b. If the applicant completed an APA/CPA accredited postdoctoral fellowship before October 29, 2021, in an area other than clinical health psychology, but at least 50% of the training was in clinical health psychology, the applicant can apply for certification after one additional year of clinical health psychology experience following the fellowship **OR**
  - c. If the applicant completed a non-accredited postdoctoral fellowship with 80% supervised training in clinical health psychology, the applicant could apply for certification after one additional postdoctoral year of supervised clinical health psychology experience<sup>1</sup> **OR**
  - d. The applicant can apply for certification after three post-licensure years with evidence of continued education including one-year post-licensure supervised experience in clinical health psychology and two additional years of post-licensure clinical health psychology experience. To qualify for this option the applicant must demonstrate a major area of study in clinical health psychology by attesting to either at least  $\geq 45$  continued education credits in clinical health psychology **AND/OR**  $\geq$  three clinical health psychology courses.<sup>2</sup>

Assuming all of the credentials are approved, the individual is then considered a candidate for board certification. The candidate must then submit a portfolio that includes the following: a curriculum vitae; a professional statement that describes current professional work, evidence-base for clinical health practice,

<sup>1</sup> Supervised clinical health psychology experience defined as supervision being provided by persons with competencies in clinical health psychology demonstrated by appropriate training, qualifications, or credentials (e.g., ABPP, HSP) as clinical health psychologists. The supervisor attests to have provided supervision for at least 1000 hours of supervised clinical health psychology experience.

<sup>2</sup> Clinical Health Psychology course: Must have content congruent with *Clinical Health Psychology 2018 Education and Training Guidelines* (available on Council of Specialties in Professional Psychology website <https://cospp.org/education-and-training-guidelines-1>).

assessment/intervention/consultation/program development activities and theoretical/empirical bases for them; examples of complex interpersonal interactions, meaningful ethical dilemma or challenges personally encountered and how the dilemma was managed; and examples of individual and cultural diversity in the candidate's practice. Two practice samples also are required and the work samples in clinical health psychology must pass review in order for the candidate to be scheduled for an oral examination.

The board certification steps conclude with oral examination administered in clinical health psychology by an ABCHP oral examining committee. The oral examination is conducted by four oral examiners and the oral examination consists of four one-hour modules: Ethics, Professional Issues, Review of Practice Samples, and Standardized Clinical Case Assessment and Integration.

Board certified clinical health psychologists are required to have a maintenance of certification (MOC) review at 10-year intervals to maintain board certification in clinical health psychology. This policy of MOC began January 1, 2015.

**2. Describe how the specialty educates the public and the profession concerning those who are identified as a practitioner of this specialty. How does the public identify practitioners of this specialty?**

The Society for Health Psychology launched a task force with the goal of constructing a cohesive, consistent identity for the field of health psychology through a “branding” process. Among the goals of this task force was to create an identity that can be easily shared with mental health professionals, other professions, policymakers and the general public. One outcome of the task force was a redesign, reorganization and relaunch of the Society for Health Psychology website in 2017 ([societyforhealthpsychology.org](http://societyforhealthpsychology.org)), which has been refreshed since that time. Another outcome of the task force was the revision of definitions for the field, as detailed immediately below.

In February 2015 the Society for Health Psychology affirmed the following definitions for public and professional audiences:

- **Health Psychology** (public definition). The field of psychology that addresses the interactions of psychological, social, cultural and biological factors as they relate to health and well-being across diverse populations and settings.
- **Health Psychology** (professional definition). The field of psychology that addresses the interactions of psychological, social, cultural, and biological influences, mechanisms and consequences as they relate to the development, prevention, treatment and management of illness and disability and the promotion of health and well-being. The field of Health Psychology produces and evaluates rigorous health research, products, and services and translates the research for the purpose of enriching empirical knowledge, public understanding, clinical practice, program design and policy across diverse populations and settings.

- **Health Psychologist.** A graduate of a doctoral program in psychology who has obtained specialized education and training and supervised research experience in the biological, psychological, social and cultural influences on health, illness and disability. Health Psychologists work in a variety of contexts across diverse populations and settings, often as part of interprofessional teams. They may engage in the production of relevant health research; the provision of clinical services; the rigorous evaluation of health research, programs, and interventions; the education, training and development of future health professionals; the education of the public; and advocacy for law and policy to promote health and well-being.
- **Clinical Health Psychology.** A professionally recognized specialty that investigates and implements clinical services with individuals, families, groups and systems across diverse populations and settings for the promotion of health and well-being and the prevention, treatment and management of illness and disability. Clinical Health Psychology (also historically referred to as behavioral medicine, medical psychology and psychosomatic medicine) sees health as the confluence of psychological, social, cultural and biological factors and applies this understanding to conduct research; to provide clinical services; to consult with, educate, and supervise other health care providers and psychologists; and to advise organizations, institutions, the public and policymakers.
- **Clinical Health Psychologist.** A Clinical Health Psychologist is a member of the professionally recognized specialty that focuses on the clinical application of health psychology research to individuals, families, groups and systems for the promotion of health and well-being or to address health-related concerns. Clinical Health Psychologists are educated and trained at the doctoral level, with supervised postdoctoral training and experience in accordance with the standards set forth by American Board of Professional Psychology certification. They work in diverse settings and contexts, often as part of interprofessional teams, demonstrating expertise in professional functions such as assessment, intervention, health promotion, consultation, research, supervision, education and training, advocacy and administration.

ABPP provides an online searchable directory of those individuals who are board certified in clinical health psychology; this directory is available to the public through the ABPP website (<https://www.abpp.org>). Individuals seeking information from the Society for Health Psychology about practitioners in clinical health psychology are also referred to the ABPP directory.

The Society for Health Psychology Program Committee devotes a significant amount of time and energy identifying both health psychologists and practitioners from disciplines outside of psychology who can bring cutting-edge assessment and intervention research to those who attend the annual APA convention. Similarly, clinical health psychologists are often invited to present at meetings sponsored by affiliated professionals in psychology,



medicine, public health, dentistry, and nursing.

3. **Estimate how many practitioners there are in this specialty (e.g., spend 25% or more of their time in services characteristic of this specialty and provide whatever demographic information is available) and how many are board certified through the process decreed in item 1.**

There is no single centralized mechanism for identifying all clinical health psychologists. Data from APA's 2021 Survey of Health Service Psychologists (APA, 2022) provides an estimate of the proportion of psychologists in clinical practice who identify clinical health psychology as a primary or secondary specialty. Of the 842 survey respondents who reported providing patient care, 14% reported clinical health psychology as their primary specialty, behind only clinical (51%), behavioral and cognitive (17%) and clinical child and adolescent (16%) psychology. Another way to estimate the number of practitioners in clinical health psychology is to examine the membership of the Society for Health Psychology (SfHP). Among those identifying clinical health psychology as a specialty, 6% were board certified. As of November 2024, 335 psychologists held active board certification in clinical health psychology from the American Board of Clinical Health Psychology.

#### References

American Psychological Association. (2022). *Health Service Psychologists Across Areas of Specialty* [Interactive Data Tool]. Retrieved August, 22, 2024, from <https://www.apa.org/workforce/publications/health-service-psychologists-survey/specialty-areas>

### **Public Description:**

An important component of the recognition process is to develop a public description of the specialty that can be used to inform the public about the specialty area. Please develop a **brief** description of the specialty by responding to the question below (total combined word limit for all five questions must not exceed 400 words). This provides the foundation for what will appear on the APA website upon recognition of the specialty and should be understandable to the general public (wording should not exceed an eighth-grade level). Descriptions will be edited for consistency to conform to the CRSPPP website standards.

1. Provide a brief (2-3 sentences) definition of the specialty.

Clinical health psychology is a professionally recognized specialty that investigates and implements clinical services across diverse populations and settings to promote health and well-being and to prevent, treat and manage illness and disability. Clinical health psychology sees health as the confluence of psychological, social, cultural and biological factors and applies this understanding to professional activities, including: Research; clinical services; consulting with, educating and supervising other health care providers and psychologists; and advising organizations, institutions, the public and policymakers.

2. What specialized knowledge is key to the specialty?

Clinical health psychology has evolved as a specialty area of knowledge and practice with foundations in health psychology, the field of psychology that addresses the interactions of psychological, social, cultural and biological factors as they relate to health and well-being across diverse populations and settings.

3. What problems does this specialty specifically address?

Clinical health psychologists have knowledge of how learning, memory, perception, cognition and motivation influence health behaviors and impact physical illness, injury and disability. Examples of problem areas addressed by the specialty include: Weight management; tobacco and nicotine use; pain management; sleep disorders; psychological adjustment to serious and chronic disease; and appropriateness for and adherence to medical treatment.

4. What populations does this specialty specifically serve?

Clinical health psychology serves any individual of any age with a disease or medical condition that could be prevented, treated or rehabilitated through the use of psychological techniques or procedures. The primary focus is on problems that present as physical complaints, as opposed to issues that are restricted to emotional or mental health.

5. What are the essential skills and procedures associated with the specialty?

Assessment. Clinical interviewing; behavioral observation; personality assessment; general and disease-specific self-report instruments; psychophysiological measures; medical record review; biological parameters associated with specific diseases.

Intervention. Evidence-based psychotherapy, health promotion and behavioral interventions provided to individuals, groups and families.

Consultation. Consultation with the health care team (including family members); participation in multidisciplinary teams; and program development.

Evaluation. Use of research methodologies to develop and evaluate practices based on the best available evidence and to develop new program evaluation methods.

# Appendix I

## American Board of Clinical Health Psychology Bylaws

**The American Board of Clinical Health Psychology  
A Member Board of The American Board of Professional Psychology (ABPP), Inc.**

**BYLAWS**

**August 24<sup>th</sup> 2023**

**Chapter 1**

**The American Board of Clinical Health Psychology**

The name and title by which this organization shall be known is the American Board of Clinical Health Psychology (ABCHP) (also referred to as “the Organization”). The ABCHP is affiliated with the American Board of Professional Psychology (ABPP), also referred to as “the Corporation”) as a Member Specialty Board, with representation on the ABPP Board of Trustees (BOT). These By-Laws are consistent with those of the ABPP, and the ABCHP has signed the Articles of Agreement between ABPP and ABCHP in accord with the ABPP Affiliations Manual\*.

**Chapter 2**

**Purposes and Goals**

- I. To serve the public and the profession by ensuring that psychologists certified by the ABPP in Clinical Health Psychology have completed and maintain the education, training, experience and standard ethical requirements of this specialty. These requirements include an examination designed to assess the competencies required to provide quality Clinical Health Psychology services and routine demonstration that these competencies and ethical standards are maintained.

**Chapter 3**

**Composition of the Board of Directors**

- I. The Board of Directors shall consist of no less than six persons, and no more than fifteen, who shall supervise, direct, and manage the activities of the ABCHP.
- II. The Board of Directors will strive for diversity in gender, ethnicity, cultural background, ability status, and primary professional background and activity, in its representation.
- III. Terms of Office: The President Elect will serve sequentially as President Elect, President, and Past President in terms of two (2) years per position (for a total of six [6] years). Only the President Elect is elected to hold office. Other members of the Board of Directors shall be appointed by the President to hold office for a term of four (4) years, beginning January 1 and ending December 31. The exception is the term of the President of the Academy of Clinical Health Psychology, who serves a two (2) year term on the Board as an *ex-officio*, voting member. All other appointments shall be for four (4) year terms and the terms shall be

staggered. No member of the Board of Directors shall serve more than two (2) consecutive four (4) year terms, except in the case of individuals who fill a position vacated early by another member of the Board of Directors and so do not serve an initial full 4-year term. After completing this partial term, these individuals are eligible to be reappointed for two additional full four (4) year terms. Prior members of the Board of Directors who have served two consecutive four-year terms may be reappointed to a new term after an interval of at least two (2) years of not being on the Board of Directors.

IV. Election of President Elect: The Board of Directors solicits nominations for the position of President Elect. President Elect candidates must be board certified specialists in clinical health psychology in accordance with Chapter 9 of the ABPP Corporate Bylaws. Self-nominations are acceptable. The Past President coordinates the nominations and conducts the election in accordance with the ABCHP Nominations and Elections policy and procedures. All ABCHP Specialists are eligible to vote in the election.

V. TimeRemoval: The Board of Directors may remove any member of the Board of Directors for cause by two-thirds (2/3) vote of the Board during any regular meeting of the Board of Directors, provided that a statement of the reason(s) for removal has been mailed by registered mail to the Board of Directors member proposed for removal, and to the other Board of Directors members, at least thirty (30) days before any final action is taken by the Board of Directors. This statement shall be accompanied by a notice of the time and date when, and the place where, the Board of Directors is to take action on the removal. The Board of Directors member shall be given an opportunity to appear and be heard by the Board of Directors at the time, date and place stated in the notice. Grounds for removal of a Board member shall include but are not limited to:

1. loss of qualifying credentials leading to revocation of the ABCHP Board Certification;
2. nonfeasance of office or of duties as a member of the Board of Directors;
3. malfeasance of office as a member of the Board of Directors.

## Chapter 4

### **Functions of the Board of Directors**

I. Consistent with the bylaws of the ABPP, the Board of Directors shall have full legal control of the ABCHP's assets, shall have the power to make contracts on behalf of the organization, oversee the conduct of all the business affairs of the ABCHP, and shall also have the authority and duty to establish, direct and promulgate policies and procedures:

1. that establish the qualifications for Board Certification in Clinical Health Psychology;
2. by which credentialing activities of the ABCHP are conducted;
3. in conjunction with the BOT of ABPP for revocation, reinstatement and maintenance of Board-Certified status in Clinical Health Psychology; and
4. all other activities engaged in by the ABCHP.

II. Policy manual: The Board of Directors shall maintain a policy manual, the intent of which is to set

forth the specific implementation of the bylaws and other actions taken by the Board. The policy manual of the ABCHP shall be reviewed as needed if procedural issues arise or if ABPP policies change.

92 III. Parliamentary Procedures: The Board shall be governed by its own bylaws. Board  
93 meetings, however, shall be conducted according to the Keesey's Abridged  
94 Parliamentary Procedures.

## 97 Chapter 5

### 99 Officers and Officer Elections

101 I. The only elected officer of the ABCHP Board of Directors is the President Elect. The elected  
102 officer's term in this position shall be two (2) years beginning January 1 and ending  
103 December 31. The President Elect then serves in successive positions as President and Past  
104 President, with two (2) years in each position.

105 II. The Executive Committee: The ABCHP Executive Committee shall consist of the President,  
106 President Elect, and the Past President of the Board.

107 III. All officers shall have the following specific functions in addition to the general  
108 responsibilities:

- 109 1. PRESIDENT: The President shall be the Chief Executive Officer of the ABCHP. The  
110 President shall preside at all meetings of the Board of Directors and the Executive  
111 Committee, shall have the power to transact all of the usual, necessary and regular  
112 business of the ABCHP as may be required and, with such prior authorization of the  
113 Board of Directors as may be required by these bylaws, to execute such contracts,  
114 deeds, bonds and other evidence of indebtedness, leases and other documents as shall  
115 be required by the ABCHP; and, in general, the President shall perform all such other  
116 duties incident to the office of President and Chief Executive Officer, and such other  
117 duties as may from time to time be prescribed by the Board of Directors. The President  
118 shall also appoint members to the Board of Directors, members to the committees and  
119 committee chairs.
- 120 2. PRESIDENT ELECT: The President Elect shall act as Chief Executive Officer in the  
121 absence of the President and, when so acting, shall have all the power and authority of  
122 the President. The President Elect shall preside over meetings of the Board of  
123 Directors and Executive Committee when the President is not available. Further, the  
124 President Elect shall have other and further duties as may from time to time be assigned  
125 by the Board of Directors.
- 126 3. PAST PRESIDENT: The Past President shall be responsible for soliciting the slates of  
127 candidates for the election of President Elect and shall contribute advice and counsel  
128 drawn from his/her experience to the Board of Directors and the Executive Committee.
- 129 4. SECRETARY: The Secretary shall record and preserve the minutes of the meetings of  
130 the Board of Directors, shall cause notices and agendas of all meetings of the Board of  
131 Directors to be given, and shall perform all other duties incident to the Office of  
132 Secretary or as from time to time directed by the Board of Directors or the President.
- 133 5. TREASURER: The Treasurer shall be responsible for all funds of the ABCHP and  
134 shall make reports to the Board of Directors as requested by the President.
- 135 6. MEMBER(S) at LARGE: The President shall appoint member(s) at large who shall  
136 function at the direction of the President of the ABCHP and as a special projects

- officer. At least one member at large shall be an Early Career Psychologist (ECP) Specialist (defined as within 10 years of doctoral degree) at time of appointment to the Board. The number of appointed members at large shall be at the discretion of the President based on the needs of the ABCHP; however, at no time shall the total number of members of the Board of Directors exceed fifteen (15).
7. CREDENTIALS REVIEWER: This Board of Directors member shall review the credentials of all ABCHP applicants.
  8. PRACTICE SAMPLE COORDINATOR: This Board of Directors member shall coordinate the review of submitted practice samples, and will report the results of the practice sample reviews to ABPP.
  9. ORAL EXAMINATION COORDINATOR: This Board of Directors member is responsible for coordinating the scheduling and administration of the ABCHP oral examinations.
  10. DIRECTOR OF MOC: In conjunction and with support by the ABPP Central Office, this Board of Directors member ensures that Specialists' certificates are maintained in accordance with ABPP and ABCHP-specific requirements. When notified by Central Office that a Specialist is due for MOC, the Director of MOC shall contact the Specialist, inform the Specialist of MOC procedures, provide access to information necessary for MOC, and oversee all aspects of the ABCHP MOC activities, under the guidance of the ABCHP President.
  11. ABPP BOT REPRESENTATIVE: The BOT Representative serves as the representative of ABCHP on the ABPP BOT. The BOT Representative is selected through a process that involves the ABCHP President forwarding a slate of two nominees to the BOT, one of whom is identified as the Board of Director's preferred nominee. From this slate of two nominees, the BOT selects the ABCHP's BOT representative. The BOT Representative serves a four (4)-year term and may serve a maximum of two consecutive four (4)-year terms in this position.
  12. CLINICAL HEALTH PSYCHOLOGY SPECIALTY COUNCIL REPRESENTATIVE: This individual serves as the representative from ABCHP to the Clinical Health Psychology Specialty Council. The specialty council is represented by its chair on the Council of Specialties in Professional Psychology. This ABCHP representative position is filled by either the ABCHP President or Past President or another board member appointed by the ABCHP President for a 3-year term to the Clinical Health Psychology Specialty Council.
- IV. The President may appoint a member of the Board of Directors to simultaneously serve in more than one of the roles listed above, based on needs of the Board of Directors. The President may not, however, appoint a member to serve as the President Elect, since this is an elected (not appointed) position.
- V. Salary: The members of the Board of Directors shall receive no salary for serving. Members may be reimbursed for expenses incurred in the performance of their duties.

## Chapter 6



181 **Executive Officer**

- 182
- 183 I. ABCHP does not have an executive officer
- 184

185

186 **Chapter 7**

187

188 **Committees**

189

- 190 I. The President may create committees consisting of both board members and
- 191 non-board members, who are also ABCHP credentialed psychologists, to
- 192 further promote the purposes of the specialty board.
- 193 II. The mission and the length of time of the committee's existence to achieve its
- 194 mission shall be determined by the president.
- 195

196

197 **Chapter 8**

198

199 **Meetings/Quorums**

200

- 201 I. Notice: All members of the Board of Directors shall be notified thirty (30) days in advance of
- 202 scheduled, in-person meetings of the Board of Directors, except in exigent circumstances as
- 203 determined by the President or President Elect.
- 204 II. The attendance of a member of the Board of Directors at any meeting shall constitute a
- 205 waiver of notice of such meeting, except where a member of the Board of Directors attends a
- 206 meeting for the express purpose of objecting to the transaction of any business because the
- 207 meeting is not lawfully called or convened. Neither the business to be transacted at, nor the
- 208 purpose of, any regular or special meeting of the Board of Directors need be specified in the
- 209 notice or waiver of notice of such meeting except as required by these bylaws.
- 210 III. A majority of all members of the Board of Directors – present physically or via electronic
- 211 medium - shall constitute a quorum for the transaction of business at meetings of the Board.
- 212 For a motion to pass, a majority of the officers present (i.e. at least 51% of those present
- 213 physically or via electronic medium) must vote in favor of the motion. When not in meeting,
- 214 should a matter requiring a vote of the Board of Directors arise, the President may authorize a
- 215 ballot by mail, e-mail, or other electronic voting method. A fifty-one (51) percent vote of the
- 216 entire Board of Directors will be necessary to carry such a motion.
- 217 IV. The following applies to Board of Directors members' presence at meetings:
- 218 1. The President may authorize a telephone conference meeting of the Board of Directors
- 219 when deemed necessary, and at least ten (10) days advance notice of such a call shall
- 220 be given to each member of the Board of Directors.
- 221 2. Should an item of business require urgent attention and action by the Board of
- 222 Directors, a telephone conference may be called without previous notice, as long as
- 223 ALL of the members of the Board of Directors have been contacted. A vote by a
- 224 majority of the Board of Directors (not just a majority of those present) will be
- 225 necessary to carry a motion presented during such an urgent meeting.

- 226 3. Even without an urgent timetable, members of the Board of Directors, or of any  
227 Committee designated by the Board of Directors, may participate in a meeting of the  
228 Board or Committee by means of telephone conference or similar communications  
229 equipment whereby all persons participating in the meeting can hear each other, and  
230 participation in this manner shall constitute in-person presence at the meeting.

## 231 Chapter 9

### 232 Income and Properties

- 233  
234  
235  
236  
237 I. In accordance with the ABPP Bylaws, the income and properties of the ABCHP,  
238 whenever and however derived, shall be applied solely toward promoting the  
239 purposes of the ABPP and/or the Specialty Board. No portion of the income or  
240 properties shall be paid or transferred directly or indirectly by way of dividend,  
241 bonus, or otherwise by way of profit to members of the organization. This  
242 prohibition shall not prevent the repayment to any Specialist for traveling  
243 expenses and other out-of-pocket cash disbursements and expenses actually  
244 incurred in connection with the proper and necessary business of the Board. As  
245 agreed to in the Articles of Agreement, the ABCHP will manage its financial  
246 affairs in accordance with ABPP financial policies and procedures

## 247 Chapter 10

### 248 Liabilities of the Board of Directors

- 249  
250  
251  
252  
253 I. In accordance with the ABPP Bylaws, no member of the Board of Directors of  
254 the ABCHP or other officer or servant of the ABPP, shall be liable for the  
255 accounts, receipts, neglects, or defaults of any other like member or agent, or  
256 for any loss or expense happening to the Corporation through the  
257 insufficiency or deficiency of any security in or upon which any of the money  
258 of the Corporation shall be invested or for any loss or damage arising from the  
259 bankruptcy, insolvency, or tortuous act of any person with whom any monies,  
260 securities, or effects shall be deposited, or for any loss or damage occasioned  
261 by an error of judgment or oversight, or for any other loss, damage, or  
262 misfortune whatever which shall happen in execution of the official duties or  
263 in the relation thereto, unless the same happened through dishonesty, willful  
264 neglect, or default.

## 265 Chapter 11

### 266 Indemnification of Directors, Executive Officer, Employees and Board-certified 267 Specialists

- I. The American Board of Professional Psychology (ABPP) (“Corporation”) carries a Directors & Officers Liability Insurance Policy. To the extent covered by said policy, each trustee, and officer of an ABPP-affiliated Specialty Board who is officially engaged in Specialty Board business shall be considered to be engaged in Corporation business, and shall be indemnified by the Corporation against all costs and expenses (including counsel fees) actually and necessarily incurred by or imposed on him/her/them in connection with the defense of any action, suit, or proceeding in which he/she/they may be involved or to which he/she/they may be made a party by reason of his/her/they being or having been such trustee or Specialty Board officer, except in relation to matters as to which he/she/they shall be finally adjudged in such action, suit, or proceeding to be liable for dishonesty, willful neglect, or default. Such costs and expenses shall include amounts reasonably paid in settlement for the purpose of curtailing the costs of litigation and as covered by the liability policy. The foregoing right of indemnification shall not be exclusive of any other rights to which he/she/they may be entitled as a matter of law or by agreement, by law, or otherwise. Any indemnification, however, shall not exceed the monetary limits of any insurance policy carried for such purposes by the Corporation regardless of the absolute monetary amount incurred by an individual trustee or Specialty Board officer engaged in Corporation business. The Corporation shall make a copy of the Directors & Officers Liability Insurance Policy available to trustees and Specialty Board officers who request to review the policy so that the requesting individual may determine what, if any, additional coverage that individual might desire to obtain independent from the Corporation. The cost of any such additional coverage will be the individual’s responsibility.

## **Chapter 12**

### **Ethical Standards**

- I. The American Psychological Association’s current ethical standards apply to the psychologist members of the Board of Directors in their work on behalf of the Board.

## **Chapter 13**

### **Amendments**

- I. The ABCHP Board of Directors may vote to amend these bylaws in whole or part after obtaining approval of proposed amendments from the ABPP, in accordance with ABPP policies and procedures. Once ABPP approval is obtained, these bylaws may be amended at any meeting of the Board of Directors, or by electronic means (e.g., email or internet vote of approval) upon the receipt of the written proposed amendment by all the Board members at least 30 days prior to the meeting or date on which the proposed amendment is to be voted on. The approval of at least two-thirds (2/3) of the

319 entire Board of Directors is required to adopt any amendment. Upon approval  
320 of an action by the Board of Directors, a 60-day advance notice will be given  
321 prior to implementation.  
322

323 The undersigned, the duly elected President of the American Board of Clinical Health  
324 Psychology, hereby certifies that the aforesaid bylaws were duly approved and adopted  
325 by the Board of Directors of the American Board of Clinical Health Psychology via  
326 electronic vote, effective on the 24<sup>th</sup> of August, 2023.  
327

328 Luis Carlos Richter, PsyD, ABPP  
329 President, American Board of Clinical Health Psychology  
330

331 These bylaws were amended: 10/02/2019; 09/12/2018; 08/17/2016; 08/01/2015;  
332 10/01/2014; 04/28/2012; 10/15/2009; 8/24/2023  
333

## Appendix II

### Letters of Support from Clinical Health Psychology Specialty Council Organizations and Other Organizations Relevant to the Specialty



September 23<sup>rd</sup>, 2024

Mark Vogel, PhD

President, Society for Health psychology:

Dear Dr. Vogel,

The purpose of this letter is to affirm the American Board of Clinical Health Psychology's (ABCHP) participation in the submission of the Society of Health Psychology's, American Psychological Association (APA) Division 38, petition on behalf of the Clinical Health Psychology Specialty Council (CHPSC). On behalf of ABCHP, I formally support the re-certification of Clinical Health Psychology as a specialty in professional psychology.

Sincerely,

Luis Carlos Richter, PsyD, ABPP

President, American Board of Clinical Health Psychology

AMERICAN BOARD OF CLINICAL HEALTH PSYCHOLOGY  
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[www.abchp.org](http://www.abchp.org)

September 17, 2024

Mark Vogel, PhD

2023-2024 President, Society for Health Psychology (SfHP, APA Division 38)

**Re: APAHC supports the re-certification of Clinical Health Psychology as a specialty in professional psychology**

Dear Mark,

**On behalf of the Association of Psychologists in Academic Health Centers (APAHC; APA Division 12, Section 8), I am writing to express our enthusiastic support for the re-certification of Clinical Health Psychology as a specialty in professional psychology.**

As you know, APAHC serves alongside the Society for Health Psychology and many other groups to form the Clinical Health Psychology Specialty Council. One of the purposes of this council is to ensure the recognition of clinical health psychology as a specialty. We all agree that clinical health psychology is an area of psychological science and practice that fulfills all the specialty criteria outlined by the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). Members of APAHC have long histories of training psychologists in clinical health psychology and forecast a healthy future for this area of specialization. Indeed, clinical health psychology remains one of the fastest growing areas in professional psychology and has received increasingly visible recognition at the national level as a fundamental specialty under health care reform.

It is our hope that re-certification of the specialty area of Clinical Health Psychology as a specialty will be approved.

Sincerely,



Elizabeth Cash, PhD

2024-2025 President, Association for Psychologists in Academic Health Settings

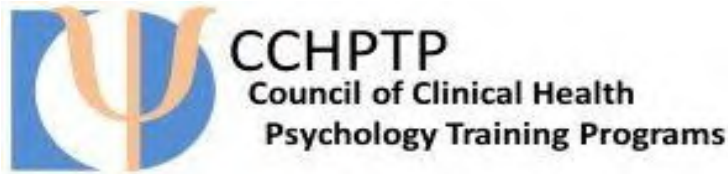
Associate Professor | Vice Chair for Research

Department of Otolaryngology-Head and Neck Surgery & Communicative Disorders

Program Leader | Cancer Control and Care Delivery, UofL Health-Brown Cancer Center

University of Louisville School of Medicine, Louisville, KY

Cell: [502.298.4561](tel:502.298.4561)



September 10, 2024

Mark Vogel, Ph.D.  
Society for Health Psychology, President (2023-24)

Dear Dr. Vogel:

The Council of Clinical Health Psychology Training Programs (CCHPTP) is the psychology training council that includes programs at the doctoral, doctoral internship, and postdoctoral stages of training. CCHPTP is a member of the Clinical Health Psychology Specialty Council (CHPSC) and our organization has been fully informed about the renewal petition to CRSPPP for recognition of Clinical Health Psychology as a specialty. In addition, two CCHPTP board members are participating on the team, coordinated by the Society for Health Psychology, which drafted the renewal petition to CRSPPP for submission on behalf of CHPSC.

Clinical Health Psychology is a unique and important specialty that sees health as the confluence of psychological, social, cultural, and biological factors and applies this understanding to conduct research; to provide clinical services; to consult with, educate, and supervise other health care providers and psychologists; and to advise organizations, institutions, the public, and policymakers. On behalf of the CCHPTP Board of Directors, I confirm this training council's wholehearted support of the renewal petition for recognition of Clinical Health Psychology as a specialty in professional psychology.

Respectfully yours,

Dwain Fehon, Psy.D.  
Chair, Council of Clinical Health Psychology Training Programs (CCHPTP)  
Chief Psychologist, Psychiatric Services  
Director, Behavioral Medicine  
Yale New Haven Hospital  
Professor, Psychiatry  
Deputy Director, Clinical Psychology Training  
Yale School of Medicine





**College of Education**  
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Schroeder Complex, 150  
Milwaukee, WI 53233

P 414.288.5730  
W [www.marquette.edu/education/](http://www.marquette.edu/education/)

November 1, 2024

Mark Vogel, Ph.D.  
President  
Society of Health Psychology, Division 38  
American Psychological Association

Dear Dr. Vogel:

I am writing in my capacity as the Chair of the Health Psychology Section through Division 17 (Society of Counseling Psychology) to convey our formal support for the renewal application of Clinical Health Psychology as a specialty area within professional psychology.

Counseling psychologists are increasingly choosing health psychology as a specialty area within clinical and research emphases and are, to a greater extent, represented within health psychology settings. Therefore, on behalf of Division 17 and the Health Psychology section, we enthusiastically support the re-certification of Clinical Health Psychology as a specialty area within professional psychology.

Please do not hesitate to reach out to me with any questions.

Sincerely,

Kavitha D. Venkateswaran, Ph.D.  
Clinical Assistant Professor  
Clinical Training Coordinator  
Licensed Psychologist  
Department of Counselor Education and Counseling Psychology  
Marquette University  
[kavitha.venkateswaran@marquette.edu](mailto:kavitha.venkateswaran@marquette.edu)



September 19, 2024

Mark E. Vogel, PhD, ABPP  
Board Certified in Health Psychology  
Professor, Michigan State University, College of Human Medicine  
2023-24 President, Society for Health Psychology

CC: SfHP Administrative Officer Barbara Keeton

Dear Dr. Vogel:

The Board of Directors of the Society of Behavioral Medicine has reviewed your request for support for the Clinical Health Psychology specialty petition drafted by Division 38 of the American Psychological Association (Society for Health Psychology). I am pleased to tell you that there was unanimous consensus for endorsement. We agree that it is very important to have Clinical Health Psychology formally recognized within the field of psychology.

If there is any other way that the Society can be of assistance with the petition moving forward, please let me know.

My best,

Ellen Beckjord, PhD, MPH, FSBM  
President



**SOCIETY FOR BIOPSYCHOSOCIAL  
SCIENCE AND MEDICINE**

*Integrating mind, brain, body and social context in medicine since 1942*

---

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**PRESIDENT**

Tara Gruenewald, PhD, MPH  
Orange, CA

September 19, 2024

**PRESIDENT-ELECT**

Janet Tomiyama, PhD  
Los Angeles, CA

**PAST PRESIDENT**

Peter Gianaros, PhD  
Pittsburgh, PA

Mark Vogel, PhD, ABPP  
President, Society for Health Psychology

**SECRETARY-TREASURER**

Anna Catriona Whittaker, PhD  
Stirling, Scotland

Dear Dr. Vogel,

**COUNCIL MEMBERS**

Nataria T. Joseph, PhD  
Granada Hills, CA

Michael Stanton, PhD  
Hayward, CA

Ali A. Weinstein, PhD  
Fairfax, VA

Christopher Celano, MD  
Medford, MA

Daryl O'Connor, PhD  
Leeds, England

I am writing to you as President of the Society for Biopsychosocial Science and Medicine regarding your request for support of Division 38: Society for Health Psychology's petition to the APA for renewal of the recognition of Clinical Health Psychology as a specialty. As we understand the request, the APA seeks external endorsement recognizing Division 38 as an appropriate entity to make such a petition to the APA.

The Society for Biopsychosocial Science and Medicine (formerly American Psychosomatic Society), founded in 1942, is an interdisciplinary organization whose mission is to advance biopsychosocial science and its application to clinical and public health practice. We have numerous members, including Society for Biopsychosocial Science and Medicine officers and society leaders, who are also members of Division 38. Thus, we are very familiar with Division 38 and its longstanding leadership in the field of Health Psychology.

**APS MANAGEMENT TEAM**

**EXECUTIVE DIRECTOR**

Laura E. Degnon, CAE

**ASSOCIATE EXECUTIVE DIRECTOR**

Connie Mackay, CAE

**EXECUTIVE ASSISTANT**

George B. Degnon

*Degnon Associates*  
6728 Old McLean Village Drive  
McLean, VA, 22101 USA

The Society for Biopsychosocial Science and Medicine is pleased to continue to recognize Division 38: Society for Health Psychology as the entity that is ideally suited to petition the APA for recognition of Clinical Health Psychology as a specialty.

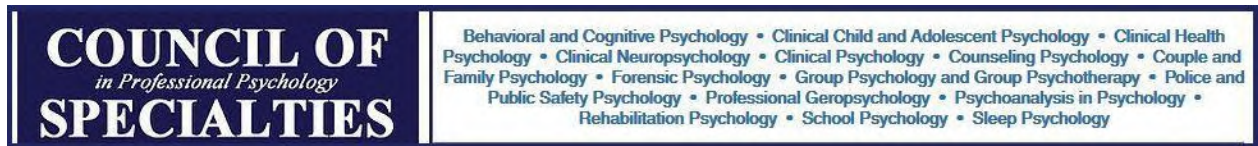
We wish you well with your petition.

Sincerely,

Tara Gruenewald, PhD, MPH  
President, Society for Biopsychosocial Science and Medicine

## Appendix III

### Approval Letter of Specialty Taxonomy by the Council of Specialties in Professional Psychology



October 10, 2024

RE: Approval of Specialty Taxonomy by the Council of Specialties in Professional Psychology

Dear Dr. Berg:

You are receiving this letter as the representative of the Clinical Health Psychology Specialty and a member of the Council of Specialties in Professional Psychology (CoS).

The CoS has completed its review of Clinical Health Psychology Specialty's taxonomy submitted in advance of the specialty's upcoming review by the Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (CRSSPP). At its fall quarterly meeting held on September 16, 2024, the CoS membership reviewed and unanimously approved the taxonomy. The members of the CoS found the taxonomy to be consistent with requirements as outlined by *the APA Guidelines: A Taxonomy for Education and Training in Professional Psychology Health Service Specialties and Subspecialties* (<https://www.apa.org/ed/graduate/specialize/taxonomy.pdf>).

Please submit this letter in your petition to CRSSPP.

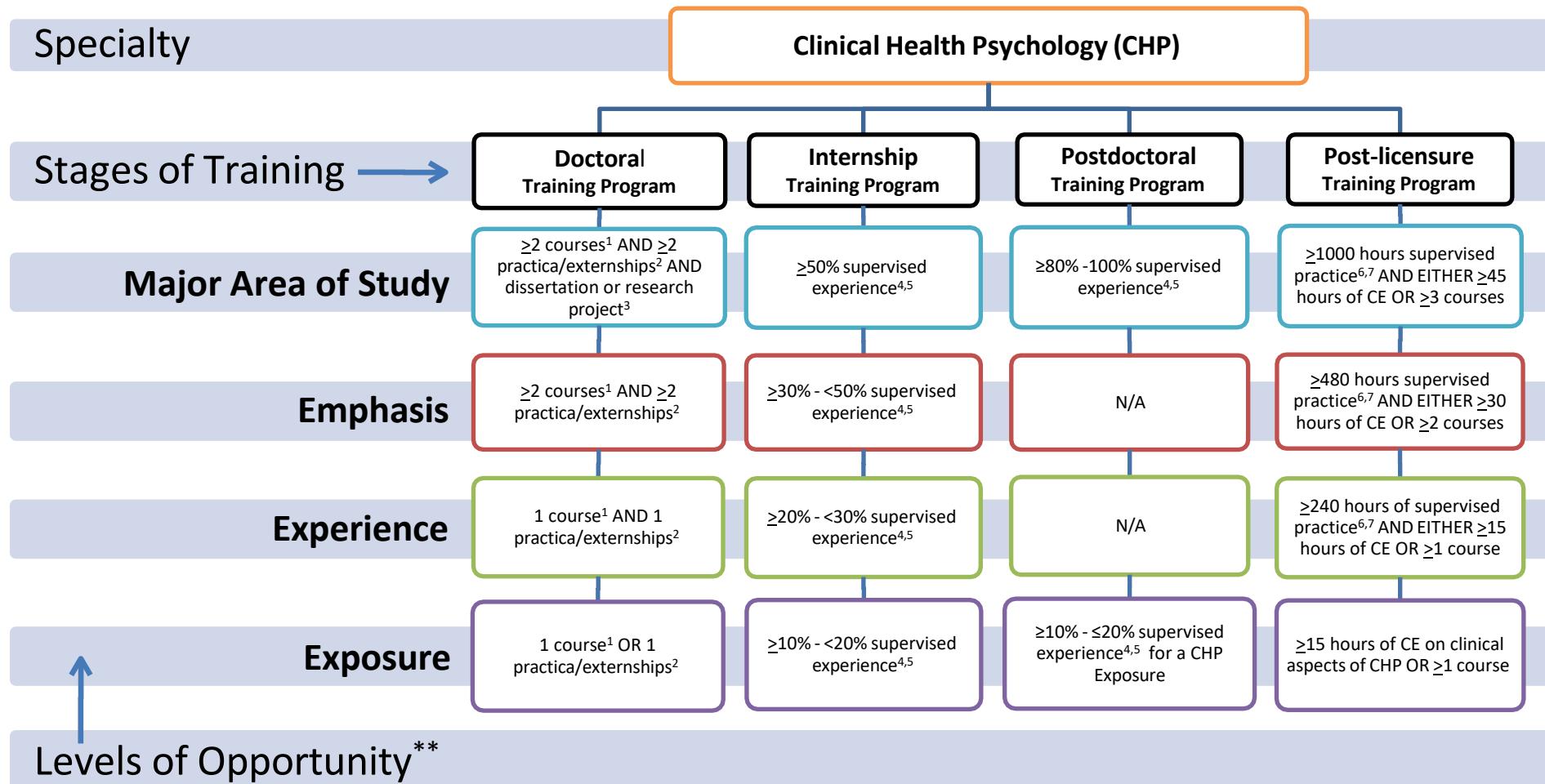
Sincerely,

*Carlen Henington*

Carlen Henington, PhD NCSP  
President, Council of Specialties in Professional Psychology

## Appendix IV

# Clinical Health Psychology Education and Training Taxonomy



\*The term “*focus*” should be used to describe opportunities in areas of training which **are not recognized specialties**. Training programs should strive to provide explicit explanations of the type of training provided in these non-specialty areas.

The original Clinical Health Psychology E & T Taxonomy was approved by CoS Board of Directors 10-29-2021; the revised version was approved by CoS Board of Directors 09-16-2024.

**Common Definitions and Criteria Across All Recognized Specialties**  
**Clarifications to help recognized specialties use the APA-Taxonomy\*\* in a consistent manner**

- Broad and general training forms the core of education and training in health service psychology. Programs are accredited by the American Psychological Association (APA), Commission on Accreditation (CoA) or Canadian Psychological Association (CPA). Programs integrate the broad and general training with those educational and training activities related to recognized specialties as determined by the specialty and described in a specialty taxonomy. In addition, each specialty will have education and training guidelines consistent with its specialty area. Specialty training may be acquired at the doctoral, doctoral internship, postdoctoral, or post-licensure stages as defined by the specialty.
- By definition, postdoctoral education and training is a Major Area of Study in a specialty recognized by the Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (CRSSPP) and requires that 80% or more of time be spent in the specialty area. At the postdoctoral training stage, as per above, it is recognized that training in the Major Area of Study will be consistent with the education and training guidelines set forth by the specialty.
- A course is typically defined as 3 semester-credit hours (or equivalent) in a health service psychology training program accredited by APA or CPA.
- A practicum is typically defined as the equivalent of one academic year (e.g., 9 months, in semester or quarter systems) consisting of supervised training for at least 8 hours per week, or its equivalent, with at least 50% of time in the provision of clinical services.
- Consistent with what is described in CoA *Standards of Accreditation*, supervision should be provided by persons with competencies in the specialty demonstrated by appropriate training, credentials, and qualifications for training in the specialty as defined by the specialty.
- Additional training experiences can also include, but are not limited to, research experiences, lab meetings, brown bags, lecture/colloquia series, and grand rounds, as defined by the specialty.
- For definitions of continuing education (CE) and continuing professional development (CPD) see the APA [Quality Professional Development and Continuing Education Resolution](#). A continuing education (CE) course is defined as an organized program by the American Psychological Association or Canadian Psychological Association, a State Psychological Association, or other major provider of CE (e.g., Society of Behavioral Medicine).

\*\* Taxonomy; [www.apa.org/ed/graduate/specialize/taxonomy.pdf](http://www.apa.org/ed/graduate/specialize/taxonomy.pdf)



## Specialty Specific Definitions and Criteria

- <sup>1</sup> Clinical Health Psychology course: Must have content congruent with *Clinical Health Psychology 2018 Education and Training Guidelines* (available on Council of Specialties in Professional Psychology website <https://cospp.org/education-and-training-guidelines-1>).
- <sup>2</sup> Clinical Health Psychology practicum/externship: Must include at least 50% of clinical service delivery with *health-related issues* of patient, family members, and/or *interprofessional* care teams.
- <sup>3</sup> Clinical Health Psychology dissertation or research project: Includes empirical research, extended case studies, literature critiques and analyses, or capstone projects.
- <sup>4</sup> Clinical Health Psychology supervised experience/practice: Must include at least 50% of clinical service delivery to clinical health psychology patients, family members, and/or interprofessional care teams (e.g., assessment, treatment, consultation). Seminar attendance, readings, supervision, interdisciplinary team participation and research may count as part of the supervised experience.
- <sup>5</sup> Primary supervisors of clinical health psychology supervised experience should have training, qualifications, or credentials (e.g., ABPP, HSP) as clinical health psychologists.
- <sup>6</sup> Clinical Health Psychology supervised practice: At least 50% of clinical service delivery to clinical health psychology patients, family members, and/or interprofessional care teams (e.g., assessment, treatment, consultation).
- <sup>7</sup> Primary supervisors of clinical health psychology post-licensure practice should have training, qualifications, or credentials (e.g., ABPP, HSP) as clinical health psychologists.

## Examples of Program Descriptors for Stages of Training in Clinical Health Psychology

### Doctoral

In our APA accredited doctoral program in Health Service Psychology at Our University we offer a Major Area of Study in Clinical Health Psychology with at least two courses and two supervised clinical practica in Clinical Health Psychology. The Major Area of Study must include a dissertation or research project within Clinical Health Psychology. We offer students an Exposure to Clinical Neuropsychology and an Experience in Clinical Child Psychology. We offer a Focus in cardiac psychology as part of our advanced practicum wherein an advanced assessment course and two additional practica semesters are available on the cardiac care unit.

### Doctoral Internship

Our internship program in Health Service Psychology is accredited by the APA-Commission on Accreditation and offers a Major Area of Study in Clinical Health Psychology at Our Health Science Center. At least 50% of trainee time will be devoted to supervised experience in clinical health psychology with direct patient assessment and treatment activities and consultation services. We also provide an Experience involving up

to 25% supervised time in family-oriented treatment of medically ill patients and their families. There is an optional Experience in Clinical Neuropsychology at our Clinic. Our internship also offers a focus on psycho-oncology service provision as part of the >50% time required in the Major Area of Study.

#### Postdoctoral Residency

The Clinical Health Psychology Postdoctoral Program at Our Health Science Center is accredited by APA-Commission on Accreditation. With the Major Area of the postdoctoral program being in Clinical Health Psychology, at least 80% of the postdoctoral resident's time will be clinical health psychology supervised experience. Within the required 80% time in the Major Area of Study in Clinical Health Psychology (CHP), residents will have >50% of clinical service delivery time devoted to clinical health psychology patients, family members, and/or interprofessional care teams (e.g., assessment, treatment, consultation). Our program provides an opportunity for a resident to focus on integrated primary care, psycho-oncology, obesity, or pain rehabilitation as part of their required 80% time in the Major Area of Study. Our program requires 2 research products (i.e., peer-reviewed publication and paper/poster presentation at national/international meeting) by the completion of the two-year postdoctoral program. Residents have opportunity for optional Exposure in Geropsychology.

#### Post-Licensure Training

Our Health Service Psychology Training Institute is an APA approved sponsor of psychology continuing education. Our course, Clinical Health Psychology in Primary and Tertiary Health Care, provides 50 hours of CE and 480 hours of supervised practice following the course. Supervision is provided on a monthly basis via Skype with an experienced clinical health psychologist mentor. This program is consistent with Emphasis level training in clinical health psychology as described in the Clinical Health Psychology Specialty Taxonomy Grid.

## Appendix V

### C-9(c) P. Postdoctoral Residency Level 3 – Specialty Competencies Clinical Health Psychology

**C-9(c) P. Postdoctoral Residency Level 3 – Specialty Competencies**  
**Clinical Health Psychology**  
(Commission on Accreditation, September 2021)

Programs that are accredited in a substantive specialty practice area, as identified in IR C-5 P, are required to provide advanced preparation for practice in the competencies and associated elements associated with the specialty practice area. Specialty competencies must be operationalized in terms of multiple elements and must, at a minimum, reflect the bulleted content for each required specialty competency.

**I. Research**

Postdoctoral residents are expected to:

- engages in Clinical Health Psychology scholarly activities which could include but are not limited to research, evaluation, or other form of inquiry
- applies scientific methods in Clinical Health Psychology activities

**II. Professional Values, Attitudes, and Behaviors**

Postdoctoral residents are expected to:

- behave in ways that reflect the values and attitudes of psychology and Clinical Health Psychology, including integrity, deportment, professional identity, accountability, lifelong learning, and concern for the welfare of others.
- engage in self-reflection regarding one's personal and professional functioning; engage in activities to maintain and improve performance, well-being, and professional effectiveness.
- actively seek and demonstrate openness and responsiveness to feedback and supervision.
- respond professionally in increasingly complex situations with a greater degree of independence.
- apply scientific knowledge and skills in Clinical Health Psychology to advocate for equity and access to quality care.
- demonstrate an emerging professional identity consistent with the Clinical Health Psychology specialty.

**III. Communication and Interpersonal Skills**

Postdoctoral residents are expected to:

- develop and maintain effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services.
- produce and comprehend oral, nonverbal, and written communications that are informative and well-integrated; demonstrate a thorough grasp of professional language and concepts.
- demonstrate effective interpersonal skills and the ability to manage difficult communication well.

#### **IV. Assessment**

Postdoctoral residents are expected to:

- select and apply evidence-based biopsychosocial assessment methods appropriate for the patient's physical illness, injury, or chronic health condition/disability and collects relevant data using multiple sources and methods appropriate for identified presenting problems and assessment question.
- communicate orally and in written documents the findings and implications of the assessment in an accurate and effective manner sensitive to a range of audiences.
- assess factors that facilitate or inhibit knowledge, values, attitudes, or behaviors affecting health functioning, treatment and treatment adherence and health care utilization of patients, and when applicable, populations.
- assesses the biopsychosocial impact of undergoing medical procedures (e.g., screening, diagnostic, and intervention/prevention procedures).

#### **V. Intervention**

Postdoctoral residents are expected to:

- implement evidence-based biopsychosocial interventions to treat or prevent health and behavioral health-related issues of patients and, when applicable, populations.
- evaluate, select, and administer appropriate biopsychosocial assessments to monitor and evaluate the process and outcomes of treatment for patients and, when applicable, populations.
- monitor adherence to medical treatment and psychological interventions and demonstrate skill in addressing health behaviors to improve adherence.

#### **VI. Teaching/Supervision**

Postdoctoral residents are expected to:

- demonstrate knowledge of supervision models and practices related to Clinical Health Psychology.
- teach and supervise others by accurately, effectively, and appropriately presenting information related to Clinical Health Psychology.

#### **VII. Consultation and Interprofessional/Interdisciplinary Skills**

Postdoctoral residents are expected to:

- demonstrate knowledge and respect for the roles and perspectives of other professions.
- conceptualize referral questions that incorporate understanding of the roles of patient, caregiver, other provider, and/or health system to answer the consultation questions effectively.
- apply knowledge of consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior.

- engage interprofessional individuals and teams to increase the likelihood of appropriate early referrals to clinical health psychologists.
- provides education about health psychology concepts and practices or methods and procedures to other professionals and/or trainees.

#### **VIII. Leadership**

Postdoctoral residents are expected to:

- demonstrate leadership within an interprofessional team or organization related to the practice of Clinical Health Psychology.
- demonstrate the ability to develop or enhance a Clinical Health Psychology practice, educational program, or program of research.

## Appendix VI

### Council of Clinical Health Psychology Training Program (CCHPTP) Membership Criteria and Application Links

## **Council of Clinical Health Psychology Training Program (CCHPTP) Membership Criteria**

Full Membership is offered to doctoral, internship, and postdoctoral programs that train health service psychology students with competencies in the science and practice of clinical health psychology and provide training at the “Major Area of Study” or “Emphasis” levels of the Taxonomy (APA, 2024). Doctoral and internship programs must be accredited through APA or CPA for full membership. Program representatives from programs with Full Membership can participate in all aspects of CCHPTP governance, including running for elected office, voting for candidates for office, and voting on initiatives being considered by the organization.

### [CCHPTP Program Membership Application](#)

Associate Membership is offered to programs that demonstrate commitment to training health service psychology students with competencies in the science and practice of Clinical Health Psychology and provide training at the “Experience” or “Exposure” levels of the Taxonomy (APA, 2024). Representatives of programs with Associate Membership are welcomed and encouraged to participate in discussion of initiatives being considered by CCHPTP but cannot participate in CCHPTP governance. CCHPTP encourages Associate Member programs to apply for Full Membership status if they meet criteria over time.

### [CCHPTP Program Membership Application](#)

Individual membership: Eligible individuals are psychologists (non-students or trainees) who have interests in, are involved in, or plan to be involved in clinical health psychology training at the graduate or postgraduate level. Individual members need not be from member programs.

### [CCHPTP Individual Membership Application](#)

### [CCHPTP\\_Individual\\_Student\\_Application.pdf](#)



## Appendix VII

### Sample Candidate Admission Evaluation Forms for Doctoral and Postdoctoral Programs

Only applicant name will be entered into review sheets per admissions subcommittee decision

Name	First Choice Mento	Mentor/Reviewer	Mentor/Reviewer
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**REVIEWER 1**

**Overcoming Challenges**

**Reviewer Name**

**Citizenship**

**Teaching**

**Clinical**

**Comments**

**REVIEWER 2**

**Overcoming Challenges**

**Reviewer Name**

**Citizenship**

**Teaching**

**Clinical**

**Comments**

**REVIEWER 3**

**Overcoming Challenges**

**Reviewer Name**

**Citizenship**

**Teaching**

**Clinical**

**Comments**

Notes for how to use this sheet: The only REQUIRED field is the OVERALL rating. Applicants must receive an overall rating of at least 3 to be considered for the program. This overall rating is NOT an average of other dimensions, but a holistic appraisal. The dimensions may not cover all you are considering in your overall score, and comments are a major way to represent considerations. The overall rating here does not need to correspond to your own personal rankings. GRE optional this year, please do not weight GRE strongly or use it as a negative in the application.

UG GPA    G GPA

Rating Key:   Poor = 1   Average = 2   Good = 3   Excellent = 4  
Research   Academic   Statement Diversity   Letter 1   Letter 2   Letter 3   Fit with pro   Overall

Rating Key:   Poor = 1   Average = 2   Good = 3   Excellent = 4  
Research   Academic   Statement Diversity   Letter 1   Letter 2   Letter 3   Fit with pro   Overall

Rating Key:   Poor = 1   Average = 2   Good = 3   Excellent = 4  
Research   Academic   Statement Diversity   Letter 1   Letter 2   Letter 3   Fit with pro   Overall

## VCU Clinical Health Psychology Postdoctoral Fellowship Applicant Interview Rating Form

Applicant: \_\_\_\_\_

Program: \_\_\_\_\_

Date of Interview: \_\_\_\_\_

Interviewer: \_\_\_\_\_

Circle a category **and** a specific number:

Definitely Accept	Accept+	Acceptable	Marginal	Weak
1      2	3      4	5	6	7

---

Strengths:

Areas of relative weakness:

Dissertation status/interest in research/publications:

Readiness for fellowship:

Compatibility with VCU Health/Clinical Health Psychology:

Interpersonal Qualities:

General Comments:

## Appendix VIII

### Sample Curricula from Exemplar Programs

## 1. University of Colorado Denver, Clinical Health Psychology PhD Program

### Program Curriculum and Program Requirements

The Clinical Health Psychology PhD Program has six components: Core Courses & Electives, Master's Thesis, Clinical Practica, Comprehensive Clinical Competency Evaluation (CCCE), Doctoral Dissertation, and Pre-Doctoral Internship. Each component contributes to developing the scientist-practitioners who are the hallmark of clinical health psychology training. It is possible to complete the program in five years. The CHP PhD program is a full-time, residency-based program. Educational activities are completed on-campus for didactic, research, and clinical training. PhD students are required to complete their training on campus for no less than 3 years prior to their full time APA accredited internship.

### Taxonomy Program Descriptor: Doctoral- Major Area of Study

In our APA accredited doctoral program in Clinical Health Psychology at the University of Colorado Denver we offer a Major Area of Study in Clinical Health Psychology with a minimum requirement of at least three courses and two supervised clinical practica in Clinical Health Psychology. Students must also complete a thesis, dissertation, or research project within Clinical Health Psychology. We offer students an optional Exposure in Clinical Neuropsychology, or Pediatric/Child Psychology with a minimum of two semester practica in each area.

### Required courses:

- Personality Assessment
- Cognitive Assessment
- Advanced Psychopathology
- Advanced Cognition & Emotion
- Advanced Developmental Psychology
- Diversity in Clinical Psychology
- Advanced Biological Bases of Behavior
- Clinical Research Methods
- Clinical Behavioral Medicine
- Clinical Practica
- Master's Thesis
- Advanced Social Psychology
- Psychotherapy I
- Psychotherapy II
- Health Psychology I
- Health Psychology II
- Ethics & Professional Issues
- Advanced Statistics
- Multivariate Statistics
- Dissertation
- Pre-Doctoral Internship

## Learning Outcomes

*Goal #1: Prepare students to be entry-level clinical psychology scientists.*

### Objectives for Goal #1:

- Students will acquire knowledge of research methods in clinical psychology.
- Students will acquire basic understanding of statistical analytic methods in clinical psychology.
- Students will be able to conduct empirical research to contribute to the knowledge base in clinical psychology.

### Competencies for Goal #1 Objectives:

- Demonstrate entry-level ability to review, integrate, and critically evaluate research in clinical psychology.
- Demonstrate entry-level ability to design and conduct empirical research.
- Demonstrate entry-level ability to disseminate research findings.
- Demonstrate critical and integrative thinking skills as well as intellectual curiosity.

*Goal #2: Students will be trained to be capable entry-level practitioners of clinical psychology.*

### Objectives for Goal #2:

- Students will acquire knowledge of theory and research to understand psychological disorders.
- Students will acquire knowledge of theory and research and related skills to conduct effective evidence-based psychological assessment and psychotherapeutic interventions.
- Students will acquire knowledge regarding the application of ethical concepts and awareness regarding professional activities.
- Students will be knowledgeable and sensitive to individual, group, and cultural differences in clinical practice.

### Competencies for Goal #2 Objectives:

- Demonstrate entry-level knowledge of psychological disorders.
- Demonstrate entry-level ability to diagnose psychological disorders.
- Demonstrate entry-level ability to conduct psychological assessment.
- Demonstrate entry-level ability to select and deliver empirically supported and evidence-based psychological interventions.
- Understand ethical principles and demonstrate ethical behavior in the application of clinical practice.
- Demonstrate sensitivity to cultural and diversity issues and adapt clinical practice accordingly.

*Goal #3: Students will be trained to be competent as entry-level clinical psychology professionals with knowledge and skills in clinical health psychology.*

### Objectives for Goal #3:

- Students will acquire basic knowledge of biopsychosocial principles and research relevant to clinical health psychology.
- Students will acquire basic, entry-level skills to conduct research on health psychology topics and provide clinical psychological services in clinical health psychology settings.

### Competencies for Goal #3 Objectives:

- Demonstrate knowledge of biopsychosocial principles.
- Demonstrate knowledge of clinical health psychology research.
- Demonstrate knowledge and entry-level skill in application of clinical psychological skills in clinical health psychology settings.

Sample curricula for students entering in odd or even years may be found here:

[https://clas.ucdenver.edu/psychology/sites/default/files/attached-files/curricula\\_rev\\_3.11.20.pdf](https://clas.ucdenver.edu/psychology/sites/default/files/attached-files/curricula_rev_3.11.20.pdf)

## 2. Harvard Medical School/Boston Children's Hospital, Internship in Health Service Psychology

### Taxonomy Descriptor: Internship–Major Area of Study:

Our internship program in Health Service Psychology is accredited by the APA-Commission on Accreditation and offers a Major Area of Study in Clinical Health Psychology. At least 50% of trainee time will be devoted to supervised experience in clinical health psychology with direct patient evaluation and intervention activities, including treatment of medically ill patients, family support and consultation services. We also provide up to 25% supervised experience in integrated primary care, emergency psychiatry services, medical specialty clinics (atopic dermatitis and functional motility), and gender-affirming care. There are optional experiences in Clinical Neuropsychology and Developmental Neuropsychiatry.

### Program Description

The Psychology Internship Program at Boston Children's Hospital adheres to the tradition of providing an intensive, high-quality training program to facilitate an intern's professional development in health service psychology. Evidence-based practices, in both assessment and treatment, are significant emphases of this program, as well as the capacity to adapt these practices in a patient- and family- centered manner with sensitivity to identity factors, including race and ethnicity, gender identity, age, socioeconomic status, and developmental functioning of the patient and their caregiver(s).

The training program is graduated and sequential in nature. Interns learn through a competency-based process: exposure to specific objectives and associated competencies through readings; observation of staff members in a specific clinical activity; collaborative engagement in that clinical activity by intern and supervisor; direct observation of intern by supervisor; and lastly the intern being responsible for the clinical activity with general oversight by supervisor. An intern will typically advance to the next aspect of their training sequence when competency at the earlier phase of the training in that particular clinical activity has been demonstrated. The program aims to provide strong support and communication throughout this process, with a



particular emphasis on sensitivity to issues of cultural diversity, training in evidence-based practices, and promotion of interns' inter-professional skills and professional development.

The Division of Psychology of Boston Children's Hospital readily embraces the mission statement for the hospital. The current program continues to adhere to the tradition of providing intensive, high- quality training with both breadth of experience and depth in teaching.

#### Program Aims

- A commitment to integrate the development of sensitivity to issues of cultural diversity into all aspects of the training program
- An emphasis on training interns in the latest clinical techniques with a focus on selecting the most advantageous assessment protocol and/or intervention technique(s) with demonstrated efficacy for specific presenting problems
- A focus on assuring that a developmental perspective underlies all teaching and supervision throughout the training program
- To promote professional development and a sense of what it means to be an ethical, collegial, and responsible psychologist
- To be able to work in an inter-professional environment, bringing the competencies of a health service psychologist to health organizations

The training year begins on July 1st, and it is expected that by October, each intern will be delivering approximately 16 to 18 hours of direct clinical service per week. Another four to six hours will be spent in supervision, and an additional four to six hours are devoted to seminars associated with the internship program, department, and specific rotations. Additional time is generally required for consultation with treatment teams, referral sources, community agencies, schools, and co-therapists. The program is designed to occupy 40 hours per week of an intern's time, although interns report investing some extra time writing evaluation and progress notes, preparing for treatment, attending special meetings as needed, and/or conducting literature searches and reading articles about particular diagnostic assessment procedures, treatments, or clinical conditions.

6 Months

6 Months

#### **Rotation A: Consultation Experience**

#### **Rotation B: Integrated Care Experience**

#### **Outpatient Psychiatry Service**

**Psychiatry Consultation Service**  
+  
**Gender Multispecialty Service**

**Emergency Department**  
+  
**Atopic Dermatitis Clinic or**  
**Motility Disorders Clinic or**  
**Children's Hospital Primary Care Center**

### Training Year

The training year is divided into two six-month semesters. One half of the year is structured around a primary clinical experience on the Psychiatry Consultation Service, and the other half of the year around an integrated care experience. Interns see patients on the Outpatient Psychiatry Service for the entirety of the training year, allowing for longer-term outpatient care experiences

### Didactics

While each rotation brings rotation-specific training and didactics, all psychology interns are also required to attend the following regularly scheduled didactics/meetings:

Pediatric Psychology Seminar, all interns, 1 hour, weekly

Internship Seminar, all interns, 1 hour, weekly

Clinical Process Seminar, all interns, 1 hour, weekly, 4 months

Peer Supervision Seminar, all interns, 1 hour, biweekly, 4 months

ED case discussion, for interns on the Integrated Care semester, 1 hour, every other week

Developmental Neuropsychiatry team meeting, for interns completing the DNP elective, 1 hour, weekly

Neuropsychology Seminar, for interns completing the Neuropsychology elective, 1 hour, weekly

Psychiatry Grand Rounds, all interns, 1 hour, twice monthly, September-June

Psychiatry Morbidity and Mortality (M&M) Rounds, all interns, 1 hour, monthly, September-June

### Supervision

All interns receive extensive supervision for their diagnostic assessment, consultative, and treatment activities. Supervisory hours are scheduled to meet the intern's needs with additional guidance available as needed, depending on the intern's progress and caseload. A supervisor is available 24/7 for case consultation, including weekends and holidays. All supervisors work directly on the rotations in which they provide supervision. An intern will typically receive three to four hours of individual supervision each week, with additional individual and some group supervision also provided. In general, use of evidence-based diagnostic and treatment approaches provide the theoretical framework for individual psychotherapy supervision. There is a major emphasis on all service planning to be patient/family- centered, impacted by cultural factors, and clinical progress systematically evaluated as the treatment proceeds. Supervision is provided primarily by psychologists, all of whom are licensed to practice in Massachusetts. Specialized supervision in some service units is provided by fully licensed social workers or staff psychiatrists.

In addition to prioritizing supervision and training, internship faculty are strongly committed to interns' professional development. Mentorship and support around topics such as postdoctoral fellowship applications, career trajectory, and work-life balance are common. Faculty meet with interns to discuss these interests during and outside of formal supervision.

### 3. San Antonio Uniformed Services Health Education Consortium – Wilford Hall Ambulatory Surgical Center

#### Taxonomy Program Descriptor: Post-Doctoral - Major Area of Study

The Military Readiness Psychology (Clinical Health Psychology) Postdoctoral Fellowship Program at the San Antonio Uniformed Services Health Education Consortium is accredited by APA-Commission on Accreditation. With the Major Area of the postdoctoral program being in Clinical Health Psychology, at least 80% of the postdoctoral resident's time will be clinical health psychology supervised experience. Within the required 80% time in the Major Area of Study in Clinical Health Psychology (CHP), residents will have >50% of clinical service delivery time devoted to clinical health psychology patients, military leadership teams, family members, and/or interprofessional care teams (e.g., assessment, treatment, consultation). Our program provides an opportunity for a resident to focus on behavioral sleep medicine, integrated primary care, obesity, pain rehabilitation, and other subspecialty areas as part of their required 80% time in the Major Area of Study. Our program requires residents to complete an empirical research article or present at a national/international conference/meeting by the completion of the two-year postdoctoral program. Residents have the opportunity for a focus on population health interventions and programming which consists of work on process/quality improvement projects with military organizational leaders. These opportunities require an emphasis on health-risk/health behaviors as they pertain to military members and overall readiness for their mission requirements.

#### Curriculum & Schedules

- Didactics
- Weekly Group Supervision
- Weekly Reading schedule for books and articles
- Regularly scheduled trainings in supervision of pre-doctoral interns
- Training in Motivational Interviewing as both clinician and trainer
- Rotation Schedule Per Year

#### First year

The initial six months will focus on training general Clinical Health Psychology concepts and interventions, training in supervision of predoctoral interns on a health psychology rotation, training on and delivery of group care pathways (weight, sleep, biofeedback).

The second six months pivot to training in interdisciplinary care as fellows rotate for two days per week at the Center for the Intrepid while continuing their supervision of pre-doctoral interns on health psychology rotation and engage in advanced biofeedback training. The CFI rotation provides on-site supervision with an adjunct faculty member who specializes in pain treatment and functional restoration programming from a holistic and interdisciplinary care model.

#### Second year

Fellows produce a proposal for an elective focus in their 2nd year which follows a balance of 50% clinical care in a specialty setting of choice (can embed in another clinic) and supervision of interns as a long-term preceptor supervisor. The remaining 50% of the time is divided into 20%

program development, 20% operational/line-related research, 10% command or leadership consultation practice or skill development.

### Elective Rotations

The first year of fellowship is largely prescriptive with an opportunity to seek a military unique curriculum (MUC) experience week. The second-year practice and project topics are largely elective in nature while maintaining a balance of both throughout the year. Fellows are given the opportunity to select a practice area and specialty clinic to prioritize for specialization for the duration of their second year. Past fellows have elected to specialize with integration in pain at the Center for the Intrepid, sleep medicine, women's health, cardiology, pulmonology, disease management and nutrition, and primary care settings.

Regarding projects, fellows can elect to prioritize work with a variety of units/topic areas and develop a plan for their elective project/research emphasis rotation during their first year to optimize efforts in the second year. Past fellows have focused on clinical research with sleep medicine, weight management, chronic pain, women's health, and others. Line-related research has been conducted in collaboration with 2nd Air Force, 37th Training Wing (Basic Military Training), other specific training technical school (Maintenance, Explosive Ordnance Disposal, Air Traffic Control), Air Force Medical Readiness Agency, and with the office of the Air Force Vice Chief of Staff. Topics of research have largely been related to health behaviors such as sleep, alcohol, tobacco, weight management, motivational interviewing for behavior change, and other broad behavioral science design programming.

### Military Unique Curriculum

While our entire programming is focused on health factors associated with military readiness, the military unique curriculum can be identified by the program development topics, military unit partnerships driving research initiatives, and a focus on developing leaders and trainers for broader military leadership communities. Fellows are afforded an opportunity to partner with other psychologists and line leaders to design a week-long MUC experience that can be funded by SAUSHEC to allow for unique opportunities to travel and gain experience that cannot otherwise be offered locally.

Past MUC experiences include a week-long occupational medicine unit assessment with the 711th Human Performance Wing lead research psychologist, week-long coaching training events with leaders in the Strategic Studies Group from Headquarters Air Force, and week-long personnel assessment and selection events for career fields in special operations.

### Required Courses

Fellows are required to complete a biofeedback training course while other required courses and training are provided directly by the fellowship faculty on-site.

### Simulation Curriculum

The primary simulation experience throughout fellowship is related to verbal skill development in motivational interviewing, group clinical intervention delivery, and biofeedback technical skills. There are additional opportunities to practice leadership coaching and consultation which

will result in deliberate practice and feedback to sharpen professional communication skills with leaders in the organization and partners outside the organization, when indicated.

#### Leadership Curriculum

As previously noted, much of the curriculum is delivered by the fellowship faculty members as it pertains to leadership training. New opportunities exist to gain experience in executive coaching skills through both official and on-site training by fellowship faculty and through other academic institutions.

#### Research

Fellows are expected to lead a research project during their fellowship and expected to contribute to at least one presentation at a professional conference or a paper submitted for peer-reviewed publication. Opportunities exist to collaborate on projects with University of Virginia, Baylor University, STRONG STAR, and any other academic institution that might generate valuable team efforts for researching military readiness factors valued by various unit leaders as organizational partners. Research training opportunities exist through primarily mentorship by seasoned research partners as well as conference attendance for fellows. The bulk of research being done by fellows is characterized as quality improvement projects and are endorsed by the local Medical Institutional Review Board.

#### Quality Improvement

Fellows are most often engaged in research projects that are characterized as Quality Improvement by the Institutional Review Board, as noted above. Further emphasis of quality improvement programming exists in the second year of fellowship when fellows are expected to monitor administrative processing in the clinic, training of residents, and program development practices throughout the duration of their second year. This is often done both with existing clinic management activities as well as elective opportunities for fellows to develop proficiency in their areas of interest.

#### 4. Virginia Commonwealth University Health/School of Medicine, Clinical Health Psychology Postdoctoral Fellowship

##### Taxonomy Program Descriptor: Postdoctoral - Major Area of Study

The Clinical Health Psychology Postdoctoral Residency Program at VCU Health within the School of Medicine, Department of Psychiatry is accredited by the APA-Commission on Accreditation. With the Major Area of the postdoctoral program being in Clinical Health Psychology, at least 80% of the postdoctoral resident's time will be clinical health psychology supervised experience. Within the required 80% time in the Major Area of Study in Clinical Health Psychology (CHP), residents will have >50% of clinical service delivery time devoted to clinical health psychology patients, family members, and/or interprofessional care teams (e.g., assessment, treatment, consultation). Our program provides an opportunity for a resident to focus on organ transplantation, cardiac care and advanced mechanical circulatory support, the trauma service, burn service, primary care, bariatric surgery and obesity-related health condition as part of their required 80% time in the Major Area of Study. Our program provides 10% protected time for the resident to dedicate to research, and typically produces peer-reviewed publication or paper/poster presentation at a national/international meeting).

### Educational Program Description

The fellows receive a minimum of two hours of individual face-to-face supervision weekly. They have daily interaction with faculty. They attend and present at the Department of Psychiatry's Grand Rounds series. They attend and present at the weekly literature seminar (journal club) in the Division of Consultation-Liaison Psychiatry. They attend a weekly educational conference in transplantation and other educational programs provided by other departments as appropriate. They attend a didactic and case conference series for psychology trainees working in academic medical settings that meets three times per month. Diversity issues are emphasized in all training venues. The fellows also participate in all required education and training for the Health System.

The fellows increase their knowledge of the scientific basis for the practice of clinical health psychology and apply this knowledge in daily clinical practice, helping them to develop more specialized skills beyond the mental health practice skills developed during graduate education and internship training. They also develop in-depth knowledge of specific medical conditions and treatment regimens to better interact with colleagues in medicine, surgery and other health care disciplines. This experience provides a prototype for their ability to work with these or other medical populations and practitioners in the future. A practitioner-scientist model of training has been adopted. Fellows are encouraged to develop collegial relationships with faculty, who provide supervision through role modeling, consultation and mentoring.

### Duties of the Fellows

Fellows provide clinical and liaison services within the designated programs, with a focus on patient assessment, short-term patient, family, and group interventions, and participation in team-based patient care and planning. At a minimum, they provide twenty hours of direct patient care services weekly. Weekly opportunities for didactic education are available across multiple settings in the health system and fellows are given time to engage with them. In addition, fellows are encouraged to participate in clinical health psychology research and other scholarly activities with faculty members as mentors and supervisors. Fellows also have a teaching role, giving presentations and supervising graduate students across the spectrum of health service provision.

### Rotations and Curriculum

Through daily clinical practice, fellows increase their understanding of the scientific basis of clinical health psychology and develop more specialized skills beyond the mental health practice experience of graduate education and internship training. They also develop in-depth knowledge of specific medical conditions and treatment regimens to better interact with colleagues across multiple health care disciplines, such as medicine and surgery.

With a minimum of 20 hours of direct patient care services each week, fellows provide clinical and liaison services within the designated programs, focusing on patient assessment, short-term patient, family and group interventions and team-based patient care and planning.

Fellows have the opportunity to develop clinical skills and research experiences across a broad range of areas, including:

- Organ transplantation
- Mechanical circulatory support
- Obesity and weight loss management

- Trauma and burn surgery
- Primary care
- Smoking cessation
- Pain management

Trainees also participate in the following educational activities:

- The Department of Psychiatry's Grand Rounds
- Weekly journal club in the Division of Consultation-Liaison Psychiatry
- Weekly educational conferences in transplantation and other areas
- Didactic and case conference series for psychology trainees

## Appendix IX

### APA Practice Guidelines Relevant to Clinical Health Psychology



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# Guidelines for Prevention in Psychology

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American Psychological Association

The effectiveness of prevention to enhance human functioning and reduce psychological distress has been demonstrated (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Greenberg, Domitrovich, & Bumbarger, 2001; National Research Council & Institute of Medicine, 2009). Successful preventive interventions are typically theory driven, culturally relevant, developmentally appropriate, and delivered across multiple contexts (Nation et al., 2003). Preventive services and interventions help to further the health and well-being of individuals, communities, and nations (Satcher, 2000; World Health Organization, 2008). Expanding preventive services reduces the costs of mental health care (Tolan & Dodge, 2005), while emerging technological innovations (e.g., telehealth) offer promise for preventive interventions (Bull, 2011; Chinman, Tremain, Imm, & Wandersman, 2009).

From infancy through adulthood, access to preventive services and interventions is important to improve the quality of life and human functioning and reduce illness and premature death (Grunberg & Klein, 2009; Konnert, Gatz, & Hertzsprung, 1999). Prevention has typically taken a developmental approach, focusing on children and adolescents, in order to facilitate trajectories leading to positive outcomes (National Research Council & Institute of Medicine, 2009). Children and adolescents are at significant risk for substance abuse, violence, and sexually transmitted infections, and their access to quality health services is limited (Centers for Disease Control and Prevention, 2007; Weissberg, Walberg, O'Brien, & Kuster, 2003). Thus, normal development may be impeded at large costs to society, and additional strains imposed on families. In any given year, 14%–20% of children and adolescents experience a mental, emotional, or behavioral disorder (National Research Council & Institute of Medicine, 2009). In addition, national surveys show that the majority of youth who could potentially benefit from mental health services do not receive services (Ringel & Sturm, 2001). Early and focused interventions can limit the length and severity of symptoms and enhance functioning (Cicchetti & Toth, 1992; Durlak, Weissberg, & Pachan, 2010). Prevention also includes the collaborative design and delivery of strengths-based health promotion and environmental improvement strategies (e.g., Cowen, 1985). Health promotion approaches equip people with life skills and coping competencies, such as problem-solving skills, contributing to their capacity to live more fully while being better able to withstand future stressful life events.

Preventive services and interventions also address issues of health, educational, and social inequities that reflect disparities across demographic groups such as those based on race, gender, and socioeconomic class. Environmental

improvement prevention strategies, such as consultation to improve community–family–school coordination or interventions to help communities create well-paying jobs, aim to inform social policy, which can minimize or eliminate factors contributing to unhealthy functioning.

The importance of prevention is consistent with the Patient Protection and Affordable Care Act (2010), which calls for expansion of preventive services to maximize positive health outcomes, as well as with the U.S. National Prevention Strategy (National Prevention Council, 2011), which “provides an unprecedented opportunity to shift the nation from a focus on sickness and disease to one based on wellness and prevention” (National Prevention, Health Promotion, and Public Health Council, 2011, p. 1) throughout the life span. Several disciplines other than psychology have been historically and currently active in prevention (e.g., public health, social work). However, beginning in the mid-20th century with the field of community psychology, psychology began to play an increasingly important role (e.g., Eby, Chin, Rollock, Schwartz, & Worell, 2011). Even with the increased focus on prevention, psychology training programs rarely require specific courses on prevention (O'Neil & Britner, 2009). In particular, conceptualizations about best practices in prevention, particularly at the environmental level, are lacking (Snyder & Elliott, 2005). In addition, the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association [APA], 2010) do not fully address unique ethical issues that may arise in prevention (e.g., Schwartz & Hage, 2009). Therefore, psychologists engaged in prevention can benefit from a set of guidelines that address and inform prevention practices.

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This article was published Online First November 4, 2013.

These guidelines were approved by the American Psychological Association (APA) Council of Representatives in February 2013. The guidelines were developed by APA's Prevention Guidelines Work Group. The Work Group members, listed alphabetically after the chair, included John L. Romano (chair), G. Anne Bogat, Robert K. Conyne, Sally M. Hage, Arthur M. Horne, Maureen E. Kenny, Connie Matthews, Jonathan P. Schwartz, Anneliese Singh, Michael Waldo, and Y. Joel Wong.

The Work Group wishes to acknowledge and thank many groups, committees, and organizations, including APA's Board of Professional Affairs and Committee on Professional Practice and Standards, as well as individuals too numerous to list here, who contributed to the development of the Prevention Guidelines during the review process and comment periods.

This document is scheduled to expire as APA policy in February 2020. After this date, users are encouraged to contact the APA Practice Directorate to confirm that this document remains in effect.

Correspondence concerning this article should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

## Purpose

APA (2002, p. 1050) refers to guidelines as

statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism . . . guidelines are aspirational . . . intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice . . . Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists.

Accordingly, the Guidelines for Prevention in Psychology (cited as Prevention Guidelines or Guidelines for the remainder of this document) are intended to “inform psychologists, the public, and other interested parties regarding desirable professional practices” (APA, 2002, p. 1049) in prevention.

The Prevention Guidelines are, in part, practice guidelines and different from treatment guidelines as defined by APA (2002). The Guidelines are recommended for the practice of psychology across areas that engage psychologists. The Guidelines are consistent with federal and state laws and regulations. In the event of a conflict between the Guidelines and any federal or state law or regulation, the law or regulation in question supersedes these Guidelines. Psychologists are encouraged to use their education and skills to resolve any conflicts in a way that best conforms to both law and ethical practice. The Guidelines are consistent with the Ethical Principles of Psychologists and Code of Conduct (APA, 2010), particularly Principles D (justice) and E (respect for people’s rights and dignity).

## Background

APA convention symposia (Hage & Romano, 2006; Kenny, 2003; Romano, 2002) initiated the development of these Guidelines, followed by an article describing prevention best practices (Hage et al., 2007). These Guidelines were later introduced as new business for the APA Council of Representatives, whereupon they underwent significant review, including APA governance and public comment periods, in accordance with Association policy relevant to guidelines (APA, 2013, Association Rule 30-8). The Guidelines were approved by the APA Board of Directors in December 2012 and by the APA Council of Representatives in February 2013.

## Definitions

Prevention has been conceptualized as including one or more of the following: (a) stopping a problem behavior from ever occurring; (b) delaying the onset of a problem behavior, especially for those at-risk for the problem; (c) reducing the impact of a problem behavior; (d) strengthening knowledge, attitudes, and behaviors that promote emotional and physical well-being; and (e) promoting institutional, community, and government policies that further physical, social, and emotional well-being of the larger

community (Romano & Hage, 2000). This conceptualization is consistent with Caplan’s (1964) definition that identified prevention interventions as primary, secondary, and tertiary prevention, and with the definition by Gordon (1987) that identified prevention interventions as universal, selected, and indicated for those not at risk, at risk, and experiencing early signs of problems, respectively. Gordon’s conceptualization was adopted by the Institute of Medicine (1994). A follow-up report from the Institute of Medicine broadened this universal, selective, and indicated framework to include “the promotion of mental health” (National Research Council & Institute of Medicine, 2009, p. 65).

Throughout this document, the terms *prevention*, *preventive intervention(s)*, *preventive program(s)*, and *preventive services* are used. Activities subsumed by these rubrics could focus on any of the five aspects of prevention included in the Romano and Hage (2000) conceptualization of prevention. Although space precludes a thorough exegesis of all types of programs, decisions about how and when to intervene might lead to different outcomes, different ancillary effects, and different ways of approaching issues within cultures and settings.

## Documentation of Need

The Prevention Guidelines are recommended based on their potential benefits to the public and the professional practice of psychology. The Guidelines support prevention as an important area of practice, research, and training for psychologists. The Guidelines give increased attention to prevention within APA, encouraging psychologists to become involved with preventive activities relevant to their area of practice.

The National Research Council and Institute of Medicine’s (2009) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions stated, “Infusing a prevention focus into the public consciousness requires development of a shared public vision and attention at a higher national level than currently exists” (p. 5). The Guidelines provide added visibility to the importance of prevention across professional practice areas and among the public. The Guidelines also support the U.S. Department of Health and Human Services’ calls for health promotion and prevention in its *Healthy People* publications outlining national health goals (e.g., U.S. Department of Health and Human Services, 2000). *Healthy People 2020* (U.S. Department of Health and Human Services, 2010) continues the tradition of earlier publications by setting goals to eliminate preventable disease, achieve health equity, eliminate health disparities, create social and physical environments to promote good health, and promote healthy development and healthy behaviors across the life span. Other U.S. government bodies have also emphasized the importance of prevention to the overall health and well-being of the population (Mrazek, 2002).

The Patient Protection and Affordable Care Act (2010) includes preventive services as an important component of overall health care. The legislation strives to make wellness and preventive services affordable and accessible by requiring health plans to cover preventive services without copayments. These services include counseling to improve habits of lifestyle (e.g., proper nutrition, weight management), counseling to reduce depression, and preventive services to foster healthy birth outcomes.

The contributions and leadership of psychologists are critical in implementing a prevention focus in the health care system. Evidence increasingly suggests that mental illness, such as depression, is linked to chronic health issues such as heart disease and diabetes (Volgelzangs et al., 2008). Therefore, the Guidelines identify best practices for psychologists who engage in preventive activities relating to the interface between physical health and emotional well-being.

The Guidelines also respond to policies and legislation that aim to prevent and reduce problems such as chemical addictions, depression, suicide, school bullying, social violence, and obesity (Institute of Medicine, 1994). The Guidelines respond to social disparities, discrimination, and bias against people based on (but not limited to) their race, ethnicity, immigrant status, sexual orientation, age, gender identity, socioeconomic status, religion, HIV serostatus, physical and psychological health status, and gender (APA, 2003, 2007; Kenny, Horne, Orpinas, & Reese, 2009). The Guidelines offer recommendations to psychologists as they respond to public policy and legislative initiatives that promote positive health behaviors in the name of prevention and health promotion (National Research Council & Institute of Medicine, 2009). In addition, the Guidelines endeavor to apply the science and practice of psychology to address major social issues and real-world problems through education, training, and public policy positions (Anderson, 2011).

The Guidelines offer guidance to psychologists on several levels, including supporting the value of prevention as important work of psychologists and providing recommendations that give greater visibility to prevention among psychologists regardless of specialty area or work setting (Snyder & Elliott, 2005).

## Expiration

Given the evolving nature of prevention, the Guidelines are scheduled to expire in the year 2020. After this date, users are encouraged to contact the APA Practice Directorate to determine if the document remains in effect. The year 2020 was selected because it coincides with the decennial *Healthy People* publications, which set national health goals for the United States every 10 years. In addition, it is expected that the Patient Protection and Affordable Care Act (2010) will be implemented fully by 2014, providing a reasonable time frame for these Guidelines, given the evolving nature of health care and psychology's place within the spectrum of health care services and research.

## Guidelines

### ***Guideline 1. Psychologists are encouraged to select and implement preventive interventions that are theory- and evidence-based.***

**Rationale.** Preventive interventions that demonstrate sustained effectiveness can be considered as meeting the highest standard for efficacy and maximum benefits to the consumer (National Institute of Mental Health, 1998). Consistent with foundational principles in psychology, theory and research should be inseparably tied to prevention practice. Research suggests that programs developed from a sound theoretical framework are more effective than programs that are not theoretically based (Weissberg, Kumpfer, & Seligman, 2003). Also, preventive programs that are based on theory and regularly evaluated are more likely to consider risk and protective factors that operate across multiple contexts (Black & Krishnakumar, 1998), especially for groups who are historically marginalized (e.g., women, people of color). Accountability to client populations, funding agencies, and policymakers demands that prevention practices be grounded in theory and research (Vera & Reese, 2000).

**Application.** Psychologists are encouraged to conduct preventive programs that have been rigorously evaluated (Guterman, 2004; Weissberg, Kumpfer, & Seligman, 2003). While no single theoretical perspective is suggested, psychologists are encouraged to select theoretically based preventive approaches when considering their prevention goals. The theoretical frameworks and intervention strategies of positive psychology, positive youth development, applied developmental science, risk and resilience, health promotion, competence enhancement, and wellness, among others, can be selected and integrated when designing preventive interventions that will simultaneously prevent negative outcomes and enhance positive outcomes (Weissberg, Kumpfer, & Seligman, 2003). It is recommended that preventive programs be selected based on a careful review of empirical evidence in order to choose programs that are empirically supported for their specific contexts and specified goals, in addition to identifying how these relate to both multicultural issues and concerns generated by social inequities. Therefore, it is recommended that psychologists stay informed regarding current outcome research in prevention science to help ensure that the preventive programs they implement offer the most promise for the identified goals and population.

### ***Guideline 2. Psychologists are encouraged to use socially and culturally relevant preventive practices adapted to the specific context in which they are implemented.***

**Rationale.** Given the increasing diversity of the U.S. population, it is crucial that preventive programs be designed, selected, and implemented with consideration of cultural relevance and cultural competence. Historically, many preventive programs were developed by professionals working with urban and suburban middle-class com-



munities and reflect heterosexual European American values and methods; furthermore, many did not address the unique issues faced by persons with disabilities. Preventive programs that lack relevance to the lives of participants will often fail (Lerner, 1995). Even when a preventive program is effective in one setting, it may not be effective in another setting with different populations (e.g., rural vs. urban communities, individuals above and below the federal poverty guidelines). Research suggests that programs perceived as socially and culturally relevant by their constituents have a greater likelihood of being sustained (Vera & Reese, 2000). As Trickett et al. (2011) noted, "Culture is not seen as something to which interventions are tailored; rather, culture is a fundamental set of defining qualities of community life out of which interventions flow" (p. 1412).

Because risk and protective factors are found within individuals and in the multiple social contexts in which individuals are situated, prevention programs that attend to both individual and contextual factors are most advantageous. Focusing only on individuals and the more proximal context of the family may place undue responsibility and blame on the individual and the individual's milieu without recognizing the roles played by social institutions and culture in determining and sustaining positive human outcomes (Kenny & Hage, 2009). Therefore, psychologists strive to understand the cultural worldviews and community contexts of individuals in order to strengthen prevention interventions, especially interventions that have been developed for one cultural group and implemented in another (National Research Council & Institute of Medicine, 2009).

**Application.** Psychologists are encouraged to be aware of and to articulate the evidence that supports their selection of specific prevention programs for implementation in different cultural contexts (Reese & Vera, 2007). Along this line, existing programs may need significant adaptation, or new programs may need to be developed, to meet social, cultural, community, and developmental norms of program participants and to ensure access to all members. Technological advances, such as the use of web-based preventive interventions and social media to promote, deliver, and assess prevention interventions, can assist with this process. Psychologists are encouraged to recognize the diversity that exists within cultural groups as cultural values may differ by race, ethnicity, social class, family income, gender, gender identity, sexual orientation, geographic region, education, ability, and acculturation level (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Psychologists are encouraged to examine cultural assumptions and biases of specific preventive programs and to consult the APA's (2003) "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" and its "Guidelines for Assessment of and Intervention With Persons With Disabilities" (APA, 2012a) in integrating considerations of culture in the design, implementation, and evaluation of prevention interventions. It is important for psychologists to acquire and demonstrate cultural competence across prevention activities and to strive to work sensitively with diverse popula-

tions. This typically means that the psychologist must immerse him- or herself in the community and culture in order to be a sensitive partner with the community.

Psychologists endeavor to include relevant stakeholders in all aspects of prevention planning and implementation to ensure program fit with the local culture and to build community investment in the program. In order to ensure that preventive programs meet local norms, it is recommended that psychologists engage in careful planning and ongoing monitoring and evaluation of programs (Nation et al., 2003). Dynamic trial designs have been proposed that avoid problems associated with randomized clinical trials and focus on whether significant information is lost as the intervention proceeds (Jason & Glenwick, 2012), whether there are unintended consequences (positive and negative) that result from the intervention, and how to consider issues of diversity when statistical power may be low (Rapkin & Trickett, 2005).

### ***Guideline 3. Psychologists are encouraged to develop and implement interventions that reduce risks and promote human strengths.***

**Rationale.** Early prevention interventions focused on reducing risks or causes of psychological dysfunction (Conyne, 2004). However, psychological research has identified personal and environmental protective factors that may also mitigate the probability of negative outcomes in the face of risk and that contribute to optimal health. Research indicates that prevention is most beneficial when attempts to reduce risk are direct and are combined with efforts to build strengths and protective factors (Eccles & Appleton, 2002; Vera & Reese, 2000). Focusing only on building competencies or only on preventing problems may not be as effective as addressing both competencies and problems (Catalano, Berglund, et al., 2002).

**Application.** Psychologists are encouraged to consider and ameliorate factors that contribute to risk and also to recognize and promote factors that enhance human strengths. Prevention programs can seek to reduce or eliminate factors, such as socioeconomic disparities, negative peer influences, family dysfunction, and school failure, or they can seek to increase social competencies and other protective factors (National Research Council & Institute of Medicine, 2009). Although psychologists may consider only the benefits of either a risk-reduction or a strength-promotion approach, an optimal approach is to address both. Protective factors, such as socioemotional skills, interpersonal connection, ethical decision making, graduating from high school, school-to-work transitions, civic engagement, and proper nutrition, might be selected as foci of interventions based upon their malleability and their relevance to daily life (Eccles & Appleton, 2002; Nation et al., 2003; Stone et al., 2003). For instance, a focus on expanding the resilience that historically marginalized groups have demonstrated despite obstacles might also serve to enhance strengths in other arenas of life (Singh, Hays, & Watson, 2011; Singh & McKleroy, 2011).

An emphasis on simultaneously reducing risks and developing competencies is consistent with research on

positive youth development, empowerment, advocacy, and participatory community research. Positive youth development posits that (a) protective factors reduce the likelihood of maladaptive outcomes under conditions of risk and (b) freedom from risk is not synonymous with preparation for life (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002; Pittman, Irby, Tolman, Yohalem, & Ferber, 2001). The APA Presidential Task Force on Prevention: Promoting Strength, Resilience, and Health in Young People recommended that prevention encompass the goals of reducing health problems and promoting health and social competence (Weissberg, Kumpfer, & Seligman, 2003).

Similarly, empowerment interventions focus on helping individuals master and maintain control over life situations. Inherently, empowerment is concerned with competencies and strengths (Zimmerman, 1995; Zimmerman, Israel, Schulz, & Checkoway, 1992). Advocacy interventions also have been implemented with populations such as adjudicated youth (e.g., E. P. Smith, Wolf, Cantillon, Thomas, & Davidson, 2004), and women experiencing intimate partner violence (Allen, Bybee, & Sullivan, 2004). Finally, participatory action research (PAR) interventions, which focus on researcher-participant collaborations and, thus, on utilizing strengths and competencies of the participants, have been successfully implemented with diverse groups of youth (e.g., Foster-Fishman, Law, Lichty, & Aoun, 2010; Jason, Keys, Suarez-Balcazar, Taylor, & Davis, 2003; L. Smith, Davis, & Bhowmik, 2010). It is recommended that PAR be a genuine community-researcher partnership (i.e., the development of shared goals, shared methods, and shared sense of the value of the project and the findings) to successfully implement the methodology (Trickett, 2011).

**Guideline 4. Psychologists are encouraged to incorporate research and evaluation as integral to prevention program development and implementation, including consideration of environmental contexts that impact prevention.**

**Rationale.** Prevention research encompasses “theory and practice related to the prevention of social, physical, and mental health problems, including etiology, methodology, epidemiology, and intervention” (National Research Council & Institute of Medicine, 2009, p. xxvii). At its best, prevention research addresses multifaceted contexts (biological, psychological, and sociocultural levels) and functions (preintervention epidemiology, preventive interventions, and preventive service delivery systems; National Institute of Mental Health, 1998). The contexts and functions of prevention research can inform each other. Problems and their prevention occur at interrelated biological, psychological and sociocultural levels. Epidemiological research can identify targets for preventive interventions; evaluation of interventions can identify preferred approaches that can be incorporated into service delivery systems; the effectiveness and efficiency of service delivery systems can be assessed by examining their impact on epidemiology. At all stages of the research process, the

dynamic interactions between biological, psychological, and sociocultural environments are important to consider (Albee, 1996). Research solely examining intrapersonal factors that affect behaviors might ignore the context in which the individuals’ behaviors occur and could result in incomplete or misleading conclusions (National Institute of Mental Health, 1998). It is important that prevention research examine the etiology of maladaptive behaviors and potential determinants, including biological, intrapersonal, interpersonal, community, and societal risk and protective factors. It is also recommended that evaluations of prevention interventions address how adaptive behavioral changes promoted by a specific program are valued within different environmental contexts.

**Application.** Psychologists conducting research on prevention are encouraged to take into account the interface between biological, psychological, and sociocultural variables and the best available evidence regarding epidemiology, intervention, and service delivery. Resources are available to identify evidence-based prevention interventions for different demographics, topical areas, and contexts. One such resource is the National Registry of Evidence-Based Programs and Practices (<http://www.nrepp.samhsa.gov/Index.aspx>), compiled by the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Psychologists are encouraged to consider the social ecology of the community in which they work (Bronfenbrenner, 1979) and to collaborate with community stakeholders on research goals and methods (Caplan & Caplan, 2000; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Sullivan et al., 2001). Researchers are encouraged to assess the differential impact of prevention programs on specific communities. Prevention researchers may unknowingly design and evaluate programs using criteria from their own cultural perspectives and worldviews and may miss important contextual factors that contribute to the success or failure of prevention interventions within specific communities and cultures (e.g., diverse social classes and socioeconomic groups; Trickett, 1998; Turner, 2000). Community collaboration is important in the interpretation and application of research findings and for the provision of oversight and monitoring of community-based research. PAR is one example of collaborative research that appreciates environmental contexts and recognizes that knowledge is coproduced through collaborative actions with those who have traditionally been left out of the research process and whose lives are most affected by the research problem (Prilleltensky & Nelson, 2002).

**Guideline 5. Psychologists are encouraged to consider ethical issues in prevention research and practice.**

**Rationale.** Psychologists are required to adhere to ethical standards of the profession and to be mindful of its highest ideals (APA, 2010). Prevention efforts may raise unique ethical issues (Bond & Albee, 1990; Waldo, Kaczmarek, & Romano, 2004). Prevention is typically conducted with numerous participants and has individual, sys-

temic, and societal implications. It is important to evaluate possible negative impacts that preventive interventions may have on individuals, the community, or the larger society (Bloom, 1993; Caplan & Caplan, 1994). For example, conducting preventive interventions that identify higher risk within a historically stigmatized group could be harmful to members of that group. Thus, it is important that confidentiality be adhered to during the prevention intervention process (Bloom, 1993). Additionally, targeted behavior may serve one or more purposes for the individual and community; eliminating the behavior without attention to its possible protective functions may lead to negative consequences for a segment of the community.

**Application.** Psychologists are encouraged to be knowledgeable regarding methods and designs in prevention research and practice within their boundaries of competence (APA, 2010, Ethical Standard 2.01). It is important that preventive interventions and research include considerations of the ethical implications of new or promoted behaviors before, during, and after a prevention intervention. Informed consent poses particular challenges with regard to ensuring that individuals and multiple stakeholders comprehend the implications of their participation. Other ethical issues to consider include equitable selection, confidentiality, cultural relevancy, socially and culturally competent research and practice (APA, 2010, Ethical Standards 8.02 and 2.01b), and researcher bias (Schwartz & Hage, 2009). It is important to evaluate the long-term effects of preventive interventions (Brown & Liao, 1999), especially as they relate to historically marginalized groups.

**Guideline 6. Psychologists are encouraged to attend to contextual issues of social disparity that may inform prevention practice and research.**

**Rationale.** Considerations of social disparities can provide a context for prevention work in which the causes and effects of oppression can be identified and considered. Reducing social disparities is essential for preventing the myriad of problems that they spawn (e.g., Vera, Buhin, & Isacco, 2009). For example, children living in disadvantaged neighborhoods are at risk for childhood behavioral difficulties, including conduct disorders, mental health problems, academic failure, and teen pregnancy (e.g., Goodnight et al., 2012; Harding, 2003; Leventhal & Brooks-Gunn, 2000; Nikulina, Widom, & Czaja, 2011). For adults, those living at or near poverty level have a greater incidence of major depressive disorder than those with higher incomes (e.g., Kessler et al., 2003). Furthermore, numerous health problems (e.g., diabetes, obesity, coronary heart disease) have been associated with living in poverty (e.g., Kittleson et al., 2006; Ludwig et al., 2011). Consistent with these considerations, the importance of creating contexts of fairness in order to improve the health and wellness of those served by prevention programs has been emphasized (Lawson, Noblett, & Rodwell, 2009; Prilleltensky, 2001, 2012; Tepper, 2001).

**Application.** Psychologists strive to be cognizant of the social implications of the preventive services they offer. For example, interventions that fail to consider those structural inequalities and contextual factors (e.g., social class, socioeconomic status) that influence behavior may inadvertently suggest that the problem lies within a particular group instead of acknowledging the influence of being marginalized in society (Walker, 2009). Prevention interventions may have maximum impact if societal inequalities related to social class, economic status, discrimination, and exploitation are considered (M. J. Perry & Albee, 1994). Dissemination of prevention findings grounded in the social ecology of the community may aid in acknowledging inequalities that may contribute to or exacerbate a particular behavior that is the target of intervention. For example, lesbian, gay, bisexual, transgender, and queer young people who are bullied in school may be experiencing not only homophobia reactions from peers but also bullying based on racial/ethnic, gender, and/or class identities (American Psychological Association, 2012b; Singh & McKleroy, 2011).

**Guideline 7. Psychologists are encouraged to increase their awareness, knowledge, and skills essential to prevention through continuing education, training, supervision, and consultation.**

**Rationale.** The *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA, 2009) stress the importance of education and training that cover the breadth of psychology. Research suggests that prevention helps to reduce the need for remedial interventions (Schwartz & Hage, 2009; Vera et al., 2009). Therefore, remediation and prevention are best viewed as complementary to one another, not in conflict. However, despite psychology's history with prevention practice and research during the 20th century (Cowen, 1973; Elias, 1987), the education of psychologists continues to emphasize crisis interventions and remedial approaches, giving much less attention to prevention as a core component of training and education (Matthews, 2003; O'Byrne, Brammer, Davidson, & Poston, 2002; Snyder & Elliott, 2005). Although some psychologists learn about the development and implementation of prevention activities in graduate school (e.g., community psychologists), most new prevention interventionists do not have a high level of training in the established content areas of prevention, and more-established professionals report low levels of knowledge in newer areas of prevention (e.g., gender and culture issues, economic analysis of prevention; Eddy, Smith, Brown, & Reid, 2005). This research suggests that much of the education and training in prevention is learned through less formal methods than graduate education. In psychology graduate education, there is a need to expand opportunities to learn about prevention by developing prevention-based courses and/or infusing prevention-related content into existing courses (Conyne, Newmeyer, Kenny, Romano, & Matthews, 2008; Matthews & Skowron, 2004).



**Application.** The training and continuing education of psychologists in awareness, knowledge, and skills related to prevention provide psychologists with resources to be proactive in reducing human suffering and in promoting positive aspects of human functioning. Psychologists are encouraged to obtain education and training in preventive approaches through various pathways, including respecialization programs, postdoctoral fellowships, continuing education programs, self-study, conferences, professional societies that focus on prevention, and combinations of such alternatives. Other avenues include service learning and experiential work in community settings less typical for psychologists (DeLeon, Dubanoski, & Oliveira-Berry, 2005). Predoctoral psychology graduate students may also consider taking advantage of coursework, practicum experiences, and predoctoral internships that have a prevention focus. Psychology training programs can also encourage enrollment in prevention courses in other disciplines, such as public health, thus encouraging training in interdisciplinary perspectives important to prevention. Those already in practice and unable to participate in concentrated, formal training programs may be able to utilize continuing education programs. Psychologists may also gain supervised experience and consultation working with psychologists, or other professionals, skilled in prevention. Because public health has a strong focus on prevention, increased training and collaboration with professionals in the field of public health are encouraged. Through more formal education, psychology trainees and psychologists may consider earning dual degrees in public health (e.g., a master's in public health) and psychology. The collaborative training, which pairs psychologists' understanding of human behavior and public health professionals' knowledge of health and prevention at community or population levels, may be particularly effective at creating change at the societal level. Literature relevant to prevention is available through professional journals, including a growing number of applied journals in, for example, psychiatry, public health, and psychology. Prevention research and applications are also disseminated through professional organizations and their respective conferences.

Scholars have noted several knowledge and skill domains important to psychologists engaging in prevention (Conyne, 1997; Hage et al., 2007; O'Neil & Britner, 2009). The domains include (a) understanding distinctions between preventive and remedial approaches; (b) designing and implementing educational programs; (c) assessing community needs; (d) understanding systemic approaches that incorporate cultural and contextual factors into preventive interventions; (e) using group skills and approaches, when appropriate, in program design and implementation; (f) collaborating with interdisciplinary teams that include professionals and community leaders; (g) grant-writing and marketing skills to address sustainability of preventive efforts; (h) promoting positive development across the life span; (i) empowering individuals and communities to work on their own behalf; (j) developing strength-based approaches that reduce risk and enhance resilience in indi-

viduals and communities; (k) influencing policy decisions and their impact on preventive efforts; and (l) evaluating preventive interventions. Each of these domains of knowledge and skill in prevention ideally would include attending to the needs and concerns of historically marginalized groups and would consider power differentials as they relate to cultural differences and concerns of social inequalities. In addition, training in newer technologies, such as telepsychology and social media, is important as these technologies are emerging methods for preventive efforts.

**Guideline 8. Psychologists are encouraged to engage in systemic and institutional change interventions that strengthen the health of individuals, families, and communities and prevent psychological and physical distress and disability.**

**Rationale.** Applications of prevention through systemic interventions are important across many domains. Systemic preventive interventions include those that affect families, schools, communities, and work environments. Individuals may not be able to achieve maximum health or full social participation if systemic barriers, such as classism, racism, sexism, and poverty, prevail. Preventive programs that focus only on changing individuals are likely to be less effective than those that also address the contexts that support or inhibit development and optimal health. Systemic interventions can be delivered across the life cycle, but the earlier prevention occurs, the greater the likelihood of reducing risk and strengthening protective factors (E. J. Smith, 2006). Systemic preventive programs that focus on developing community norms that promote healthy lifestyle behaviors are effective in reducing societal problems (Orpinas, Horne, & the Multisite Violence Prevention Project, 2004).

**Application.** Psychologists are encouraged to engage in activities that produce positive systemic, institutional, and organizational change. Psychologists can contribute to systemic change that strengthens protective and resiliency factors of individuals, families, schools, workplaces, faith communities, community centers, and health care centers (Johnson & Millstein, 2003; Kumpfer & Alvarado, 2003; Morsillo & Prilleltensky, 2007; Wandersman & Florin, 2003). For example, organizational psychologists can assist in the development of corporate policies to reduce work stress and stress-related illnesses and to increase worker satisfaction and productivity (Murphy, Hurrell, & Quick, 1992). Other examples include school-based preventive programs that address the multiple needs of students across the school and community. Such programs have yielded positive results and enhanced students' emotional, social, and academic development (e.g., August, Hektner, Egan, Realmuto, & Bloomquist, 2002; Greenberg et al., 2003; Newman-Carlson & Horne, 2004). School-based interventions that incorporate health promotion, competence enhancement, and youth development as frameworks for prevention can reduce youth risk behaviors and enhance protective factors (e.g., C. L. Perry, 1999; Weissberg & Greenberg, 1998). A recent meta-analysis of

after-school programs indicated that programs that foster personal and social skills of youth provide the greatest benefit (Durlak et al., 2010). School-based systemic interventions may also inform policies that address inequities and discrimination among groups of students (Morsillo & Prilleltensky, 2007).

Psychologists can influence the structure, role relationships, premises, rules, and assumptions governing systems to empower communities and to promote justice and equity (Evan, Hanlin, & Prilleltensky, 2007). Psychologists in health care settings can promote employee programs that strengthen employee resiliency in order to inoculate employees against the physical and psychological demands of the work setting (Freeman & Carson, 2006). Another area of systemic application is advocating for healthy food choices in cafeterias, lunchrooms, and vending machines to promote healthy nutrition, which, when coupled with an active lifestyle, can reduce obesity and resulting health risks (Hawkes, 2007; Suarez-Balcazar et al., 2007).

Parent- and family-based interventions can help parents and other caregivers learn effective child-rearing skills to strengthen adult and child relationships, which, in turn, reduce child and adolescent behavior problems and enhance learning (Thornton, Craft, Dahlberg, Lynch, & Baer, 2002). Applications of systemic prevention interventions at later stages of life include community-based programs that support older adults living in their homes. Elders with sufficient physical and emotional capacity will benefit from community preventive programs that involve them in community volunteer opportunities, public policymaking, neighborhood networking, and social support groups (Konert et al., 1999).

**Guideline 9. Psychologists are encouraged to inform the deliberation of public policies that promote health and well-being when relevant prevention science findings are available.**

**Rationale.** Psychologists are well positioned to educate and inform policymakers about the importance of prevention to enhance health and well-being (Kiselica, 2004). For example, public policy-based prevention programs such as Project Head Start have been an integral part of preventive initiatives that promote human functioning and reduce negative health outcomes (Ripple & Zigler, 2003). Psychologists are encouraged to apply their expertise by informing policymakers about the value of evidence-based preventive initiatives and to communicate their research findings clearly and concisely to policymakers (Coates & Szekeres, 2004; Hage et al., 2007; Ripple & Zigler, 2003).

**Application.** Psychologists are encouraged to become informed about public policy debates in which prevention research and programs may have relevant information to contribute to the discourse. Psychologists strive to enter such discussion and inform policymakers at local, state, and national levels by using their expertise and scholarship in prevention science as appropriate. For example, at the Surgeon General's Conference on Children's Mental

Health in 2000, psychologists provided recommendations to help formulate a national policy on children's mental health (Levant, Tolan, & Dodgen, 2002). It is suggested that psychologists become familiar with APA resources that are relevant to health care policy and health promotion. They are also encouraged to consider strengthening their efforts by forming multidisciplinary partnerships that include government, legal, and policymaking experts, as well as professionals from the health, social, and educational sciences. For example, Jason (2012) described a 20-year collaborative effort between psychologists and patient advocacy organizations to effect change in multiple areas regarding the problem of chronic fatigue syndrome, including epidemiological evidence, criteria for diagnosis, and leadership at the Centers for Disease Control and Prevention. As another example of collaboration, in 1965, Head Start began as a White House initiative that included the collaboration of psychologists, sociologists, and pediatricians focused on the goal of reducing the deleterious effects of poverty on young children (Styfco & Zigler, 2003). Furthermore, it is recommended that graduate programs teach students about the relationship between research and its relevancy to informing policy (Ripple & Zigler, 2003).

## Conclusion

The Prevention Guidelines encourage psychologists, including those within the policymaking process, to strive to engage in prevention practice, research, and education to enhance human functioning. Prevention has numerous benefits, including the potential to strengthen the integration of science and practice in psychology (Biglan, Mrazek, Carline, & Flay, 2003). Moreover, as discussed throughout the Guidelines, the benefits of prevention have been demonstrated through the reduction of illness and problem behaviors, the enhancement of human functioning, and the potential to reduce health care costs (Durlak et al., 2010; Institute of Medicine, 1994; Nation et al., 2003; National Research Council & Institute of Medicine, 2009). An increased focus on prevention has the potential to mobilize psychologists to respond more effectively and sensitively to conditions that place individuals, communities, and institutions at risk for various problems and to promote strengths that contribute to human functioning.

The Guidelines provide a framework for best practices in prevention and the promotion of health and well-being, regardless of an individual psychologist's specialty area, employment setting, or professional interests. Infusing prevention across the profession will help to orient psychologists to a broader application of psychological research and practice, with the goal of more effectively and sensitively responding to major societal needs for all individuals, especially those with the fewest resources and groups historically underserved by the profession.

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## Appendix

### Guidelines for Prevention in Psychology

Guideline 1. Psychologists are encouraged to select and implement preventive interventions that are theory- and evidence-based.

Guideline 2. Psychologists are encouraged to use socially and culturally relevant preventive practices adapted to the specific context in which they are implemented.

Guideline 3. Psychologists are encouraged to develop and implement interventions that reduce risks and promote human strengths.

Guideline 4. Psychologists are encouraged to incorporate research and evaluation as integral to prevention program development and implementation, including consideration of environmental contexts that impact prevention.

Guideline 5. Psychologists are encouraged to consider ethical issues in prevention research and practice.

Guideline 6. Psychologists are encouraged to attend to contextual issues of social disparity that may inform prevention practice and research.

Guideline 7. Psychologists are encouraged to increase their awareness, knowledge, and skills essential to prevention through continuing education, training, supervision, and consultation.

Guideline 8. Psychologists are encouraged to engage in systemic and institutional change interventions that strengthen the health of individuals, families, and communities and prevent psychological and physical distress and disability.

Guideline 9. Psychologists are encouraged to inform the deliberation of public policies that promote health and well-being when relevant prevention science findings are available.

# Guidelines for Psychological Practice in Health Care Delivery Systems

American Psychological Association

Psychologists practice in an increasingly diverse range of health care delivery systems. This diversification is due to widening recognition of psychology as a health profession (Belar, 2000; Brown et al., 2002), of the unique skills of psychologists, and of the value of psychological services for health and well-being. It is also due to rapidly evolving systems in which health care is delivered (American Psychological Association [APA], 2009b). At the same time, psychologists' roles within these settings are expanding, and multidisciplinary collaboration within health care is becoming commonplace. The following guidelines are intended to assist psychologists, other health care providers, administrators in health care delivery systems, and the public to conceptualize the roles and responsibilities of psychologists in these diverse contexts.

These guidelines are informed by the "Ethical Principles of Psychologists and Code of Conduct" ("APA Ethics Code"; APA, 2002a, 2010)<sup>1</sup> and the "Record Keeping Guidelines" (APA, 2007). These guidelines address psychologists' roles and responsibilities related to service provision and clinical care, including teaching and administrative duties. There are additional obligations related to conducting research in health care delivery systems that are not included here; guidance in this area can be found in the APA Ethics Code (Ethical Standards 8.0 through 8.15). In accordance with ethical standards, the practice of psychology in health care delivery systems is based on established scientific and professional knowledge (APA Ethics Code, Standard 2.04).

These guidelines also may be used to inform rule making and decision making in health care delivery systems about the roles of psychologists that are commensurate with their training and licensure. Federal and state laws, (including those governing service delivery, payment arrangements, and business structures), standards of accrediting bodies (e.g., Joint Commission, 2009), and institutional bylaws are also relevant to these rules and decisions. These guidelines build upon earlier guidelines regarding hospital privileges, credentialing, and bylaws specific to hospital settings (APA, Board of Professional Affairs, Committee on Professional Standards, 1987; APA, Board of Professional Affairs, Task Force on Hospital Privileges, 1991) and draw on the issues highlighted in an additional APA document regarding practicing psychology in hospitals from that same time period (APA Practice Directorate, 1998).

There are a wide variety of systems for health care delivery, including, but not limited to, primary care and integrative care facilities, tertiary care hospitals, rehabilitation

centers, nursing homes, outpatient surgery centers, and substance abuse treatment centers. Similarly, there are a wide variety of patient populations with whom psychologists work within these systems (e.g., pediatric, geriatric, acutely versus chronically ill, those being treated for mental health or medical conditions, those from diverse cultures and socioeconomic groups, etc.) There are also different entry points for psychologists to deliver professional services for both direct and indirect patient care within health care delivery systems, ranging from being employed by the organization to being independent practitioners—with either contractual arrangements or following their patients as they enter a health care delivery system. In all cases, psychologists have special expertise in communication, behavioral issues, patient decision making, human interaction and systems that is relevant to the full spectrum of health and mental health issues and settings; these guidelines apply to that full spectrum. It is recognized that there is rapid growth in the use of technology (in areas

This article was published Online First October 1, 2012.

These guidelines revise and build upon earlier guidelines regarding hospital privileges, credentialing, and bylaws specific to hospital settings (APA, Board of Professional Affairs, Committee on Professional Standards, 1987; APA, Board of Professional Affairs, Task Force on Hospital Privileges, 1991). Renamed "Guidelines for Psychological Practice in Health Care Delivery Systems," they were developed by the Committee on Professional Practice and Standards (COPPS). Members of COPPS during the development of this document were Mary Ann McCabe (chair, 2010), Lisa Drago Piechowski (chair, 2009), Eric Y. Drogin (chair, 2007–2008), Bonita Cade, Lois Condie, Nabil El-Ghoroury (Board of Professional Affairs [BPA] liaison, 2007–2008), Ruth Fassinger (BPA liaison, 2009–2010), Terry S. W. Gock, Robert Kinscherff, Stephen J. Lally, Gary D. Lovejoy, Julia Ramos-Grenier, Bonnie Spring, and John Zervopoulos. COPPS is grateful for the support and guidance of BPA, and particularly to BPA Chairs Judith Patterson (2010), Cynthia A. Sturm (2009), and Jaquelyn Liss Resnick (2008). COPPS acknowledges the helpful consultation of APA Practice Directorate Legal and Regulatory Affairs staff members Maureen Testoni, Shirley Higuchi, Alan Nessman, and Stacey Larson. COPPS extends its sincere appreciation to the APA Practice Directorate staff members who facilitated both the work of COPPS and this revision effort: Mary G. Hardiman, Lynn F. Bufka, Ronald S. Palomares, Ayobodun Bello, LeShawn Lumpkin, and Sheila Kerr. Finally, COPPS wishes to thank the many other APA colleagues and governance groups who offered comments on drafts of these guidelines.

This document is scheduled to expire in February 2021, 10 years from the date of approval by the APA Council of Representatives. After this date, users are encouraged to contact the APA Practice Directorate to confirm that this document remains in effect.

Correspondence concerning these guidelines should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

<sup>1</sup> Hereinafter, this document is referred to as the APA Ethics Code.



such as telehealth) with unique considerations for practice that are beyond the scope of these guidelines. Ethical and legal standards for the practice of psychology pertain to the full range of health care delivery systems, and to every professional psychological role within such systems, unless otherwise specified.

The term *guidelines* refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from *standards* in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists.

The following glossary of terms found in these guidelines may be helpful. For the purpose of these guidelines, *psychologists* are considered “health service providers” (APA, 1996), having been duly trained and experienced in the delivery of preventive, assessment, diagnostic, and therapeutic intervention services related to the psychological and physical health of consumers, based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level.

We use the term *patient* to refer to the child, adolescent, adult, older adult, couple, family, group, organization, community, or other population receiving psychological services in health care delivery systems. However, we recognize that in many situations there are important and valid reasons for using such terms as *client* or *person* in place of *patient* to describe the recipient of services. Finally, we use the term *multidisciplinary* throughout the guidelines but recognize that in some instances psychologists may actually be working in a “transdisciplinary” context where holistic care is being provided that crosses disciplinary boundaries.

## **I. Distinct Professional Identity Within the Health Care Delivery System**

### **Guideline 1. Psychologists Remain Cognizant of Their Ethical and Legal Obligations as Members of a Distinct and Autonomous Profession**

**Rationale.** Participation in multidisciplinary diagnosis and treatment within complex systems necessitates psychologists’ careful attention to maintaining their distinct professional identity and responsibilities. Persons treated in health care delivery systems, as in all other settings, should receive the highest quality of psychological services. Integration of psychological services into a broad range of modalities and systems of care necessitates that these services be the best available care delivered or supervised by psychologists with the necessary training and experience.

**Application.** Consistent with applicable legal requirements, psychologists strive to avoid providing services beyond the boundaries of their competence (APA Ethics Code, Standard 2.01). Similarly, they strive to avoid delegating work to persons who cannot be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided (APA Ethics Code, Standard 2.05). They strive to avoid compromising their professional judgment in response to constraints or pressure posed by other professionals or systemic factors (APA Ethics Code, Standard 1.03; APA, 2010). Psychologists advocate for adequate budgeting, staffing, business arrangements (e.g., contracts, billing), supervision, and specialty competence for psychological services. When psychologists are administratively responsible to someone of a different professional discipline, they seek to sensitize the administrator to the psychologist’s own responsibility for planning, directing, and reviewing psychological services.

### **Guideline 2. Psychologists Seek to Understand the Internally and Externally Imposed Expectations and Requirements of the Systems Within Which They Practice**

**Rationale.** Effective and appropriate patient care depends upon sufficient familiarity with the environment, culture, and context in which such care is delivered. Psychologists recognize that they sometimes need to address or negotiate system requirements in relation to the needs of patients. Health care delivery systems are complex and highly structured organizations that rely upon the prompt and accurate availability of personal data and clinical services. Psychologists are typically obliged to disclose to patients the nature of their relationship with the organization, the probable use of the services provided and information obtained, and who will have access to the information (APA Ethics Code, Standard 4.02). Psychologists strive to educate themselves about the different tiers of health care record release that are based upon the sensitivity of the health care information (APA Ethics Code, Standards 2.01, 6.02; APA, 2007; Drogin, Connell, Foote, & Sturm, 2010).

**Application.** Psychologists strive to maintain a comprehensive and up-to-date understanding of the health care delivery systems within which they practice, including site-specific expectations and requirements for: patient admission, management, and discharge; assessment and treatment protocols; emergencies; patient safety, restraint, and restrictions of freedom; procedure codes and billing/bundling; informed consent; documentation, record keeping systems, sharing of patient information; and other issues. They seek to learn the institutional bylaws, administrative reporting, multidisciplinary relations, and organizational and governing structure of the institutions. They also strive to familiarize themselves with the pertinent regulations of the accrediting bodies for the health care delivery systems, the Health Insurance Portability and Accountability Act of 1996 (HIPAA; APA Practice Organization, 2005, 2007, 2009; U.S. Department of Health and Human Services, Office of Civil Rights, 2003, 2009), and applicable state and federal laws governing the

practice of psychology and hospital licensure. Psychologists recognize that active participation in the administration of health care delivery systems enables them to contribute to the development of optimal institutional policies and procedures regarding psychological practice and records, thereby maintaining high professional standards. In turn, this enhances the capacity of the health care delivery system to utilize psychologists' expertise to provide maximum benefit to patients and to the organization itself.

Psychologists appreciate that their ethical obligations to protect patient confidentiality may be more stringent than, or qualitatively and/or procedurally different from, other rules governing the exchange of health information among providers within the health care delivery system. This discrepancy necessitates vigilance on the part of psychologists in their informal communication with multidisciplinary colleagues, their communication with patients via technology, and in formal documentation within patient records. Psychologists strive to adhere to their ethical obligations while participating effectively in integrated care. In settings where it is relevant, psychologists strive to inform both institutional policies and technology for safeguarding confidential mental health information in electronic or other health records. Psychologists working in health care delivery systems where electronic health records are utilized strive to inform patients about efforts to protect confidential information (APA Ethics Code, Standards 3.10, 4.02; APA, 2007; Benefield, Ashkanazi, & Rozensky, 2006; Condie, Grossman, Robinson, & Condie, in press; Drogin et al., 2010; Richards, 2009).

### **Guideline 3. Psychologists are Prepared to Clarify Their Distinct Roles and Services and How These Relate to Those of Other Health Care Professionals**

**Rationale.** The successful development, integration, and delivery of psychological services in health care delivery systems depends upon psychologists' abilities, willingness, and opportunities to explain how they might contribute to effective prevention, diagnosis, consultation, treatment, rehabilitation, and/or end-of-life care. Psychologists aim to enhance patient participation in decision making about, satisfaction with, and adherence to recommended care. Fostering other professionals' understanding of the skills and potential contributions of psychologists is dependent upon psychologists' reciprocal understanding of the roles, skills, and contributions of other professional disciplines. Psychologists maintain a level of familiarity with the APA Ethics Code that enables them to convey its requirements in an appropriate fashion and accessible language to their nonpsychologist colleagues.

**Application.** Psychologists strive to create opportunities for collegial as well as public discourse regarding their distinct roles and services, and to demonstrate how psychologists' knowledge, skills, training, education, and experience complement and enhance those of other health care professionals. In order to do this effectively, psychologists continually strive to understand and appreciate fully the roles and services of other professionals within

the health care delivery system. When organizational demands conflict with ethical obligations, psychologists clarify the nature of the conflict, establish their commitment to mandatory sources of ethical guidance, and take reasonable steps to resolve the conflict consistent with the APA Ethics Code (APA Ethics Code, Standard 1.03; APA, 2010). These processes reflect the general purpose that, when indicated and professionally justified, psychologists cooperate with other professionals in order to serve their patients effectively and appropriately (APA Ethics Code, Standard 3.09; Institute of Medicine, 2001a, 2009).

## **II. Privileges**

### **Guideline 4. Psychologists are Encouraged to Seek Appropriate Staff Appointments and Clinical Privileges Within Health Care Delivery Systems**

**Rationale.** Psychologists seek the highest level of staff membership within the departments, specialty units, and/or clinical programs in health care delivery systems, as well as the broadest range of privileges within those systems, that is consistent with their training and expertise. They develop an accurate understanding of the medical staff categories and the range of clinical privileges for which they may be eligible, including the training and experience qualifications required for each. Psychologists' applications for staff appointments and privileges reflect the boundaries of their professional competence and the nature of their involvement in a given health care delivery system. They recognize that they may need to seek temporary privileges to deliver services to their patients when they move into a health care delivery system. Psychologists strive to establish the expectation that they be addressed by colleagues, staff, and patients as "doctor" if that formal title is used within a given medical culture. This title connotes their extensive doctoral-level education and training, as well as their longstanding history of independent licensure and independent management of patient care.

**Application.** The nature and requirements for staff appointments within health care delivery systems are determined by institutional bylaws and accreditation standards (e.g., Joint Commission, 2009) and, in some cases, state and federal laws. Health care delivery systems vary in terms of the categories for staff appointments (e.g., "full medical staff," "allied health provider," "active," "consulting," etc.). Most, however, distinguish between full-time, part-time, and temporary staff. Whenever possible, psychologists seek a level of staff appointment that allows voting for bylaws, officers, and other governance matters; typically this will mean full medical staff membership and privileges (Eckleberry-Hunt, Van Dyke, Stucky, & Misch, 2009). The criteria for assigning clinical privileges (patient care responsibilities) are determined by the rules of clinical departments, specialty units, or programs, under the auspices of the medical staff. There may be regional differences in established practices within health care delivery systems. Psychologists working in rural and underserved regions are encouraged to obtain the level of

privileges necessary and available to provide high quality care for patients.

Psychologists who do not have privileges or appointments but will continue to provide psychological services to patients within a health care delivery system (e.g., when a patient is hospitalized) seek temporary privileges or appointments to permit continuity of care. It is important for psychologists to understand the staff categories, clinical privileges, application processes, and timeline for review and approval, as well as the supervision requirements for patient care pending the assignment of privileges. Psychologists are encouraged to familiarize themselves with procedures governing staff appointments, privileges, sanctions, and appeals.

### **Guideline 5. Psychologists Strive to be Involved in the Development of Institutional Policies Regarding Professional Scope of Practice and Participation in Service Delivery**

**Rationale.** Psychologists recognize that active participation in the administration of health care delivery systems enables them to contribute to, as well as to monitor, the development and implementation of institutional policies and procedures that affect and promote the practice of psychology. In turn, optimal policies and procedures for the practice of psychology ensure that their expertise is utilized appropriately and for maximum benefit, and that high professional standards for psychological practice are upheld.

**Application.** Commensurate with their training and expertise, psychologists seek to be involved in program, service, and departmental leadership, including participation in establishing criteria for specific clinical privileges for psychologists (e.g., admitting privileges). They seek and accept appointment to medical staff committees for credentialing that provide peer review and oversight for the granting and renewal of both staff appointments and clinical privileges, as well as the determination of internal sanctions for psychologists who violate rules and regulations. Similarly, they strive to be actively involved in leadership activities concerned with quality improvement and risk management. Psychologists seek to recognize and create opportunities for workforce development and retention, particularly when providing services to underserved populations or in underresourced settings or systems. They strive to develop and maintain awareness and strategies to minimize health disparities in health care delivery systems that are in part due to race/ethnicity and socioeconomic status (Adler & Rehkopf, 2008; Agency for Healthcare Research and Quality, 2009; Institute of Medicine, 2003, 2008; President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 2005).

## **III. Integrative and Collaborative Care**

### **Guideline 6. Psychologists are Encouraged to Function in Multidisciplinary Positions With Diverse Roles and Responsibilities**

**Rationale.** Psychologists may continue to provide traditional psychological services in health care delivery systems, such as mental status examinations, emer-

gency evaluation and triage, diagnostic evaluation and assessment, and psychotherapy. However, psychologists increasingly perform other services within multidisciplinary teams in health promotion and disease prevention programs, primary care, behavioral medicine (or mind-body medicine) programs, care of patients with acute and chronic medical conditions, and end-of-life care.

**Application.** Psychologists' scope of practice includes direct service delivery, consultation, and training within teams of other health care providers. Their training and expertise are well-suited for collaboration with other disciplines, such as: enhancing communication with patients; observing behavior change in relation to symptom/disease progression, medication, and other interventions; attending to problems with continuity of care; facilitating decision making; problem solving to maximize adherence to treatment regimens; adjusting practices as needed for patients with developmental, behavioral, or psychiatric conditions; attending to gender, age, culture, spirituality, socioeconomic status, and other factors related to health beliefs and behavior; attending to life span developmental issues and aging; involving family or other support systems in order to maximize treatment outcome; ensuring quality of life considerations in treatment decision making, including end-of-life care; and negotiating differences of opinion among patients, families, or health care providers. Therefore, psychologists are urged to seek ways to integrate their unique expertise in diverse aspects of patient care, including the integral use of science as it pertains to psychological practice (APA Ethics Code, Standard 2.04; APA, 2005, 2009b; Belar, 2000; Institute of Medicine, 2001a, 2001b, 2009; President's New Freedom Commission on Mental Health, 2003). Psychologists remain mindful that, as members of a multidisciplinary team and as a result of their expertise, they may be called on to help team members address issues such as those arising from the stress associated with professional caregiving and maintaining work-life balance.

### **Guideline 7. Psychologists are Encouraged to Promote the Optimal Delivery of Their Services Through Effective and Timely Communication With Other Health Care Professionals**

**Rationale.** Health care delivery systems are comprised of providers from a variety of disciplines and training backgrounds. To effect optimal patient care, psychologists strive to learn and speak the "languages" of the systems in which they work (e.g., medical terminology) and are mindful of communicating psychological concepts in a manner that is comprehensible to other professionals. Psychologists seek to communicate in a timely manner and participate in interdisciplinary team meetings, rounds, and case consultations, where the goals, observations, and services of different providers can be integrated for optimal care.

**Application.** As participants in multidisciplinary health care delivery systems, psychologists understand the formal and informal means by which information is exchanged and documented. Psychologists are prepared to communicate their ideas, opinions, and questions in lan-



guage that is understandable to the nonpsychologist health care providers with whom they interact. Psychologists operationalize discipline-specific terms and concepts, including those explicating the mind–body connection in the context of the specific health issues in question. They appreciate that the timeliness of their communication can determine the degree to which it is perceived as helpful for patient care.

**Guideline 8. Psychologists Strive to Provide Collaborative Services in the Broadest Range of Health Care Settings, and to Apply Their Expertise to the Full Spectrum of Health Issues**

**Rationale.** As health care delivery systems become increasingly diverse and comprehensive, the roles played by psychologists also become more varied and potentially complex. Psychologists are increasingly found in a variety of health care settings dealing with the full range of conditions and diagnoses, whether considered medical, behavioral, developmental, or psychiatric.

**Application.** Psychological expertise is useful in a wide range of settings (e.g., psychiatric and general hospitals, primary care and other outpatient settings, surgery centers, rehabilitation facilities, nursing homes, and assisted living centers), serving patients with a variety of conditions (e.g., infectious diseases, obesity, diabetes, cancer, cardiac conditions, traumatic injuries, and neurological, developmental, and psychiatric conditions). Specifically, psychologists' roles include, but are not limited to: helping patients and families adjust to diagnoses of acute, chronic and/or life-threatening medical conditions, including assisting them with complex treatment decisions; preparing patients for invasive medical procedures; assisting patients with adherence to difficult treatment or rehabilitation regimens; assisting patients and providers with pain management; evaluating candidates for surgery or transplantation; promoting positive health behaviors, such as smoking cessation and adherence with diet and exercise regimens; providing consultation to physicians and other providers regarding effective ways to communicate with patients and their families; providing developmental, psychological, or neuropsychological assessment; providing or overseeing intervention for developmental or behavioral problems; evaluating and treating psychiatric conditions; helping patients and families with access to resources; and consulting with providers in systems other than health care delivery systems (e.g., schools, corrections, social service agencies, and independent practitioners). Additionally, some psychologists collaborate with medical providers regarding medications or prescribe medication themselves; discussion of these roles can be found in the "Practice Guidelines Regarding Psychologists' Involvement in Pharmacological Issues" (APA, 2009a).

Psychologists recognize the need to continually explore how their skills and training may apply to new and emerging health care environments (APA, 2009b). They strive to adapt their practice to new and evolving service delivery models and emerging technologies, including

thoughtful consideration of the issues involved in the use of technology and electronic media in psychology.

## **IV. Competency**

**Guideline 9. Psychologists Involved in Practice Within Health Care Delivery Systems Strive to Gain and Maintain Appropriately Specialized Competence**

**Rationale.** In health care delivery systems, psychologists are called to take on wide-ranging roles within their areas of expertise. These include, but are not limited to: providing psychological assessment; developing and implementing prevention programs; consulting; leading and participating in multidisciplinary treatment planning; conducting psychotherapeutic or counseling intervention; taking a leadership role in admission, diagnosis, treatment, consultation order, and discharge decision making; training and professional development for both psychologists and professionals from other disciplines; engaging in scientific research; and serving in health care delivery system management and administration roles. Psychologists are qualified to fulfill these roles in health care delivery systems by virtue of their doctoral-level education, specialized training, and experience. It is important that they keep abreast of the specific knowledge and skills and scientific literature relevant to their particular job roles and duties and practice only within the boundaries of their competence (APA Ethics Code, Standard 2.01).

**Application.** Psychologists are encouraged to seek continuing education and training that would enhance the performance of their specific job roles and duties within health care delivery systems. In new emerging areas in health care service delivery, they strive to take reasonable steps to ensure the competence of their work by using relevant research, training, consultation, and/or study (Bellar et al., 2001). It is important that they maintain cultural competence for health care delivery to diverse patient groups, including specific competence for working with patients of varying gender, race and ethnicity, language, culture, socioeconomic status, sexual orientation, religious orientation, and disabilities (APA Ethics Code, Standard 2.01; APA, 2002b). Psychologists are mindful of the specialized training needed for working with pediatric or geriatric populations. As the issues with which they are faced become increasingly complex, and the potential emotional burden of their work increases, psychologists actively seek to maintain self care to ensure their continued competence (APA Ethics Code, Standard 2.06).

**Guideline 10. Psychologists are Encouraged to Offer Their Special Expertise in the Administration and Management of Both Psychological and Other Professional Practice Within Health Care Delivery Systems**

**Rationale.** The doctoral-level education and training of psychologists includes: clinical service delivery; research methodology and program evaluation; program, system, and organizational development; and human behavior in groups and organizational systems. In conjunction with their

specific training and experience working within health care delivery systems, psychologists offer unique perspectives and expertise in the administration and management of psychological and other professional practice.

**Application.** Psychologists strive to be involved in those aspects of the management of psychological and other professional practice within health care delivery systems that are within the scope of their education, training, and expertise. These include, but are not limited to, the supervision of psychological and related services; involvement in health care ethics committees; and membership on Institutional Review Boards (IRBs). Psychologists are also encouraged to be involved in those organizational bodies within health care delivery systems that conduct peer review, address scope of practice issues, grant initial and continued credentialing, and oversee quality improvement initiatives.

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# APA GUIDELINES on Evidence-Based Psychological Practice in Health Care

WORKGROUP OF THE COMMITTEE ON PROFESSIONAL PRACTICE AND STANDARDS (COPPS)  
AND THE BOARD OF PROFESSIONAL AFFAIRS (BPA)

APPROVED BY APA COUNCIL OF REPRESENTATIVES  
FEBRUARY 2021



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

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**Suggested Citation**

American Psychological Association. (2021). Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care. Retrieved from <https://www.apa.org/about/policy/evidence-based-psychological-practice-health-care.pdf>



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## ACKNOWLEDGEMENTS

Members of the Committee on Professional Practice and Standards (COPPS) developed this document in collaboration with members of the Board of Professional Affairs (BPA) and APA staff. The workgroup included Michael J. Cuttler, PhD, ABPP; Nayla R. Hamdi, PhD (Chair); Steven D. Hollon, PhD; Timothy P. Melchert, PhD; and Michael Tansy, PhD, ABPP (2018-2019).

The workgroup acknowledges the consultation of Christine A. Courtois, PhD, ABPP; John C. Norcross, PhD, ABPP; Mary Ann McCabe, PhD, ABPP; and APA staff members Lynn F. Bufka, PhD and Jared L. Skillings, PhD, ABPP. The workgroup extends its appreciation to the APA staff members who facilitated its work, including Mary G. Hardiman, MS; Sarah Rose; and Bethel Yeshiwas.

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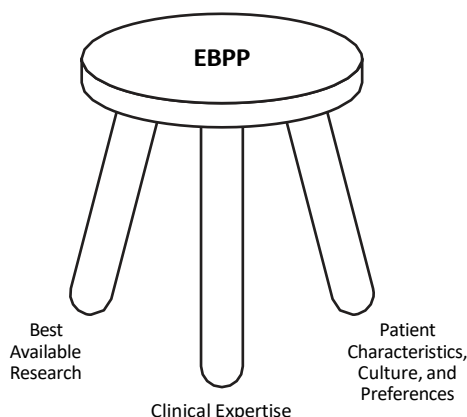
## INTRODUCTION

Since its inception at the end of the 19th century, applied psychology has sought to harness science for practical purposes, including the provision of clinical services within health care. Over the course of the 20th and early 21st centuries, the field deepened its commitment to evidence-based practice through endorsement of training models that integrate science and practice and proliferation of research on psychological treatments. At the turn of the 21st century, the concept of “evidence-based medicine” began to take hold in public policy discussions, prompting the American Psychological Association (APA) to develop a policy statement on Evidence-Based Practice in Psychology (EBPP). APA policy calls for “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006a, p. 273). This tripartite model, illustrated in Figure 1, explicitly defines EBPP as the intersection of high-quality research, clinical expertise, and patients’ characteristics, sociocultural backgrounds, and preferences.

## Components of Evidence-Based Practice in Psychology (EBPP)

APA's EBPP policy clearly identifies each of the three components of the tripartite model. The current professional practice guidelines illustrate *how* psychologists can apply these components to professional practice in health care. They provide a framework for integrating research evidence with clinical skill and patient identities and preferences. These guidelines seek to clarify and extend APA's EBPP policy by articulating practical considerations and providing illustrative examples of evidence-based psychological practice in health care.

Figure 1. Components of Evidence-Based Practice in Psychology (EBPP)



## Need for Guidelines

Professional practice guidelines offer psychologists guidance on roles, patient populations, or practice settings based on current research and professional consensus (APA, 2015c). They differ from clinical practice guidelines, which make recommendations for the treatment of specific disorders or conditions based primarily on systematic reviews that summarize research evidence of treatment efficacy. The current professional practice guidelines were developed in recognition that clinical practice guidelines emphasize research, particularly treatment efficacy, with relatively little guidance regarding either clinical expertise or patient characteristics, culture, and preferences. Thus, there is a need to discuss the roles of both of these factors in evidence-based psychological practice in health care.

Moreover, a more complete delineation of EBPP can provide a useful foundation from which to begin to explore questions related to the treatment of specific disorders or conditions (e.g., see Henriques, 2018). A foundational approach to psychological treatment makes sense because treatment extends beyond any particular theory, orientation, method, set of techniques, diagnosis, or health condition and takes place within a larger intervention process. Though the intervention process does not have to proceed in a particular sequence, it often includes some or all of the following elements: conducting a psychological assessment; developing a treatment plan; cultivating and maintaining an effective therapeutic relationship; tailoring psychological services to patient characteristics, culture, and preferences; assessing patient progress and outcomes over time; and modifying the clinical approach when it does not

produce the desired outcomes.

It is important to define the scope of EBPP and to distinguish it from empirically supported treatments (ESTs). EBPP is more comprehensive and encompasses a broad range of clinical activities including psychological assessment, diagnosis, case formulation, prevention, treatment, psychotherapy, and consultation. It involves a decision-making process for integrating research, clinical expertise, and patient characteristics, culture, and preferences to achieve the best outcome for the patient. In contrast, ESTs are specific treatment methods found to be efficacious for certain conditions or problems under specified circumstances in controlled clinical trials. Given this distinction between EBPP and ESTs in addition to the differences between professional practice guidelines and clinical practice guidelines, endorsement of specific treatment methods is not the aim of the current professional practice guidelines. A wide range of treatment methods and principles of change are consistent with EBPP.

## Purpose of Guidelines

The term *guideline* in this document refers to statements that suggest or recommend specific professional behaviors, activities, endeavors, approaches, or conduct for psychologists. Guidelines differ from standards in that the latter are mandatory and may be accompanied by an enforcement mechanism whereas the former are purely aspirational in intent and implementation. Guidelines aim to facilitate the systematic development of the profession and promote a high level of professional practice by psychologists. They are not intended to change, limit, or define the scope of practice for any group of psychologists. "Guidelines are not intended to be ... exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists" (APA, 2002b, p. 1048). In other words, guidelines serve an educative function for psychologists and health care professionals, not a regulatory function (APA, 2015c). They are not intended to create a requirement for practice or to be used by third parties to limit coverage for reimbursement.

These guidelines are informed by APA standards and positions and are consistent with the Ethical Principles of Psychologists and Code of Conduct (APA, 2016), the Resolution on Psychotherapy Effectiveness (APA, 2012b), and the Guidance for Developers and Users of Professional Practice Guidelines (APA, 2015c). Existing guidelines about the provision of psychological services in particular settings such as health care delivery systems (APA, 2013) or for specific communities such as girls and women (APA, 2018b), boys and men (APA, 2018a), persons with diverse racial, ethnic, and other sociocultural backgrounds (APA, 2017; 2019b), people with low income and economic marginalization (APA, 2019a), individuals with disabilities (APA, 2011), lesbian, gay, and bisexual clients (APA, 2012a), transgender and gender nonconforming people (APA, 2015b), and older adults (APA, 2014b) are important resources for psychologists that complement and strengthen the current guidelines. When applicable, federal and state laws and regulations supersede this guidance.

## Definitions

These guidelines encompass “all direct services rendered by health care psychologists, including assessment, diagnosis, prevention, treatment, psychotherapy, and consultation” (APA, 2006a, p. 273). Psychological intervention is broadly defined to include all of these services and should not be interpreted to imply any particular therapeutic technique, method, or orientation. This inclusive definition was originally set forth in APA’s EBPP policy statement and is retained in the current guidelines. That said, APA’s EBPP policy statement focuses primarily on treatment while acknowledging that the “same general principles apply to psychological assessment, which is essential to effective treatment” (APA, 2006a, p. 273). The current guidelines retain the same focus on psychological treatment within the context of health care.

Throughout these guidelines, the term ‘patient’ refers to the child, adolescent, adult, older adult, couple, family, or other individual or group receiving psychological services. The authors recognize that, in many instances, there are valid reasons for using alternative terms including client, consumer, individual, or person instead of ‘patient’ to describe the recipient of psychological services. ‘Patient’ was chosen in accordance with APA’s 2018 resolution for the use of this term in policy and rules pertaining to health care services and settings (APA, 2018c). The authors also acknowledge the existence of community- and school-based intervention and prevention efforts with multi-tiered behavioral components that are evidence-based in design and to which aspects of these guidelines apply despite the fact that the term ‘patient’ is typically inappropriate in these settings.

## Background

These guidelines were developed by an APA workgroup comprised of members from the Board of Professional Affairs (BPA) and the Committee on Professional Practice and Standards (COPPS). No group or individual contributed financial support for this project, and no member or sponsoring organization will derive financial benefit from the review, approval, or implementation of these guidelines. In an effort to be inclusive and comprehensive, the workgroup invited and incorporated feedback from a variety of subject matter experts. As is customary, the guidelines also underwent a 60-day public comment process, during which members of the public were invited to provide written comments. The workgroup made substantive changes to the guidelines to address this feedback.

The literature supporting these guidelines reflects a broad range of established psychological research, theory, and policy. References include primarily publications from the past 15 years, although older seminal studies are also referenced. The literature review, however, was not exhaustive nor was it the kind of systematic review that would be customary when developing clinical practice guidelines.

# **APA Guidelines on Evidence-Based Psychological Practice in Health Care**

# THE GUIDELINE STATEMENTS

## Overview of the Guidelines

### THE INTERVENTION PROCESS

- **Guideline 1:** Psychologists are mindful of the principles and importance of evidence-based practice.
- **Guideline 2:** Psychologists strive to maintain and enhance their knowledge of the research and scholarly literature applicable to their practice.
- **Guideline 3:** Psychologists endeavor to conduct assessments that are appropriate for the setting, purpose, and population.
- **Guideline 4:** Psychologists seek to participate in collaborative treatment planning with patients and others when appropriate.
- **Guideline 5:** Psychologists aim to cultivate and maintain effective therapeutic relationships, therapist characteristics, and change principles.
- **Guideline 6:** Psychologists endeavor to adapt their clinical approach to patient characteristics, culture, and preferences in ways that increase effectiveness.
- **Guideline 7:** Psychologists aim to monitor the treatment process and clinical outcomes routinely.
- **Guideline 8:** Psychologists seek to modify their clinical approach when appropriate and terminate treatment when the patient is no longer benefitting or when treatment goals have been met.

### COLLABORATION AND WHOLE HEALTH

- **Guideline 9:** Psychologists endeavor to collaborate with other professionals when appropriate to facilitate effective care.
- **Guideline 10:** Psychologists strive to promote overall patient health, functioning, and well-being.

# THE INTERVENTION PROCESS

## GUIDELINE 1

### **Psychologists are mindful of the principles and importance of evidence-based practice.**

#### **Rationale**

Professional psychology is deeply committed to EBPP in health care for several reasons. First, EBPP is grounded in reliable research evidence. This research evidence is not limited to therapeutic methods but extends to the entire treatment process including the therapeutic relationship, different facets of clinical expertise, and the patient's biopsychosocial characteristics, intersecting identities, and circumstances. Second, EBPP involves the development of effective therapist interpersonal skills that facilitate strong therapeutic relationships. Third, EBPP entails flexibly tailoring services to patient characteristics, culture, and preferences, which minimizes dropout and improves outcomes (Swift, Callahan, Cooper, & Parkin, 2018). Fourth, by virtue of training in both research and clinical practice, psychologists are among those uniquely qualified to delineate evidence-based practice. They have the necessary expertise to lead the expansion of evidence-based health care into the future. Fifth, psychologists' commitment to EBPP ensures that practice and training do not stagnate over time but rather continue to advance in accordance with the best available research, development of clinical expertise, and the field's growing understanding of how to adapt treatment to each patient. Sixth, EBPP has the potential to enhance public health by increasing societal access to effective care.

As psychologists strive to provide the most effective care, they have an important opportunity to identify and disseminate all of the active ingredients in evidence-based practice, enhance public health, influence mental health policies, and drive the field toward offering the best possible psychological services.

#### **Application**

APA policy on EBPP (2006a) calls for the integration of three factors in the delivery of psychological care: the best available

research evidence, the expertise of the clinician, and patient characteristics, culture, and preferences.

Psychologists seek to consult research evidence of relevance to their practice. Relevant research evidence includes but is not limited to the literature on human development and functioning; personality; psychopathology; therapeutic treatments, relationships, and processes; preventive strategies; assessment; outcomes monitoring; ethical, legal, and cultural considerations; as well as professional practice guidelines and clinical practice guidelines. Understanding human development, functioning, and behavior change involves broad knowledge of a full range of biological, psychological, sociocultural, and developmental factors. Guideline 2 offers psychologists guidance about staying abreast of the research literature relevant to their practice areas, distinguishing between different types of evidence, and critically evaluating research findings.

Clinical expertise is defined as "competence attained by psychologists through education, training, and experience that results in effective practice" (APA, 2006a, p. 275). It entails a wide range of competencies including but not limited to interpretation and application of relevant research evidence; knowledge about theories, models, and effective practice in psychotherapy; critical thinking and integration of multiple streams of information; assessment; case formulation; clinical decision-making; treatment planning; development and maintenance of a therapeutic relationship; delivery of treatment and other clinical services; adaptation of psychological services to patients' characteristics, culture, and preferences; monitoring of patient progress and outcomes; modification of the clinical approach when needed; and consultation (Health Service Psychology Education Collaborative, 2013). Additionally, clinical expertise encompasses therapist characteristics such as empathy, positive regard, congruence, and attendance to one's own reactions to patients (Elliott, Bohart, Watson, & Murphy, 2018; Farber, Suzuki, & Lynch, 2018; Hayes, Gelso, Goldberg, & Kivlighan, 2018; Kolden, Wang, Austin, Chang, & Klein,

2018). These traits predict better patient outcomes in routine clinical practice. All human beings, including psychologists, are prone to errors stemming from various biases (e.g., confirmation bias, a tendency to favor information that confirms one's preexisting beliefs) and inappropriate use of heuristics (e.g., availability heuristic, a mental shortcut that favors information recalled most quickly). Clinical expertise therefore also requires attention to biases and heuristics that can adversely affect judgment, awareness of the bounds of one's knowledge, as well as openness to external sources of feedback. Regular consultation with colleagues and systematic collection of patient feedback can offer protection from the adverse effects of biases and heuristic shortcuts and contribute to improved patient outcomes. The different facets of clinical expertise are described in greater detail throughout many of the following guidelines.

Research suggests patients attain better outcomes when treatment is adapted to patients' preferences, sociocultural backgrounds, and other dimensions of individual differences (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Specifically, research supports adapting psychotherapy to patient race, ethnicity, religion, spirituality, preferences, reactance level, stage of change, and coping style (Norcross & Wampold, 2019). Guideline 6 provides guidance for adapting treatment to these patient characteristics. It also presents a clinical vignette to illustrate how treatment can be tailored to patient preferences.

## GUIDELINE 2

### **Psychologists strive to maintain and enhance their knowledge of the research and scholarly literature applicable to their practice.**

#### **Rationale**

Scientific progress is an ongoing process. As new research findings emerge, the depth and breadth of the scientific evidence base grow. To provide the best available care, psychologists endeavor to monitor the evolving research literature and achieve and

maintain familiarity with scientific sources of professional guidance. Psychologists also strive to evaluate the quality of research and relevance of findings to their particular practices and settings.

## Application

Psychologists attempt to stay abreast of the research literature relevant to their practice areas. This literature includes a variety of topics related to the scientific understanding of human psychology, assessment procedures, therapeutic approaches, processes, and relationships, as well as analyses of ethical, legal, and cultural factors important in clinical practice. Psychologists develop professional knowledge, for example, by participating in continuing educational opportunities, attending state, regional, or national conferences, completing in-person, video-, or audio-based training, participating in peer consultation groups or journal clubs, researching online databases, engaging in independent reading, and delivering presentations and trainings. When developing professional knowledge, psychologists strive to deepen existing skill sets while also broadening exposure to other relevant topics. Participation in these types of learning and educational opportunities is consistent with the expectation that psychologists make ongoing efforts to maintain competence (2.03 Maintaining Competence; APA, 2016) and base practice on established scientific and professional knowledge (2.04 Bases for Scientific and Professional Judgments; see also 2.01e Boundaries of Competence; APA, 2016).

Psychologists also seek to familiarize themselves with current standards of practice by reviewing professional practice guidelines and clinical practice guidelines. As stated previously, professional practice guidelines provide psychologists guidance on roles, patient populations, or practice settings, whereas clinical practice guidelines systematically summarize the evidence base on the efficacy of treatments for specific health conditions. Though very useful for evaluating treatment efficacy, clinical practice guidelines do not address the entire range of symptoms, co-occurring

conditions, populations, settings, and roles that psychologists are likely to encounter in practice. Thus, psychologists use clinical practice guidelines in conjunction with professional practice guidelines and other sources of relevant research to tailor services to the individual patient. For example, when initiating psychotherapy with a 68-year-old African-American male patient with depressive symptoms, the psychologist might consult clinical practice guidelines for recommendations about specific efficacious treatment methods for depression across age groups and may additionally refer to professional practice guidelines for information about psychological practice with men, older adults, and individuals from racial and ethnic minority groups to tailor treatment to the patient's intersecting identities.

Several professional groups offer evidence-based clinical practice guidelines and similar reviews of research evidence on treatment efficacy relevant to psychological practice within health care. These groups include the Emergency Care Research Institute (generally known as ECRI Institute), the National Institute for Health and Care Excellence, the Cochrane Collaboration, the Campbell Collaboration, the World Health Organization, the American Psychological Association, the American Psychiatric Association, and the International Society for Traumatic Stress Studies, among others. In addition, both the Society of Clinical Psychology (APA Division 12) and the Society of Clinical Child and Adolescent Psychology (APA Division 53) maintain resources that provide information about effective treatments for various psychological diagnoses.<sup>1</sup> Of note, some health care systems, third-party payers, professional associations, and other entities produce guidelines that may not align with current standards for developing practice guidelines. Psychologists endeavor to gauge the quality of the guideline development process before following guideline recommendations. Gauging the quality of practice guidelines facilitates clinical decision-making about whether, when, and how to follow the recommendations. When evaluating guideline quality, psychologists are encouraged to consult APA's "Criteria for Evaluating Treatment Guidelines"

(APA, 2002a) and the Institute of Medicine's (2011) "Finding What Works in Health Care: Standards for Systematic Reviews." Important factors to consider are the type and amount of research evidence on which guidelines are based and the extent to which the evidence answers the questions posed and supports the conclusions reached.

When evaluating the research evidence, psychologists endeavor to pay attention to both efficacy (i.e., the strength of evidence for a causal effect) and clinical utility (i.e., generalizability, feasibility, and cost-benefit analysis; APA, 2002a). As such, psychologists recognize the value of various study designs including but not limited to systematic reviews and meta-analyses, randomized controlled trials (RCTs), cohort studies, case control studies, case series, single-case experimental designs, process-outcome studies, effectiveness research, ethnographic research, clinical observation, qualitative research, and mixed-methods research (APA, 2006a; Murad, Asi, Alsawas, & Alahdab, 2016). They appreciate that different designs are best suited to answering different questions.

Research designs vary in the specific practical implications they can offer. For example, RCTs control most effectively for threats to internal validity and are thus best suited for drawing causal inferences about treatment effects. However, RCTs often have specific selection criteria that may not generalize to patients typically seen in practice. Moreover, they generally study changes in diagnostic symptoms or status, even though patients frequently have additional idiographic symptoms and personal goals. Additionally, RCTs typically do not test the mechanisms hypothesized to underlie the treatment, meaning that the causal pathway for patient change remains unknown. Finally, RCTs generally examine treatments as a whole. As a result, RCT findings for multicomponent treatment methods do not identify the necessary and sufficient subcomponents. To provide additional examples of the utility of different research designs, effectiveness studies are well positioned to establish the ecological validity and portability of treatments in real-world practice settings, and qualitative

<sup>1</sup> <https://www.div12.org/psychological-treatments>  
<https://effectivechildtherapy.org>



research lends itself to understanding the richness and complexities of lived experiences, personal goals and values, the meanings of psychological constructs, and the processes of therapy, but neither research design is capable of distinguishing causal effects.

Though treatments recommended by high-quality clinical practice guidelines warrant strong consideration in treatment planning, psychologists maintain awareness of the limitations of such guidelines. Specifically, clinical practice guidelines primarily include treatment methods that have been systematically studied with RCTs and generally do not include treatments that either do not lend themselves to this type of study or have not yet been evaluated in the literature. As a result, the absence of guideline endorsement does not imply the absence of efficacy. Therefore, treatments that do not appear in clinical practice guidelines but enjoy other research support may be reasonably considered in treatment planning. Moreover, research has identified not only efficacious treatment methods but also effective therapeutic relationships, therapist characteristics, change principles, and therapy adaptations to patient characteristics. Psychologists endeavor to familiarize themselves with this literature in addition to the research on evidence-based treatments so that they can offer a more holistic approach to therapy.

#### GUIDELINE 3

### **Psychologists endeavor to conduct assessments that are appropriate for the setting, purpose, and population.**

#### **Rationale**

The overarching purposes of psychological assessment are to clarify patients' presenting concerns, gather information that contributes to case conceptualization and informs treatment planning, and identify patient characteristics, goals, and preferences that are relevant to the treatment process. Effective assessments also engage patients in their care.

#### **Application**

Assessment is often an ongoing process that occurs throughout treatment, from the

initial intake through periodic progress monitoring to evaluation of final therapy outcomes. The specific sequence and components of assessment vary depending on the clinical setting, patient presentation, and assessment purposes. The initial assessment typically includes diagnosis of presenting problems and disorders, case conceptualization, and identification of patient strengths, characteristics, sociocultural contexts, and preferences. Before beginning the assessment, the psychologist informs the patient of confidentiality requirements, limits to confidentiality, as well as the purpose, format, and possible outcomes of the assessment. The psychologist endeavors to answer the patient's questions and, as appropriate, obtains informed consent before proceeding. When applicable, the psychologist also inquires about the patient's goals for the assessment (i.e., what the patient hopes to learn from the assessment) and takes steps to ensure that the assessment is responsive to those goals. Because assessment is often the first step in the psychological intervention process, it provides psychologists with an early opportunity to set the tone for a successful therapeutic relationship. Therefore, psychologists strive to adopt a collaborative approach to assessment and develop an effective working relationship with the patient. Psychological assessments that include collaborative and personalized feedback are associated with more positive treatment processes and better clinical outcomes (Poston & Hanson, 2010).

Psychologists endeavor to ground assessment practices in the best available research on psychological assessment, psychometrics, measurement, clinical judgment, psychopathology, personality, development, and patient biopsychosocial circumstances and characteristics that can influence assessment results. Structured clinical interviews and adherence to diagnostic criteria are associated with higher diagnostic reliability (Garb, 1998; Garb, Lilienfeld, & Fowler, 2016). Tests of personality and psychopathology can permit inferences about response consistency and validity, clarify complex diagnostic pictures, and aid with differential diagnosis. When assessments include tests, psychologists seek to select measures that are reliable, valid for the intended use, and appropriate for the assessment purpose,

population, setting, and context in accordance with the ethical mandate for the appropriate use of assessment (9.02 Use of Assessments; APA, 2016). They strive to demonstrate knowledge of the psychometric properties, valid applications, and appropriate interpretations of the tests that they employ. When interpreting test findings, psychologists account for a range of possible sources of variability related to context, setting, purpose, and population (e.g., depression in children is often misconstrued as a lack of motivation whereas depression in older adults is sometimes mistaken for early-stage dementia; see 9.06 Interpreting Assessment Results; APA, 2016).

Psychologists endeavor to ask about patients' sociocultural backgrounds and preferences and how patients would like to incorporate those aspects of their lives into treatment. This information allows psychologists to tailor treatment to patient preferences, which can result in higher treatment retention and better outcomes (Swift, Callahan, Cooper, & Parkin, 2018; Swift, Callahan, & Vollmer, 2011). Psychologists are mindful of demographic and cultural biases that may affect assessment and diagnosis (e.g., the tendency to diagnose certain mental health conditions more readily in one gender). They strive to mitigate the adverse effects of these biases through careful attention to diagnostic criteria, use of semi-structured interviews and evidence-based personality tests as appropriate, and consideration of disconfirming as well as confirming evidence. Psychologists also seek to reduce vulnerability to demographic and cultural biases by interpreting assessment results within the context of the patient's developmental history and sociocultural background. They refrain from pathologizing behaviors that are normative for the patient's culture (e.g., distinguishing appropriate spiritual and religious expressions from psychopathological hallucinations and delusions) or developmental stage (e.g., distinguishing normative adolescent risk-taking from an externalizing disorder).

Psychologists aim to assess and account for comorbid conditions. Co-occurrence of two or more mental health conditions is very common (Hamdi & Iacono, 2014). Individuals with mental health disorders also experience higher rates of medical



disease and premature death from medical causes (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011; Parks, Radke, & Mazade, 2008). Given the prevalence of co-morbid disorders, psychologists seek to assess for co-occurring conditions, develop familiarity with common comorbid presentations in the population they treat (including common physical health conditions), consult the relevant literature on comorbid conditions, and create treatment plans that account for these conditions. For example, a psychologist working with a patient who experiences depression and chronic pain would attempt to formulate a treatment plan that addresses the interrelations between the patient's pain, mood, and functioning. Thus, the treatment plan might include exploration of how pain fits into and influences the patient's self-perception, interpersonal dynamics, and sociocultural context, suggestions for pacing during efforts to activate behaviorally, discussion of realistic and relevant goals, and management of pain flares.

Psychologists attempt to adapt assessments to the patient, purpose, and setting. For example, psychologists who work with children and families often solicit parent and teacher perspectives, especially when information from collateral informants is necessary for accurate assessment and diagnosis. Moreover, crisis assessments that aim to ascertain imminent risk of harm will likely have a narrower scope and may focus more specifically on major risk factors compared to more extensive mental health assessments. Psychologists accepting same-day referrals in a fast-paced primary care setting may opt to conduct briefer and more goal-oriented assessments compared to psychologists taking psychotherapy referrals in an outpatient mental health setting. Likewise, psychologists working in schools, long-term care facilities, other residential places, organizations, correctional institutions, and other settings tailor assessments in ways that are appropriate for these specific settings.

At the end of the assessment process, psychologists strive to communicate impressions, findings, and recommendations to the patient using accessible and sensitive language, and they attempt to provide thoughtful answers to any questions the patient raises.

#### GUIDELINE 4

### **Psychologists seek to participate in collaborative treatment planning with patients and others when appropriate.**

#### **Rationale**

Shared decision-making is the process through which the psychologist, the patient, and, when appropriate, others (such as family caregivers, health care team members, and teachers) jointly discuss treatment options to develop a treatment plan consistent with the patient's goals and needs. This process is also known as collaborative treatment planning. Treatment planning typically includes consideration of the relative benefits and risks of each treatment option as well as the possibility of no treatment, and it is documented as part of the informed consent process. Shared decision-making has the potential to lead to better decisions, increased patient engagement, reduced premature discontinuation, more coordinated care, and improved outcomes (Barry & Edgman-Levitan, 2012; Stacey et al. 2017; Tryon, Birch, & Verkuilen, 2018).

#### **Application**

Psychologists strive to engage patients and appropriate others in collaborative discussions about treatment. They typically begin treatment planning by ensuring that patients understand their rights and responsibilities related to treatment in accordance with the ethical mandate for informed consent (10.01 Informed Consent to Therapy; APA, 2016). At times, crisis stabilization or patient safety may compel psychologists to provide services in the absence of patient consent (e.g., older adults diagnosed with failure to thrive may be unresponsive to efforts to obtain consent; individuals with acute psychotic or manic symptoms may refuse medications required for stabilization). In these instances, psychologists attempt to involve relevant others in treatment decisions as appropriate and share important information and decisions with the patient to the extent possible. When stabilization and safety are attained, more collaborative discussions can occur.

Psychologists seek to share information about different treatment options with

patients and appropriate others and, together, they agree on the process through which they will work together. For example, psychologists may describe available treatment methods, the efficacy of each method, and the associated risks and side effects. They also acknowledge when the efficacy of a particular treatment has not been adequately evaluated. When recommending a treatment, they strive to rely on the best available research, their clinical expertise, applicability of the treatment to the setting and patient characteristics, as well as patient values and preferences. They aim to avoid treatments that have been discredited or found harmful. Psychologists actively seek patients' input during treatment planning and listen to their perspectives. They frequently inquire about patients' goals for treatment and work towards agreement on how they will collaborate to achieve these goals. Psychologists aspire to respect their patients' autonomy and do not coerce them to participate in an unwanted or aversive treatment. In most cases, the patient makes the final treatment decision. Exceptions include situations involving potential harm to the patient or others, crises and threats to safety or stability, or lack of decisional capacity.

When research evidence is limited, psychologists attempt to proceed cautiously based on the best available research relevant to the clinical situation (e.g., evidence on similar clinical presentations, settings, contexts, cultural factors, patient preferences), their clinical expertise (e.g., including a careful assessment of the sources underlying the patient's presenting problems and integration of multiple streams of information about the clinical situation), consultation with knowledgeable colleagues, and patient input. Psychologists appreciate that no treatment is universally efficacious and that different patients may respond differently to any given treatment (Cohen & DeRubeis, 2018; DeRubeis et al., 2014). If a patient has a history of non-response to a given treatment, the psychologist attempts to understand why the prior treatment was not successful, tries to assess any current treatment barriers, and recommends the most suitable treatment course based on the information learned.

Apart from the treatment method, psychologists also seek to discuss the treat-

ment format, the therapeutic relationship, and therapy processes with patients during treatment planning. For example, they may discuss the advantages and disadvantages of involving the patient's support persons in treatment or consider the possibility of group psychotherapy. Psychologists are also encouraged to ask patients about the type of therapeutic relationship (e.g., empathic, collaborative) and therapist (e.g., directive, warm) they desire, as well as the activities they would like therapy to entail (e.g., psychoeducation, skill-building, insight development, emotional release).

Given that multiple factors inform clinical decision-making, psychologists document treatment discussions with patients and appropriate others including the rationale for why care proceeded in a given direction. Psychologists revisit the treatment plan periodically and document treatment plan updates. Documentation serves as a historical record for the psychologist and is informative for others if questions arise about the care provided.

#### GUIDELINE 5

### **Psychologists aim to cultivate and maintain effective therapeutic relationships, therapist characteristics, and change principles.**

#### **Rationale**

Psychological treatment is provided in the context of a collaborative professional relationship. Compelling evidence shows that the quality of the therapeutic relationship is associated with treatment outcome (Norcross & Lambert, 2019). A large body of literature suggests that “nonspecific” factors, including the therapeutic relationship, therapist skills and traits, change principles, and patient characteristics, affect treatment outcome, independently of the specific therapeutic technique (e.g., transference interpretation, empty chair technique, cognitive restructuring, prolonged exposure; Cuijpers et al., 2012; Wampold & Imel, 2015). Also known as “common factors” because they are shared between different therapeutic orientations (e.g., psychodynamic, humanistic, cognitive-behavioral, interpersonal), these factors

likely account for as much, if not more, outcome variance as the technique itself. For example, in the depression literature, a meta-analytic decomposition of overall patient improvement found that about half could be attributed to “common factors,” a third to extra-therapeutic factors (e.g., factors associated with waiting-list and care-as-usual controls such as spontaneous remission, self-directed change, social support, and fortuitous occurrences), and only a sixth to specific factors associated with the therapeutic orientation such as the particular technique (Cuijpers et al., 2012). Psychologists are mindful that this is not a question of therapeutic relationship OR technique, but relationship AND technique, and that appropriate attention to each maximizes positive change. Thus, applying specific evidence-based techniques in the context of the therapeutic relationship appears to produce incremental benefits for the patient beyond the positive change attributed to “nonspecific factors” such as the therapeutic relationship.

#### **Application**

The therapeutic relationship powerfully predicts patient outcomes across treatment modalities (i.e., individual, couple, and family therapy), therapeutic orientations, treatment delivery mechanisms (i.e., Internet-based psychotherapy versus face-to-face psychotherapy), and patient age groups (Flückiger, Del Re, Wampold, & Horvath, 2018; Friedlander, Escudero, Welmers-van de Poll, & Heatherington, 2018; Karver, De Nadai, Monahan, & Shirk, 2018). This relationship is characterized by several interrelated facets including empathy (Elliott, Bohart, Watson, & Murphy, 2018), congruence (Kolden, Wang, Austin, Chang, & Klein, 2018), goal consensus and collaboration (Tryon, Birch, & Verkuilen, 2018), and rupture repairs (Eubanks, Muran, & Safran, 2018). Each of these facets is discussed in greater detail below.

Empathy has been conceptualized both as an intrapersonal therapist trait and an interpersonal and interactional relationship quality (Elliott, Bohart, Watson, & Murphy, 2018). Neuroscientific research points to three functional components of empathy: automatic affective sharing between the self and an other, self-other

awareness including the ability to distinguish between self and other, and conscious perspective-taking and self-regulation including the capacity to inhibit one's own perspective while attending to someone else's (Eisenberg & Eggum, 2009). Therapy researchers differentiate among three modes of therapeutic empathy, including establishment of rapport, moment-to-moment attunement to the patient's communication, and understanding of the patient's current experiencing within the context of their personal history (Elliott, Bohart, Watson, & Murphy, 2018). In therapy, psychologists strive to develop empathic relationships by attuning to the impact of the patient's emerging feelings and impressions and continually adjusting their own understandings and assumptions. Empathic responses go beyond simple reflections of patient statements and include exploratory empathy (i.e., efforts to capture the patient's unspoken feelings, such as “This experience left you feeling hurt”), evocative empathy (i.e., bringing the patient's experience to life in session through rich, evocative language and imagery, such as “I can picture you running around frantically trying to put out fires everywhere”), and process empathy (i.e., attending to the patient's inner experience in the moment, such as “Your face lit up when you started talking about your new interest”).

Like empathy, congruence has intrapersonal and interpersonal facets. The intrapersonal facet is characterized by genuineness, personal awareness, and authenticity, whereas the interpersonal facet includes the capacity to articulate one's experience to another person transparently (Kolden, Wang, Austin, Chang, & Klein, 2018). Psychologists aspire to build congruent therapeutic relationships by being open to joint experiencing with patients, owning their emotions and reactions, and being willing to reflect on their experiences aloud in therapy. Congruent responses may include targeted self-disclosure or articulation of one's own thoughts and feelings. Such responses are sincere and not intellectualized to the point of avoiding emotional realism. To maintain congruence over time, psychologists attempt to recognize moments of incongruence and then engage in self-reflection to facilitate a return to greater authenticity.

Psychologists encourage congruence in others by striving to create an environment in which patients are able to express themselves transparently (Kolden, Wang, Austin, Chang, & Klein, 2018).

Goal consensus refers to agreement between the therapist and patient on treatment directions and objectives. Psychologists seek to achieve goal consensus by identifying treatment goals in collaboration with patients and agreeing on the process through which they will work together to achieve these goals (Tryon, Birch, & Verkuilen, 2018; see Guideline 4 for a discussion of shared decision-making in treatment planning).

A rupture is a breach in the therapeutic relationship or alliance, which may involve a confrontation between the therapist and patient or the patient's withdrawal from therapy. Rupture repairs are associated with improved patient outcomes (Eubanks, Muran, & Safran, 2018). Psychologists seek to repair ruptures by attending to potential signs of a breach in the therapeutic alliance (e.g., patient expressions of annoyance or dissatisfaction with the therapist or the treatment; patient disengagement or withdrawal; therapist misstep or error) and endeavoring to address these issues in a non-defensive manner, as is discussed in greater detail in Guideline 8.

Apart from these components of the therapeutic relationship, therapists vary in certain traits and skills that are associated with patient outcomes in routine clinical practice. These therapist characteristics include empathy and congruence, as well as positive regard (Farber, Suzuki, & Lynch, 2018) and attunement to "countertransference" reactions, defined as therapist affective, cognitive, behavioral, and somatic reactions to their patients (Hayes, Gelso, Goldberg, & Kivlighan, 2018). Positive regard encompasses affirmation, non-possessive warmth, respect, support, acceptance, validation, and prizing. Therapists can convey positive regard for patients both verbally through choice of words and nonverbally through tone of voice, body language, and eye contact. Psychologists may attend to their own affective, cognitive, behavioral, and somatic reactions to patients in several ways. At times, a psychologist's reactions to a patient provide valuable information about the patient's

personality and interpersonal dynamics. The psychologist can utilize this information to guide case conceptualization and the treatment plan. Alternatively, or additionally, psychologists' reactions can serve as an indicator of their own interpersonal processes and emotional well-being. In this case, attunement to their reactions can help psychologists cultivate self-awareness and recognize when to attend to their own health and well-being or seek consultation. When psychologists recognize that their reactions to a patient are based on their own personal dynamics, they may consider the potential value of sharing this realization with the patient (Hayes, Gelso, Goldberg, & Kivlighan, 2018).

Beyond the therapeutic relationship and therapist characteristics, several change principles cutting across different treatment methods are associated with better outcomes. They include promoting treatment credibility, cultivating patients' positive expectancies (i.e., their beliefs in the benefit of treatment) and self-efficacy (i.e., their beliefs in their own ability to make meaningful and lasting changes), and offering patients the opportunity to release emotion and have new, corrective experiences (Goldfried, 1980; GrenCavage & Norcross, 1990; Weinberger, 2014). Translating these principles into practice involves providing patients with an informed, compelling, and individualized rationale for the proposed treatment and thoughtfully addressing questions and concerns to build their trust in the treatment approach (Constantino et al., 2018). Further, when working with patients who have low expectancies, therapists strive to adopt an affiliative and supportive attitude, as this stance is associated with better outcomes among these patients (Constantino et al., 2007). Psychologists also endeavor to display appropriate emotion in therapy and create a safe space for patients to express, process, and explore their own emotions (Peluso & Freund, 2018). Therapists thus strive to avoid criticism and inflexibility, both of which can inhibit patient emotional expression. Finally, psychologists seek to provide patients with opportunities for new learning and acquisition and practice of new behaviors.

Last, but certainly not least important, among the "common factors" are patient characteristics. These include positive expectancies, motivation for treatment, greater self-efficacy, and higher levels of functioning (Norcross & Lambert, 2019; Weinberger, 2014), all of which are associated with better treatment outcomes. Treatment outcomes also improve when psychologists adapt psychotherapy to patient race, ethnicity, religion, spirituality, reactance level, stage of change, coping style, and preferences (Norcross & Wampold, 2019). Guideline 6 offers guidance about how psychologists can effectively individualize treatment to these patient characteristics and preferences.

A rich literature has addressed how best to integrate these "common factors" with specific therapeutic techniques (Hofmann & Weinberger, 2007; Wampold & Imel, 2015; Wampold & Ulvenes, 2019; Weinberger, 2014). Based on this research, an effective approach to therapy cultivates patients' positive expectancies, fosters their self-efficacy, and provides them with opportunities to confront their problems and build mastery by applying the insights they gleaned or developing new skills, all within the context of a strong therapeutic relationship. Moreover, research on psychodynamic psychotherapy has found that certain dynamic techniques—namely, connecting current feelings to the past, identifying recurrent patterns in patients' experiences, and attending to similarities among patients' relationships over time, settings, or people—are most effective when the therapeutic relationship is strong (Owen & Hilsenroth, 2011).

Although attention to the therapeutic relationship, therapist skills and traits, change principles, and patient characteristics is always important, some of these factors may warrant special consideration with certain patient populations. For example, investment in the therapeutic relationship may be particularly critical in psychotherapy with individuals who have PTSD, other trauma-related disorders, attachment disorders, or personality disorders. These individuals often have difficulty trusting others (Zurbriggen, Gobin, & Kaehler, 2012), may have a history of invalidating interpersonal experiences, and might lack a foundation for secure attach-

ments (Wallin, 2007). As a result, psychologists strive to pay special attention to relationship dynamics when working with these populations and foster and maintain trusting therapeutic relationships. As another example, patients who are depressed are sometimes unduly pessimistic about the likelihood that they will respond to treatment. For this reason, the instillation of hope and cultivation of positive expectancies may be particularly important in work with individuals who experience depression (van Grieken et al., 2016).

#### GUIDELINE 6

### **Psychologists endeavor to adapt their clinical approach to patient characteristics, culture, and preferences in ways that increase effectiveness.**

#### **Rationale**

APA policy on EBPP (2006a) affords special consideration to patient characteristics, culture, and preferences. APA's (2017) multicultural guidelines encourage psychologists to recognize that identity and self-definition are fluid and complex, interact dynamically, and are shaped by the individual's multiple social contexts. Engaging these aspects of a person's culture and identity in psychological practice improves patient engagement and treatment outcome and reduces premature termination (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Harris, Kelley, & Shepard, 2015). Research supports adapting psychotherapy to aspects of patients' culture including their race, ethnicity, religion, and spirituality (Norcross & Wampold, 2019). Meta-analyses have found that culturally informed practice addresses simultaneously the ethical mandate for cultural sensitivity and the clinical pursuit of effective treatment (Smith & Trimble, 2016; van Loon, van Schaik, Dekker, & Beekman, 2013). In addition to cultural adaptations, tailoring treatment to patients' stage of change, reactance level, and coping style is likely also effective. Beyond these patient characteristics, research supports adapting treatment to patients' preferences (Norcross & Wampold, 2019). Failure to heed patient preferences may result in premature dropout and worse outcomes

among those who remain in treatment (Swift, Callahan, Cooper, & Parkin, 2018; Swift, Callahan, & Vollmer, 2011).

#### **Application**

Psychologists strive to respect patient characteristics, culture, and preferences by partnering with the patient and appropriate others in clinical decision-making (Barry & Edgman-Levitan, 2012). They endeavor to attend to these patient attributes throughout the treatment course, from assessment through treatment planning and delivery to termination of services.

Psychologists seek to adapt their clinical approach to patients' presenting concerns because different presentations often require different approaches. For example, patients with a trauma history often avoid thinking and talking about their trauma, and this avoidance impedes emotional processing and delays symptom resolution. For some of these patients, development of trust in the therapeutic relationship may be necessary before they are able to discuss their trauma in greater detail. With this consideration in mind, a set of competencies has been developed for therapists who treat traumatized patients and for those who train and supervise these therapists (Cook, Newman, & The New Haven Trauma Competency Group, 2014). As another example, patients who are depressed typically have difficulty initiating responses; it is not that they cannot engage in activities, they have trouble getting started (Koval, Kuppens, Allen, & Sheeber, 2012; Miller, 1975). Psychologists' efforts to help their patients break a large task down into its component parts and to overcome inherent inertia increase the likelihood of treatment success (Dimidjian, Barrera, Martell, Muñoz, & Lewinsohn, 2011).

Psychologists also attempt to tailor treatment to patient characteristics such as stage of change. Patients may share a diagnosis but differ notably in their readiness for change, meaning that the same treatment may not be appropriate for all individuals with the same diagnosis. Patients expressing ambivalence about initiating a change in substance use (i.e., patients in the contemplation stage) may need a therapy stance quite different from patients actively working to change their substance use (i.e., patients in the action stage; Krebs, Norcross, Nicholson, &

Prochaska, 2018). Specifically, therapeutic approaches that increase patient insight, awareness, and emotional salience may be more useful during earlier stages, whereas approaches fostering behavioral change may be more effective for patients in later stages.

Given the effectiveness of tailoring treatment to patients' sociocultural backgrounds including race, ethnicity, religion, spirituality, and their intersection, psychologists attempt to develop familiarity with culturally informed approaches (Zane, Bernal, & Leong, 2016). Meta-analytic results indicate that individuals from racial and ethnic minority groups tend to have better therapy outcomes when they participate in culturally adapted mental health interventions compared to traditional or unadapted interventions (Griner & Smith, 2006; Hall, Ibaraki, Huang, Marti, & Stice, 2016). Moreover, mental health interventions which have been adapted for a particular cultural group are more effective than interventions delivered to individuals from a variety of cultural backgrounds (Griner & Smith, 2006). Effective cultural adaptations include delivery of treatment in patients' preferred language if it is other than English (Griner & Smith, 2006) and incorporation of culturally relevant explanations of mental illness into treatment (Benish, Quintana, & Wampold, 2011). In general, when deciding whether and how to adapt treatment, psychologists seek to balance fidelity to evidence-based methods with sensitivity to patient culture and preferences (Sanetti, Collier-Meek, & Fallon, 2016). For more specific guidance in this area, they can avail themselves of several heuristic frameworks for culturally adapting treatment (e.g., Barrera & Castro, 2006; Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Hwang, 2006; Lau, 2006; Leong, 1996; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999).

Several conceptual models provide frameworks for the provision of culturally competent care by situating psychological services within a sociocultural context. For example, the ADDRESSING model encourages specific consideration of age, developmental disabilities, acquired disabilities, religion, ethnicity, sexual orientation, socioeconomic status, indigenous group membership, nationality, and gender for a more complete understanding of



cultural identity (Hays, 2016). Additional characteristics such as rural residence and language use may also be important, as may be their intersectionality. As another example, the Layered Ecological Model of the Multicultural Guidelines (APA, 2017) posits dynamic, nested social systems that interact over time. This model encourages psychologists to seek to understand the role of these social systems in patients' lives.

Individuals from racial and ethnic minority groups are less likely to receive psychological services, face more barriers to accessing care, and are more likely to terminate treatment early (Wang et al., 2005a; Snowden, 2001). Psychologists recognize that socioeconomic disadvantage, injustice, and discrimination pose barriers to accessing mental health care and contribute to mental health difficulties. They refrain from unduly attributing underlying causes of mental illness to the individual. Rather, psychologists try to understand the influence of personal history and societal forces on the individual's experience, perspective, and functioning. They strive to practice with cultural humility, which involves a continuous process of deliberate self-reflection and self-evaluation, an attitude marked by genuine curiosity and openness toward learning about another's experience, awareness of and willingness to explore power dynamics, and development of mutually respectful relationships with patients (Gallardo, 2014). Because people vary in how they think about and experience psychological distress and what they expect from treatment, psychologists aim to incorporate these diverse understandings into their practice to provide the most evidence-based care. They attempt to anchor psychological explanations in references, examples, anecdotes, and metaphors relevant to an individual's cultural background. For example, when working with a population that embraces non-Western healing traditions, psychologists seek to adapt their language and conceptual models accordingly and show openness to collaborating with community partners when appropriate (Gone, 2010).

Aside from adapting treatment to patient characteristics and culture, psychologists strive to offer treatments that meet the preferences of each particular patient. Patient preferences include

activity preferences (also known as role preferences), therapist preferences, and treatment preferences. Activity preferences consist of the types of activities in which patients want to engage during treatment (e.g., joint completion of worksheets, no homework assignment outside of sessions), as well as preferences about treatment setting and format (e.g., individual versus group psychotherapy, involvement of parents or teachers). Therapist preferences include the demographic characteristics (e.g., sex, race, ethnicity, religion) and personality traits (e.g., directiveness, warmth) that patients desire in a therapist. Finally, treatment preferences refer to patients' preferred intervention type (e.g., pharmacotherapy alone, psychotherapy alone, different types of psychotherapy, a combination of pharmacotherapy and psychotherapy; Cabral & Smith, 2011; Swift, Callahan, Cooper, & Parkin, 2018). Incorporation of these patient preferences into the treatment plan is associated with better outcomes. For example, a randomized preference trial found that patients with PTSD who received their preferred treatment between prolonged exposure therapy and sertraline were more likely to be adherent and experienced greater symptom reduction compared to patients who did not receive their preferred treatment (Zoellner, Roy-Byrne, Mavissakalian, & Feeny, 2019).

The following brief vignette illustrates how patient preferences can be incorporated into the initial treatment plan and throughout the treatment process. A female psychologist initiated treatment with a 30-year-old male combat veteran experiencing PTSD symptoms. She began the treatment planning process by inquiring about the patient's treatment goals and preferences. The psychologist actively elicited what types of treatment appealed to the patient, how he wanted to work with his therapist, what qualities he desired in a therapist, and what outcomes he hoped to achieve. Within the context of this discussion, the psychologist offered information about a variety of treatment options including the rationale for the proposed approaches and a description of what these treatments might entail. She recommended a trauma-focused therapy. She also invited further feedback from the

patient, who indicated a preference for working with a therapist who is warm, validating, and willing to listen. While the patient was assigned to this particular therapist and they were of the same racial background, he did not indicate any preferences regarding other therapist characteristics. He added that he needed to build trust in the therapeutic relationship before he felt comfortable engaging in a trauma-focused therapy. To accommodate these preferences, the psychologist invested in developing a supportive therapeutic relationship; she offered frequent expressions of validation and adopted a non-judgmental and empathic stance. She also continued to seek periodic feedback from the patient about his experience in therapy and his preferences for the remaining treatment course. As the patient's preferences changed over time (e.g., he expressed interest in more therapist directiveness, more structured treatment, and increased readiness to address the trauma), the psychologist accommodated those preferences through a collaborative discussion with the patient about potential next steps in treatment.

Although the relevance of patient characteristics to treatment outcome is widely recognized, studies of treatment efficacy often do not examine specific patient characteristics other than patient diagnoses or, rarely, patient preferences. When such characteristics are studied, they frequently do not occur in a large enough proportion of the sample to meet criteria for statistical significance as moderators of differential response to treatment. Patient-by-treatment interactions (the basis for identifying differential patient response to treatment) can be difficult to detect, and the scientific literature sets a fairly high bar for establishing the existence of such interactions (Pocock, Assmann, Enos, & Kasten, 2002). Moreover, existing research is based primarily on individuals from dominant cultural groups, which limits the applicability of findings to underrepresented and marginalized populations. Continuous efforts should be made to include culturally and economically diverse communities in research and to create culturally competent evidence-based practices. Of note, the recent development of treatment selection algorithms (Cohen & DeRubeis, 2018; DeRubeis et al., 2014) based on "big data"

(Kessler, 2018) suggests that we are approaching an era in which the identification of the optimal treatment for a given patient may become possible.

#### GUIDELINE 7

### **Psychologists aim to monitor the treatment process and clinical outcomes routinely.**

#### **Rationale**

Psychologists recognize that routine monitoring of patient progress is a tenet of evidence-based practice (APA, 2006a) and consistent with Ethical Principle A to benefit patients and do no harm (Beneficence and Nonmaleficence, APA, 2016). Routine monitoring may include regular assessment of patient psychological symptoms, interpersonal functioning, and social support, as well as the quality of the therapeutic relationship. Such monitoring allows the clinician to take note of and respond to the needs of the patient. Patient progress monitoring can be used to identify patients at risk for problematic treatment response and, when used, is associated with lower deterioration rates and increased clinically significant change rates in those patients (Lambert, Whipple, & Kleinstäuber, 2018). Although the effects of progress monitoring appear to be negligible when averaged across all patients, they are larger and statistically significant among patients predicted to respond poorly to treatment (Kendrick et al., 2016) and when feedback is frequent and timely (Fortney et al., 2017).

#### **Application**

Several existing patient progress monitoring instruments have been found effective with different populations and in various settings (Barkham, Mellor-Clark, & Stiles, 2015; Boswell, Kraus, Castonguay, & Youn, 2015; Brown, Simon, Cameron, & Minami, 2015; Duncan & Reese, 2015; Kopta, Owen, & Budge, 2015; Lambert, 2015; Youn et al., 2015). Psychologists make efforts to use patient progress monitoring instruments that are appropriate for the population and setting at hand. They strive for cultural and contextual sensitivity. Psychologists attempt to implement monitoring processes that are reliable, valid, sensitive to change, and relevant (APA, 2009). They appreciate the value

of progress monitoring for integrated case conceptualization, and they endeavor to link initial and ongoing assessments to treatments that achieve desired outcomes for their patients, including outcomes such as symptom reduction and improved quality of life and role functioning. When monitoring patient progress, psychologists seek to solicit real-time patient feedback about treatment response and satisfaction with the therapeutic relationship. With the resultant data, psychologists can identify patients at risk for a poor treatment outcome (e.g., patients who do not demonstrate expected treatment gains, show symptom deterioration, experience a perceived loss of social support, or report an alliance rupture). Psychologists then attempt to acknowledge any areas of concern via open and collaborative discussion with patients. These discussions may involve consideration of changes to the treatment approach, as is described in greater detail in Guideline 8.

Although there is evidence that monitoring patient progress can contribute to beneficial outcomes (Lambert & Shimokawa, 2011; Shimokawa, Lambert, & Smart, 2010), currently, most psychologists do not engage in routine patient progress monitoring (Ionita, Fitzpatrick, Tomaro, Chen, & Overington, 2016). This gap between evidence and practice is somewhat disconcerting in light of research showing that clinicians have difficulty identifying warning signs of patient deterioration and treatment failure (Hatfield, McCullough, Frantz, & Krieger, 2010). Given the research evidence supporting routine patient progress monitoring, psychologists are encouraged to seek guidance about effective implementation of the most suitable instruments for their setting.

#### GUIDELINE 8

### **Psychologists seek to modify their clinical approach when appropriate and terminate treatment when the patient is no longer benefitting or when treatment goals have been met.**

#### **Rationale**

Psychologists intend to provide high-quality care and are sensitive to the possibility that the current clinical approach might not be appropriate or effective for a given patient.

The emergence of additional presenting problems (e.g., revelation of trauma or substance misuse) or compelling research evidence may suggest that a change to the clinical approach is indicated. Additionally, routine patient progress monitoring might reveal lack of progress, patient deterioration, loss of support, or dissatisfaction with the therapeutic relationship (Lambert, Whipple, & Kleinstäuber, 2018). Psychologists are open to patient feedback suggesting a need to change the clinical approach or repair an identified rupture. Meta-analyses indicate that rupture resolution is associated with better patient outcomes such as higher treatment completion rates and greater symptom reduction (Eubanks, Muran, & Safran, 2018).

#### **Application**

Psychologists are open to information that indicates a need to modify the clinical approach. When psychologists become aware that their clinical approach is not appropriate or effective, they attempt to initiate changes to increase the likelihood of a favorable patient response. A psychologist may solicit the patient's perceptions of the clinical approach, treatment progress, and any possible barriers. The therapist might then seek additional feedback about the patient's needs and preferences including consideration of whether and how engagement of the patient's culture and values might be helpful. When indicated, the psychologist may conduct additional assessment of the patient's presenting concerns and diagnoses, consult the relevant research literature, or obtain consultation or supervision to determine how best to proceed in an evidence-based manner. The psychologist could use all of this information to engage in collaborative decision-making with the patient and appropriate others (Tryon, Birch, & Verkuilen, 2018). Within the context of this conversation, the therapist might discuss the possibility of referring the patient to another provider who can offer an alternate approach such as a different kind of psychotherapy, pharmacotherapy, or other intervention either as an adjunctive treatment or in lieu of the current treatment. In the end, the psychologist tries to help the patient consider different options for moving forward, which may include accommodating

new information within the existing treatment approach, modifying the treatment approach, adopting a new approach, or discontinuing care.

Psychologists endeavor to attend to potential signs of alliance ruptures including confrontation ruptures (e.g., patient expresses annoyance with the therapist or discontent with the therapy) and withdrawal ruptures (e.g., patient disengages from the therapy; Safran & Muran, 2000). They strive to address these issues in a non-defensive manner. For example, the clinician might validate the patient's statements, reflect the patient's emotions and perspective, invite the patient to share their experience of the rupture, and emphasize the patient's right to make their own choices. Psychologists aim to accept and communicate responsibility for their own behavior. At times, it may be therapeutic for a psychologist to help a patient recognize potential parallels between in-session ruptures and interpersonal dynamics in the patient's life (Eubanks, Muran, & Safran, 2018). If direct exploration

of the rupture is not clinically indicated (e.g., patient experiencing significant emotional dysregulation in the moment), the psychologist might acknowledge the rupture indirectly (e.g., helping the patient regulate their emotions). Psychologists also strive to recognize and work through their own emotions that may be triggered by an alliance rupture. At times, psychologists' emotional reactions to their patients may provide valuable information about their patients' personalities and interpersonal processes. In these cases, psychologists allow this information to inform the treatment approach. At other times, psychologists' affective reactions may serve as an indicator of their own emotional state. In these situations, psychologists seek to cultivate self-awareness and self-insight, practice self-care, and avail themselves of consultation or supervision as needed.

Psychologists terminate treatment if patients have not benefitted sufficiently or when patients' goals have been met and there is no ongoing need for treatment. In

the former case, the psychologist would generally consider alternative treatment options with the patient and arrange referral as appropriate. In either case, the psychologist would typically review treatment progress with the patient prior to termination, process the patient's thoughts and feelings about termination, identify the conditions that would warrant a return to working together, discuss how to reinstate treatment when needed, and say goodbye. If the therapist and patient agree to terminate treatment because of apparent patient improvement, they might choose to extend the intervals between sessions before termination to monitor patient functioning during periods of reduced therapeutic contact and to identify and address any challenges that arise. When appropriate, the psychologist and patient may also formulate a relapse prevention plan to help the patient maintain treatment gains after the conclusion of therapy.

## COLLABORATION AND WHOLE HEALTH

### GUIDELINE 9

**Psychologists endeavor to collaborate with other professionals when appropriate to facilitate effective care.**

#### Rationale

Many people with mental health concerns first come to the attention of non-mental health professionals. In fact, individuals who receive treatment for mental health problems often rely on general medical providers for these services (Wang et al., 2005b), and approximately 20% of all primary care visits include care for a mental health concern (Olson, Kroenke, Wang, & Blanco, 2014). In recognition of this reality, psychologists frequently partner with other professionals to deliver integrated care to patients.

There is growing recognition of the need for integrated care given that many individuals with mental illness die prema-

turally from medical causes; their average lifespan is more than eight years shorter than that of the rest of the population (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011). Individuals with serious mental illness (e.g., severe psychotic disorders) experience even higher rates of chronic disease and early death, and they die 25 years earlier, on average, than the general population (Parks, Radke, & Mazade, 2008). For the population as a whole, behavioral factors contribute significantly to the onset and exacerbation of medical disease. The Institute of Medicine (2004) concluded that roughly half of the causes of morbidity and mortality in the United States (U.S.) are related to behavioral and lifestyle factors—factors that psychologists are well-positioned to address. These factors are linked to the leading causes of death including cardiovascular disease, cancer, chronic respiratory illness, and diabetes.

Apart from the comorbidity between mental illness and medical disease, other

co-occurring problems across the biopsychosocial domains of human health and functioning often require collaboration between psychologists and professionals from various disciplines as well as patients' family members and support communities.

#### Application

Given the biopsychosocial nature of human development and functioning, the high rates of co-occurring biopsychosocial problems, and the fact that individuals commonly seek help for mental health problems from their primary care providers, psychologists recognize the need to work collaboratively with professionals from other disciplines. These collaborative efforts can result in several benefits to the patient including improved detection of mental health problems and increased access to effective behavioral health treatment. This is particularly important since it is estimated that only one-third of U.S. adults with mental

health disorders receive adequate treatment for these conditions (Kessler et al., 2005). Currently, the majority of individuals receiving treatment for their mental health conditions take psychotropic medications, though patients with non-psychotic disorders respond at least as well to psychotherapy and often with more enduring effects (APA, 2012b). Moreover, the large majority of individuals (75%) actually prefer psychotherapy to medications (McHugh, Whitton, Peckham, Welge, & Otto, 2013). Through collaboration with other providers and development of seamless referral mechanisms, psychologists can increase patient access to psychotherapy.

Psychologists can also help patients make positive health behavior changes such as improved chronic disease management, better adherence to treatment recommendations, increased exercise, reduced substance use, improved stress management, and stronger coping tools. Health psychologists, child psychologists, geropsychologists, and neuropsychologists have long worked collaboratively with medical professionals in the diagnosis and treatment of a wide range of health issues (e.g., O'Shea Carney, Gum, & Zeiss, 2015). Delivery of an integrated, biopsychosocial approach in the context of collaborative primary care is associated with improvements in health status, chronic disease management, preventive services, as well as cost savings (Jabbarpour et al., 2018).

Outside of traditional health care systems, many psychologists collaborate with educators in schools to address students' emotional, behavioral, and academic difficulties. Psychologists also engage in integrated care in correctional, occupational, and other settings. In addition, psychologists recognize the potential benefits of partnering with important social systems including families, cultural communities, and mental health advocacy and support groups to facilitate patient health care engagement and informed decision-making about health, wellness, and treatment.

The benefits of integrated care are increasingly being recognized. This approach has been heralded as an important step for improving health care in the U.S. (e.g., Institute of Medicine, 2001) and throughout the world (World Health

Organization, 2010). It has become a priority for psychologists as well (APA, 2015a).

## GUIDELINE 10

### **Psychologists strive to promote overall patient health, functioning, and well-being.**

#### **Rationale**

More and more, psychologists are focusing on preventing the development of mental health problems and promoting health and well-being in addition to treating distress and dysfunction. Over four decades ago, George Engel (1977) popularized the biopsychosocial approach that emphasized the full range of biological, psychological, and social factors in health and human development as an alternative to the traditional biomedical focus on disease. The biopsychosocial perspective steadily gained ground across health care fields and was endorsed by APA and a wide variety of other health professions in the early 2000s (APA, 2006b). Around the same time, positive psychology with its focus on human strengths and flourishing also became more widely accepted (Seligman, Rashid, & Parks, 2006; Snyder & Lopez, 2002). Positive psychology built on a longstanding humanistic tradition to leverage patients' strengths in psychotherapy (Maslow, 1943; Rogers, 1951). Today, psychologists are increasingly practicing in accordance with these broader and more integrated approaches to health care.

Beyond these changes in psychological practice, effective implementation of a population health approach to physical and emotional well-being includes partnership between multiple systems including patients' social communities, health care providers and delivery systems, social service and criminal justice agencies, policymakers, and researchers.

#### **Application**

For most of the 20th century, psychologists and medical professionals focused heavily on treating disease, disability, and dysfunction. In recent decades, they are increasingly turning attention to preventing problems and disorders from developing as well as promoting health and wellness (APA, 2014a; Melchert, 2015).

There has been growing recognition

that improving the health and well-being of the general population will require more attention to prevention in addition to the traditional emphasis on treating existing problems (National Research Council & Institute of Medicine, 2009). In the case of children, for example, prevention strategies could include reducing the prevalence and severity of risk factors (e.g., child maltreatment, parental substance abuse) while enhancing the impact of protective factors (e.g., resilience, presence of supportive parents and adults in the lives of children). On the other end of the age continuum, older adults could benefit from prevention initiatives that reduce risk factors for mental health disorders (e.g., social isolation, caregiver stress) while increasing protective factors (e.g., resilience, connection to community resources such as peer support groups). Similarly, administering routine screens for problematic substance use, depression, suicidal ideation, anxiety, and other issues to all patients during primary care visits is becoming more commonplace, permits early detection of emerging behavioral health difficulties, and can facilitate intervention before the development of more significant problems. Because negative consequences can result from either overpathologizing or underpathologizing, psychologists seek to interpret behavioral health screening data within the context of each patient's background and history to ensure that they are providing appropriate and respectful care that meets the patient's needs. Collaboration among health care professionals increases the health care system's ability to implement these preventive and early detection strategies universally with the population as a whole and respond appropriately with the best available care (Kazak, Nash, Hiroto, & Kaslow, 2017).

Alongside such preventive and early detection efforts, psychologists have been focusing on the promotion of health and well-being across the biopsychosocial domains. For example, behavioral treatments for obesity illustrate the unique value that psychologists add to traditional medical practice in promoting health and well-being. Indeed, recommended interventions for children who are overweight or obese are multicomponent and include psychological tools such as goal-setting



around physical activity and diet, problem-solving barriers, initiating and maintaining behavior change, and engaging the broader family system in healthy lifestyle choices (APA, 2018d).

Despite the emergence of broader population health initiatives that encompass prevention, early detection, treatment, and health promotion, several barriers challenge the effective implementation and dissemination of these evidence-based integrated approaches. These barriers include acceptability of this approach to health care providers, third-party payers, administrators, policymakers, and affected communities; potential administrative and workload burdens; incompatible organizational structures; insufficient provider reimbursement; training costs; and cultural concerns (Kazak et al., 2010). Effective implementation and dissemination therefore require engagement of multiple systems, including patients' social communities, health care providers, health care delivery systems, policymakers, and researchers (Hoagwood & Johnson, 2003; Kazak et al., 2010). There is a need for partnership between researchers and health care providers to ensure that researchers conduct the most useful dissemination and implementation studies and providers influence research questions and engage in the most evidence-based practices. Collaboration among different types of health care providers permits a truly interdisciplinary and integrated approach to health care that addresses patients' concerns across all biopsychosocial domains. Engagement of health care administrators can allow proper alignment of health care delivery systems around evidence-based, integrated principles of care. Outreach to policymakers and state and federal agencies increases the likelihood that funding and policies favor evidence-based, integrated approaches to improving health and health care. Partnerships with at-risk or affected communities including underrepresented or marginalized groups, peer support groups, and advocacy groups have the potential to increase the reach of mental health intervention efforts and to ensure their cultural acceptability and responsiveness. Finally, some of the most important strategies to promote mental health involve social change such as addressing homelessness, social inequities,

and systemic racism. Psychological interventions and prevention strategies will only be as successful as the broader social context permits. Thus, psychologists strive to build coalitions to address these underlying societal challenges to promote population well-being.

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AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

# Appendix X

## Society for Health Psychology Training Continuing Education Programming





**SfHP Virtual Programming Series  
(CE Events 2021-2024)**

October 24, 2014: Burnout/Flourishing as a Provider

October 9, 2024: Psychologists as Educators in Integrated Primary Care

September 19, 2024: Advancements & Barriers in Treatment of Perinatal Mood

September 5, 2024: Novel Psychological Treatments for Chronic Pain

July 10, 2024: Teams in Integrated Primary Care

June 6, 2024: Psychotherapy for Pregnancy Loss

April 4, 2024: IPC-IG: Population Health – What it Means for Integrated Primary Care

March 21, 2024: DEI Principles and Practice in Psychology Undergraduate and Graduate Education

February 15, 2024: Measurement in Adolescent/Young Adult (AYA) Oncology: From Development to Implementation

October 19, 2023: Growing Advocacy and Policy Efforts in Health Psychology: A Multi-Stakeholder Perspective

June 15, 2023: Look What I Can Do: How to Advocate for Expanded Roles for Health Psychologists in Healthcare Settings

May 11, 2023: Advocating for Women Facing Trauma and Oppression

April 20, 2023: Health Research on Cannabis

September 13, 2022: Improving Transition from Pediatric to Adult Health Care for Emerging Adults: A Case Example of Integrated Behavioral Health Approaches in a Diabetes Program

March 17, 2022: Psychological Treatments for Headache Disorders

October 18, 2021: Practice Management in Integrated Primary Care (IPC): Innovations and Expansion in COVID-19 and Beyond

June 18, 2021: Racial Disparities in Clinical Communication

May 14, 2021: Health Equity and Power: Misogynoir and Black Women's Health

March 25, 2021: Core Competencies for the Emerging Specialty of Pain Psychology

**2018 Society for Health Psychology PROGRAM at the APA Convention, San Francisco, CA**

TIME	Thursday, August 9, 2018		Friday, August 10, 2018		Saturday, August 11, 2018		Sunday, August 12, 2018	
8:00					8-9 INVITED ADDRESS *CE* How Integrated Primary Care Can Reduce Behavioral Health Disparities Bridges MC Rm 208		8-9 SYMPOSIUM *CE* Health Psychology Practice in Cuba Garcia-Shelton MC Rm 306	
8:30								
9:00	9-11 SYMPOSIUM Adapting Integrated Primary Care Models to Specialty Care Linton MC Rm 2007	9-11 SYMPOSIUM *CE* HP in Acute Medical Settings Seime/Butt/Berg MC Rm 160	APA Council  Marriott Marquis	9-11 SYMPOSIUM Health Psychologists in Non-Traditional Careers McCabe/Khatri/Follick/Ruddy MC Rm 2011			9-10 SYMPOSIUM Models for Integrated Care Shahane MC Rm 2009	
9:30								
10:00					10-11 INVITED ADDRESS *CE* Applying Psychological Science for Pain Relief and Opioid Reduction Darnall MC Rm 159		10-12 SYMPOSIUM *CE* Scientific & Economic Trends Transforming the Practice of Health Psychology Ruddy/Bruns/Kearney MC Rm 308	
10:30								
11:00	11-12 INVITED ADDRESS *CE* Integration of Behavioral Health Into Safety Net Primary Care Settings Khatri MC Rm 216	11-1 APA Early Career Science Award Winners Kazak MC Rm 2005	Yerba Buena Salon 9	11-12 POSTER SESSION B Health Disparities, Stress, Child Health, Chronic Pain MC Hall ABC	11-1 SYMPOSIUM Cost-Effectiveness Methodologies in Clinical/Non-Clinical Settings Wilson/Kaplan/Christensen MC Rm 2022	11-1 SYMPOSIUM Responding to Community Violence Shahane/Illes MC Rm 2024		
11:30								
12:00	12-2 SYMPOSIUM *CE* Evidence-Based Interventions for Chronic Pain Prasad/Lumley MC Rm 159		1-2 POSTER SESSION A Diabetes, Obesity, Health Behaviors MC Hall ABC					
12:30								
1:00								
1:30								
2:00	2-4 SYMPOSIUM *CE* Perinatal Mood and Anxiety Disorders Van Arsdale MC Rm 152	2-3 SYMPOSIUM *CE* Personalized Medicine Wiley MC Rm 105			2-3 SfHP PRESIDENTIAL ADDRESS Challenges of the Underserved in Integrated Care Settings: Implications for Design of Services Nash Marriott Marquis, Nob Hill Rooms C&D			
2:30								
3:00		3-4 SYMPOSIUM *CE* Knowledge Translation Weinstein MC Rm 105			3-4 SfHP MEMBERSHIP MEETING and AWARDS Nash/Wilson Marriott Marquis, Nob Hill Rooms C&D			
3:30								
4:00	4-5 APA Exhibits		4-5 INVITED ADDRESS *CE* Psychology of Rehabilitation from Athletic Injury McCabe MC Rm 152					
4:30								
5:00	5-6:30 APA Opening Session		5-6 Conversation Hour Making Board Certification as Painless as Possible MC Rm 104	5-6 Conversation Hour Pre-Doc Internship Q&A Marriott, Yerba Buena 10				
5:30								
6:00			6-7 Social Hour Meet & Greet Health Psych Training Directors Marriott Marquis, Yerba Buena Salons 11&12		6:00-7:30 – SfHP Social Event Le Colonial, 20 Cosmo Place, San Francisco			
6:30								





# Society for Health Psychology

(Division 38)

2019 CONVENTION SCHEDULE: Chicago, IL – McCormick Place (MP)

TIME	Thursday, August 8, 2019		Friday, August 9, 2019		Saturday, August 10, 2019		Sunday, August 11, 2019			
8:00	8-10 Making Connections: How to Thrive when Professionally Isolated in Interdisciplinary Health Systems MP S105bc	8-9 *CE* Identifying & Addressing Stigma in Health Care MP W184d	9-11 SfHP Presidential Programming: Chronic Disease Management Post- Natural Disaster – A Role for Health Psychology MP S105a		8-10 Diverse Health Psychology Careers: Teaching, Research & Practice MP W194b	8-9 *CE* Dismantling Disparities: Overcoming Inequities MP W187a	8-10 *CE* Understanding & Improving Adherence to Treatment & Prevention: HIV as a Case Study MP W178a	8-9 *CE* Hopelab: Using Digital Interventions for Young People MP W180		
8:30		9-10 *CE* Culturally Competent Healthcare for Marginalized Populations MP W179a						9-10 *CE* Minority Cancer Patients & Survivors MP W185bc		
9:00										
9:30										
10:00							10-12 Interdisciplinary Science & Tobacco Product Regulation: Informing the FDA about Electronic Cigarettes (w/D6) MP W187a	10-11 Navigating Diversity-Related Funding MP W470a		
10:30										
11:00	11-12 Role of Health Psychologists on Interdisciplinary Teams: Difficult Patient Behavior Management MP W187c		11-12 How to Prepare for the Future of Integrated Practice MP W192b		11-12 Poster Session I MP Hall F					
11:30										
12:00	12-2 *CE* Healthcare Provider Well-Being Programs MP W185bc	12-1 *CE* Opioids & Chronic Pain MP W179a	12-1 Technology-Based Behavioral Health Intervention in Integrated Care Settings: Lessons from HIV Care MP 192a		12-1 Poster Session II MP Hall F					
12:30										
1:00										
1:30										
2:00	2-4 SfHP Presidential Programming: Leadership Strategies for Psychologists in Academic Health Centers & Community Hospitals MP W196bc				2-3 SfHP Presidential Address: Psychology - A Health Services Profession? A Call to Action MP S102bc					
2:30										
3:00										
3:30										
4:00			4-6 *CE* Reducing Perinatal Mood & Anxiety Disorders MP W178a	4-5 Pre-Doctoral Internship Panel: Q&A MP W192b	3-5 SfHP Membership Meeting & Awards MP S102bc					
4:30										
5:00	5-6:30 APA Opening Session		5-6 Meet the Editors of Health Psych MP W181b	5-6 ABPP Certification MP W187a						
5:30										
6:00										
6:30			6-7 Meet & Greet Health Psychology Training Directors Marriott Marquis, Glessner House Rms A-C		6-7:30 SfHP Social Event Pizano's Pizza 2106 South Indiana Avenue					

Virtual APA 2020: Society for Health Psychology Program					
Session ID	Session Type	Title	Accepted in Virtual?	APA/SfHP	Notes
0786	Co-Sp Sym	Fostering collaborations among psychologists involved in public policy work to assist vulnerable populations	?	APA-D14	
0878	Co-So Sym	Ready Psychologist One: Simulation Experiences as Learning in High-Stakes Education	?	APA-D19	
0461	Posters	Poster Session A	indiv	APA	Top student member poster submitted to
0462	Posters	Poster Session B	indiv	APA	Science in the Morning competition.
0463	Posters	Poster Session C	indiv	APA	All other posters self-submitted.
0478	Sym	Adult Pre-Surgical Psychosocial Evaluations in Health Settings	Y	APA	
0469	Sym	Approaches to Palliative Care, Death, and Dying	Y	APA	
0479	Sym	Caring for the Caregiver: Report from the Organ Transplant Caregiver Initiative	N	APA	
0474	Sym	Culturally Competent Research in Health Psychology	?	APA	
0475	Sym	Fatigue in Chronic Illness: Exploration of Measurement and Mechanisms	Y	APA	
0477	Sym	Health Care Financing in 2020-2025: Funding Psychology Services in Academic Health Centers and Community Health Systems	N	APA	
0480	Sym	Leveraging Technology to Address Health Behaviors and Health Risks Among At-Risk Populations	Y	APA	
0481	Sym	Opportunities for Behavioral Health Navigation in Pain Management	N	APA	
0470	Sym	Pain and Somatization In 2020: Explaining and Treating "Medically Unexplained" Conditions	Y	APA	
1109	Sym	Towards Cultural Humility: Identity, Awareness and Bias Reduction for Psychology Professionals	?	APA	
0473	Sym	How to Get Involved in Health Policy	Y	APA	Health Policy Council
0111	Webinar	ABPP: Making Board Certification as Painless as Possible	N	SfHP	Clinical Health Services -> web resources
0472	Webinar	Exciting Career Opportunities in Health Psychology	N	SfHP	Education & Training
0112	Webinar	Health Psychology: Skill-Building Strategies for Scientific Journal Peer Reviewers	N	SfHP	Publications -> web resources

0453	Networking	Open Social: Celebrating Diversity Across APA Divisions and International Collaborators	N	SfHP	Diversity Council International Relations Committee
0476	Zoom	Pre-Doctoral Health Psychology Internship Panel	Delayed	SfHP	Student Advisory Council - late August 2020
0114	Zoom	Health Psychology Training Directors -> Panel	Delayed	SfHP	Student Advisory Council - late August 2020
0471	Interactive/ Zoom with breakouts	Leadership Strategies for Psychologists in Academic Health Centers and VA's: Interactive Mentoring	Y	SfHP	Saturday, 8/8/20, 11:00 am E - 1:00 pm E Mid-session change of rooms. Details due 6/29 for 7/1 launch; registrations due 7/15
0113	Zoom	SfHP Board of Directors Meeting	Zoom	SfHP	Wednesday, August 5, 5-7 pm E
n/a	Zoom	SfHP Executive Committee Meeting	Zoom	SfHP	Thursday, August 6, 5-7 pm E
0108	Presidential Address	State of the Society	tbd	SfHP	Pre-recorded; posted to website
0109	Business Meeting	Announcements	tbd	SfHP	Combo: recording/newsletter/listservs/ Social media
0110	Awards	Introductions and Presentations	tbd	SfHP	Live Zoom, plus transcripts on website After Presidential Address
	Networking/ Inreach	2020 SfHP Annual Social Event	tbd	SfHP	Social Media Meet-up Mystery Member Match



# Program Summary Sheet

APA Annual Convention

## Division 38

### Program Summary Sheet

#### Session ID: 152

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Discussion (A): Society for Health Psychology Diversity, Equity, and Inclusion Goals	8/14/2021 Sat 20		
<u>Chair</u>			
Tanecia Blue, PhD, VA, HONOLULU, HI			

#### Session ID: 161

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Integrating Heart Rate Variability Biofeedback With Trauma Treatment in a Telehealth Environment	8/14/2021 Sat 40		
<u>Cochair</u>			
Ana Abu-Rus, MA, Alliant International University–San Diego, San Diego, CA			
Constance J. Dalenberg, PhD, Alliant International University–San Diego, San Diego, CA			

#### Participant/1stAuthor

Ana Abu-Rus, MA, Alliant International University–San Diego, San Diego, CA  
Title: Heart-Rate Variability and Its Implications in Trauma Treatment

Co-Author: Constance J. Dalenberg, PhD, Alliant International University, San Diego, CA

Monica Ortiz, MA, Alliant International University–San Diego, San Diego, CA  
Title: Biofeedback-Assisted Prolonged Exposure (BAPE) in an Online Format

Donald Moss, PhD, Saybrook University, Pasadena, CA  
Title: Integrating Physiological Monitoring Into Trauma Practice

#### Discussant

Richard Gevirtz, PhD, Alliant International University–San Diego, San Diego, CA

**Session ID: 156**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Skill-Building Session (A): Technical Training for the Structured Clinical Interview for Sleep Disorders - Revised	8/14/2021 Sat 40		

Cochair

Kristi E. Pruiksma, PhD, University of Texas Health Science Center at San Antonio, San Antonio, TX

Hannah Tyler, PhD, University of Texas Health Science Center at San Antonio, San Antonio, TX

Participant/1stAuthor

Jessica R. Dietch, PhD, Oregon State University

Title: Technical Training for the Structured Clinical Interview for Sleep Disorders – Revised

**Session ID: 153**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Skill-Building Session (A): Applying evidence-based assessment and intervention strategies in primary care	8/14/2021 Sat 40		

Chair

Kriston Schellinger, PhD, UC San Diego Health, San Diego, CA

Participant/1stAuthor

Katrin Seifert, PsyD, UC San Diego Health, San Diego, CA

Title: Addressing Depression and Suicidal Ideation in Primary Care

Kriston Schellinger, PhD, UC San Diego Health, San Diego, CA

Title: Screening and Brief Intervention for Individuals With Substance Use Concerns

Eric Yelsa, PhD, UC San Diego Health, San Diego, CA

Title: Incorporating Clinical Hypnosis and Neuro-linguistic Programing With MBSR in Primary Care

Sarah Linke, PhD, MPH, UC San Diego Health, San Diego, CA

Title: Addressing Physical Activity With the Exercise is Medicine Initiative

**Session ID: 165**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium ( ): Interdisciplinary research at the intersection of psycho-oncology and aging	8/14/2021 Sat 40		

Chair

Kelly M. Trivino, PhD, Memorial Sloan Kettering Cancer Center, New York, NY

Discussant

Christain Nelson, PhD, Memorial Sloan Kettering Cancer Center, New York, NY

Patricia Parker, PhD, Memorial Sloan Kettering Cancer Center, New York, NY

**Session ID: 150**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Discussion (A): Evidence-Based Practice in Psychology: How Far We've Come and Future Directions	8/14/2021 Sat 40		

Chair

Robert P. Franks, PhD, Judge Baker Children's Center, Boston, MA

Participant/1stAuthor

Jeffrey J. Magnavita, PhD, Glastonbury Medical Arts Center, Glastonbury, CT  
 Title: Clinical Decision Making within Evidence Based Psychological Practice

Lynn F. Bufka, PhD, APA, Washington, DC  
 Title: Policy and Advocacy to Broaden Access and Advance Quality

Arthur M. Nezu, PhD, Drexel University  
 Title: Ethics As the Fourth Leg of Evidence Based Practice in Psychology

**Session ID: 149**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Discussion (A): How can we support each other? Establishing staff resilience programs in Healthcare Systems	8/14/2021 Sat 40		

Chair

Kristine M. Diaz, PsyD, MEd, Walter Reed National Military Medical Center, Bethesda, MD

Participant/1stAuthor

Kristine M. Diaz, PsyD, MEd, Walter Reed National Military Medical Center, Bethesda, MD

Title: Using climate assessment data in resilience program evaluation

Jennifer C. Collins, PsyD, Penn Medicine-Lancaster General Health, Lancaster, PA

Title: Using a framework to establish a resilience program

Mary G. Brownsberger, PsyD, Good Shepherd Rehabilitation Network, Allentown, PA

Title: Allocation of multiple resources in the creation of a staff well being program

Lynne H. Unikel, PhD, Einstein Healthcare Network, Philadelphia, PA

Title: Challenges With prioritizing staff wellness during a pandemic

**Session ID: 189**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Increasing the Visibility of Behavioral Scientists in Critical Public Health Challenges and Policies	8/14/2021 Sat 40		

Chair

Kristen E. Riley, PhD, Rutgers the State University of New Jersey, New Brunswick, NJ

Participant/1stAuthor

Anthony Biglan, PhD, Oregon Research Institute, Eugene, OR

Title: Increasing Focus on Population Health and Contextual Factors

Kenneth E. Freedland, PhD, Washington University School of Medicine in St. Louis, St. Louis, MO

Title: Building Expertise in Infectious Disease in Health Psychology

Kenneth Resnicow, PhD, University of Michigan--Ann Arbor

Title: Increasing the Profile of Behavioral Science during the COVID-19 Pandemic

Discussant

Dawn K. Wilson, PhD, University of South Carolina, Columbia, SC

**Session ID: 190**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Medical Decision Making: Current Considerations about Capacity	8/14/2021 Sat 40		

Chair

Kristen E. Riley, PhD, Rutgers the State University of New Jersey, Piscataway, NJ

Participant/1stAuthor

Maria M. Olex, PhD, Ascension Medical Group, Columbia St. Mary's, Milwaukee, WI

Title: Medical Decision Making Capacity in Hospital Settings during the COVID-19 pandemic

Taisel H. Losada, PhD, Henry Ford Health System, Henry Ford Cancer Institute, Detroit, MI

Title: Assessing Medical Decision Making Capacity in Cancer Patients

Mary O. Odafe, PhD, Edward Hines, Jr. VA Hospital, Chicago, IL

Title: Cultural Considerations in Medical Decision Making Capacity

**Session ID: 155**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Skill-Building Session (A): Training Gender Affirming Care in a Behavioral Health Setting	8/14/2021 Sat 40		

Chair

Shannon M. Smith, PhD, BayCare Medical Group and Florida State University College of Medicine, Winter Haven, FL

Participant/1stAuthor

Dani Rosenkrantz, PhD, University of South Florida Counseling Center, Tampa, FL

Title: Training Gender Affirming Care in a Behavioral Health Setting

**Session ID: 164**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): The Impact of COVID-19 on Integrated Primary Care in the United States	8/14/2021 Sat 40		

Participant/1stAuthor

Martha V. Saucedo, LCSW, Collaborative Health Care Association, Oregon, WI

Title: The Impact of COVID-19 on Integrated Primary Care In the United States

Chair

Neftali Serrano, PsyD, Collaborative Health Care Association, Chapel Hill, NC



**Session ID: 186**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
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Symposium (A): Caring for the Caregiver: Report From the	8/14/2021 Sat 40		
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Organ Transplant Caregiver Initiative			
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Participant/1stAuthor

Gloria Chen, MSW, LCSW, Memorial Hermann Hospital, Houston, TX			
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Title: Something New: The Organ Transplant Caregiver Consensus Conference and Caregiver Toolkit			
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Michelle Jesse, PhD, Henry Ford Health System, Detroit, MI			
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Title: What Works: Current State of Evidence-Based Practices and Interventions for Transplant Caregivers			
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Jorge Mallea, MD, Mayo Clinic Florida, Jacksonville, FL			
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Title: An Overview of Caregiving in Organ Transplantation			
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Cochair

Heather Bruschwein, PsyD, University of Virginia School of Medicine, Charlottesville, VA			
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Michelle Jesse, PhD, Henry Ford Health System, Detroit, MI			
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Discussant

Heather Bruschwein, PsyD, University of Virginia School of Medicine, Charlottesville, VA			
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**Session ID: 185**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
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Discussion (A): Creative Approaches to Maintaining	8/14/2021 Sat 40		
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Professional Well-Being During a Time of Stress and			
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Uncertainty			
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Chair

Nathaly Desmarais, PsyD, Florida International University			
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Participant/1stAuthor

Sasha Jaquez, PhD, University of Texas at Austin, Austin, TX			
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Title: Creative Approaches to Maintaining Professional Well-Being During a Time of Stress and Uncertainty			
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Suzanne Danhauer, PhD, Wake Forest School of Medicine, Winston-Salem, NC			
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Title: Creative approaches to maintaining professional well-being during a time of stress and uncertainty			
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Allison Dempsey, PhD, University of Colorado School of Medicine, Denver, CO

Title: Creative approaches to maintaining professional well-being during a time of stress and uncertainty

## Session ID: 157

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Embedding Brief Mindfulness Based Interventions in Medical Settings Improves Patient Outcomes	8/14/2021 Sat 40		

### Chair

Adam W. Hanley, PhD, University of Utah

### Participant/1stAuthor

Adam W. Hanley, PhD, University of Utah

Title: Brief Preoperative Mindfulness Based Interventions for Knee and Hip Replacement Patients: Two RCTs

Rebecca Wilson Zingg, MD, Huntsman Cancer Institute, Salt Lake City, UT

Title: Mindfulness-Based Waiting Room Interventions: Two Pilot RCTs

Co-Author: Pamela A. Hansen, MD, Huntsman Cancer Institute, Salt Lake City, UT

Co-Author: Jeremy Gililland, MD, University Orthopaedic Center, Salt Lake City, UT

Eric L. Garland, PhD, MSW, University of Utah

Title: RCT of Brief Mindfulness Training for Acute Pain Relief in the Hospital Setting

## Session ID: 163

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Psychosocial Implications of a COVID 19 Outbreak in a Nursing Home Facility	8/14/2021 Sat 40		

### Cochair

Barbara Cubic, PhD, West Virginia University School of Medicine, Morgantown, WV

Ruben Tinajero, PhD, West Virginia University School of Medicine, Morgantown, WV

### Participant/1stAuthor

Amber Billingsley, MS, West Virginia University School of Medicine, Morgantown, WV

Title: The Impact on Staff at a COVID 19 Infected Nursing Home

Co-Author: Alaina Tiani, MS, West Virginia University School of Medicine, Morgantown, WV

Rachael Spalding, MS, West Virginia University School of Medicine, Morgantown, WV

Title: Impact of a COVID 19 Outbreak in a Nursing Home on the Residents

Kalo Sokoto, MA, West Virginia University School of Medicine, Morgantown, WV

Title: Being a Family Member of a Resident in a Nursing Home Impacted by COVID 19

## Session ID: 162

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Unscreened And Unseen: Interpersonal Violence and HIV In The Time Of The COVID-19 Pandemic	8/14/2021 Sat 40		

### Chair

Dana J. Lehman, PsyD, AIDS Care Group, Chester, PA

### Participant/1stAuthor

Julia J. Hodgson, PsyD, MEd, AIDS Care Group, Sharon Hill, PA

Title: Unscreened And Unseen: Interpersonal Violence And HIV In The Time Of COVID-19

## Session ID: 154

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Skill-Building Session (A): Mind-Body Strategies for Working With Dyspareunia and Vaginismus	8/14/2021 Sat 40		

### Cochair

Tamar R. Kelson, PhD, UW-Madison, University Health Services, Madison, WI

Sarah S. Kohlstedt, PhD, UW-Madison, University Health Services, Madison, WI

## Session ID: 589

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Poster Session (F): Society for Health Psychology Poster Session 2	8/14/2021 Sat 60		

Participant/1stAuthor

Domonique M. Stevens, BS, University of La Verne, La Verne, CA

Title: Intersectional Discrimination and Self-Report Cardiovascular Risk Factors in LGBTQ Hispanic/Latinos

Co-Author: Daniel A. Palafox, BS, University of La Verne, La Verne, CA

Co-Author: Neda Awad, BA, University of La Verne, La Verne, CA

Co-Author: Samantha Liu, BS, University of La Verne, La Verne, CA

Co-Author: Taymy J. Caso, PhD, University of Minnesota Medical School, Minneapolis, MN

Co-Author: James J. García, PhD, University of La Verne, La Verne, CA

Christy Anderson, MS, Frank H. Netter School of Medicine, North Haven, CT

Title: Education Interventions on Osteoporosis Knowledge, Health Beliefs, and Self-Efficacy: SR, MA

Co-Author: Jillian Silverberg, MS, Quinnipiac University, Hamden, CT

Co-Author: Richard S. Feinn, PhD, Frank H. Netter School of Medicine at Quinnipiac, North Haven, CT

Co-Author: Katherine M. McLeod, PhD, Frank H. Netter School of Medicine at Quinnipiac, North Haven, CT

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Co-Author: Debra D. Bendell, PhD, Fielding Graduate University, Santa Barbara, CA

Co-Author: Connie S. Veazey, PhD, Fielding Graduate University, Santa Barbara, CA  
Nguyen Nguyen, MA, Texas Tech University, Lubbock, TX  
Title: How Job Discrimination Affects Chronic Pain: The Mediating Roles of Self-Acceptance and Self-Esteem

Co-Author: Vendela K. Parker, Pace University

Co-Author: Manik Ahuja, PhD, MA, East Tennessee State University  
Christina M. New, PhD, University of Memphis  
Title: Transgender Health Care: GAHT Symptom Disclosure, Gender Minority Stress and Health Status

Co-Author: Sara K. Bridges, PhD, University of Memphis  
Kendra E. Hinton, PhD, Indiana University School of Medicine, Indianapolis, IN  
Title: Relations Between the SIPAT and Lung Transplant Outcomes

Co-Author: Lisa Teh, PhD, Montefiore Medical Center, The Bronx, NY

Co-Author: Chadi A. Hage, MD, Indiana University School of Medicine, Indianapolis, IN

Co-Author: Yelena Chernyak, PhD, Indiana University School of Medicine, Indianapolis, IN  
Justin M. Kimber, MA, University at Albany, State University of New York, Albany, NY  
Title: Needs assessment for treating chronic pain: What do medical and mental health providers need?  
Ling-Jun Liu, MS, Changhua Christian Hospital, Changhua City, Taiwan  
Title: Smoking habits and opioid use in patients With chronic non-cancer pain

Co-Author: Ming-Chou Ho, PhD, Chung-Shan Medical University, Taichung, Taiwan

Co-Author: Pao-Sheng Shen, PhD, Tunghai University, Taichung, Taiwan

Co-Author: Sayward E. Harrison, PhD, University of South Carolina, Columbia, SC  
Cheyenne T. Reyes, MPH, University of Rhode Island  
Title: Attitudes towards chronic pain and its treatment Among students in healthcare-related majors

Co-Author: Allegra Sacco, BA, University of Rhode Island

Co-Author: Natalie Fenn, MA, University of Rhode Island

Co-Author: Zoe Mushkat, MA, University of Rhode Island

Co-Author: Mark Robbins, PhD, University of Rhode Island

Co-Author: Elena T. Gori, University of Rhode Island

Katherine A. Lawliss, MA, Widener University

Title: Let's Talk About Sex: Even If You Have Cystic Fibrosis

Linda K. Dao, MS, Fielding Graduate University, Santa Barbara, CA

Title: The Psychological Impact of Health and Financial Worries During a COVID-19 Pandemic Lockdown

Co-Author: Shantay Mines, EdS, Fielding Graduate University, Santa Barbara, CA

David B. Feldman, PhD, Santa Clara University

Title: Relationships Among Hope, Burnout, and Life Satisfaction in Oncology Healthcare Professionals

Co-Author: Matthew F. Hudson, PhD, MPH, Prisma Health Upstate Cancer Institute, Greenville, SC

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Title: The Measurement and Assessment of COVID-19 Influences on Mental Health in Emerging Adulthood

Co-Author: Dylan G. Serpas, BA, California State University, Fullerton, Fullerton, CA

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Title: Predicting Covid-19 Concealments during the COVID-19 Outbreak

Co-Author: Richard Rogers, PhD, University of North Texas, Denton, TX

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Title: Longitudinal Effects of Stigma and Social Support on Health Outcomes Among People Living With HIV

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Title: Perceived Racism and Perseverative Cognitions Predict Cannabis use in young African American Adults

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Title: The Predictors of Sexual Health Among Previsor Women

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Title: Social Support and Pain Questionnaire: Measurement Invariance across Sex and Ethnic Minority Status

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Title: Gender Differences in Pain Rehabilitation: The Mediating Role of Pain Acceptance

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Co-Author: Rebecca Kilpatrick, PhD, Medical University of South Carolina, Charleston, SC

Co-Author: Kelly Barth, MD, Medical University of South Carolina, Charleston, SC

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Title: When a Virus Goes Viral: Humorous Internet Memes and Coping With the COVID-19 Pandemic



Co-Author: Kathryn G. Low, PhD, Bates College, Lewiston, ME

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Title: Provider Race and Healthcare Disparity Awareness During the COVID-19 Pandemic

Co-Author: Pius Nyutu, PhD, Fayetteville State University, Fayetteville, NC

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Title: How Women With Cancer Cope With Issues of Identity by Seeking Solitude

Co-Author: Kathleen Novak, Boston University

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Co-Author: Whitney Wall, PhD, MPH, Fayetteville State University, Fayetteville, NC

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Title: Sexually Transmitted Disease History, Risk Attitudes and Behaviors Among Women In Drug Treatment

Co-Author: Zhengkai Lu, BA, University of Miami

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Co-Author: Michele Jean-Gilles, PhD, Florida International University

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Title: Enhancing Meaning in Life for Young patients With Systemic Lupus Erythematosus (SLE)

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Title: Positive psychology strategies employed Among solid organ transplant recipients

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Title: Quarantine During COVID-19: Implications for Anxiety and Disordered Eating and Exercise Behaviors

Christine M. Curley, MA, University of Connecticut

Title: Sexuality As a Health Behavior: Examining the Influence of Sexual Satisfaction on Well-being

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Title: Post-Traumatic Stress and Post-Traumatic Growth of cancer survivors: A scoping review of interventions

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Title: Vaping, Smoking, Dual Use, and Stealth Vaping/Smoking Among First Responders

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Title: Stress, Anxiety, and Depression Were Not Associated With BMI During COVID-19

Co-Author: Kristin L. Schneider, PhD, Rosalind Franklin University of Medicine and Science, North Chicago, IL

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Title: Development of a Health Self-Care Scale

Co-Author: Nadeen Majeed, MA, Michigan School of Psychology, Farmington Hills, MI

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Title: Perinatal Depressive Symptom Trajectories and Child Temperament at Age Four

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Title: Dispositional Motivation and Reactions to the COVID Pandemic: An RST Study Among US College Students

Co-Author: Amy Gencarelli, MA, East Carolina University

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Title: The Role of Attachment in Texting Behaviors and Sex Among Heterosexually Active Women

Meagan Henry, MA, University of Florida

Title: Factors Related to Physical and Psychological Quality of Life Among Black Seniors

Co-Author: Carolyn M. Tucker, PhD, University of Florida

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Title: Multimorbidity's Effect Over Functionality and Chronic Pain in a Hispanic American Sample

Co-Author: Marcos Reyes-Estrada, PhD, Carlos Albizu University, San Juan, PR

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Title: Eat, Sleep, and Play - How Health Behaviors Influence Health and Well-Being Among Cancer Survivors

Co-Author: Kandace McGuire, MD, Virginia Commonwealth University

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Title: Investigating the Effect of Mindfulness-based Interventions on Health-Promoting Behaviors

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Title: Effects of the COVID-19 Pandemic on the Mental and Physical Health of University Students

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Title: College Student Vaccine Knowledge, Participation and Fears: Understanding Uptake and Hesitancy

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Title: Early indicators of motivation and readiness to change in a mobile weight loss program

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Title: Resiliency and COVID-19 Beliefs in Healthcare Providers

Co-Author: David E. Oberleitner, PhD, University of Bridgeport, Bridgeport, CT

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Title: Psychological Impact of COVID-19 on Healthcare Professionals

Co-Author: Ceewin N. Louder, MA, University of Miami

Co-Author: Kyle J. Self, BS, University of Miami

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Title: Art Therapy Drawing Protocols for Chronic Pain: Quantitative Results From a Mixed-Method Pilot Study

Victoria Obeng-Adjei, BA, Ohio University, Athens, OH

Title: COVID-19 Worries Moderate the Association Between Chronic Pain Severity and Substance Use

Co-Author: Kevin Saulnier, MS, Ohio University, Athens, OH

Co-Author: Julie A. Suhr, PhD, Ohio University, Athens, OH

Co-Author: Dominik Mischkowski, PhD, Ohio University, Athens, OH

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Selin S. Odman, MS, Emory University School of Medicine, Atlanta, GA

Title: Patient and Provider Satisfaction: Outcomes From an Integrated Behavioral Health Clinic

Co-Author: Katherine Goodman, MS, Alliant International University, Los Angeles, CA

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Zeev N. Kain, MD, University of California Irvine, Department of Anesthesia, Orange, CA

Title: Cultural Tailoring of a Perioperative mHealth Intervention for Latinx Children and Parents

Co-Author: Haydee G. Cortes, BA, University of California Irvine, Department of Anesthesia, orange, CA

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Aimee K. Rovane, MA, University of South Carolina, Columbia, SC

Title: Effect of Parental HIV on Emotion Socialization of Children in China

Co-Author: Xiaoming Li, PhD, University of South Carolina, Columbia, SC

Johanna M. Cimilluca, MS, MPH, East Tennessee State University

Title: Ability to Pay for Healthcare and its Association With Mental Health in Tennessee

Leslie Rodriguez, PhD, MS, Johnson and Johnson, Inc., Jacksonville, FL

Title: Type D Personality As a predictor of COVID-19-related psychological trauma in essential workers

Co-Author: Hilary DeShong, PhD, Mississippi State University

Co-Author: Michael Shriner, PhD, Northcentral University, La Jolla, CA

Maisa Ziadni, PhD, Stanford University

Title: The Impact of COVID-19 on Patients With Chronic Pain: A CHOIR Study

Co-Author: Dokyoung S. You, PhD, Stanford University

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## Session ID: 582

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Poster Session (F): Society for Health Psychology Poster Session 1	8/14/2021 Sat 60		
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Kelsi Ovca, PhD, Fordham University

Title: Experiences of Self and Family Relationships for Adolescents With Chronic Conditions

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Title: Psychosocial Challenges of Aging With HIV and a History of Childhood Sexual Abuse

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Title: The association between pain attitudes and endorsement of medically or behaviorally-based treatments

Co-Author: Cheyenne T. Reyes, MPH, University of Rhode Island

Co-Author: Mark Robbins, PhD, University of Rhode Island

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Title: Incorporating Weight Bias Reduction Interventions in Health Care Training: A Systematic Review



Co-Author: Andrew Lac, PhD, University of Colorado at Colorado Springs, Colorado Springs, CO

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Title: Social and Emotional Impacts of Diabetes on Depression Symptoms

Kyle Tackett, MS, Marshall University, Huntington, WV

Title: Dogmatism, Disordered Eating, and Weight Loss Strategies

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Title: A Closer Look at the Relationship Between Personality Factors, Binge-Watching, and Health Outcomes

Todd Jackson, PhD, University of Macau, Taipa, Manitoaba, Macao, SAR China

Title: Perceived Injustice and Emotional Distress in Clinical Pain Samples: A Meta-Analytic Review

Co-Author: Hong Chen, PhD, Southwest University, Chongqing, China

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Title: Physical activity, nutrition, and health-related quality of life in persons With HIV

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Tiffany A. Chenneville, PhD, University of South Florida, Saint Petersburg, FL

Title: Feasibility and Acceptability of a Sexuality Education Program for Black Youth in Florida

Keesha K. Jones, MA, Nova Southeastern University, Davie, FL

Title: Interventions supporting Well-being in Black and Latino Alzheimers/Dementia Caregivers

Co-Author: Brittany Hylander, BA, Nova Southeastern University, Fort Lauderdale, FL

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Title: Reflections of COVID-19 on the mental disease of university students

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Co-Author: Thomas V. Petros, PhD, University of North Dakota

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Title: Vital Exhaustion, Perceived Stress, and Anger: The Role of Adaptive and Maladaptive Coping

Co-Author: Jennifer A. Schmaus, MS, University of Miami

Co-Author: Alex Gonzalez, BA, University of Miami

Co-Author: Neil Schneiderman, PhD, University of Miami

Co-Author: Barry E. Hurwitz, PhD, University of Miami

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Title: The MDH-CI: Predicting Well-Being Through a Novel Coping Instrument

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Title: The Salience of a Health Threat: Comparing NSCLC Patients and Controls on Perceptions of COVID-19

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Title: Others' Beliefs of Illness Severity Among Patients With Metastatic Breast Cancer

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Sydney K. Black, MS, MA, Spalding University, Louisville, KY

Title: Burnout in Primary Care Providers in the age of COVID-19 and the fight for racial justice

Co-Author: Sydney K. Black, MS, MA, Spalding School of Professional Psychology - IBHSP Program, Louisville, KY

Brian G. Collin, PhD, MA, Spalding University School of Professional Psychology – IBHSP Program, Louisville, KY

Title: Depressive Symptoms Before and After Pandemic Response in an Integrated Primary Care Setting

Co-Author: Brian G. Collin, PhD, MA, Spalding University Integrated Behavioral Health Scholars Program, Louisville, KY

Marely Diana, PhD, MA, Ponce Health Sciences University, Ponce, PR

Title: Psychological Distress and the Role of Resilience Among Healthcare Professionals facing COVID 19

Co-Author: Ernesto Rosario, PhD, Ponce Health Sciences University, Ponce, PR

Co-Author: Maria Garrido, PsyD, Ponce Health Sciences University, Ponce, PR

Co-Author: Sarah Shelton, PsyD, Spalding School of Professional Psychology - IBHSP Program, Louisville, KY

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Nicole Milani, BA, Teachers College, Columbia University

Title: Effect of Individuals' Beliefs and Attitudes on their Responses to COVID-19 in the US

Co-Author: Nicole Milani, BA, Teachers College, Columbia University

Yiyi Wang, MS, University of Toronto, Toronto, ON, Canada

Title: Mental Training for Academic Success during the Pandemic

Co-Author: Norman Farb, PhD, University of Toronto, Toronto, ON, Canada

Co-Author: Maria G. Michels, MA, Spalding University, Louisville, KY

Dorothy R. Jolley, PhD, Walden University, Minneapolis, MN

Title: Historical Trauma, Contemporary Trauma, and Type-2 Diabetes Self-management Among AI/AN women

Gabrielle Glorioso, MA, University of Indianapolis

Title: Outcomes of a Motivational Intervention for Facilitating Health Behaviors in Emerging Adults

Co-Author: Erin M. Fekete, PhD, University of Indianapolis

Co-Author: Katie Kivisto, PhD, University of Indianapolis

Sharon D. Malinowski, PsyD, San Francisco VA Health Care System, San Francisco, CA

Title: Implementation and Delivery of Telehealth After-Visit Summaries in a VHA Primary Care Setting

Co-Author: Naina D. Mahtani, PsyD, San Francisco VA Health Care System, San Francisco, CA

Co-Author: Lauren Yannucci, DSc, San Francisco VA Health Care System, San Francisco, CA

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Megyn Jasman, Central Connecticut State University, New Britain, CT  
Title: PTSS From Campus Mass Shootings and Physical Health: Catastrophizing and Resilience

Co-Author: Joanne DiPlacido, PhD, Central Connecticut State University, New Britain, CT

Co-Author: Kemesha Gabbidon, PhD, University of South Florida, Saint Petersburg, FL

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Co-Author: Julianna Capobianco, BA, University of South Florida, Saint Petersburg, FL  
Marla Munro, MEd, University of Houston, Houston, TX  
Title: Blame, Shame, and Barriers: Stigma Experienced by People With Rare Diseases

Co-Author: Maryam Kia-Keating, PhD, University of California–Santa Barbara, Santa Barbara, CA  
Jasmin M. Calcote, MA, Marshall University, Huntington, WV  
Title: Impact of Health Literacy on the Selection of Sources used to Obtain Health Information  
Mikhaela McFarlin, BA, University at Albany–State University of New York, Albany, NY  
Title: Trust in provider care Among adults With chronic pain based on geographic region

Co-Author: Alexandria Brunkow, BS, University at Albany–State University of New York, Albany, NY

Co-Author: Rebecca L. Weber, BA, University of Detroit Mercy  
Norma S. Monico-Cristales, MS, PGSP-Stanford PsyD Consortium, Palo Alto, CA  
Title: Discrimination and Pain Self-Efficacy Among Overweight/Obese Chronic Pain Patients in Primary Care

Co-Author: Norma S. Monico-Cristales, MS, Palo Alto University, Palo Alto, CA

Co-Author: Robert Holaway, PhD, Palo Alto University, Palo Alto, CA  
LaTanya D. Tolan, MSW, MA, Fielding Graduate University, Santa Barbara, CA  
Title: Health and Disease Outcomes Predict Suicide Across Countries

Co-Author: Amanda Abbie-Hall, MA, Fielding Graduate University, Santa Barbara, CA

Co-Author: Meghan M. O'Brien, BA, Fielding Graduate University, Santa Barbara, CA

Co-Author: Richard Valencia, MS, Palo Alto University, Palo Alto, CA

Richard Valencia, MS, Palo Alto University, Palo Alto, CA

Title: Race-Related Stress, Trait Mindfulness, and the Somatic-Anxiety-Depressive Triad

Co-Author: Richard Valencia, MS, Palo Alto University, Palo Alto, CA

Carolina Lara-Lerma, MA, Arizona State University, Tempe, AZ

Title: Fatalism, Alcohol Use, and ART Adherence Among HIV+ Latino MSM Living At The U.S./Mexico Border

Co-Author: Abby C. Romero, BA, BS, Arizona State University, Tempe, AZ

Kylie M. Steinhilber, MS, Suffolk University, Boston, MA

Title: Challenges and Provider Supports for Chronic Pain Patients During COVID-19: A Qualitative Analysis

Co-Author: Hannah E. Robins, BA, Suffolk University, Boston, MA

Co-Author: Samantha Plezia, Suffolk University, Boston, MA

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Co-Author: Molly Becker, BS, Suffolk University, Boston, MA

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Co-Author: Kelly Wawrzyniak, PsyD, Tufts University School of Dental Medicine, Craniofacial Pain Center, Boston, MA

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Hannah E. Robins, BA, Suffolk University, Boston, MA

Title: Conceptualizing Empowerment in the Context of Chronic Pain: A Qualitative Investigation

Co-Author: Kylie M. Steinhilber, MS, Suffolk University, Boston, MA

Co-Author: Merle Keitel, PhD, Fordham University–Lincoln Center, New York, NY

Abriana M. Gresham, BS, BA, Ohio University, Athens, OH

Title: Examining COVID-19 stressors, intimate partner violence, health, and health behaviors

Co-Author: Brett J. Peters, PhD, Ohio University, Athens, OH

Co-Author: Gery Karantzas, PhD, Deakin University, Burwood, VIC, Australia

Co-Author: Linda D. Cameron, PhD, University of California–Merced, Merced, CA

Co-Author: Jeffry A. Simpson, PhD, University of Minnesota–Twin Cities, Minneapolis, MN

Co-Author: Frank R. Dillon, PhD, Arizona State University, Tempe, AZ

Co-Author: Kristi A. Costabile, PhD, University of Iowa

Co-Author: Susan J. Persky, PhD, National Human Genome Research Institute / National Institutes of Health, Bethesda, MD

Co-Author: Susan J. Persky, PhD, National Institutes of Health, Bethesda, MD

Co-Author: Jedediah Bondy, Drexel University

Co-Author: Karol Osipowicz, PhD, Drexel University

Brandi L. Roelk, MA, University of Detroit Mercy

Title: Enhancing Diabetes Management Through Personality Assessment

Co-Author: Theresa Poppe, MD, IHA Family and Internal Medicine, Canton, MI

Co-Author: Ellen Day, MA, University of Detroit Mercy

Co-Author: Kate Lowe, BS, University of Detroit Mercy

Co-Author: Mohammad Sibai, MA, University of Detroit Mercy



Patricia Cabral, PhD, Occidental College, Los Angeles, CA

Title: Health risk behaviors that predict annual wellness visits Among emerging adults

Co-Author: Steve Martino, PhD, VA Connecticut Healthcare System, West Haven, CT

John J. Sellinger, PhD, VA Connecticut Healthcare System, West Haven, CT

Title: Psychosocial impacts of COVID-19 pandemic on veterans With chronic pain

Co-Author: Christina Lazar, MPH, VA Connecticut Healthcare System, West Haven, CT

Co-Author: Kathryn Gilstad-Hayden, PhD, Yale University School of Medicine, New Haven, CT

Co-Author: Marc Rosen, MD, VA Connecticut Healthcare System, West Haven, CT

Co-Author: Lening A. Olivera Figueroa, PsyD, Yale School of Medicine, New Haven, CT

Alison Jane Martingano, PhD, National Institutes of Health, Bethesda, MD

Title: Mom and Dad Know Best: How Parenthood Influences Beliefs About the Heritability of Common Diseases

Kelly Cuccolo, PhD, University of North Dakota

Title: Motivation for Engaging in Intermittent Fasting Impacts Eating Disorder Symptomology

Carly R. Wallace, MA, Midwestern University, Downers Grove, IL

Title: Medical Students' Attitudes and Beliefs Toward Interdisciplinary Care when working With ACEs

Co-Author: Rachel Pisczor, PsyD, Midwestern University, Downers Grove, IL

Co-Author: Constance Gundacker, MD, MPH, Medical College of Wisconsin, Milwaukee, WI

Co-Author: Leilani Feliciano, PhD, University of Colorado at Colorado Springs, Colorado Springs, CO

Co-Author: Katherine A. Johanson, MA, University of Colorado at Colorado Springs, Colorado Springs, CO

Sydney H. Telaak, BA, National Human Genome Research Institute / National Institutes of Health, Bethesda, MD

Title: Psychosocial Well-being of Individuals With Diabetes: Impacts of Weight Status and Disease Type

Anish K. Ponna, Drexel University

Title: Perceptions of Social Distancing, COVID-19 Infection, Testing, and Vaccination

Alexander Unger, PhD, University of Business and Society Ludwigshafen, Ludwigshafen, Deutschland, Germany

Title: How the Deviation From a Negative Time Perspective reduces Burnout Among Nurses and Caregivers

Rachel M. Reyes, BS, University of California, Irvine, Irvine, CA

Title: Mindfulness-based Interventions to Address Psychological Distress during COVID-19

Co-Author: Amada L. Cipres, BA, University of California, Irvine, Irvine, CA

Co-Author: Dana R. Garfin, PhD, University of California, Irvine, Irvine, CA

Sophie R. Brickman, BA, University of Colorado at Colorado Springs, Colorado Springs, CO

Title: Predictive Pathways From Demographics to Protective Behaviors to COVID-19 Mental Health Outcomes

Estefania M. Texidor, BA, Albizu University, San Juan, PR

Title: Quality of Life in a Sample of Women in Puerto Rico Diagnosed With Breast Cancer

Co-Author: Estefania M. Texidor, BA, Albizu University, San Juan, PR

Co-Author: Jose Rodriguez Gomez, MD, PhD, Albizu University, San Juan, PR

Ida Taghavi, MA, University of California, Santa Barbara, Santa Barbara, CA

Title: Adverse Childhood Experiences and Yoga: An Integrative Approach for Healing

Co-Author: Megan M. Kincaid, MS, Marshall University, Huntington, WV

Co-Author: Kathleen R. Bogart, PhD, Oregon State University

Co-Author: Steven K. Huprich, PhD, University of Detroit Mercy

Allison Walden, MA, MEd, University of Colorado at Colorado Springs, Colorado Springs, CO

Title: An Investigation of the Impact of Coronavirus Pandemic Restrictions on the Health of US Adults

Co-Author: Michele L. Okun, PhD, University of Colorado at Colorado Springs, Colorado Springs, CO

Co-Author: Courtney Barry, PsyD, Medical College of Wisconsin, Milwaukee, WI

Co-Author: John S. Wiebe, PhD, University of Texas at El Paso, El Paso, TX

Roxana V. Jacob, MA, Alliant International University, Alhambra, CA

Title: Connection Between Mental Health Symptoms and Gastrointestinal Symptoms, Moderated by Attachment Style

Co-Author: Julie Papastamatelou, PhD, University of Business and Society Ludwigshafen, Mannheim, Deutschland, Germany

## Session ID: 973

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
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Participant/1stAuthor

Kelsey L. Berry-Tippett, PsyD, Midwestern University

Title: Medical Students' Fear of Alzheimer's Disease: A Psychological Phenomenon

Co-Author: Michelle M. Lee, PhD, Midwestern University

Co-Author: Mireille Rizkalla, PhD, Midwestern University

Raymond C. Hawkins, PhD, Fielding Graduate University

Title: Family Routines for Meals and Bedtime and College Students' Problem Eating and Sleeping Behaviors

Co-Author: Kathryn G. Low, PhD, Bates College

Kayla Braverman, BA, Bates College

Title: The Relationship between Pornography Use, Orgasm, and Perceived Norms

Madison Firkey, MS, Syracuse University

Title: Personalized Normative Feedback for College Student Condom Use: Referent Discrepancy and Specificity

Co-Author: Sarah E. Woolf-King, PhD, MPH, Syracuse University

Arpine Markosyan, BA, Alliant International University-Los Angeles

Title: The Role of Family Structure, Family Relationship Quality, and Parenting Style on Risky Behavior

Co-Author: Iakovos Anastasakis, BA, University of Cincinnati

Co-Author: Natalia Revzina, MD, Emory University

Co-Author: Ariadna Capasso, MA, New York University

Co-Author: Ekaterina Boeva, MD, First Saint Petersburg State Pavlov Medical University, Saint Petersburg, Russian Federation, Russian Federation

Co-Author: Lorna H. London, PhD, Midwestern University

Co-Author: Vadim Rassokhin, MD, First Saint Petersburg State Pavlov Medical University, Saint Petersburg, Russian Federation, Russian Federation

Co-Author: Adrienne Crusey, BA, University of Cincinnati

Co-Author: Jessica M. Sales, PhD, Emory University

Co-Author: Anthony Hitch, MA, University of Cincinnati

Co-Author: Tiffaney Renfro, MS, Emory University

Co-Author: Ralph J. DiClemente, PhD, New York University

Kajsa Sibley, AA, University of California, Irvine

Title: Fear of Missing Out (FoMO): Substance Use During COVID-19 Among Young Adults

Co-Author: Yvonne Dai, AA, University of California-Irvine

Co-Author: Vitica Arnold, AA, University of California-Irvine

Co-Author: Morgan McLoughlin, BA, University of California-Irvine

Co-Author: Shauna G. Simon, MA, University of California-Irvine

Co-Author: Larry D. Jamner, PhD, University of California-Irvine

Arpine Markosyan, BA, Alliant International University

Title: The Role of Family Structure, Family Relationship Quality, and Parenting Style on Risky Behavior

Co-Author: Michi Fu, PhD, Alliant International University

Co-Author: Itzel Tapia, BA, Alliant International University

Co-Author: Marilisa Raju, PhD, Alliant International University

Co-Author: Pia Ahmed, BA, California State Polytechnic University-Pomona

Co-Author: Azadeh Jalali, MS, MA, Alliant International University

Jennifer L. Brown, PhD, University of Cincinnati

Title: A Computer-Delivered Alcohol Intervention for Russian Women Living With HIV/HCV: Cultural Adaptation

James P. Loveless, PhD, Middle Tennessee State University

Title: Temporal Changes in the Relationships between Personality Factors and Responses to the Pandemic

Co-Author: Amy Gencarelli, MA, East Carolina University

Co-Author: Myra Pennington, BA, Middle Tennessee State University

Co-Author: Samantha Eisenberg-Godsey, BA, Middle Tennessee State University

Co-Author: D Erik Everhart, PhD, East Carolina University

Co-Author: Alexander Sheppard, BA, Wright State University

Celeena Joseph, BS, Wright State University

Title: Are Some Lives Just Worth Less? an Exploration of Structural Ableism in COVID-19 America

Co-Author: Rachel Wininger, BA, Wright State University

Co-Author: Krista Tice, MA, Wright State University

Co-Author: Wendy Dragon, PhD, Wright State University

Jessica S. Choe, MS, Nova Southeastern University

Title: The Physiological Role and Clinical Implications of Heart Rate Variability in Stress and Depression

Co-Author: Barry Nierenberg, PhD, Nova Southeastern University

Co-Author: Jeffrey Kibler, PhD, Nova Southeastern University

Megan McComas, MA, BA, University of North Carolina at Charlotte

Title: Impact of Social Media Use on Health Following University Shooting

Co-Author: Virginia Gil-Rivas, PhD, University of North Carolina at Charlotte

Co-Author: Rachel Uri, BA, University of North Carolina at Charlotte

Co-Author: Audre Tyner, BA, University of North Carolina at Charlotte

Co-Author: Amelia Hardy, BA, University of North Carolina at Charlotte

**Session ID: 148**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Discussion (A): Pathways to Careers in Health Policy and Program Development	8/14/2021 Sat 60		

Cochair

Maria H. Anastasiades, PsyD, Brooks Rehabilitation Hospital, Jacksonville, FL

Jessica Naftaly, MS, Rosalind Franklin University of Medicine and Science, North Chicago, IL

Participant/1stAuthor

Melissa H. Laitner, PhD, MPH, Society for Women's Health Research, Washington, DC, DC

Title: Pathways to Careers in Health Policy and Program Development

W. Douglas Tynan, PhD, Center for Psychology and Health - APA, Washington, DC, DC

Title: Pathways to Careers in Health Policy and Program Development

**Session ID: 160**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Pain Management in 2021: Understanding the Basics Plus The Impacts of Disparities and a Pandemic	8/14/2021 Sat 60		

Chair

Ravi Prasad, PhD, University of California, Davis School of Medicine, Sacramento, CA

Discussant

Dan Bruns, PsyD, Health Psychology Associates, Greeley, CO

Jennifer Kelly, PhD, Atlanta Center for Behavioral Medicine, Atlanta, GA

**Session ID: 192**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Psychology, HIV Disease, and COVID-19: A Tale of Two Pandemics	8/14/2021 Sat 60		

Chair

Amit Shahane, PhD, University of Virginia School of Medicine, Charlottesville, VA

Participant/1stAuthor

Chanda Graves, PhD, Emory School of Medicine, Atlanta, GA

Title: HIV Disease and COVID-19: Key Pandemic Differences

Rachel Ammirati, PhD, Emory University School of Medicine, Atlanta, GA

Title: HIV Disease and COVID-19: Key Pandemic Similarities

Amit Shahane, PhD, University of Virginia School of Medicine, Charlottesville, VA

Title: HIV Disease and COVID-19: Lessons Learned for the Psychological Response

Discussant

Eugene Farber, PhD, Emory University School of Medicine, Atlanta, GA

**Session ID: 166**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): The Role of Psychologists in the Care and Recovery of Critically Ill COVID-19 Patients	8/14/2021 Sat 60		

Cochair

Erin L. Hall, PsyD, Geisinger Medical Center, Danville, PA

James C. Jackson, PsyD, Vanderbilt University Medical Center, Nashville, TN

Participant/1stAuthor

Erin L. Hall, PsyD, Geisinger Medical Center, Danville, PA

Title: Issues in Caring for Critically Ill COVID-19 Patients

James C. Jackson, PsyD, Vanderbilt University Medical Center, Nashville, TN

Title: Long-Term Issues in Survivors of COVID-19: Focus on Cognitive Impairment and PTSD

Megan Hosey, PhD, Johns Hopkins School of Medicine, Baltimore, MD

Title: Issues in Caring for Family Members of COVID-19 Patients in the ICU

Renee Madathil, PhD, University of Rochester Medical Center, Rochester, NY

Title: Issues in the Rehabilitation of COVID-19 Survivors: A Review of Needs and Opportunities

Discussant

James C. Jackson, PsyD, Vanderbilt University Medical Center, Nashville, TN

**Session ID: 188**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): International Collaborations in Health Psychology: Research Findings, Insights, and Funding	8/14/2021 Sat 60		

Cochair

William Tsai, PhD, New York University, New York, NY

Patricia Moreno, PhD, Northwestern University Feinberg School of Medicine, Chicago, IL

Participant/1stAuthor

Chloe Huelsnitz, PhD, National Cancer Institute, Bethesda, MD

Title: Motivations Associated With Health-Related Social Control Attempts

Manueltiz S. Or, PhD, University of La Frontera, Temuco, Chile

Title: Weight stigma, psychological stress, diet, and obesity in Chilean adults

Joshua F. Wiley, PhD, Monash University, Clayton, Australia

Title: Collaborating to Optimize Treatment for People With Cancer

Discussant

Courtney Barry, PsyD, Medical College of Wisconsin, Wauwatosa, WI

**Session ID: 191**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): The Impact of COVID-19 on Underserved Cancer Patients	8/14/2021 Sat 60		

Cochair

Andrea Hamilton, PhD, New York City Health + Hospitals/Queens and Mount Sinai Hospital, Jamaica, NY

Irina Mindlis, MPH, MA, City University of New York Hunter College, New York, NY

Participant/1stAuthor

Marcie Haydon, MA, University of California–Los Angeles, Los Angeles, CA

Title: Underserved Cancer Patients During the COVID-19 Pandemic: Clinical Implications



Sugandha Gupta, MA, City University of New York Hunter College, New York, NY

Zeba Ahmad, MA, City University of New York Hunter College, New York, NY

## Session ID: 158

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Innovation Amid Crisis: How Psychologists in Healthcare Settings Responded to the Covid-19 Pandemic	8/14/2021 Sat 120		

### Participant/1stAuthor

Megan Hosey, PhD, Johns Hopkins School of Medicine, Baltimore, MD

Title: Psychological Care of the Critically Ill COVID-19 Patient

Amy Williams, PhD, Henry Ford Health System, Detroit, MI

Title: Bioethics, COVID, and the Psychologist in Academic Health Centers

Sheila Dowd, PhD, Rush University Medical Center, Chicago, IL

Title: COVID-19 Innovations: The Center for Clinical Wellness at Rush University Medical Center

Philip Fizur, PsyD, Cooper Medical School at Rowan University, Camden, NJ

Title: Prioritizing each other: Psychologists' role in peer support programs within a health system

Co-Author: Anastasia Bullock, PsyD, Cooper Medical School at Rowan University, Camden, NJ

Claire Houtsma, PhD, Southeast Louisiana Veterans Health Care System, New Orleans, LA

Title: The multi-faceted response of VA psychologists to a pandemic

Co-Author: Joseph Boffa, PhD, Southeast Louisiana Veterans Health Care System, New Orleans, LA

Co-Author: Amanda Raines, PhD, Southeast Louisiana Veterans Health Care System, New Orleans, LA

Co-Author: C. Laurel Franklin, PhD, Southeast Louisiana Veterans Health Care System, New Orleans, LA

Co-Author: Kenneth Jones, PhD, Southeast Louisiana Veterans Health Care System, New Orleans, LA

Joanna S. Yost, PhD, University of Virginia School of Medicine, Charlottesville, VA

Title: Psychology, Frontline Staff, and Covid-19: Development and Implementation of Services and Advocacy

Co-Author: Casey E. Cavanagh, PhD, University of Virginia School of Medicine, Charlottesville, VA

### Cochair

Joanna S. Yost, PhD, University of Virginia School of Medicine, Charlottesville, VA

Casey E. Cavanagh, PhD, University of Virginia School of Medicine, Charlottesville, VA

Discussant

Zeeshan A. Butt, PhD, Northwestern University Feinberg School of Medicine, Chicago, IL

**Session ID: 151**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Discussion (A): Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente	8/14/2021 Sat 120		

Cochair

Anna V. Koper, PsyD, Kaiser Permanente, PLEASANTON, CA

Margot Green, PhD, Kaiser Permanente, Walnut Creek, CA

Participant/1stAuthor

Amy Griffin, PsyD, LCSW, Kaiser Permanente, Antioch, CA

Title: Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente

Jacqueline Shiels, PsyD, Kaiser Permanente, Antioch, CA

Title: Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente

Cassidy Gagnon, MD, Kaiser Permanente, Pleasanton, CA

Title: Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente

Julia P. Polk, MD, Kaiser Permanente, Antioch, CA

Title: Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente

Alena Schabes, PsyD, Kaiser Permanente, Antioch, CA

Title: Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente

Kimberly Saelee, PsyD, Kaiser Permanente, Antioch, CA

Title: Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente

Leeza Reyburn, PsyD, Kaiser Permanente, Sacramento, CA

Title: Strengthening Maternal Infant Resilience: Integrated Trauma-Informed Care at Kaiser Permanente

**Session ID: 159**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): Pain, somatizing and trauma: Explaining and treating medically unexplained conditions	8/14/2021 Sat 120		

Chair

Daniel Bruns, PsyD, MA, Health Psychology Assoc, Greeley, CO

Participant/1stAuthor

Maija Bruzas, PhD, Health Psychology Associates, Greeley, CO

Title: Pain, somatizing and the evolutionary model of trauma

Emma Smith, PsyD, Health Psychology Associates, Greeley, CO

Title: Case Histories: Explaining and treating "medically unexplained conditions."

**Session ID: 187**

Event Title	Day/Time	Facility/Room	Co-Listing Divisions
Symposium (A): "What did you just say?" Strategies to Reduce Overt and Subtle Discrimination in Healthcare Settings	8/14/2021 Sat 120		

Cochair

Lynne H. Unikel, PhD, Albert Einstein Healthcare Network, Philadelphia, PA

Allison J. Carroll, PhD, Northwestern University Feinberg School of Medicine, Chicago, IL

Discussant

Amanda L. Almond, PhD, CUNY- New York City College of Technology, Brooklyn, NY

Participant/1stAuthor

Sean M. Phelan, PhD, Mayo Clinic, Division of Health Care Policy and Research, Rochester, MN

Title: Body Size and Shape Bias in Health Care

Kacey Y. Eichelberger, MD, Prisma Health, Greenville, SC

Title: Systematic Responses to Harassment and Discrimination in Medicine

Joseph W. Kanter, PhD, University of Washington, Seattle, WA

Title: Racial Microaggressions in Patient-Provider Interactions

Jazmine Tooless, DP, DPT, MP, LAMP Institute for Leadership Certificate of Healthcare Leadership, Philadelphia, PA

Title: Healthcare Professionals and Cultural-Diversity Special Interest Groups

Total Number of Sessions: 585

**Society for Health Psychology (Division 38)**  
**CONVENTION SCHEDULE: Minneapolis, MN**

TIME	Wednesday, August 3, 2022	Thursday, August 4, 2022	Friday, August 5, 2022	Saturday, August 6, 2022					
8:00	HRM = Hyatt Regency Minneapolis MCC = Minneapolis Convention Ctr L = Level, Rm = Room	Weight Stigma: Mechanisms & Consequences Hunger/Standen/Leget MCC - L1 - Rm 101B	Leadership Strategies for Psychologists in Academic Health Centers, VAs & Community Hospitals: Interactive Mentoring Coons MCC - L2 - Rm 200GH	(CE): Providers' Perspectives in Pain Care among Linguistic, Cultural, & Ethnic Minority Patients Kim/Nguyen MCC - L1 - Rm 102F	Health Technology Industry Butt MCC - L2 - Rm 202AB	Delivering Value-Based Care in Cardiovascular Populations Smolderen MCC - L1 - Rm 101A			
8:30		DEI & International Collaborations Moreno/Tsai MCC - L1 - Rm 101B		(CE): The Opioid Epidemic: Where we Were, Where we Are, & the Role of Psychology Prasad/Pritzlaff/Bruns MCC - L1 - Rm 101G					
9:00									
9:30									
10:00		APA Council HRM Great Lakes Ballroom	SfHP Presidential Programming: Cancer Research Data Blitz MCC - L1 - Rm 101B		APA Council HRM Great Lakes Ballroom	Health Psychology Research Practicalities: Advice & Opportunities for Students & ECPs Park/Smith/Wagener MCC - L2 - Rm 211A		APA Exhibit Hour	
10:30				APA Main Stage Event		APA Main Stage Event	Health Psychology Poster Session MCC - L1 Exhibit Halls BCD	APA Main Stage Event	
11:00									
11:30									
12:00									
12:30									
1:00			SfHP Presidential Programming: Invited Address NCI at 50 - Implications for the Psychological Care of Cancer Survivors – Rowland MCC - L1 - Rm 101B		APA Presidential Programming, Boards & Committees	2020-21 SfHP Awards Data Blitz Zilioli MCC-L1 Auditorium Rm 1	APA Presidential Programming, Boards & Committees		
1:30			Supporting the Quadruple Aim of Cancer Healthcare Delivery Ehlers/Andersen MCC - L1 - Rm 101C					Health Psychology Honors Data Blitz: Top 2022 Submissions MCC - L1 - Rm 101I	ABPP: Navigating Board Certification in Clinical Health - Steps & Benefits MCC - L2 - Rm 208A
2:00									
2:30									
3:00			(CE): Psycho-Oncology within Head & Neck Cancer Care Williams MCC - L1 - Rm 101E		Pre-Doctoral Internship Panel Konsor/Radico MCC-L1-Rm 101I	Consultation-Liaison Svc Development Yost MCC-L2-Rm 209AB	APA/APF Awards	SfHP Presidential Address: Biobehavioral Research in Cancer Andersen  Membership Meeting & Awards Ceremony Andersen/Coons  MCC-L1 Auditorium Rm 1	APA Closing Event
3:30					Gaining Student Leadership Experience in APA Divisions 38, 54, 17 & 22 Mastrili/Ward-Zimmerman MCC - L1 - Rm 101I				
4:00									
4:30									
5:00	5-9p, SfHP Board of Directors Meeting HRM, 4 <sup>th</sup> Fl, Lake Harriet Rm	APA Exhibit Hour							
5:30									
6:00		6-9p, SfHP Executive Committee HRM – SfHP Suite		6-8p, Networking Event with Health Psychology Training Directors (Internship & Post-Doc) HRM – 2 <sup>nd</sup> Level – Regency Rm		6-730p, SfHP Social Event Brit's Pub - Long Room 1110 Nicollet Mall, Minneapolis			
6:30									

**Society for Health Psychology (Division 38)**  
**2023 CONVENTION SCHEDULE: Washington, DC**

TIME	Wednesday, August 2, 2023		Thursday, August 3, 2023		Friday, August 4, 2023		Saturday, August 5, 2023							
8:00	MM = Marriott Marquis CC = Convention Center				(CE) 8-9a Interventional Pain Medicine vs Behavioral Tx Bruns, Prasad, Kelly CC-L1-140A									
8:30			(CE) 8:30-9:30a Pumping the Pipeline: IPC Training for Doctoral Programs – Ruddy, Vogel CC-L1-145B											
9:00														
9:30					9-11a Leadership Strategies in Academic Health Centers & Hospital Systems Coons CC-L2-202		9-10a Poster Session B CC-L2-HallsD&E							
10:00		10a-5p APA Council  Marriott Marquis	APA Sessions Only				10-11a Poster Session A CC-L2-HallsD&E		10-11a Exhibits Only CC-L2-HallsD&E					
10:30														
11:00					11a-1p Systemic Integrated Healthcare: Context Matters! Ruddy, McDaniel, Vogel CC-L2-204C		11a-1p Growing Advocacy & Policy Efforts in Health Psychology Gillaspy, Smolderen CC-L1-146C		(CE)11a-1p Supporting Well-Being in Healthcare Ferrand, Williams CC-L1-140A		11-1p Integrated Care in Women’s Health: Models, Financing, Outcomes Coons CC-L1-147A		(CE)11a-1p Promoting DEI in Graduate School Weinstein, et al. CC-L1-140B	
11:30														
12:00														
12:30														
1:00			1-2p Pre-Doctoral Internship Panel and Q&A Leite CC-L1-147B				1-2p A Path Forward: Psychologists Advancing Health Equity Kelly, Winford, Miller, Holden CC-L1-146C				1-2p Late Pregnancy Loss: Strategies for Implementing Behavioral Health Programming across Settings Kelleher CC-L1-147A			
1:30			2-3p Transition: Student->ECP Leite, Robison CC-L1-147B				2-3p – SfHP Presidential Programming: Reducing Racism-Related Health Disparities Tucker CC-L1-145B				2-4p The Enigma of Adolescence & Young Adulthood: Clinical Challenges/Medical Illness McKelvey/Allen CC-L1-147A			
2:00														
2:30														
3:00		3-5p Meet & Greet: Health Psychology Training Directors MM-L2 Marquis Salons 9&10												
3:30														
4:00				4-5p Primary Care Behavioral Health Houston, Johnson-Esparza, Gibson-Lopez CC-L1-145B										
4:30														
5:00	5-9p SfHP Board of Directors Meeting Marriott Marquis, Level 4, Archives Room		5-6p Exhibits Only CC-L2-HallsD&E			5-6p The Mental/Physical Health Distinction: Obsolete? Burg, Freedland, Cavanagh, Ehlers, Kessler, Tynan CC-L1-146C								
5:30														
6:00														
6:30			6:30-9p SfHP Executive Committee (MM-suite)			6:30-8p – SfHP Social Event Supra, 1205 11 <sup>th</sup> St NW, Washington, DC								



TIME	Wednesday, August 7, 2024		Thursday, August 8, 2024		Friday, August 9, 2024		Saturday, August 10, 2024	
8:00	SGS = Sheraton Grand Seattle Hotel SCC = Seattle Convention Center				8-9 Career Journeys- Maintaining Wellness Malcore SCC-Arch@800 Pike YakimaL1/Yakima 1	8-9 (CE) - Pre-Surgical Psychological Evaluation Branagan SCC-Arch@705 PikeL6/Rm 606	8-9 Where is DEI Going? Eyer SCC-Arch@705 Pike L2/Rm 2B	8-9 (CE) Psychologists' Influence at the System Level – Bullock SCC-Arch@705 PikeL6/Rm 606
8:30								
9:00		9-4p APA Council SGS-2nd FL Grand Ballroom AB	9-10 Navigating the Path to Board Certification in Clinical Health Psychology Radico, Gomez SGS-Virginia Rm (4 <sup>th</sup> FI-Union St Tower)		9-10 (CE) Pathways to the Specialty Vogel, Berg SCC-Arch@705 Pike-L6/Rm 606		9-10 (CE) - Strategies to Advance Health Equity Ward-Zimmerman SCC-Arch@705 Pike-L6/Rm 609	
9:30								
10:00			10-11(CE) HP Integration on Med Services – Segal SCC-Arch@705 Pike L6/Rm 612	10-11 (CE) Mentorship Model for Research in Academic Med – Hall SCC- Arch@705 Pike L6/Rm 611				
10:30								
11:00			11-12 (CE) Primary Care Journey – Bauman SCC- Arch@705 Pike L6/Rm 612	11-12 (CE) HP’s Role in Communicating Research – Anastasiades SCC-Arch@705 Pike L6/Rm 611				
11:30								
12:00			12-1 Integrated Care- Past/Future – Ruddy SCC- Arch@800 Pike YakimaL1/Yakima 1	12-1 - Community- Engaged Research Strategies - Tan SCC-Arch@705 Pike L2/Rm 2B	12-1 Poster Session I SCC-Arch@705 Pike-L4/Hall4AB			
12:30								
1:00			1-2 Pre-Doctoral Internship Panel Q & A – Ozmeral SCC-Arch@800 Pike- YakimaL1/Yakima 1		1-2 Invited Address: 15 Tips to Ascend the Leadership Hierarchy in Academic Health Centers Linton SCC-Arch@800 Pike-YakimaL1/Yakima 1		1-2 Poster Session II SCC-Arch@705 Pike-L4/Hall4AB	
1:30								
2:00		2-3 Meet the Editor: Health Psychology Ruiz SGS-Virginia Rm (4 <sup>th</sup> FI-Union St Tower)		2-3 (CE) - Helping the Helpers Williams SCC-Arch@705 Pike-L6/Rm 609		2-3 (CE) We Are CL Psychology – Simpson SCC- Arch@705 Pike L6/Rm 606	2-3 Serious Illness: Cope & Plan – Shen SCC-Arch@705 Pike L2/Rm 201	
2:30								
3:00		3-4 (CE) Chronic Pain in Older Adults – Seng SCC-Arch@705 Pike- L6/Rm 609		3-4 (CE) - Connecting the Dots: Engaging the Health Psychology Community to Improve Wellbeing Vogel SCC-Arch@705 Pike-L6/Rm 609		3-4 (CE) Managing Disruptive Behavior through CL Cavanagh SCC-Arch@705 Pike-L6/Rm 606		
3:30								

4:00		4-5 (CE) Future of Pain Psychology – Bruns SCC-Arch@705 Pike- L6/Rm 608	4-5 Psychologist Well-Being: Rock/Hard Place & Ethics Andersen SCC-Arch@800 Pike-YakimaL1/Yakima 1	
4:30				
5:00	5-9p, SfHP Board of Directors Meeting SGS – 2nd FL Cedar Rm		5-6 (CE) - Ethical Issues in AYA Murphy SCC-Arch@705 Pike-L6/Rm 609	
5:30				
6:00		6-7:30 52 Meet & Greet Health Psych Training Directors SGS – 2ndFL Redwood Rm	6-7:30 SfHP Social Event Victor Tavern, 2121 6 <sup>th</sup> Ave, Seattle, WA	
6:30		2		