Association of VA Psychologist Leaders

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Special Double Issue

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MARK YOUR CALENDAR .................................

AVAPL/APA Leadership Conference VII
“VA Psychology Goes To Washington: Working Together To Keep Veterans First”
April 22-24, 2004
Crystal City Marriott
Washington, DC

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APA 2004
7/28/04-8/2/04
Hawaii
See Page 3 for more details.
Association of VA Psychology Leaders

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Greetings

I invite any of you to submit articles, web sites, etc. to the newsletter via Outlook, and my address is june.malone@med.va.gov.

If you would like additional copies of the newsletter, please send me your address with the number of copies you want, and I will mail them to you.

I invite you to share this special double issue of the newsletter with other psychologists at your station and invite them to join AVAPL.

APA Convention 2004
in Hawaii

The 2004 APA convention will be substantially different from previous meetings. **First** of all, it will be in Hawaii, a location noted for sand, sun, and exotic atmosphere. **Secondly**, the program will run from 8am to 2pm each day in an effort to encourage members to combine the annual meeting with a vacation. **Thirdly**, the convention will run from July 28 through August 2, approximately 1-2 weeks earlier than usual. **Fourth**, the cluster programming that was first introduced in Chicago will not be used in Hawaii due to the greater length of the program. Program hours allotted in the divisions will be fewer due to the smaller size of the Honolulu Convention Center, but poster sessions will be given unlimited time. The BCA hopes to encourage poster submissions so that a larger number of members can participate in programming. All in all, Hawaii promises to be a very different kind of APA Convention.

In recent years, the Board of Convention Affairs has noted the steady decline in convention attendance. Recent conventions have attracted only about 5% of the membership. A decision was made to experiment with different formats and different locales in an effort to raise attendance and interest. Future years can expect to see more innovations as APA searches for ways to make the convention a highlight of membership.

Submissions for the 2004 convention are due by Friday, November 14, 2003. The details can be found in the September issue of the Monitor and are also available on APA's website at APA.org. Division 18 has always been flexible and innovative in convention programming, and this year will be no exception. We encourage submissions for posters, symposia, and discussion sessions. Submissions of similar interest may be invited to develop symposia. The format for submissions will be either by mail or email through APA's website. Fax submissions cannot be accepted.

Please encourage your colleagues and students to submit proposals. Division 18 members provide more internship training than any other division, making the training mission of division 18 one of its most prominent features. Our Student Breakfast has grown in popularity and will be scheduled again this year. This is an excellent way for training directors and prospective interns to meet and make contact. Look for more details in the next issue.

We're hoping to make Hawaii 2004 a very special meeting. Don't hesitate to call or email Celia Michael Ph.D., 2004 Program Chair at 505-265-1711 x2440 or celia.michael@med.va.gov or c.a.michael@att.net.
It is pleasing to be able to report to you that we have had a very productive year in what are tumultuous times for our nation and its Federal Health Care systems. Our most recent (April) AVAPL/APA Leadership Conference was a resounding success in the view of virtually everyone who attended. The leadership efforts of Russell Lemle, the planning committee, and the APA Staffers (Anthony Chuukwu and our masterful and loyal liaison, Randy Phelps) made this event interesting, smooth, and informative from gavel to gavel. We managed to get up to date briefings from Central Office leaders, Congressional staffers (including our own Pat DeLeon) and a terrific workshop finale on police evaluations arranged by Bob Gresen. There are so many people deserving of our thanks in this entire effort.

The tensions and uncertainties leading up to the Conference because of the impending war made for many concerns, and we learned some lessons that will be important in planning next year’s event. Also, we unknowingly had our event in close temporal continuity to the biennial APPIC Conference which is something we couldn’t avoid this time, but should make every effort to avoid in the future. Some have even suggested some joint planning to create some form of hybrid that would meet the needs of both organizations. Your thoughts on this would be welcomed by your elected leadership.

In a related set of developments, we have enjoyed increasing communication and progress towards works in common cause with the Division 18 VA Section. Section President Dolly Sadow was a stalwart member of the planning committee for the AVAPL/APA Conference and disseminated information and encouragement to their membership, which I made a point of recognizing from the podium at the Conference. The work we all need to do for VA Psychologists is sufficient to require continuous and close collaboration between APA Practice Directorate, AVAPL, and the Division 18 VA Section. While we are three separate organizations, each of us has a distinctive organizational role and advantage in our existence and operations. VA Psychology represents a vast national practice, training, and research constituency for the Practice Directorate. Every VA Psychologist should be a member of APA and would (and should) be ashamed not to if they realized the full extent of what our national association does for us. AVAPL has a distinctive role to play as a private professional association not part of the APA apparatus. Under the AVAPL umbrella and in coordinated action with APA we can be welcomed (and are) into the highest level of VA administration and their congressional oversight offices to hear our concerns without problem or conflict as government employees. The welcome that this organization has created and fostered in congress and Central Office is simply priceless.

The Division 18 VA Section has a distinctive place in the APA organizational chart and constitutes our link to a Public Service or Institutional Practice constituency more broadly. Sections and Divisions of APA cannot go off on their own policy and lobbying expeditions except with the collaboration and blessing of the association more generally, but we have managed to create a rather unique troika of organizations that makes sense and confers advantages.

Thus, there is a good case to be made for each VA Psychologist to be a part of all three constituencies. There is no practical or productive reason for those in administrative or clinical leadership positions to view themselves as being in any different place or having any more necessary permanence and tenure in the VA system than the newest Staff Psychologist. Events of the last decade have shown that to be a proven hypothesis (p<.001). I have offered the phrase, “Every Psychologist a Leader”, as the sound bite motto and justification for AVAPL Membership and I mean it. If we want opportunities and our careers and profession to move forward, we need to think of ourselves in
this way and act like it. That is not to say there won’t be difficulties in actualizing such a self-image, but this has always been the case in VA when you look back carefully at history. The other reason to comport ourselves this way rests simply in the comparison of what this means for our well-being and sense of self-efficacy when compared to the embrace of professional victimhood and dissolute despair.

Finally, in this regard I want to emphasize that whatever past differences between VA psychology membership groups or constituencies based upon “chief versus staff” status within the VA are just not productive ones anymore. Or to put it in video speak, “that is SO over”. Any out there with unburied hatchets should get digging, please. We need each other now more than ever.

It appears that APA Convention in Toronto will be going forward as planned, which is just a recent certainty as this column is being written. Public Health concerns about SARS has been weighed carefully and thought to merit our going ahead with the APA conference. This is just one more in the clouds of uncertainty that have been overhead this year on an almost continuous basis.

As a final bit of update, I want to let you know that the progress in exploring the Title 38 Hybrid status for psychology seems to have gather some momentum. As many of you know already, the House Congressional Staffers – both majority and minority – requested a white paper outlining our rationale for legislation arising from Congress, since repeated attempts to push it through the Executive branch in both Republican and Democratic administrations have stalled, even though VA Central Office has been a supporter of Psychology (among a total of 17 professions) going Hybrid 38.

There is a lot to this that cannot be spelled out fully here, but a couple of things are vitally important to know and tell your colleagues. First, any change to Hybrid Title 38 status would apply to those hired after its adoption, and would only be applicable to those current employees who sought conversion themselves.

There are many features of Hybrid status, but the ones we are examining do not gut due process protections for employees. So any change that goes forward as we see it now will have a very big up side in terms of flexibility in appointment, compensation in a person-based rather than position-based system, and appropriate protections. The down side is minimal. More as we know it.

One other caveat about our Title 38 efforts is that we are trying to adopt a personnel change in law for reasons having to do with improved hiring, pay, and access to promotions. There is a great temptation here to see this as a holiday tree and to want to jump in to hand amendment ornaments about Board Certification, prescriptive authority, and other agendas. Simply put, it ain’t going to happen in the legislative language, but will be more generically indicated and defined in subsequent regulatory language whose creation will hear our voice as input, if we are reading the omens correctly. So save the e-mails about you favorite board or the one you see as a fleabag. It really doesn’t matter whether you like Board Certification or not. It’s part of a health competencies culture that has tremendous sway in this country. I would counsel my colleagues to study carefully how our medicine and nursing colleagues have structured their competency systems.

In conclusion, I believe that we are living in the proverbial “exciting times” expressed so often in the Chinese proverb of well-wishing. Frankly they have been a little more exciting and uncertain than I would like, but I have a sense that we better get used to it. For those of you who are, or soon will have the privilege or seeing and caring for our most recent veterans back from the Middle East, please share your experience and expertise with your colleagues. After the heroes are welcomed, there will be work to do.

Ken Adams
President AVAPL
First and foremost, the AVAPL conference planning committee deserves a big round of applause for putting on yet another very successful conference in Denver. As always, Dr. Russell Lemle and his committee did an extraordinary job, and did so under unusually adverse conditions which included cancellations by several keynote speakers due to the war in Iraq. Despite all of this, conference attendees expressed great satisfaction with the conference and noted the important benefits received from their attendance. Congratulations to all on an exceptionally good conference.

In my last article for the Newsletter, I reported on progress toward getting a directive signed that would establish a Psychology Executive at each facility. At the time I wrote the last article, I was quite optimistic that the directive would be signed quickly. Unfortunately that has not happened. However, the Under Secretary for Health has reaffirmed his commitment to issuing the directive and specifically wanted me to assure those in attendance at the AVAPL conference of his intention to sign it. As a result, I remain hopeful that the Psychology Executive directive will be signed and issued to the field.

It is also important to recognize the important role that the AVAPL Executive Committee played during their visit to Washington at the end of February. The Executive Committee met with high-ranking Central Office leaders and had a very fruitful meeting with Dr. Roswell. It was during their meeting with the Under Secretary that he read the Psychology Executive directive and determined that he wanted to sign it. The Executive Committee’s meetings in Central Office and in particular, the meeting with Dr. Roswell, were very productive and helped to cement the excellent relationship the AVAPL has established with the Under Secretary.

On more generic mental health issues, I would like to report that the Interdisciplinary Fellowship in Psychosocial Rehabilitation is moving along well and all three sites have successfully recruited Psychology fellows. The three sites are having some difficulty recruiting fellows in some of the other disciplines, but the Psychology positions have been filled. This is great news because it will firmly establish Psychology as the lead profession for psychosocial rehabilitation in VHA. As I have stressed several times on conference calls and during various talks that I have given, VHA is moving toward a model of mental health treatment that is based on a two-pronged approach – psychopharmacology and psychosocial rehabilitation. The more that psychologists can be seen to be the leaders in psychosocial rehabilitation the more that we will be able to establish ourselves as the leadership in mental health treatment in VHA. It is important to remember that psychosocial rehabilitation encompasses a broad array of interventions ranging from cognitive behavioral therapy, to social skills training, to independent living, to vocational skills training, and includes VHA’s version of assertive community treatment, Mental Health Intensive Case Management programs. I have previously encouraged psychologists to take leadership roles in as many of these areas as possible, and I’d like to encourage this again. Psychologists have been at the forefront of developing and testing many of these interventions and Psychologists should be the directors of these programs wherever possible. Many of the psychosocial rehabilitation interventions are the ones with the greatest research base behind them and have demonstrated efficacy on non-VHA populations. With Psychologists as directors of these programs in VHA, fidelity to the proven models can be assured and where possible, additional research using veterans could be undertaken, establishing efficacy or effectiveness in veteran populations. This would be a tremendous accomplishment, not only for Psychology in VHA but for our veteran patients as well.

Many of those that read this column are also involved in the internship and post-doctoral fellows training programs. As most of you know, we have accumulated several “floater” or temporary positions that have been given out on
a one-year basis for the past few years. The Office of Academic Affiliations plans to issue a Request for Proposals (RFP) that will allow facilities to compete for these positions. If interested, watch for this announcement which should be coming out over the summer months.

Lastly, I want to encourage as many psychologists as possible to attend the annual convention of the American Psychological Association in Toronto this August. In addition to the substantive meetings and the many VA meetings that take place each year and are planned again this year, there are many special events that will take place this year because of special relationship that exists with the Canadian Psychological Association. Toronto is a lovely city with a great international flavor and I encourage all who can attend, to do so. And, most importantly, be sure to attend all of the VA meetings and the substantive sessions where our VA colleagues will be presenting. Please be sure to come to the VHA Mental Health Strategic Health Care Group meeting which will be held on Friday, August 8 from 1 – 2:50 pm in the British Columbia Room of the Fairmont Royal York Hotel. I look forward to seeing all of you there.

Mary A. Jansen, Ph.D.
Deputy Chief Consultant

VA Psychologists on Editorial Boards

Robert. R. Hutzell, Ph.D.
Editor of The International Forum for Logotherapy
Editorial Board of Psychological Services
Reviewer for the Journal of Traumatic Stress
Member of the International Board of Editors of a multi-language European journal titled Logotherapy & Existential Analysis Journal

NOTE: In past issues we have acknowledged VA Psychologists who are members of editorial boards. If you are or know someone who is on an Editorial Board and want that recognized in our newsletter, send the information to the newsletter editor – june.malone@med.va.gov.
Dr. Adams presented the agenda for the meeting as well as the schedule for the upcoming week of meetings. Dr. Fischer presented the treasurer’s report, which shows a present balance of $15,797.04 dollars with 145 paid members. The institution of an “early-bird” dues price from October first through December 31st prompted members to pay in a more timely fashion. The Board discussed ways of increasing membership and new leadership in AVAPL. The Board discussed the issues to be focused on during our visits with the leadership of VACO, APA, and legislators and their staffers. Some of the key issues to discuss during our meetings this week include:

1. The decrease in the quality of services psychologists are able to provide because of current budget cuts. We have fewer psychologists being asked to do more.
2. The issue of de-professionalization – hiring unqualified and untrained staff to provide psychological services
3. Equality of access to leadership positions and the benefits of passing Hybrid Title 38
4. Increasing consistency and retaining high professional standards in patient services by the implication of a VHA Directive that institutes a Psychology Executive at every VA station.
5. The value of psychological services in all aspects of health care.

We met with Dr. Mary Jansen, Ph.D. Deputy Chief Consultant, MHSHG, to go over the issues to be discussed during the week. Dr. Jansen always welcomes AVAPL officers with open arms. The major topic of discussion with Dr. Jansen was the need for the VHA Directive that establishes a Psychology Executive at all VA stations to be signed by Dr. Roswell. The Psychology Executive would serve as a liaison with other services or care lines, other facilities, VISN offices and VACO for psychology matters. Additionally, the Psychology Executive would be responsible for monitoring compliance with psychology professional standards and providing guidelines for service delivery at the medical center. The PE would oversee clinical privileging and scope of practice issues as well as participate in the development of performance standards for psychologists, monitor the quality of services provided, and participate in the development of position descriptions for Psychologists.

We then met with Jill E. Manske, ACSW, LISW, Director, Social Work Service, VACO, who enthusiastically talked about her work in this position at VACO. The Social Workers were able to get their Directive establishing a SW Executive passed. She agreed that not having someone in this position creates problems with professional standards and quality of care. She also talked about some of the projects her office is involved in: an informal mentor program which consists of monthly conference calls to learn leadership skills, presentations to recruit Social Workers to serve on 1 of 6 committees (Public Relations, Information Management, Education, Resource Planning, Research, and Professional
Standards). [Individuals actually apply to be on these committees!] Her office also puts out the SYNERGY, the SWS National Newsletter.

The AVAPL Board met with Robert Gresen, Ph.D. Chief, Treatment Services Division, VACO, to discuss our concerns about psychology within the VA system. Dr. Gresen made some helpful suggestions regarding our lobbying efforts to pass Title 38 and the Psychology Directive. Dr. Gresen encouraged AVAPL members to find out what is going on at the VISN level and how that impacts mental health care.

Our last visit of the day was to Richard Suchinski, MD, Assoc. Chief Consultant, Substance Abuse Disorders, MHSG. Dr. Suchinski explained the financial challenges in maintaining quality treatment for substance abuse since funding for treatment has decreased 47.5% from 1995-2002.

Dr. Judith Patterson met individually with Tom Holohan, M.D. Chief Patient Services Officer to discuss some of psychology’s current concerns about patient safety and the hiring and retention of psychologists throughout the VA system.

Tuesday, February 25, 2003

The Board began our Tuesday visits meeting with Stephanie Pincus, M.D, Chief Academic Affiliations Officer; Linda Johnson, RN, Ph.D., Acting Director, Associated Health Education Office; and Dr. Gloria Holland, Staff Assistant, from the Office of Academic Affiliations. Our discussion focused on the current status of postdoctoral programs and other training programs in the VA. Dr. Johnson reported that MIRREC-funded postdocs are now available for a 3rd year of postdoctoral training if necessary. She also reported that Congress passed a bill that the VA must have four Bioterrorism Programs in place, but unfortunately, did not designate funding sources for these programs.

Our next visit was with Larry Lehmann, MD, Chief Consultant Mental Health Strategic Group. The topic of discussion with Dr. Lehman focused on the importance of Succession Planning. This is necessary in order to bring younger people in to the VA system.

The Board, Dr. Mary Jansen, and Dr. Larry Lehmann met with Dr. Robert Roswell, M.D., Under Secretary of Health, to discuss the current status of health care in the VA. Dr. Roswell talked about some of the challenges facing the VHA today: finding new revenue to continue quality care for veterans or limiting the current demand for VA healthcare services; managing the demand for services more efficiently by reducing the waits for primary care and long-term care. Dr. Roswell suggests shifting from a “provider-centric” to a “patient-centric” orientation in the method of care. The key to this concept of healthcare is coordinated care that focuses on the patient and his or her needs instead of the needs of the institution. The remainder of our visit with Dr. Roswell covered the Psychology Directive written by Dr. Mary Jansen implementing a Psychology Executive in every VA. After a lively discussion, Dr. Roswell indicated that he would support the Directive with a minor change in wording.

We then visited Dr. Randy Taylor, Acting NOB Staff Officer for an update on the Baldridge Program and Brian McVeigh, Program Analyst, Management Support Office to talk about Hybrid Title 38. Mr. McVeigh reiterated the advantage of Title 38 is direct hire authority without going through the competitive civil service examining process. Also Title 38 is a rank-in-person system rather than a rank-in-position system (which Title 5 is). Mr. McVeigh reported that psychology is 1 of 17 disciplines included under Title 38 in Dr. Roswell’s general legislative package.
APA Executive Offices  
Wednesday, February 26, 2003

The executive Board spent the day at VA headquarters meeting with program directors and staff. Our day of meetings began with Russ Newman, Ph.D., J.D., Executive Director of the Practice Directorate and Randy Phelps, Ph.D. Administrative Director to discuss professional issues confronting VA psychologists as well as AVAPL organizational concerns.

We then met with Cynthia Belar, Ph.D. Susan Zlotzow, Ph.D., and Nina Levitt, from the Education Directorate. Dr. Belar announced the Directorate’s good news that Congress approved $6 million for psychology education and training in the Bureau of Health Professions. Three million is earmarked to continue the Graduate Education Program (GPE) overall and an additional 3 million is designated to support graduate training in geropsychology. Dr. Zlotzow explained the guidelines for postdoctoral accreditation and current issues facing psychology internship programs.

We met with Dr. Kurt Salzinger, Ph.D., Executive Director for Science and Heather Kelly, Ph.D., Senior Legislative & Federal Affairs Office in the Public Policy Office. Dr. Salzinger gave an overview of the Science Directorate’s activities during the last year. Dr. Heather Kelly gave an update on the Science Public Policy Office that included information on current VA research. She also offered to assist with the Research SIG.

The Board met with Henry Tomes, Ph.D. Executive Director of the Public Interest Directorate, Robin Kelly Ph.D., BSSV Program, and Diane Elmore, Ph.D., SPSSI Scholar, Public Policy Office. Dr. Tomes discussed some of the Directorate’s current projects during the last year: end of life issues for children, the International Conference on Work, Stress, & Health, and the Summit on Women and Depression. End of Life issues and Aids education continue to be a major focus of the Public Interest Directorate.

Our last meeting was with Michael Honaker, Ph.D., Chief Operating Officer and Deputy Chief Executive Officer who was filling in for Dr. Anderson for the day. Dr. Honaker talked about some of the current challenges facing APA in today’s economy and briefly explained some adjustments made in staff work time. Dr. Honaker also described Dr. Norman Anderson’s goals for APA.

Capitol Hill Visits  
Thursday, February 28, 2002

We addressed our key issues at all of the visits on Capitol Hill:

1. The decrease in the quality of services psychologists are able to provide because of current budget cuts,
2. The issue of de-professionalization – hiring unqualified and untrained staff to provide psychological services
3. Equality of access to leadership positions for psychologists and the status of Hybrid Title 38
4. Increasing consistency in patient services in the midst of decentralized networks
5. The specialized training of psychologists to provide evidence-based treatments
6. The use of psychological services to reduce overall health care costs.

We met with John Bradley, Majority Staff Director, and Susan C. Edgerton, Minority Staff Director, House of Representatives Staff, Committee on Veterans Affairs. The focus of our visit with Mr. Bradley and Ms. Edgerton was the proposed budget for 2004 and the importance of getting Title 38 passed. Mr. Bradley asked the Board to come up with a white paper addressing the critical reasons psychologists need to be under Title 38 promised to work on getting it passed from the legislative side.
Pat Deleon, Ph.D. Executive Assistant to Senator Daniel Inouye graciously took us to lunch in the Senate Dining Room. Accompanying us was Senator Inouye's Congressional Detaillee, Captain Kathleen M. Pierce U.S. Navy.

After lunch, we met with William Cahill, Professional Staff Member, Senate Committee on Veterans Affairs and Alexa K. Grollman, Legislative Aide. We discussed Title 38, psychologists’ expertise in teaching coping skills and resiliency to veterans and civilians, and VA’s mandate to develop Terrorists Centers. We stopped to see Alexandra Sardegna, Legislative Assistant for Health Programs, and Julie Fischer.

Friday, March 3, 2002

Even though Fran Murphy M.D, Co-Chair, Commission on Older Adults holds a new position, she was kind enough to meet with the Board to discuss the status of some of the issues discussed last year and make suggestions for our lobbying efforts in getting Title 38 and the Psychology Directive passed. Our last visit was with Louise van Diepen, Assistant to Dr. John Perlin, to discuss the status of the Psychology Directive.

Plans for next year’s Mid-Winter Meetings are already in progress. Be sure to let one of the officers in AVAPL know about issues that you would like discussed at these very important meetings.
Psychological Health Care

From my current vantage point as both a dean of a graduate school of psychology and an officer of the American Psychological Association, I have a unique opportunity to reflect on the evolution of professional psychology. The scope of psychological practice is expanding and diversifying into new areas -- areas where the distinction between applied scientist and professional practitioner begins to blur -- such as health psychology (and its related aspects such as psychology in primary care, psychoneuroimmunology, and applied psychophysiology), neuropsychology, rehabilitation psychology, forensic psychology, child and family psychology, multicultural psychology, geropsychology, business and industry consultation, and psychopharmacology. It cannot be emphasized enough that the future evolution of professional psychology will entail the development of roles that do not now exist - in health care, public sector care, the courts, the correctional system, schools, businesses, etc. - in the numbers that psychologists entered the role of outpatient therapists in the 1970s and 80s.

In this column I want to highlight the new opportunities for expanding the roles of professional psychologists in psychological health care. I will first discuss the redefinition of psychology from specialty mental health care to primary health care and then take up the psychological management of disease and health.

Redefinition: From Specialty Mental Health Care to Primary Health Care

One of the most important aspects of the evolving nature of professional practice: is the redefinition of psychology from specialty mental health care to primary health care. As a specialty profession of mental health care, we deal primarily with the people who self-identify as having psychological problems and who have access to a mental health specialist, which is just a fraction of those who need psychological services. As a primary health care profession we would be able to serve the much larger group of people who do not have access to mental health care or who do not identify their problem as psychological. To grasp this potential, please consider a few facts about health care: (1) The U.S. Department of Health and Human services has pointed out the seven top health risk factors—tobacco use, diet, alcohol, unintentional injuries, suicide, violence, and unsafe sex—are behavioral; (2) Seven out of the nine leading causes of death have significant behavioral components (McGinnis & Foege, 1993); (3) At least 50% (and maybe as much as 75%) of all visits to
primary care medical personnel are for problems with a psychological origin (including those who present with frank mental health problems and those who somatize) or psychological component (including those with unhealthy lifestyle habits such as smoking, those with chronic illnesses, and those with medical compliance issues); (4).

Moreover, there is a growing body of empirical evidence supporting the effectiveness of psychological interventions in ameliorating a wide range of physical health problems, including both acute and chronic disease affecting literally every organ system and encompassing pediatric, adult and geriatric populations. In addition to being clinically effective, these interventions are dramatically less expensive than alternative somatic interventions across a wide variety of illnesses and disorders, including cardiovascular disease, diabetes, traumatic brain injury, etc. (5) The vast majority of people receiving mental health treatment are cared for by medical professionals with minimal specific training in mental health.

The Cartesian world view, which separates mental health from physical health, is breaking down, and as a result psychology has a tremendous opportunity to evolve into a premier primary health care profession. At the very least this would put psychologists on the front lines of health care, working collaboratively with physicians and nurses. The more visionary perspective is that health care should be reorganized so that psychologists serve as primary caregivers at the gateway to the health care system, functioning to diagnose and treat the more prevalent psychological problems, and referring to medical physicians when indicated.

Psychological Management of Disease and Health

Over the past several years, it has been a consistently predicted that psychology’s potential contribution to the prevention, assessment, treatment, and management of acute and chronic illnesses will play an important role in the future development of the profession. Much of the work in health psychology—and a significant opportunity for the field of psychology in general—focuses on behavioral contributors to health and disease (Newman & Reed, 1996).

Moreover, as noted, psychological interventions are effective and cost-effective in ameliorating a wide range of physical health problems. For example, data regarding the efficacy and cost-effectiveness of psychological interventions for chronic pain are so compelling that the National Institutes of Health (NIH) published a consensus statement calling for wider acceptance and use of behavioral treatments in conjunction with typical medical care (NIH, 1995). In primary care settings, medical utilization can be substantially reduced through the availability of behavioral interventions. Total ambulatory care visits have been shown to decrease an average of 17 percent, with even greater reductions when visits for specific illnesses such as asthma (49 percent) and arthritis (40 percent) are tracked (Sobel, 1994).

All of this suggests a huge potential market for psychological services in health care systems. In order to access these opportunities, however, psychology must define itself as a health profession rather than as a mental health profession. In fact, the APA Board of Professional Affairs Work Group on Expanding the Role of
Psychology in the Health Care Delivery System has recently called for a “figure-ground reversal” in professional psychology (APA, 2000). That is, rather than viewing itself as a mental health profession with health psychology representing a subset of its expertise, the group advocated a view of psychology as a health profession, with mental health as a subset of its expertise.

Psychologists’ core skills in assessment and treatment can be integrated with roles in supervision, administration, program design, program evaluation, and research. As a consequence, psychologists are uniquely positioned to assume a greater role in the management of both health and disease. Potential functions include coordinating complex interventions, assisting patients to evaluate and select among treatment options, helping people to make necessary lifestyle changes and to comply with complex and difficult treatment regimens, and providing treatment for coexisting psychological problems as well as the psychological and emotional reactions of patients, their families, and other health care providers. Further, our strong research background—a unique qualification of psychologists among health care professionals—prepares us to play key roles in the design, implementation, and evaluation of prevention, and intervention programs at the individual, system, and community level.

A serious limitation on psychologists’ ability to participate in integrated care has been the absence of payment mechanisms to reimburse psychological services within general health care settings. Psychologists have not been permitted to bill under procedure codes such as evaluation and management of medical disorders, patient education, and preventative services. As a consequence, they were forced to bill under mental health codes, which are often inappropriate, or to make arrangements with systems to bundle their services (e.g., using DRG or per diem methodologies). Moreover, psychologists frequently do not have access to reimbursement for services provided to patients related to non-psychiatric diagnoses, even when these services are well accepted clinically and are strongly supported by the empirical literature. However, the recent approval of the Health and Behavior codes for psychologists will begin to address these problems.

Some of the more specific trends in health care also have implications for psychology. For example, information about genetic factors in a variety of diseases and disorders is rapidly becoming available, largely as a result of the Human Genome Project, and genetic testing is becoming increasingly common. Genetic testing will confront people with profound choices and decisions. Assisting people to evaluate the available information, make appropriate choices, and implement preventative programs are roles that psychologists may fulfill in the future (see Shiloh, 1996). The aging of our society will also present significant opportunities for psychologists to enter health and disease management in the geriatric area (see Haley, Salzberg, & Barrett, 1993; Qualls, 1998; Takamura, 1998). As a part of a large and growing interest in complementary or alternative medicine (see Eisenberg et al., 1998), Americans are increasingly consuming herbal and nutritional remedies for a variety of prevention and treatment.
purposes. As an aspect of their practice, psychologists can play a key role in helping consumers to evaluate the available empirical data about the effects and the effectiveness of these remedies.

As always, I welcome your thoughts on this column. You can most easily contact me via email: Rlevant@aol.com.

1 Sections of this column were adapted, with permission, from Levant, R., Reed, G., Ragusea, S., Stout, C., DiCowden, M., Murphy, M., Sullivan, F., & Craig, P (2001). Envisioning and accessing new roles for professional psychology. Professional Psychology: Research and Practice, 32, 79-87. Copyright 2001 by the American Psychological Association. Adapted with permission.

References


This article was submitted to the AVAPL Executive Board for inclusion in the newsletter. If others of you have similar articles that you would like to see in the newsletter, please send them to June Malone, AVAPL Newsletter Editor (june.malone@med.va.gov).
On February 12, 2003, Congress approved a three-fold increase for the Graduate Psychology Education (GPE) Program in the U.S. Department of Health and Human Services. Despite tight budget allocations and other pressing considerations, Congress approved $6 million for psychology education and training in the Bureau of Health Professions (BHPr): $3 million to continue the GPE Program overall, and an additional $3 million to support graduate training in geropsychology within the GPE.

**Background**

This unique program was established in FY 2002 to support the training of health service psychologists and to meet demonstrated needs for integrated, interdisciplinary health care services for underserved populations and in areas of emerging need (e.g., elderly, children, rural persons, chronically ill, and victims of abuse and trauma). With an initial start-up funding of $2 million, last year, 18 GPE grants were awarded, including one to the MCG-VAMC consortium (Medical College of Georgia Research Institute and Veterans Medical Center), which provides health care for veterans, children and individuals with chronic illness.

The GPE initiative has been the top legislative priority for the APA Education Directorate and Education Advocacy staff and the culmination of tremendous grassroots efforts. It is especially noteworthy that the GPE program advances the recognition of psychology as an essential health profession of national significance within the BHPr, which is charged with “coordinating, evaluating, and supporting the development and utilization of the Nation’s health personnel.”

Much of the credit for the “big win” with the FY2003 $6 million for GPE goes to APA members across the nation, who provided the critically needed grassroots support. APA member Herbert Goldstein, PhD (of St. Petersburg, FL), successfully launched an effort to gain first-ever FY 2002 funding for the GPE program, by enlisting the support of Representative Bill Young (R-FL), Chair of the full House Appropriations Committee. In addition, APA member Robert Devies, PhD (of Alliance, Ohio) was instrumental in garnering the support of Representative Ralph Regula (R-OH), Chair of the House Labor-Health and Human Services-Education Appropriations Subcommittee.

In addition, Peter Nathan, PhD, of the University of Iowa, with the help of the Education Directorate and the Iowa Psychological Association, hosted a reception honoring Senator Tom Harkin (D-IA), Chair of the Senate Labor-HHS-Education Appropriations Subcommittee. Senator Harkin’s support for GPE was evident in the final Senate bill, which included specific instruction in the committee report to continue GPE with a separate geropsychology component in FY 2003.

Finally, members of APA’s Committee on Aging, as well as APA grassroots networks, including the newly established Federal Education Advocacy Coordinators (FEDAC) network, played a vital role in
participating in visits on Capitol Hill, sending letters and making calls to their members of Congress in support of the GPE program.

GPE Program Overview

The Graduate Psychology Education (GPE) program provides funds to train health service psychologists to work with other health professionals in the provision of services to underserved populations (e.g., children, rural persons, chronically ill, and victims of abuse and trauma). In addition, funding to train geropsychologists who provide health care services to older persons will be established in 2003. Funding is provided through a competitive grant process to APA - accredited doctoral and internship (or postdoctoral residencies if allowed by the agency) programs for basic or advanced training. Allowable use of funds is likely to include trainee stipends, support for clinical teaching psychologists, faculty and curriculum development, model demonstration programs and technical assistance.

Last year approximately 65 applications were received, and 18 grants awarded. The request for proposals (RFP) was announced on April 2nd, 2002, in the Federal Register, and application materials were made available at the Bureau of Health Professions website with links from the APA website. Technical assistance was provided through a series of conference calls arranged following the Federal Register announcement. In addition, a Peer Review Panel made up of psychologists from around the country met in the summer to review the grant applications. Funds for FY 2002 were disbursed on September 30, 2002 (the last day of the fiscal year). A similar schedule is expected for the FY 2003 funding cycle.

Further information about the GPE grant program can be found at the BHPr website http://bhpr.hrsa.gov. In addition, APA’s Education Advocacy staff will send out announcements on various psychology training listservs, and provide updates and information about GPE FY 2003 funding and application process on its own website http://www.apa.org/ppo/edppo.html.

Submitted by Sheila Forsyth
Co-sponsored with the American Psychological Association Practice Directorate, AVAPL hosted its sixth annual VA Psychology Leadership Conference on April 3-6, 2003 at the Hyatt Regency, Denver. The first week of April coincided with early, uncertain beginnings of the Iraq War and it played as the backdrop of our event. Ken Adams, Ph.D., AVAPL President opened each day with a minute of reflection, and several presentations addressed resilience in the face of trauma. The war acutely reminded us not only of fulfilling our primary mission in serving veterans, but also how all persons and organizations can best respond to adversity.

As in every year since its inception, APA’s abiding commitment to the conference was ubiquitous. Robert Sternberg, President, APA, Russ Newman, Ph.D., J.D. Executive Director, APA Practice Directorate, and Pat DeLeon, Ph.D., J.D. Past-President APA all presented. Randy Phelps, Ph.D., Administrative Director, APA Practice Directorate, reiterated the vital importance of this conference to APA and how it is a time when we put our collective shoulders to the wheel. The invaluable Anthony Chuukwu, Finance/Professional Issues Associate of the APA Practice Directorate held all the pieces together. Our gratitude and respect are enormous.

The conference served to strengthen and deepen our connections with each other, always a primary objective of the meeting. We used the time to network, commiserate and join together in shaping the future of Psychology in the VHA. A number of psychologists noted that our annual conference is their single most important professional activity. A related thought of mine: Every presentation about resilience noted that “social support” and “accurate information” were two of the most essential predictors of positive response to trauma. Though of course they were alluding to individuals, it was an apt analogy to AVAPL. These were the cornerstones of this conference in building organizational resilience to deal with the enduring impact of the VHA’s restructuring.

Both Robert Roswell, M.D., Under Secretary for Health, Department of Veterans Affairs and Anthony Principi, Secretary Department of Veterans Affairs had intended to attend. The Iraq War necessitated that they remain in Washington, D.C. but they sent remarks (included elsewhere in this issue). Secretary Principi observed that Psychology’s professional leadership and dedication with veterans has made the DVA a world leader in mental health treatment. Dr. Roswell forwarded two items to convey. First was his full commitment to signing the Psychology Executive Directive, the importance of which all of us in the room well appreciated. Second, he forecast that PTSD engendered in the Iraq conflict would surpass what occurred in Vietnam and he challenged psychologists at every station to take proactive leadership roles to meet the needs of returning soldiers.

The theme of this year’s conference was “Added Value and Expanding Roles of VA Psychologists.” The featured role was helping to build resilience. APA’s Public Education had made this a priority for the past two years and Russ Newman, Ph.D., J.D. updated this endeavor in times of terrorism and war. He observed that psychologists are the profession best suited to aid patients, their families, employees and the public to move forward in spite of uncertainties and external threat. The APA website (http://helping.apa.org/resilience/war.html) is a superb resource to assist us. Russ also urged us to be “loud” advocates -- to team up with our
colleagues to redress disadvantages that still confront us as a profession.

A VA panel on Disaster Response and Resiliency followed Russ’s address. Judy Patterson, Ph.D., Past-President of AVAPL, was the moving force in getting this topic on our agenda. She encouraged us to join with APA and utilize their extensive materials to promote growth amidst adversity. Jim Breckenridge, Ph.D., Chief Psychology Service, Palo Alto VAMC, discussed the soon-to-be opened National Center on Disaster Psychology and Terrorism of which he is a co-director. Jim reported that active coping and resiliency can definitely be taught. It is important to stay current with the literature since some interventions, such as Critical Incident Debriefing, have not been confirmed to be effective.

Larry Lehmann, M.D. Chief Consultant, VHA Mental Health Strategic Healthcare Group, who also remained in D.C. as a consequence of the Iraq conflict, delivered his planned presentation via audio hookup. Larry reviewed the VA’s national efforts with disaster response, dating to the 1989 Loma Prieta earthquake. He commended the VA National Center for PTSD website (www.ncptsd.org) for its guidelines for mass casualty situations and reminded us how “stress responses” go well beyond PTSD diagnoses. Larry’s concerted effort to make his three live presentations from two time zones away were a demonstration of his abiding support for this conference, for which we are grateful (and for Jim Williams as well, who again made the trip to be with us).

The success of the audio feeds was a mixed blessing for it hinted at the possibility of teleconferencing in lieu of in-person gatherings. I have no uncertainty that this conference succeeds because we personally come together. There is no electronic substitute. I strongly believe that the face-to-face contact we have at these conferences has also led to more interactive monthly conference calls and consultative e-mailings and has bolstered our individual and collective efforts as psychology leaders.

A second major panel topic for the conference was the work of the SMI Committee. Matt Blusewicz, Ph.D., Associate Chief of Staff/Mental Health, Northern California Health Care System and Steve Cavicchia, Psy.D., Co-Chair, Committee on Care of Veterans with Serious Mental Illness, ACOS, Mental Health Patient Care Line, Coatesville VAMC reviewed the history of the committee since it was established in 1996. It was created to render direct advice to the Under Secretary and Congress (annually) to ensure that capacity within mental health programs does not decline below FY96 levels. Among the accomplishments it has been involved with include: (a) the number of MHICM teams increasing 49% and the number of SMI patients treated up 37%, (b) MIRECCs establishing SMI research centers (c) the Psychosis Registry tracking patients to maintain capacity, (d) recommendation that CBOCs include mental health staffing standards, (e) recommendation that Medical Center Directors performance measures include SMI treatment and (f) CARES Committees at the VISN and lower levels include mental health representation. Steve summarized 19 recommendations that the committee made in its Seventh Annual Report to the Undersecretary for Health.

Also on the SMI panel were Mary Jansen, Ph.D., Deputy Chief Consultant, VHA Mental Health Strategic Healthcare Group), Fred Frese, Ph.D. Coordinator, Summit County (Ohio) Recovery Project, and Larry Lehmann. Mary summarized the Capacity Report and staffing levels. Staffing for mental health programs is at 76% of 1996 levels, although capacity is within acceptable levels with the exception of in Substance Abuse. Larry reported on work in progress to ensure that patients do not fall through the cracks as budgets get leaner. One recent idea is “Just in Time Care,” a facility-community coordination that encourages patients to drop in to clinics at the point that they are having problems.

Fred Frese gave undoubtedly the most rousing talk of the conference. The tremendous gains in pharmacological treatments of schizophrenia have opened the door for psychological interventions with attention, memory, executive decision-making, vocational rehabilitation and self-determination. He pressed us to get out into the community and not wait in our hospital offices, and wondered why only 10% of the MHICMs have psychologists in them.

Bob Gresen, Ph.D., Chief, Treatment Services, VHA Mental Health Strategic Healthcare Group, and Jim Breckenridge, Ph.D. gave an update on
the second Provider Workload Guidelines draft which was issued in March 2003. These guidelines are the product of a field-based workgroup representing VACO, six VISNs and the four major mental health disciplines. This topic proved to be the most contentious of the weekend. As one example, many in the audience experience the proposed 47 minutes a day allotted to non-clinical time as deterring psychologists from adequately preparing for sessions, obtaining professional education, volunteering for committee assignments or keeping up with emails. Some saw the managed care approach as perilously undermining morale. Others were supportive of the guidelines and believed that they were achievable and amenable to local adjustments as needed. Bob reminded the group that these guidelines remained a work in progress and would change over time as better data became available. Jim observed that leaving the development of guidelines to people outside of mental health runs the risk of standards being established without any sensitivity to what we do. Also, many facilities/VISNs appear to be operating within suggested guidelines.

Jim and Bob returned to the podium to update the far less controversial topics of VERA and CARES. Jim views VERA 10 as good news for mental health compared to where we used to be, even though we remain under reimbursed. VERA 10 represents a significant increase in funding for mental health. PTSD (intensive inpatient programs) and Domiciliary Care are allocated somewhat less funds, primarily as a result of increased allocations for outpatient utilization and other areas of mental health (e.g. dual diagnoses). Bob gave an overview of CARES, which assesses veterans’ national healthcare needs and attempts to realign resources for the next 20 years. At this point, CARES data has not looked specifically at SCMI, PTSD or the Homeless; the only mental health initiatives being considered at this time are resources for acute inpatient psych and inpatient substance abuse (both increases and decreases) and resources for outpatient mental health (increases).

Two Congressional staff directors who also had intended to attend the conference (but needed to remain in Washington) had a friendly and frank interaction with us via speakerphone. They were John Bradley, Majority Staff Director, Committee on Veterans Affairs, U.S. House of Representatives, and Susan Edgerton, Democratic Staff Director, Committee on Veterans Affairs Committee on Veterans Affairs, U.S. House of Representatives. Both were explicitly supportive of adequate mental and behavioral health services of veterans. John noted that the DVA ought to provide these services because it “is the right thing to do” and in some instances, “because no one else will.” They commented on the need for more VA money in the FY03 budget (which may or may not be allotted) for bioterrorism training, mental health services in CBOCs and intensive case management. They have personal commitments to moving forward in Congress the Title 38 classification for psychologists and social workers, a significant breakthrough on this proposal. Susan and John repeatedly invited us to contact them with relevant information and issues.

Robert Sternberg, Ph.D., APA President flew across country to speak to us, and we are deeply appreciative for that effort. His talk on “A Model for Developing Expert Leaders” was a stimulating and sage presentation. Pointing beyond effective administrative skills, he called for creativity (in viewing problems in new ways), wisdom (especially in integrating common good of all involved), and intelligence (especially in knowing one’s own limitations and learning from experience). It was refreshing to be reminded of the importance of drawing on these human values as we work as psychology leaders.

Pat DeLeon, Ph.D., J.D., has attended five of our six Psychology Leadership Conferences. This year, he stayed for two entire days, a remarkably generous gesture and a source of our strength. He is an abiding friend. As usual, he passionately exhorted us to courageously rise to discipline challenges. He observed how clinical pharmacologists and nurses have made inroads in behalf of their professional scope of practice and prodded us to proactively attempt to shape our own future.

Pat, noting Secretary Principi’s openness, advocated for the VA to become a pilot site for psychologists to practice with prescriptive authority. Kathy McNamara, Ph.D. hoped that those individuals who did not want to obtain prescription privileges should not block those who desired to take on this responsibility. For many in the audience, it was a question of when rather than whether to actively pursue this issue,
and there was tentativeness about if this year is the best timing.

As is our custom, we devoted time for updated mental health administrative and training take-home information. Mary Jansen reviewed the status of Title 38 conversion, Directive 99-018, the new Psychology Executive Directive, national FTEE figures and problems with proper classification. Though it is an age-old situation, there continues to be significant difficulty with administrators from other disciplines truly understanding what we do. Complementing Mary’s talk, Larry Lehmann reviewed other mental health issues: the expansion of clinical practice guidelines, workplace violence & suicide prevention, performance outcome measures, integration of mental health primary care with geriatrics, MIRECCs and a directive for CO to be informed whenever mental health programs change.

Linda Johnson, R.N., Ph.D., Director, Associated Health Education, Office of Academic Affiliations, VA Central Office had to miss the conference with a broken ankle, and sent her presentation via PowerPoint. Regarding postdoctoral training, she reported on the new fellowships in psychosocial rehabilitation with the chronically seriously mentally ill, $1100 continuing education funds, and possibilities for 3rd year fellowships at MIRECC and HSR&D sites. The predoctoral internship float funds that have been allocated every two years will be assigned to permanent locations following an RFP later this year. Other announcements included the feasibility of locality adjustments in stipends starting 2005, increased collaboration between VA and DOD and possible reallocation of resources secondary to CARES.

For the second year, we offered the opportunity for poster presentations. We had several excellent projects. One was by Pat Sloan, Ph.D. (with Heather O’Mahen) entitled “Psychology Leadership in Medical Settings: Training Predoctoral Interns in Psychology Administration.” Brian Pilgrim, Ph.D. had three posters “Entrepreneurship and the Therapeutic Enterprise,” “Creating Opportunity in Vocational Rehabilitation: One Venue for VHA Psychologists to take the lead on the ‘One VA’ Initiative,” (with Patrick Zolliithesis, M.A.) and “The Psychologist Leader Project” (co-authored with Dolly Sadow and Steve Holliday).

It is always our goal that in addition to imparting essential information for effective leadership and promoting collegial networking that this conference will lead to proactive advocacy following the conference. With that in mind, we spent 90 minutes in breakout groups discussing five topics: Group #1 was “Disaster preparedness, anticipating terrorism and psychological resiliency: Bringing it to the field in the VA.” They proposed circulating APA’s resilience material (including at CBOCs), providing in-services and perhaps a weekly newsletter for VA staff, putting fact sheets on our website and educating families of veterans. Group #2 was “Anticipating the transition: Planning for services and positive steps to help returning troops and their families.” They suggested linking with DODs in local areas, making presentations to veteran advisory groups and getting involved in Vet-to-Vet programs. Group #3 was “Career path concerns: New responsibilities, the protected class theme, new directives, and other ways to leverage psychologist career growth.” They recommended that standards for performance appraisals be revised so that a Psychologist Leader always co-signs evaluations of psychologists and that we volunteer to serve on more medical center and VISN committees. Group #4 was “Building a competent, expert and effective workforce: Education and training.” They suggested that CO issue a guideline for release time for Directors of Training (and that every supervisor be given release time from their productivity guidelines), using experts from around the country as remote teachers and developing a fact sheet for Psychology in Primary Care. The last group was “Meeting the challenge of serious mental illness. How can psychology be a part of the revolution?” They proposed that Psychology have dedicated time within Primary Care where we can coordinate the care of the SMI. Thus, within a brief time there was an abundance of ideas generated; the key for us is to follow up through the year.

On Sunday, we were blessed (indeed) by a wonderful five-hour workshop on “The Psychological Assessment of Police” by Mark Zelig, Ph.D. The session began at 7:30 a.m. to a packed house of approximately 40 participants. That timing had to account for the fact that we had “leapt” forward, losing yet an additional hour of sleep due to daylight savings time. The sleep deprivation was well worth it.
Mark covered the legal landscape associated with these assessments, ethical standards, statistical concepts and provided a terrific overview of assessment tools, both structured interview items and objective psychological testing alternatives. This was clearly a presentation tailored to VA, recognizing both the historical restrictions on our practice and the unique mandate to reevaluate officers on a yearly basis.

The conference climate was inspired and confident. We were heartened that DVA executives, APA leaders and Congressional staffers recognized what we do. Though we continue to face unequal opportunities (e.g. for leadership positions, for position classification), there was a sense that progress is being made (e.g. movement on Title 38 conversion, Psychology Executive Directive, the number of psychologists serving as Chiefs of Mental Health). Another hopeful piece this year was the attendance of nine predoctoral and postdoctoral trainees. It was fortifying to see the future of VA Psychology in the room.

These positive reflections are a fitting point for me to comment on my change in role. After six years of organizing the Annual Leadership Conference, I will be stepping aside. June Malone, Ph.D. will chair the conference planning for 2004 (though I plan to be extremely involved.) This conference has provided bountiful richness and meaning in my life. I have deeply appreciated the chance to give back to the profession of psychology and to the VA that have been so good to me.

In closing, I would like to acknowledge those who were essential to the success of the conference. First and foremost is Randy Phelps. As always, he continued to be a tireless, devoted friend whose contributions to every aspect of the event were vast. Division 18 lent considerable support in planning and promoting. The planning committee was a testament to the adage of the whole being greater than the sum of the parts. We worked hard and cohesively for ten months. Committee members were Ken Adams, Ph.D., Judy Patterson, Ph.D., Jeff Burk, Ph.D., Bob Gresen, Ph.D., Mary Jansen, Ph.D., Randy Phelps, Ph.D., June Malone, Ph.D., Dolly Sadow, Ph.D., Matt Blusewicz, Ph.D., Pam Fischer, Ph.D., Steve Holliday, Ph.D. and myself. Jeff pitched in to ensure CEU credit. Tony Chuukwu was the glue in preparation for and on-site administration of the conference. Lisa Brenner, Ph.D. provided essential local help with logistics and audiovisual aids. I relied upon my secretary Gloria Patel for letters of invitation to speakers and CEU submissions. Finally, it is fitting to underscore Ken’s leadership. His promotion of issues crucial to the organization, his thoughtful and eloquent introductions of speakers and his dynamic presence set a strong tone.

AVAPL/APA Leadership Conference VII

VA Psychology Goes To Washington:
Working Together To Keep Veterans First

April 22-24, 2004

Crystal City Marriott
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Don’t Miss It!!!!!!!!!
The Expanding Role Psychologists Can Play
In The Area Of Building Resilience

Presented by
Russ Newman, Ph.D., JD, Executive Director, APA Practice Directorate

VA Psychology Leadership Conference
Denver, Colorado
April 3-6, 2003

Dr. Newman: Good Morning Everybody! I think I probably have more training than I care to think about, and when I get these introductions it sort of forces me to think about all of those training experiences. But I have to say I learned very early in my training, probably on internship at the Oklahoma City VA with none other than Rich Carothers. It's always better to be the tip of the spear than the butt of it. And I've carried that message on since then as you can hear Ken's introduction for me. I want to talk eventually this morning about the role I think psychologists can play, the expanding role a psychologist can play in the area of building resilience, something we've been working on in the Directorate for some time now which I think has some applications for our current predicament and for your setting. But before I get there I want to pick up with a message I had started to communicate at the August convention meeting of the VA Psychologist, some of you may have been there some not. It was a big convention in Chicago I guess is where we were.

When I talked to the VA folks there I used an analogy of VA psychology at this point in time and analogized it to what in legal parlance is often referred to as a protected class—a class of people who are given statutory and even constitutional protections and advantages in some way in order to compensate for a history of past disadvantages, if you will. And the analogy came to me as I began to look at some of the fairly recent history of psychology in the VA where there were positions that were historically closed off to psychologists, where there were grade levels that were difficult if not impossible to attain by psychologists as compared to their other health professional colleagues, where there was disadvantage and a disproportionate impact of the reorganizations into VISNs that had taken place over the last few years. And in fact where directives alone, as we've seen like the directive from Ken Kaiser, weren't enough to get psychologists into the positions that we believe they need to be in. And of course I'm referring to the directive that psychologists should be able to be product and service line heads just like those in other health professions. The directive alone didn't do the trick. So for me, those kinds of things happening and those kinds of characteristics were a lot like those groups that in legal circles ultimately get the label of "protected class" so that they then can get some advantages to help move them along.

The good news about my discussion with the VA folks then was that it seemed like it got people excited. People got charged up, and I've always aspired to be able to come in and charge people up the way one of my mentors, Pat DeLeon, has always been able to come in to you all and really charge you up. So you know I was gratified to know that I'd been able to get people excited to move forward. The bad news was some of the crowd thought I was telling them that they should go file a lawsuit against the VA. Now I must say you know the ? of my heart were warmed by those that came up to me and said, "God that was great." You said go sue those bastards. We can't wait. Mary on the other hand didn't feel quite so warm and fuzzy about that. But, I wasn't saying that, and I want to kind of build on that and sort of remind people what I was saying. And those of you who have worked with me around legal issues know, I don't get to lawsuits lightly. It's a last resort, and
it’s not what was applicable in this situation. It was the analogy that psychologists in the VA need to do more than just have directives that say, “We should be treated this way or that way; that we should have some extra protections in light of the disproportionate impact and disadvantage that we’ve suffered within the health community within VA and outside of VA as well; And that we should have some advantages that help compensate for past disadvantages.” And what I meant by that is some things are actually starting to happen, and so I’m very gratified about that.

The Psychologist Executive Directive is one of those things that I think is consistent with a kind of remedy that’s useful for a group that I would suggest needs to be considered a protected class to get something. If we’re able to have psychologists in those positions throughout the system, it’s not a panacea. It doesn’t solve everything, but it does help move things along. The work that Mary’s done on that, and the work that your leadership has done when they were in Washington talking with folks in your Central Office, are good examples of the kinds of steps that need to happen in order to get us going in a direction different from some of the directions that have occurred in the past. I think another of the steps that fits very well with the protected class analogy that I was using is the proposal for Title 38 which your leadership and my staff, Randy, have done a lot of work on to date with relevant hill staffers in an effort to get that proposal moving forward into a legislative arena where it can get enacted. That’s a kind of step that I think is necessary for a group that has experienced some disadvantages in the past that need that extra advantage at this point in time.

I think we need more things like that, and I think it’s going to be left to your creativity and your leadership’s creativity to determine what works in your system. I and my staff are more than happy to help make those things happen and to strategize with you when you design some of those things, but far be it for us to tell you what’s going to work best in your system. So we really need to rely on you to creatively work with us so that we know what additional kinds of steps can be taken to perhaps remedy some past disadvantages that we’ve experienced.

I think we need louder advocacy, and by that I don’t mean raising one’s individual voice louder or civil disobedience in any way. I’m sort of mind full now, I don’t want to be interpreted as having left you with a message, “Boy civil disobedience were all going to go sit in, in a Secretary’s office.” I’m not much for civil disobedience. Although Rich will tell you that even back as an intern in Oklahoma I was pretty big on petitions and generated a few petitions about changing the system there. It never changed, but it didn’t stop me from trying. Louder advocacy, and by louder advocacy I mean more collective advocacy, more collaborative work between AV/PL and Division 18 to bring the whole community of VA psychologists together. I mean your being able to take what you’ve learned here back to your colleagues back at your hospitals along the lines of what Steve was saying and what Randy was saying. We’ve done a lot of different kinds of leadership meetings through the Directorate over the years, and it’s always important I think to remember that in leadership meeting kinds of things you’re not here just to get information for yourself. And sometimes I think we often say, “Great information, I learned a lot. It was very educational.” You’re here to get information to take back to others because you’re part of the leadership, and we need to impart these same messages back to the larger community. We need more people, and maybe at some point, will have twice the number of people here. So that’s another of the kinds of steps I think are important and necessary and what I mean when I talk about the analogy of psychology like a protected class needing to take some steps to get some extra protections. To get some advantages to remedy past disadvantages and simple directives without action to support and enforce them really won’t be enough.

Because the conference I think is so timely in its’ notion of expanding roles I wanted to share with you a bit of how we in the Practice Directorate have arrived at the work that we’re currently doing in the area of resilience. I think it really is continuing to be very relevant in our society, and as a result of current war times circumstances may have some very particular relevance to your community and your system. It really tracks back to the work that we had been doing in public education for a number of years that had frequently taken the pulse of the public to determine what were the issues of concern for them. Prior to 9/11 what we were working on was a message we were hearing from the public that clearly identified a high level of stress that people were experiencing, primarily around financial and economic conditions, difficulties in balancing work place,
family life kinds of demands. Within that area we were really hearing from people that they were feeling pretty stressed out. We were continuing to develop messages that responded to the issue of work family kinds of stress that was one of the themes of our talk to someone who can help a public education campaign.

With the wake of 9/11 you know we certainly didn’t feel we could just continue on as though nothing had changed and decided we needed to retake the public’s pulse to find out what was of concern to the public at that point and how our messages that we had been working on in public education would still resonate with the public. What we expected was that things would have been qualitatively different. We expected what we called a new uncertainty as a result of 9/11 and the continuing fears of terrorism and Anthrax – and other things that were going on at the time. We really thought the public was going to tell us their concerns were very different than they had previously been. What we found though really surprised us. We found there was nothing new or qualitatively different about it. What the public said is this was just another of a series of continuing stressors that were being dumped on top of them that they felt they had to deal with. In fact, they were feeling the level of stress becoming a chronic condition as opposed to perhaps a more situational event that they would have described prior to 9/11. It was here we began to first see the seeds of resilience being part of the public’s lexicon.

Now let’s face it. We’ve had resilience as a part of the psychology lexicon and psychology research for years, but it wasn’t particularly something that was part of the public’s language. After 9/11 and in our surveying and focused group testing of the public we began to hear people say they were not so much interested in wanting to just cope with what was happening or live with what was happening. They wanted to be able to bounce back from what was happening. They wanted to be able to be resilient in the face of adversity, trauma, tragedy, and even significant ongoing life stressors. It appeared to have a kind of desire to be inoculated quality to it as opposed to just simply coping with it. It was with that understanding of what the public was looking for that we began to look closely at the resilience research and literature. Those of you who may know the research know it’s not a unitary construct. It’s a whole series of actions, behaviors, and practices that are associated with resilience, and there is no one way to do it. There’s no right or wrong, and there’s no one single piece that determines resilience. It took some interpretation of the research, but we ultimately began to put materials together for the public that focused on how people could build their resilience. While for us it seemed like taken for granted that this was something that could be learned, it wasn’t an innate trait that you were born with or not. That was not so true of the public’s understanding. They didn’t know it was something that could be learned. Many people we heard from thought you’re either resilient or you’re not, and boy those people who are resilient are pretty lucky. But in fact, the research is clear it can be taught. It’s a learned kind of thing associated with a whole series of behavior. So we began to put that message together with a whole set of materials—steps to take in order to build your resilience, tips for the public to increase their level of resilience in the face of what were continuing stressors that were not only those that existed prior to 9/11 but then the addition of the anxieties and uncertainties about terrorism that grew from 9/11.

The materials we put together then, I think, had a pretty wide spread appeal and it wasn’t just related to 9/11; although we did a documentary with the Discovery Health Channel about resilience that started with what happened at 9/11 and then built on it. As we began to see the development of this country’s preparations for war and peoples growing concern about what the impact war in Iraq would have on the country, we began to tailor and revise the resilience materials specifically to deal with resilience in a time of war and take advantage of all the research related to resilience, all the kinds of behavior and actions that are associated with resilience but began to focus it around the situation we at that time would have expected the country to experience in the event that we went to war and has been eluded too. Ken talked about how war this time around has a relatively unique characteristic of having us all here at home being in harms way as well as our armed forces as a result of the kinds of terrorism that are of concern, have been of concern, and continue to be of concern.

So we began to tailor that material, and the fact that in addition to the concerns we have about the war and possible terrorism, add on top of that now the additional stressor I think we have to deal with created by the Sudden Acute
Respiratory Illness that now is spreading in ways that people aren’t entirely clear of. You know I have to tell you on the plane flying to Minneapolis where I did a talk, I guess it was yesterday before coming here I, I must admit I was as concerned about the person coughing behind me as I was the about the kinds of potential anxieties you might have of flying to begin with. Now I hesitate to tell you that I’m next headed to San Jose, which if you have been following the news is where they recently sidetracked a jet coming in from Japan because five people in first class were coughing. So they wanted to have them medically checked before they let anybody off of the plane. Again another of the stressors added on top of what we are dealing with.

While the concept of resilience may be straightforward in some regards, although as I said it’s not a unitary construct, it’s implementation is anything but simple. I say this because I think there might be a tendency for highly trained mental health professionals like ourselves to sort of dismiss it as the latest in the public’s notion of pop psychology. I think it’s anything but pop psychology. I think it is something that taps into the public in ways that we’ve not historically been able to tap into the public at large. The materials that we put together on resilience in a time of war have had pick up like I’ve not seen before. Sesame Street has picked up materials we’ve done for preschoolers. MTV has picked up the materials we’ve done for teens. The newspapers are picking up the array of materials. I did ten radio interviews about resilience in one morning. There’s something about this concept that I do believe is really resonating, and it isn’t just a simple feel good sort of a thing. Trying to understand that then, I think is important, and trying to use it and implement it is an important part of anything we do with resilience. While we may have one level of resilience out there for the general public, and it might be a kin to some self-help kinds of activity, and I don’t say that in a pejorative way, providing information and material to the public in ways that they can apply it to themselves, use it, and take advantage of it I think is a goal and an activity that we need to be more engaged with.

But resilience also has application not just for the general public out there. It has application for the patients that you see, and it’s not in place of any psychotherapy or psychological treatment that you offer them for Post Traumatic Stress Disorder. Nobody’s suggesting that the answer here to somebody with PTSD is, “Oh, let’s just help build their resilience”, but it’s to help build their resilience in addition to everything we’re doing as professional psychologists to treat other more significant serious disorders like PTSD, like Clinical Depression. Resilience even has application to individual’s with Serious Mental Illness. Again it’s not the only thing you do; it’s not in place of; it’s not a panacea; but it’s something that has to be titrated in with the rest of the treatment. Its importance is really in an inoculation kind of way. All of our patients, as well as the public, deserve to learn ways to be resilient, to be able to bounce back from those things that they experience whether its daily stressors or whether it’s part and parcel of the psychological disorder that they struggle with through good portions of their lives.

So it’s not an easy task to provide help and enable patients dealing with other kinds of problems to build their resilience. It isn’t a simple matter of just give them some material, let them read it, and expect they’re going to be able to be resilient. It requires the kind of thinking and understanding about the learning process, about emotions, about cognitions, about what the research says about resilience that we as psychologist have been well trained to do. As I said before, it also isn’t just a simple feel good kind of thing. There’s no question I think one of the implications is that people hopefully feel better and are not as constrained by the ongoing adversity and stress and uncertainty that they face no matter who they are or in what circle they may be. But it’s much more than that if you look at some of the behaviors associated with resilience, and I say it purposely that way because that’s how the research really paints the picture. It’s behaviors associated with resilience. If you look at some of these behaviors, probably the most relevant, important, and frequent behavior associated with resilience is connections with others, relationships, supports, being able to use those supports to make those connections whether it’s friends, family, community is as important. But the point I’m trying to make with this one is we also know that relationships and connections go far beyond just helping build resilience or helping us feel better. We know from the research that that’s among the most important factors that are determinants of our health. We know that people with good relationships and in good connections are healthier than people without those relationships and without those
Longevity

boss, Norman Anderson, Emotional Longevity, seen the book that just came out by my new associate with resilience. If any of you have able to put into practice one of the behaviors physical health can be affected by whether I'm not feeling as much stress when my actual connections. So there is more to that than just I don't feel as much stress as much stress when my actual physical health can be affected by whether I'm able to put into practice one of the behaviors associated with resilience. If any of you have seen the book that just came out by my new boss, Norman Anderson, Emotional Longevity, you also know that that kind of behavior, connections, relationships which can lead to good health also according to the research leads to longer life. So we've got a behavior associated with resilience that not only helps us feel better, it helps us have better health and may help us live longer.

Another one of the behaviors frequently associated with resilience is maintaining an optimistic view of the world. It helps people feel better. But we also know now from the research that those who maintain an optimistic view of the world are healthier than those who hold a pessimistic view of the world. And again, another of the findings highlighted by Emotional Longevity is the fact that that too is a behavior associated with living longer. So people who have good connections and hold a positive view of the world not only are healthier than those who don't but are people who live longer than others. So for me right away I see many more implications for the applications of behaviors associated with resilience than simply having somebody feel good.

Resilience has implications for homeland security, and I'm not going to get into that much, but I'll sort of leave that to you to think about what that would mean for a country who has to continue to keep it's vigilance quite high as a part of homeland security. I'll just underscore the point by a bit of a side track in an experience in seeing some information and data following 9/11 that I think speaks to a potential role for resilience in homeland security. A lot of survey's were done after 9/11 in various places in the country looking at people's reactions and their mental states at the post 9/11 time and survey after survey continued to say that people in Washington, not withstanding those who may have been very directly affected by the attack on the Pentagon, but people in Washington tended to be less anxious and depressed following 9/11 than people virtually any where else in the country - even places that were no where near as touched by the events of 9/11. Now at first I started to think that that was some version of denial, but it was not placed in its best possible light. Ultimately I decided maybe it's a rationalization on my part. Frankly I was glad that this country's leadership in Washington wasn't feeling anxious and depressed given what we were needing to deal with because we all know what the effect is of those kinds of distress on our ability to function. We need to be able to function at peak quality, particularly when it comes to homeland security.

There were even economic implications of resilience. If you look at what's happening in the economy right now, we've got manufacturing that's down, production that's down, consumer confidence that's down, consumer demand that's down, and no change in sight. Well there are those, and I'm in part one of them, who believe that the country's economy is frozen right now for a number of reasons. One of those reasons is a prior threat of the Cold War that we used to experience in this country that dissipated through a variety of events over the years has recently been replaced with a threat of global terrorism. And the country's economy by virtue of peoples actions is waiting for that to clear in order to move forward. There's a lot of speculation prior to the start of the war that it would be quick and it would be over, and everything would return back to normal and it would push the economy forward. Well that may or may not happen. We don't know, but there's also an understanding that things are different now; it's likely to take longer; and there's still many threats of global terrorism even after we conclude a war in Iraq. The kinds of stresses and pressures and uncertainties that people feel that are forcing them now to not buy, to not do growth, to not do expansion are going to continue to affect this country. As a country we are going to need to learn that we are going to have to move forward despite these kinds of stresses and uncertainties. To move forward in the faces of these stresses and uncertainties, we're going to have to be resilient in the face of these kinds of threats and uncertainties if we want this country's economy to get back on track and move forward. So I think there again we have another implication for helping people build resilience in individual ways, in group ways, in collective ways that for me make psychology's role in helping build resilience at this point in time a pretty important one.

And as I mentioned before what we heard from the public was, at least in their minds, resilience had a kind of inoculation quality to it. And if that's so, it's probably as good a preventive care model within behavioral and psychological healthcare as we're ever going to find. If in fact it does enable us to
inoculate people against the kinds of adversity and traumas and stressors that they will no doubt continue to experience, whether it’s just somebody from the lay public, whether it’s one of our patient’s who’s in treatment for any kind of disorder, they will have to deal with things in the future.

It also is something that enables us to move out into the community in ways I think we as psychologists have been __ but have been looking and been needing to do more of. The VA system has reorganized in such a fashion so as to get services out into the vets community much better than when it was centralized in hospitals. Even beyond that this begins to get our help, our work, our services even out of physical locations out into the community, out into your staff’s community, out into your patient’s community, and I think even out into the VSO communities. Think about what the application of resilience should, could, would be for your VSO groups who are vets who are probably experiencing the current war with Iraq different from most other people in this country. It may be more difficult for them in light of their past experiences. Here’s a way we can provide something out there into the community use that to help build our relationship with those groups with the community.

So the prevention part of this is something I think is really important, really key for psychologists because of where we are in the health care system right now, where we need to be, where we need to be going. I think psychologists more than any other mental health professional indeed is better suited to provide the kinds of services related to building resilience. We know how to read the research. We know how to interpret the research. We know about the learning process. We know how to take a holistic approach to the delivery of services so care is multi-determined. It isn’t one thing that we do, it’s a psychological model of care. It’s not a medical model of care. Who better than we to be providing this kind of service to our country, to publics most in need of it right now. So while we all know there’s been some controversy about the vaccinations that have been used for Anthrax, Small Pox in recent months, last year, or so, I doubt that there will be any adverse effect of the next shot of resilience you give to your staff, your patients, to the public, to your community. Thank you!

(Man Speaks) Thank you. I think I’d like at this point to ask you to use the microphones on both sides of the room. And there’s so much to think about with Russ’s comments actually in relationship to the program coming after the break. The only thing I can say is hold those thoughts. Are there questions that people have or remarks you’d like to make? If you would and Russ can address these please come to the microphone. Please identify yourself and the question, and we’ll go from there.

(Steve Cavicchia) Hi, Steve Cavicchia. While you were talking Russ it really struck as I was reviewing the resilience material in our packet, “Why couldn’t we have a VA psychology in APA educational packet similar to what was put out for the private sector?” I think this would be really up front and out there right now because our veterans are clearly having, being impacted by this war.

(Dr. Newman) Yeah, absolutely Steve. In fact, our notion of public education is and always has been that it’s a grass roots effort. While we put together some basic materials, there are different groups, community settings out there for which it needs to be more specifically tailored to fit that group. We look forward to working with who ever you think from your group should work to help us put that together. I think we leave it to you to advise how that needs to be tweaked so that it’s most appropriate for the folks that you work with.

(Man Speaks) I had a question, Russ. If you can comment on the relationship of how this initiative is developing in relation to the positive psychology movement?

(Dr. Newman) I think it varies of what we’ve in the past called positive psychology, and while as I mentioned there’s certainly is application of building resilience to individuals who do have some kind of significant psychopathology that we’re dealing with, it also has application to people who don’t have any particular psychopathology but are dealing with the very common life tragedies, stressors and alike. I think that’s one of the reasons why it’s found a popular appeal with the people. People can step forward and use it and ask for it and not feel the stigma that, unfortunately, remains connected with Mental Health treatment, gets attached to them. So in that regard it is a
variation of a movement that is much larger than resilience as we refer to positive psychology.

(Woman Speaks) Russ, I know we’re going to have a lot of time to talk about this again at our next panel but I would hope that I can just change the topic a moment here. Because I think there’s an issue that for me is very important in terms of AVAPL and APA. As you know, I share your optimism in terms of the directive, and I know that Mary has worked very hard on the directive and some of the things that were accomplishing with Title 38, but I think back at the home front psychology is not really doing well. And I know that some of these, I share the optimism that we can get involved in a lot of projects and so forth, but I am really concerned that despite some of these things we do not have at the local level psychology really being strong and being able to be a separate profession and have the professional components that we’ve always been used to. My concern is that as VA goes psychology goes, people are not so optimistic at the local level as we are when we get here. And I’m wondering how we can join even more together with APA, AVAPL, Division 18 and changing some of what’s going on in VA. And it’s a very serious thing when we have these changes that Russ, Randy talked about this morning in terms of service lines and we don’t have psychologists really doing psychological work but now we have a new directive, well it’s not a directive. What would you call it? The time, the workload kind of guidelines, but not really guidelines that have come out that put psychology, in many of us view, as just people that are going to be doing therapy, one therapy session after the other without time for some of the professional component and some of the things that we as psychologists ought to be doing when we talk about how do we evaluate programs, how to look psychologists out there leading these things and then we have the move at the local level of just keeping psychologists in there offices seeing patients. I’m very concerned about that. I think that there are other people that are concerned about that and I’d like to know how we can work with APA to really look at some of these issues and move forward? We need your help in doing this. (Applause)

(Dr. Newman) You know I think what you described is part and parcel of continuing deprofessionalization that’s occurred in health care and not to negate what you were saying, but it isn’t as goes the VA so goes healthcare. It’s as gone healthcare so goes the VA. This has been happening in healthcare for quite some time now so it isn’t unique to just VA that makes the problem more difficult to deal with rather than less difficult to deal with. From my vantage point, it is obviously something we need to address. Resources are always an issue as you know, and as I told your leadership and I’ll say it to all of you, I have a certain amount of limited resources to deal with the entire problems of the psychology community. Some of those resources I’m well able to and delighted to devote to VA psychology because it’s an important piece of the community, and it’s a significant piece of the community. I think we need to evaluate what those resources are and how they best can be used so that my resources can be working with you in order to identify what those problems are and how we want to attack those problems. Until we have a strategic plan and a systematic way to do it, it’s not going to do us much good. I think this conference is one very good piece, but this conference isn’t going to be enough. Simply putting information in the hands of all you to go back to your communities in order to try to rally those folks the way I think we’re able to rally ourselves while we’re here is alone not going to be enough. We need to figure out other ways to do it. I hope you and the leadership of AVAPL will continue to work with me and my staff so that we can figure out and problem solve together because it really is a strategic problems solving approach. The problems are big. They don’t have easy solutions. They don’t have singular solutions. We’ve got to attack it from all angles, and let’s continue to do what we’ve been doing and build on that.

(Man speaks however doesn’t identify himself) I had a question for the AVAPL leadership in terms of the comment about networking with the Veteran Service Organizations. Are there some examples of where we’ve increased their awareness, or memorandums of understanding, or just how to network between VA psychology leadership and the VSO’s.

(Man Speaks) Well at a national level that is somewhat uneven because a lot of the service organizations are membership organizations where in the elected officials change. I think where we’ve had some success in the past is working with the more permanent staff in Washington,S and there’s been some
turn over in that. At the local level I think there’s a huge amount of variation in terms of how people, how, who is the American Legion representative or who’s the Vietnam Veterans of America representative and what steps do you do to meet with those organizations to essentially network with them and have them in turn playback the value of what you do in their relationship with the local management or administration. So I think there’s sort of two levels. At a national level our particular message or what we are talking about I think is very welcomed. For example for remarks that Russ just made with respect to resilience and actually things that can help the experimental needs of veterans and the health needs of veterans. The problem is when it gets into a national policy making level those things are valuable but there’s a lot of other things competing for them. When the administration suggests they want a two-hundred and fifty dollar cash co pay or some other kind of algorithm, those things go right to the top of the heap in terms of what they are going to lobby congress for testify. So I think there’s sort of two things. One is in terms of our leadership is to try to build links and we have done some of that traditionally through a lunch when we do a midwinter meeting, but subscriptions to that have kind of fallen off because by the time we get there, there are a lot of other things going on. So what we have to do is build as we did last year more individual relationships with people who are professionally representing those organizations. But at a local level I think you can think about that and design that or integrate that into your service as you can. For example I know that there are some internship training programs that utilize the service organizations heavily, particularly at the beginning of the year in designing what amounts to an acculturation section or module to introduce interns - many of whom, or fellows, for that matter, who’ve never been in the VA. There’s a social psychology and a culture to VA, and who better to help you in sort of orienting students to what that’s like through service organizations. So there’s many individual things at a local level that can be done. But nationally it’s a tougher job to see what’s clear, what are priorities. But we have to continue to press that case. Ken, Ed.

(Ed) Yeah, can I just add onto that? Locally there are two possibilities you might think about. One is many veteran centers, excuse me, Veterans Medical Centers have what they call VAVS, Veterans Advisory Voluntary Organization, and they typically meet once a month, and in some places they meet only once a quarter, but all of the so called accredited representatives of the various organizations go there. I have traditionally made it a point of attending those meetings and occasionally having one or another of my staff make a presentation on some thing that would be of interest to those folks to carry back to there organizations. So for example the information Russ has provided on resilience is a wonderful kind of entrée into a group like that.

Second these folks have concerns about processes that we are very much involved in such as the compensation and pension examination process. Some of their constituencies are not always happy with the outcomes of those exams because not everybody gets service-connected fifty or hundred percent for PTSD. So we have actually met with people who were very angry and very upset, who were spokespeople for those who were unhappy with some of these results and done a whole education program. We put on a three hour program that educated them as to what the process is, how we bring science to bare in the process, how we bring psychological testing to it, how some of the research that we’ve been doing for example on the FP scale has made it possible to interpret an MMPI in favor of the veteran that previously we would have said were technically invalid. So doing things like that builds you in at a level where these folks have concerns. So that’s what I’d suggest.

(Man Speaks) Thank you Ed, Those are just examples of concrete ways to utilize this. We have time for one more comment.

(Fred Frese) I’m Fred Frese from Ohio. I was very interested in Russ’s comments on resiliency, but within the advocacy consumer movement in the last ten years the bumper sticker watch word has been “Recovery” and “Recovery Movement”. And I understand the president’s new freedom commission is going to come out with recommendations for a Recovery Initiative. I am just wondering whether you see any association between the concepts of resilience as articulated by Dr. Newman and the hope empowerment and recovery more subjective perspective from that initiative that’s about to wash across the land quite frankly.
Does anybody know what I'm talking about? (Laughter from the audience.)

(Man Speaks) Yeah, that's a key thing for break out gross but there's and obvious, I know exactly what your talking about Fred, and there's some obvious sort of conceptual and practical questions about how to link what we're talking about in terms of resilience to the framework for recovery which has another set of organizing principles as well. There's an interface but I'm not sure we need to think how to co-op that but in a way to align that so that what we are talking about plays as well into the rubric of recovery.

(Fred Frese) Thank you very much.

(Someone in the background) It will be the next version of R&R.

(Man Speaks) Resilience and Recovery, I like it. We've reached a point where we need to give ourselves a break. And please do that because there's a lot to talk about.

Transcribed by Syvonne Carter.

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**Model for Developing Expert Leaders**

**Presented by**

Robert Sternberg, Ph.D. President, American Psychological Association

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Dr. Sternberg: Well, at least my suit didn't split while I was picking this up. It's a size too small, but we'll go into that at a different time. Look, it's really early in the morning, and I know that people are tired and they need to be woken up. So I thought I would give you a brainteaser to start this off. Then I'll give the talk and then at the end I'll tell you the solution to the brainteaser. Here's the brainteaser: So last night I came from Hartford to Denver via Chicago. The weather was very bad in Chicago. My flight arrived like two hours late in Chicago, so I rushed to get my connection; and I get to the connection gate, and it says that the flight is going to New Orleans. I then discovered that my flight had been cancelled. Now here's the brainteaser. My flight was cancelled. It was the last American Airlines flight from Chicago to Denver last night and there was no connection through anywhere else. I did not switch to another airline. How can I be here? So that will give you something to think about to wake you up just in case the talk doesn't. And for the rest of the time, I'm going to talk about a model for developing expert leaders; and hopefully, that'll appear on the screen at this point. If it does not appear on the screen at this point you can think about ____ of it.

So let me start with a different story, which is not about myself. There was a principal in a school in Oregon and she had a problem. And the problem was that her middle school girls were just starting to learn to use lipstick. So what they would do is they would go into the girls' room. They'd put on lipstick and then they would press their lips against the mirror like this (Dr. Sternberg gave a physical demonstration). And what would end up happening is that the mirror would become full of lip prints. After they did this for a while, the principal, who was the leader of the school, realized she had to do something. So she identified the offenders, called them into the girl's room and also asked the janitor. And she said, "Look it's really not fair that you keep putting lip prints on the mirror because it's a lot of work for the janitor to have to keep cleaning the lip prints. And if you don't believe me, let me show you what he has to do in order to clean it up. So she asked the janitor to show them and the janitor takes a long handle...
squeegee; he dips it in the toilet; and he then cleans the mirror with the squeegee. And after that none of the girls ever put lip prints on the mirror again. So today we’re talking about leadership and this would seem to be a very good example of leadership. Of somebody who needed to get her followers, the students, to a certain place and had an effective way of doing it so that it accomplished the ends at the same time that she maintained good relations with the students. So that’s what we’re going to be talking about today.

I don’t see the talk up there, but rather than waiting for it to happen, I’m going to just keep going (had difficulty with his slides). So had you been able to see what might have been on the screen, the first thing I want to do is just say that the talk is a model for developing expert leaders and there’s really no talk you give by yourself. So on the second slide, which is on the screen-some of you can’t see it because you’re blind-it lists my collaborators. My collaborators are the PACE Center, _____, and external collaborators especially at the United States Military Academy at West Point. I do want to emphasize that anytime I ever give a talk, I’m just representing a whole team of people who work together to create the work that goes into the talk. The second thing that you don’t see on the slide is the funding agencies, which are the Army Research Institute, the Institute of Educational Sciences, and the National Science Foundation. So that’s just to acknowledge people properly. The goal of this work that I’m going to be talking about today is to develop expert leaders. And the sort of critical message, and you’ll see by the end why I think it’s the critical message, is that the ends to which leaders apply their knowledge and the thinking process that act on it matters. In other words, what that means is that sometimes you have certain ends. As a leader you really want to get to the ends, but taking sort of a strayed ethical proper path it seems like it is going to take too long or there’s too many obstacles, too many problems. So what you do is you start to find short cuts, or you bypass a few people, or you do things in a way that is not really right, and the argument is that when you change the means you change the ends. You can’t say, “I’m going to change the means. I’m going to take some short cuts. I’m going to do a few things that are not quite right, and it’s okay because when I get to the end I would have gotten to the end faster, more efficiently.” That’s not what happens. What happens is that suddenly in the process, the end changed.

I call the model of leadership that I propose WICS, W-I-C-S, and the reason is that it’s a combination of four ingredients - Wisdom which is the W, Intelligence which is the I, Creativity which is the C, and the S is Synthesize. So it’s a synthesis of these ingredients. What I’ll do is I’ll talk about these ingredients today and how they come together in successful leadership. Now you might say, “Well, why WICS? I mean, where did that come from?” So the main argument is that you need creative skills to come up with ideas. In order to be an effective leader, you have to have ideas. We were just talking about it at the table. You can’t just sort of do your administrative work and push the papers. And so you know you basically do the very minimum of the job. Any good leader needs to have creative skills. You know, as APA President you can do a sort of minimally, okay job if you just push the papers. But really the way you’re going to be evaluated in large part is whether you had good ideas for initiatives and ideas that really can have an impact on APA, on Psychology, and hopefully, on society. So the first ingredient then is creativity. You need the creativity to come up with ideas.

Now, intelligence in my framework has three parts. You also need analytical skills to decide whether your ideas are good ideas. One of the things that doesn’t work out is if you have a creative leader, but he or she has such a high opinion of him or herself that they don’t bother to ask whether their ideas are good ideas. They simply think, “Well, you know, it’s my idea. Isn’t that enough? I mean, I always come up with good ideas.” And no matter how creative you are, everybody sometimes has bad ideas. Einstein did. Picasso did. There is no one who can say, “I’m such hot stuff that I don’t have to worry about this.” So you have to ask yourself and get feedback from other people in terms of whether the ideas are good ideas. So you need analytical skills to decide whether the ideas are good ideas.

The third element of intelligence broadly defined in my theory is practical skills, and that is, I don’t view intelligence as just getting high scores on IQ tests. Like you look the Wechsler, and you got a 130. Wow! You need practical skills in any leadership job to make your ideas functional. You can have the highest IQ in the world, and if you can’t actually make the ideas work in your context, it really doesn’t make any
difference. So you need the practical skills to implement the ideas as a leader and to convince others of the value of your ideas. One of the things you discover pretty quickly is that just because you have a good, creative idea doesn’t mean that other people are going to listen to it. On the contrary though, often if it’s a really creative idea, they won’t listen to it. So part of the whole package is that you have to say, “Hey, you know the selling of ideas is not something separate. It’s not something I can just say well you know I had the good idea, and if these people don’t get it, they’re a bunch of jerks.” That’s not the way it works. Part of your role as a leader is to persuade other people to listen to you. It doesn’t matter how creative you are. If you can’t persuade people to listen to you, you’re not effective.

And finally, you need wisdom to balance the effects of your ideas on yourself, others, and institutions in both the short and long term. In other words, you have to say, “Hey look. You know if I do this, I not only want to look at what the effect is going to be on me or my particular group here at whatever institution I’m at. I have to look at it more broadly and what the global effect of this idea is going to be. So we’re talking about creativity, and then the sort of more academic or analytical part of intelligence, the more practical part and the wisdom to do what’s best for all. So what I’m going to do is go in that order and start with creativity. And because our time is somewhat limited, I’m not going to try to talk in detail about every element of creativity, but I do want to talk about a few of them.

And the first thing I think that’s important in creative leadership is the desire to redefine problems. Now you’ll notice, I say key creative decisions. And one of the things that’s essential to this view of leadership as Dr. Adams talked about is that I view abilities as modifiable into competencies, and competencies into expertise. To a large extent you make the decision to be a leader. It’s not how much you are born with particular skills, but rather, do you decide to do what you need to do in order to be an effective leader? And the reason I believe that most people are not as effective as they would like to be is simply because they don’t make the decision that needs to be made to be effective. So it doesn’t help to sit there and say, “Well, you know poor me. I didn’t have the right genes.” It’s really a matter of decisions. Redefining problems, I think, is one of the most crucial elements, and that means that in any leadership situation you very quickly find that things don’t go the way you plan. It doesn’t matter almost what level you’re at, where you’re at you sort of have the trajectory, and then, pretty soon you find that things aren’t going according to the trajectory. I mean, if we take the war that is going on now, not that many things go according to plan. When you are in a leadership position in the department or in APA or whatever, there are plenty of monkey wrenches that come by. And the critical thing here is to say, “Look, if I’m trying to solve a problem, and I’m hitting my head against the wall, then maybe what I have to do is see the problem in a new way. Instead of keep trying to hit my head against the wall, is there some other way to see the problem?”

An example I like to give, which is a true story told to me by a very high level executive in Detroit, who was in the auto industry, one of the big three, and he was having a problem. And the problem was he really loved his job. He made a lot of money, but he hated the guy he worked for. And after working for this guy whom he hated for a number of years, he decided he couldn’t stand it anymore. So he went to a head hunter, and the head hunter said, “No problem. You know I can get you another job.” So the guy went back and told his wife that he’s going to get another job, no problem. And as they were talking, she was teaching a unit in her class in college on redefining problems. And they realized that they could redefine his problem. The guy went back to the head hunter. He gave the head hunter his boss’s name, and the head hunter started looking for another job for the boss. Sometime later, the boss got a call offering him a job. He didn’t know that this stuff was going on, and he took that job. So this guy redefined the problem. He didn’t like his boss, and he sensibly found his boss another placement. The special reward was that he then got his boss’s job. But the point is, that having this kind of flexibility, to say is there some other way to see a problem that somehow seems like a nut you can’t crack, is really important to leadership. I mention the importance of analyzing solutions, and I mention the importance of selling solutions.

When I started out as an Assistant Professor, I had what I thought was some new ideas about intelligence. And of course, I wanted to persuade people to listen to me. The second colloquium I was asked to give was at a very well known testing company, and I won’t mention names because it seems inappropriate and undignified. So I got this invitation. I
thought this is great. I have an opportunity to go to this testing company. So I went to their headquarters in Princeton, NJ to give this talk on my new ideas about intelligence. And I thought, “Well you know these guys have been doing the same thing for like a zillion years. What do they need more than some new ideas about intelligence? I mean, yeah they really need to hear this stuff.” And to my surprise, the talk boggled. Since then, I’ve had many others like that, but at the time, it was disappointing. And I asked myself, “Well, I thought it was a good talk. What went wrong?” Then I realized that the problem was that here’s a company that has a huge investment in traditional notions of indulgence and traditional testing. They’re very successful. They have very nice gardens, and like, why are they going to listen to this 25-year-old tell them how they ought to view intelligence? I mean, like what do I expect? Someone who’s sixty gonna come up to me and say, “Boy, am I sorry I wasted thirty-five years of my life doing this crap. I mean, you know, I’m so glad you came to show me what I should have been doing. Too bad I’m retiring in a few years.” That isn’t the way it works. Mostly, if you have ideas that disagree with the way things are done, people are going to tell you, “You’re nuts.” So, you have to be willing to sell the solutions.

Another really critical aspect I believe is realizing the limitations of knowledge because what can happen to leaders if they have more and more success is that they think well, “I’m really an expert now. I’m truly an expert.” And then they sort of lose sight of the fact that no matter how expert you are, there’s always a lot you don’t know. That in fact, knowledge can be a double-edged sword. Let me explain what I mean. On the one hand, obviously you need knowledge to be an effective leader. If you don’t know your organization, if you don’t know its context, you really can’t do a good job. And many leaders fail. I’ve seen this a lot, especially with superintendents, because we work a lot in schools. They’ll go from one district to another. They’ll have this vision of what they want to do, and without even getting to know the context where they’re working, they blaze through, upset a lot of people, and they’re not affected. So you have to have the knowledge, but knowledge can also hurt. Some years ago, a very famous psychologist invited me to another country, and he wanted me to have a sort of tourist program. So he took me to the zoo in his city, and when we got to the zoo, the primates were engaged in what euphemistically could be called strange and unnatural sexual behavior. So they were doing this stuff, and I, as you can probably tell from my accent, am from a highly prestigious state, New Jersey. And I being culturally refined, averted my eyes, which is the way I was brought up in a sort of cultured way. This guy was a real slob. He started staring at the primates as they did this stuff. After staring at them for a while doing this stuff, he started to talk, and he was starting to analyze their sexual behavior in terms of his theory of intelligence. I remember thinking at the time that there are very few things that I know for sure, but one of them I really thought I knew for sure, is that whatever it is that motivates sexual behavior, it has nothing to do with either his theory of intelligence or anyone else’s. I mean you know I think that Clinton made it clear as have others that your sexual behavior and your IQ are just not the same thing. And so what I realized is that there are costs of expertise. And the cost of expertise is that you can become so used to thinking in a certain way, like your own way, that you start to discount what other people say. You start to not try to keep expanding your horizons, and you can actually become a less effective rather than a more effective leader. In fact, your experience starts to hurt you.

So one of the things a good leader realizes is the limitations of his or her own knowledge and is constantly seeking feedback from people of all kinds including subordinates because they’ll often see things that you don’t see precisely because they have less experience than you do. You’ve got to be willing to take sensible and principled risks. What you sometimes say is, “Nothing ventured, nothing gained.” And if you’re not willing to take risks, you’ll find out that very little is going to happen.

You have to be willing to overcome obstacles. I said that a large part of creativity is selling your ideas. If you’re creative as a leader, the question is not whether you’re going to encounter obstacles, you will. That’s not even an issue. The question is what are you going to do about it when you encounter them? In my own case, I became interested in intelligence when I was very young because I did poorly on IQ tests. And so I wanted to try to understand why I did so poorly. So when I was in the seventh grade I did a project on the development of mental testing, and I went into the adult section of the library and found the Stanford-Benet Intelligence test. So I thought it would be good practice to give it to some of my classmates. So I gave it to this girl. There was
this girl I was romantically interested in, and I was sort of shy. I wasn’t quite sure how to break the ice, so I figured a good way to do it would be to give her the IQ Test. It was not effective. This is actually a very good practical lesson. If you’re romantically interested in someone, giving them an IQ test is not a good way to break the ice. Then I gave it to a guy I had known from the Cub Scouts. It turned out that unbeknownst to me, he had a mental illness. I know that you are sophisticated psychologists, so I can use the technical term. The guy was a tattletale. He told his mother that I’d given him this test, and apparently being a tattletale is inherited because she told the junior high school Guidance Counselor. And it turns out it’s also contagious because she told the School Psychologist. So the School Psychologist came to my school, balled me out for forty minutes, and threatened to burn the test if I ever brought it into school again. That’s what I mean by obstacles. I decided that if he was making such a big deal out of it, I would keep studying it. But the point really is, if as a leader you try to do things that are sort of out of the ordinary, you’ll encounter obstacles. You just need the fortitude to go on.

There are other attributes, and I don’t have time to talk about them in as much detail, but you’ve got to believe in yourself. You have to have the courage to be creative. You have to maintain a perspective on yourself which means that you don’t start to think that you are so hot, such a great guy, such a great woman because when people think too much of themselves they never move on. They’re just so happy with who they are that they don’t try to learn anything new. You’ve got to be willing to tolerate ambiguity. You’ve got to allow time because creativity takes time. It doesn’t happen quickly, and you’ve got to be willing, when appropriate, to defy the crowd. So that to me then is the main message, is that creativity and leadership is a decision. It’s a decision that’s made by doing these things. Incidentally, if anyone wants the Power Point slides so you don’t have to rush and take notes, I’m happy to send them to you. Again it’s Robert.Sternberg.edl.edu or I can send it to Randy here. He has the disk and he can send it to you.

Okay, so the second ingredient in successful intelligence—what is that? It’s the ability to attain one’s goals (oops that should say in life). There are these little things that go wrong. Like spelling the word wrong, finding that the button on the right side of your shirt has come off. I mean, part of it’s flexibility. I spent a lot of time this morning if I only have one button do I button that one which calls attention to the fact that there’s only one button or do I leave them unbuttoned, hoping people won’t notice. And I hope you don’t notice. Anyway it’s the ability to attain one’s goals in life within one’s socio-cultural context, and that means that intelligence is not just about getting good school grades, doing well on tests. It’s about making a go of it in your life. But capitalizing on strengths in correction or compensation for compensating for weaknesses. And what that means is very simply that if you look at people who are really effective leaders it’s not that they all do one thing. And you can read as many books as you want on leadership, but it doesn’t quite work. The reason is that very good leaders figure out where their strengths are, and they make the most of that. If you look at great presidents or great any things, great managers, the people who figure out what they’re doing, then make the most of it and things they don’t do so well they either make themselves good enough to get by or they find someone else to do it. I mean that’s what I do at the PACE center. The reason we do everything in teams is because there are lots of things I don’t do well and other people do. Just as they don’t do things well that I may do better, so I might end up doing those. So you develop a pattern of strengths and those are the things I’m going to make the most of. What I don’t do well, I’ll compensate for.

I was once listening to a guy give a lecture, and I said to the woman next to me, “He’s such a terrific lecturer. I wish I could give a talk like that.” And she said to me, “That’s the wrong thing to wish for. What you should wish for is that you can give a good talk like yourself.” And I said to her, “You know, you’re right of course.” I should have said that because that’s my theory. And what I realized is that I was going against what I’d always been saying, and that is that you know you’re not going to be a great leader like somebody else. What you have to do is find what is the stuff you have in yourself that gives you the potential, and make the most of that by adapting to, shaping, and selecting an environment. And what that means is, that as a leader, some of the times you go into an environment, there are things about the system you don’t like that much. And what you do is you just get use to it. Or like you know with APA, anyone who has a leadership in APA, if you can’t find anything you don’t like you really need your head examined. I mean, in any large
Practical intelligence is not much related to IQ or general ability. It’s not much related to personality or cognitive styles. It predicts managerial and leadership performance, and it predicts it singly and incrementally. In other words, I mean you know it’s worked for me, and it should work for you. That is very bad. I’m going to talk later about egocentrism. I mean, some leaders become egocentric. It’s a very bad attribute. It predicts managerial performance both singly and incrementally, in other words, over IQ and personality. It differs somewhat from management vs. leadership. Practical intelligence is something you can develop. It’s nothing with which you’re born. It’s by being in an environment, watching how things work there, and making the most of it.

Now, the reason I thought that intelligence is not enough is because some smart leaders can be dumb. So let me explain what I mean. What can happen to people when they’re very smart and they become more and more powerful? They start thinking like dumb people instead of thinking like smart people. They think like dumb people, and I believe that they commit up to five fallacies. The first is what I call the “What Moo-way Fallacy” after Alfred E. Newman, if you ever read Mad Magazine or still do. And basically they are—I’m such a hot shot. I’m so smart. I’m so successful. I can really do whatever I want, and I don’t have to worry about it because I’m me. You know, so that’s enough. The second fallacy is what I call the Egocentrism Fallacy. It’s like the leader who presses the button on the computer and expects that that’s going to change the slide. It’s when you become preoccupied with yourself. We’ve seen this in Enron and World Com. We’ve seen this with some of our political leaders—that they have so many people fawning over them and have been so rewarded that they lose sight of what they are originally to do which is to serve others and to serve their institutions. They just, it starts to be all about them. And so like with the guys at Enron and other similar situations like how many of millions of billions of dollars do they need to feel successful. They’re basically robbing it from the people there suppose to lead. We’ve seen it in politics too. Sometimes with our politicians it becomes all about them and they seem to forget about their states or countries they’re suppose to lead. The Initiations Fallacy is when you start to think you know it all. You lose sight of the fact that no matter how much you know, there is much more to know. The Omnipotence Fallacy is when you

organization there are going to be things you don’t like. There are things that I don’t like at Yale. There are things that I don’t like at APA. There are things I don’t like anywhere. That’s to be expected, of course, but are you going to try to change every little thing you don’t like? No. Because very soon you’re going to be wasting your time on every little detail that just isn’t important. So what you do is you say, “Look you know no system is perfect. I’m not perfect. So what I’m going to do is adapt to things because in order to be an effective leader, to some extent, I have to understand the organization, work effectively with in it. But if that’s all you do, if all you do is adapt like a chameleon, then you’re not an effective leader.

So, the second ingredient is shaping. And that means you say, “Look, there are some things in the organization I don’t like, and I think they’re really important things.” It can be where ever you work. You know it can be at Yale. It can be anywhere. It can be in your family. And you say these are the things I really care about, that in principle, I think have to be changed. I’m not going to just sit here and wait for it to happen. I’m going to make it happen. So shaping is about going out and saying, “I’m going to pick the battles that I think are really important, and I’m going to try to change things to make my organization better.” And selecting environments is simply that sometimes it doesn’t work. You know, you try to change things, it’s not getting better, and you decide it’s the wrong place to be, it’s the wrong organization, it’s the wrong relationship, or whatever.

So successful intelligence is about this balance among adaptation, selecting, and shaping through a synthesis of analytical, creative, and practical abilities that we’ve talked about. The creative abilities to come up with ideas, the analytical abilities to decide if they’re good ideas, and the practical abilities to make them work. And what we think is crucial is what we call tacit knowledge. It’s what you need to know that’s not explicitly taught and usually is not even verbalized. And I’m not going to talk much more about it. But it’s going into an environment and figuring out what really makes things work here and then doing the things. And what we’ve found regarding practical intelligence and the tacit knowledge that comprises it is that experience matters. But what really matters is how much one learns from it. So you know a good leader is not just someone who has had N years of experience. It’s how much has the person learned from the experience they’ve had.
believe because you’re a hot leader you can do what ever you want. It’s fine. And the Invulnerability Fallacy is you think “I can do whatever I want because I’m going to get away with it.” Or like in my position, either nobody’s going to find out what I did or even if they find out, you know, I’m so powerful I can I can deal with them. And so what you get is leaders who become much less effective than people who have been less successful. And it’s their success that begins to be the basis of their failure.

Intelligence I believe is not really enough for effective leadership. In the 1980’s Louis Alberto Michato became the first minister ever for the development of intelligence in the world. He was in Venezuela. And his goal was to increase the intelligence of the population. Because he believed that if we increased people’s intelligence, then they would become better people, more humanitarian people, better leaders, everything you’d want. He was just talking about IQ. He wasn’t talking about a broad sense of intelligence. Do increases in IQ make people better people in any sense? Well, we kind of know the answer because of the _____ Effect. For those of you who don’t know what it is, the question is this-The average IQ is 100. It’s a 100 now, it was a 100 fifty years ago, it’ll be a 100 in fifty years. Why is the average IQ 100? Well of course, it’s not because God set the average IQ to 100. It’s because test publishers do. They keep restandardizing the test to make the average IQ 100. Well that’s fine, but the question James Fern asked is- suppose they hadn’t kept restandardizing the test? What would have happened to IQ’s over the course of the twentieth century? Would they have stayed the same because the average IQ is always 100? Would they have gone down because of the dysgenic hypothesis that dumb people have more kids than smart people? So we keep breeding dummies. You know the dumb ones breed like rabbits, and the smart ones don’t even have kids. Or is the intelligence going up because education has improved, technology has improved, the environment has improved and so on. And the answer was very clear, It’s going up. Three points every ten years in the twentieth century or about 10 points per generation. So the questions you have to ask are you know, well, if IQ has been going up, Why did we have so many massacres’ and genocides in the 1990’s? Why do we have so much terrorism? Why do we have all these wars?

Clearly IQ at least is not enough to make people more humanitarian, better people. And we can see this in the tragedy of the commons which is a term that came from Early New England as I understand it. Where farmers would have their cows eat the grass and the smart farmer would have the cow eat a lot of grass because the more grass he’d eat, the fatter the cow. The fatter the cow, the more money you’d make. But if every farmer has his or her cow eat all the grass then there’s no grass and so everybody loses. So what can be smart in the short term for you can be stupid in the long term for everybody including you. And you see this in Arms races, you see this in many things where people are short sided. They only look out for themselves, and then everybody loses. So what we begin to realize is that smart isn’t enough.

Leaders can be creatively intelligent, For example generating novels, strategic targets for terrorist attacks. They can be analytically intelligent, for example, in assessing the advantages and disadvantages of those targets. And they can be practically intelligent in delivering the attacks to those targets. So, they can be smart without being wise. So, why is wisdom especially important in current times?

Humans have made enormous strides in technology, including destructive technology, without corresponding advances in their wisdom with regards to the uses of this technology. This mismatch between the development of technology and the development of wisdom or the lack of development of wisdom posses the world an enormous risk. And so where this leads us is to what I’ve been saying, which is that wisdom means knowing what you know but also knowing what you do not know and knowing what you can know at a given time and place and knowing what you can not know. Now some people say that, well you know, studying wisdom-you really can’t do that because it means different things in different places. What we consider wise, someone else might consider foolish. So is wisdom universal? Well, I don’t know. But, it does seem to me that fundamental values appear to be largely the same across the world’s great religions and ethical systems. For example, in their stressing in relations with other things like reciprocity, sincerity, honesty, integrity, compassion and so forth. So there really is a common core, and it’s a common core in which we all can participate.

So the balance theory of wisdom, which is where I’m sort of ending the talk is that
wisdom - the application of successful intelligence what I talked about before but it’s not just doing what’s good for you. It’s towards the attainment of a common good so it’s good for everybody. Through a balance among intrapersonal - your own interests, interpersonal - other peoples interest,s and extra personal interest - meaning interest that goes beyond the individual people. It can be your company, it can be your country, it can be God, but it’s something that goes beyond just people. Over the short and long term, meaning that you’re looking out for what is going to happen over a long term not just tomorrow through the mediation of values, by acting so as to balance adaptation to, shaping and selection of environments. So the next slide just shows it in pictorial form. So it’s basically just using your intelligence for a common good and that’s what leadership should be about, asking how can I use the talents I have to do what’s best for the most of __ ___. It’s certainly what my main theme as APA President is, Unity. This is what I try to do whether I succeed or not-to say, “Look you know, the wrong thing to do is to go in as a APA leader and say well you know me as a Scientist, or as a Practitioner, as an Educator or someone in public ____. I’m going to represent my constituency.” That’s a loser because what you need to do is say, “How can I balance everybody’s interest to do what’s best for the organization as a whole?” Now some people say well, you know you can just use proverbs to tell you what to do. It doesn’t work because sometimes they contradict each other. Like - Out of sight out of mind. Absence makes the heart grow fonder. Sometimes they’re just plain wrong like- Spare the rod, Spoil the child. Sometimes the lessons they teach are often a matter of interpretation like-All’s well that ends well. Well what does that mean.

So my conclusion then is that WICS provides a useful model for leadership. It begins with wisdom. Without wisdom there’s no expert leadership. It doesn’t matter how smart you are, how creative you are if you’re not using your skills for a common good, you’re not a good leader. And wisdom can and should be developed. Finally, I’m happy to hear from you. As I mentioned, my e-mail address is Robert.Sternberg@el.edu and our website is www.el.edu/Pace. And my main message is that anyone can be a great leader, the decision is within you. Thank you very much!

(Applause)
Sure I’d be glad to answer questions.

(Man Speaks): I would just offer the thought that if we could, in APA Counsel, substitute this talk for the Thursday evening caucuses before we have our plenary sessions. I think it would have a marvelous effect. It’s just a personal observation that it would.

(Another Man Speaks): Are there other questions or comments or reactions? I know this is such a wonderful ____, it also has tremendous relevance to the Darwin Awards which we enjoy every year that are the counter example of what Bob’s talking about.

(Leon Green): My name is Leon Green. Can you give us some practical examples in which you applied this particular theory?

(Dr. Sternberg): You want me to give you practical examples. Is that what you want? Oh, yeah. I can give you a practical example. I can give you lots of practical examples. Why don’t I just give you one. Oops I see my time is up too. When I was running for APA President we had this issue of - I don’t know if you know the background. Scott ?_____ wrote an article that was critical of some aspects of the way APA handled the ?_____ fiasco which as an article in Psychological Bulletin about childhood sexual abuse and it’s later affects. The ?_____ editor wrote a letter accepting the article, and then the editor of the journal wrote back and said, “Oh well, it’s not quite accepted it. There has to be some more, a lot of changes.” He didn’t reject it. He just asked for more changes. ?_____ got angry and sent an e-mail on a lot of list serves, and other people circulated the list serves. Some people got very upset with APA that this looked like a cover up because ?_____ was critical of APA. Then all of a sudden this article seemed to be accepted and then rejected. So a lot of stuff went out on the list serves that was extremely critical, mostly from the academic community. One department, Harvard, wrote a joint letter, open letter criticizing what APA did. And so this was kind of very steamy, and I felt that I wasn’t sure I didn’t think that APA handled this in an ideal way. On the other hand, I thought that before you pass a judgment you ought to give people at APA a chance to respond. They may have made a mistake. They may have totally screwed up, but what seemed to me wrong about this situation is there’s all this stuff on e-mails, and the editor hadn’t even responded. So my feeling was that
before you get all hot and steamed up, at least we should hear the other side of the story. In any conflict you should hear two sides of the story.

But I was running for president, and so I faced the problem. Should I say anything on the list serves? Everyone I talked to advised me not to saying anything because I was taught my main constituency is the academic constituency. Most of them are siding so called with ? and if I go out and say, “Well, look. You haven’t heard the other side of the story.” What I’m doing is stabbing myself in the heart because I’m going to lose the votes of the people who are going to vote for me, and so, that that’s the end of that. So I found myself in this dilemma of feeling like it isn’t right what’s going on. Again I wasn’t defending APA or criticizing APA. I just think they ought to have a chance to defend themselves. But people were saying shut up, and I thought about it a lot. I was talking to Elena, who is now my wife, and I said to her, “Look, if I don’t say anything, I’ll feel like I sold out because I really have a strong view in this. I think the academics who are going so hot on the list serves are not acting, you know they’re talking. They teach their kids to think critically but you can’t think critically unless you hear all points of view. So, I may, if I go on the list serves, it may cost me the election, but if I don’t go on the list serves and I win the elections I’ll feel like it’s a hollow vote. If I lose I’ll be sorry I lost but I do have to live with myself for the next year.” So I went on the list serves said what I thought, and I lost some votes. Some people got very angry at me. Maybe I gained some, I don’t know, but the point was I asked myself what probably was good for me individually in the short term was to say nothing. But I felt the wise thing to do, what you have to do, is when you have a strong view you have to say it even if it costs you the election. So I was really trying to apply my own theory.

(Woman Speaks): Hi, Good Morning, I wanted to talk a little bit more about the wisdom aspect to your theory which is very interesting because we’ve actually been studying wisdom in my bible study class. And we have developed a concept that wisdom actually is a very spiritual aspect of who we are, and I wanted to know your thoughts about this. That wisdom is much more a relationship between life experiences, an internal process of knowing oneself, the ability to have patience, and conceptualize a bigger picture, a larger connection with other people. And that wisdom is like you said, it’s a developmental process, and it’s not as related to intelligence or success as it is to a person’s ability to use their life experiences. So I wanted to know what you thought about that.

(Dr. Sternberg): Well I agree with half of it I guess or 70%, but there’s one thing I don’t agree with. I think it does draw very heavily on experience and good use of experience. In the theory I actually talk a lot about the role of tacit knowledge in experience, and so I agree with that. And I agree about the importance of balancing different aspects of yourself-cognitive, affective, motivational. The one place where I might disagree is that I don’t think that it’s… I think it is related to intelligence, but not the narrow view of intelligence, but a broader view of intelligence. And the reason for that is that you don’t want to put yourself in a position where you say, “I’ve had a lot of experience and I feel good about this decision.” I think that’s it’s really important to do critical thinking and ask yourself what are the consequences if I do this. I mean it really involves your, quite deliberately, mapping out what are the effects going to be on this group, what are the effects going to be on that group, and if I have a commitment and I don’t follow through on it, what’s going to happen. So I think in a broad sense, you do need to use your critical thinking in order to be wise. But all the rest of what you said I agree. What I would say though is that intelligence is not sufficient. You can have people who are very intelligent but very unwise. And anyone who works in a department knows that. But after the last question then I’m going to tell you how I got here.

(Man Speaks): That was my question. I’m wondering if the solution to the brain teaser is illustrative of the principles you have been discussing. Thank you.

(Dr. Sternberg): Well, it was more illustrative of being lucky. So I told you that I was on the last flight out. It was cancelled, and I didn’t change to another Airline. The good luck was that there was an earlier flight that because of the bad weather had been delayed for a number of hours. So I took the earlier flight that left later than my flight would have left and I even got a better seat. That’s the answer.
Mary Fruit, PsyD

I entered the VA healthcare system as an intern 12 years ago and decided to continue to care for our veterans, and have never regretted that decision – although at times questioning how things happen (or don’t) within that system. I still firmly believe in “the mission” – and never more so than now as we wait for another generation of our military to complete their difficult missions and come safely home. They will no doubt need us in the years to come, and we must stand ready. Increasing my involvement with AVAPL is one way I plan to insure that happens. Whether that occurs as president-elect is a decision that rests in the hands of the AVAPL membership. This can also occur by involvement in SIGs and special projects within AVAPL as needed in the future – one way or another, I hope to be part of the continued growth and development of Psychology within VHA. My current position as Chief, Mental Health Service Line, at the VAMC in Fayetteville, NC, is my opportunity to do so in a more immediate and direct manner with the veterans residing in southeast North Carolina. As it is customary to provide some professional background information, let me share with you that I am very much a “home-grown” VA Psychologist. I completed my internship at the VAMC in Bay Pines, FL, before becoming one of the first Geropsychology Post-Doctoral Fellows at what was then the Audie Murphy Memorial Veterans’ Hospital in San Antonio, TX. I continued my VA career at the VAMC in Salisbury, NC, for the next 8 years as a staff psychologist before accepting my current position in Fayetteville.

I had the pleasure of attending my first AVAPL/APA conference in Denver earlier this year, and admit to being very much a newcomer to AVAPL in any formal sense. I have, however, been fortunate enough to train and interact with some of the leaders within VA Psychology over the years, and value the informal mentoring offered so willingly. I am a recent graduate of the Behavioral Health Leadership Training Program in Little Rock– You all know that program…. It began as a means to train and support developing psychology leaders. The “leaders” (read that as “wise ones”, “gurus”, “mentors”, “teachers”, “role-models”, or whatever best fits from your perspective) became so good at it that the doors were opened to others in Behavioral Health professions. I see that evolution as having occurred to improve VHA’s ability to provide mental health care to our veterans, foster interdisciplinary interactions within mental health, and enhance succession planning in support of the continued need for strong leadership in mental health programs within VHA. It’s also a classic example of “Value Added Service” from Psychology! The ability of those psychology leaders to see beyond our own needs to those of the system as a whole reflects what a first-class group of psychologists can accomplish – with motivation, creative thinking, dedication, and many long hours of hard work. The potential for AVAPL and its partnership with APA to continue to move both Psychology and Mental Health forward within VHA is great, and a movement I wholeheartedly support – and will do so with energy and determination.

It is humorous how things come full circle – there I was – back in Denver! My first clinical exposure to veterans happened in a graduate school practicum at the DAV Outreach Center in Denver, with Vietnam-era combat veterans. I was initially overwhelmed, quickly progressed to wanting to accept the clinical challenges they presented, and ended up with a strong sense that there was much work to do if things were going to “get better”. Those veterans educated me in a way no classroom could have done, with a rather steep learning curve… and one I imagine a few others have experienced in one way or another!

As I looked around the room this spring and tried to absorb the presentations, questions, discussions, frustrations and possible solutions that were shared, I was once again initially overwhelmed by the many tasks before us as VHA psychologists. Having moved from a staff psychologist position less than two years ago to a service line chief’s position, it seems I have already accepted the next challenge - with the AVAPL/APA conference serving to further solidify that intent. I also left that meeting with an increased
awareness of how much there is still to accomplish as psychologists for things to continue to “get better”!
It’s a safe bet there is another steep learning curve not found in any classroom awaiting me within AVAPL, whether as president-elect or simply via increased involvement in general. I look forward to that growth and opportunity.

I fully realize how critical it is for Psychology as a professional entity (and myself as one small part of that greater body of knowledge and commitment) to continue to provide leadership within VA. Many important concerns require ongoing effort and diligence on our part, yet the most important focus for me remains the protection and advancement of our profession’s ability to provide quality care to our veterans without erosion of our autonomy and high standards for the provision of that care. AVAPL, with strong support from APA, already is addressing many of the factors that support our ability to do so – Increasing opportunities for psychologists to advance within VHA; training and research opportunities; succession planning; Hybrid Title 38; Psychology Executive Directive; and yes, even those controversial prescription privileges. Our profession as a whole continues to research, develop, and advance our scientific knowledge base and clinical practice capabilities – we must ensure that Psychology within VHA remains healthy and vital so we can provide quality clinical care to our veterans in keeping with our profession in the greatest sense. I am honored at the opportunity to be a part of this mission within AVAPL. If elected I will continue the work so capably underway by AVAPL and APA to advance the practice of psychology within VHA. Our ultimate goal is the best possible mental health care for our nation’s veterans.

Joel Schmidt, Ph.D.
Reno, Nevada

I have had the chance to get to know many of you at various AVAPL meetings over the last several years. For those who don’t know me, I run the Mental Health Clinic in Reno and have been here four years since moving from the VA in Fayetteville, NC. I stumbled onto AVAPL in 1997 when I attended the VA Mental Health Leadership Training in Minneapolis. What a great accident that was! At the time, I was a very green service chief in a small Psychology Service on the verge of a bumpy service line reorganization. My reorganization story is similar to many of yours and I found contact with AVAPL folks to be a lifeline in coping with presumably well intended administrators who didn’t always know or fully appreciate the value of psychology in delivering and organizing mental health treatment. More than anything, AVAPL’s brilliance, in my mind, has been the consistent ability to take our very complicated profession, synthesize a clear, coherent message about its importance, and get that message to the right people. Of course not everything has gone our way over the last several years. But AVAPL members and leadership have directly championed several implemented directives that substantially benefit both Psychology and Mental Health.

Given my feelings about this organization, being nominated to run for president-elect is a huge honor. Being president-elect would be a huge responsibility. If elected, here’s what I pledge to do:

Carry on the legacy: AVAPL has had great leadership year after year. I will do my humble best to continue this great tradition, maintain the strong relationship with APA, build on our successes, and regroup where we need to. Psychology is on the cutting-edge of VA clinical service delivery, education, research, and administration and AVAPL needs to continue to shine the spotlight on these areas.

Hone and deliver the message: I won’t create the agenda, as I believe this should be done collectively by the membership. Instead, I will help craft our key points into concise, coherent messages and repeat, repeat, repeat.

Encourage debate: With healthy diversity comes healthy debate. Differences of opinion exist in several areas (prescription privileges and provider workload guidelines are obvious examples). Being a
professional advocacy organization, we need to have both thriving debate within the organization and a united cohesive message to deliver to the outside world.

Keep up the energy level: Passion and commitment have been the lifeblood of this organization and I vow to throw myself into this important job at full velocity.

We live in interesting times. Demographics suggest that the VA will be facing a wave of employee retirements in the context of dramatic increases in health care (especially pharmaceutical) costs and massive federal budget deficits. As psychologists leave the system, there will likely be a need, station by station, to pitch the benefits of refilling psychology positions with psychologists. Our organization will have to take the lead on this. Selecting the right leadership is particularly important at this point in history and I appreciate your consideration.

Terence M. Keane, Ph.D.
VA Boston Healthcare System

I've spent over twenty-five years in the Department of Veterans Affairs as an intern, staff psychologist, and then Chief Psychologist. My career began as an intern at the University of Mississippi Medical Center/Jackson VA Consortium. Upon completion of my internship I became a staff psychologist at the Jackson VA. There I began work providing psychological consultation to medicine, surgery, neurology, and the nursing home care unit. While an intern and continuing into my time as a staff member I became increasingly interested in the psychological problems of Vietnam theater veterans who were scarcely older than I was and who presented with such a diversity of problems that I rapidly became intrigued. Shortly thereafter my career became dedicated to developing treatment programs for war-ravaged veterans and their families.

Somewhat accidentally, I became the Chief of the Psychology Service in Jackson in the midst of my second year on staff in 1980. In 1985 I moved to Boston where I've served as Chief for the past eighteen years, Director of the Behavioral Science Division of the National Center for Posttraumatic Stress Disorder, and for the past two and a half years as the Acting Associate Chief of Staff for Research and Development. Currently I am Professor and Vice Chairman for Research in Psychiatry at Boston University as well as Professor in the Departments of Psychology and Behavioral Neuroscience.

Immediately upon becoming Chief I made use of the Chief's organization to help orient me as to what was expected and how to manage. This group saved me on multiple occasions, providing expert and sage advice on how to lead a relatively young Service, how to interface with administration, and how to succeed professionally. I owe the membership past and present a debt of gratitude.

It is this background that compels me to run for President-Elect of AVAPL. Should you support my candidacy, I will work hard to address the needs of VA psychologists nationwide and I'll tirelessly study the issues at hand to advise our group as to preferred direction on difficult matters. As well, I'll bring a focus on the future of psychology in healthcare systems more broadly, emphasizing the new roles now open to psychologists in our system while attempting to preserve the fundamental role of mental health service delivery.

My career in VA has highlighted the importance of integrating healthcare delivery, teaching, and the development of new knowledge through application of scientific method and the use of technology. It is this experience that I would bring to the organization. In addition, my skill in working successfully in complex hierarchically arranged organizations will be a benefit. In the past, I've been President of the International Society for Traumatic Stress Studies and a member of APA Council of Representatives from Division 18. I've been a member of NIH Study Sections for grant application review and chaired one
section for a year. As well, I’ve been a member of the VA Merit Review Board and numerous Blue Ribbon panels for VA and the NIMH. I am currently the past president of the Board of Directors of Fenway Community Health Center in the city of Boston, an organization with which I’ve been affiliated for some ten years on a volunteer basis. Since 1986 I have had the responsibility for oversight of the National Vietnam Veterans Readjustment Study, possibly the most influential epidemiological study of veterans in history. Its follow-up phase is currently in the planning.

My views on the issues confronting us in Psychology focus on the need for vigilance and rapid response. Change is a constant for us in VA and it is the obligation of those in leadership to analyze the problems, suggest solutions, and influence decision making at the highest level. Keeping in focus the needs of patients at all times is the key to success. To insure this we need a well-educated and experienced work force and accordingly efforts to recruit and retain the best people are priorities. I believe the Hybrid Title 38 is central to this goal.

The annual meetings of AVAPL, inaugurated so remarkably well by Dr. Russ Lemle of San Francisco, are fundamental to keeping our organization strong and visible. Insuring their continuance will be a foremost objective. Attendance by VA leadership in clinical care, education, and research helps us to set and achieve goals during the course of the year. Our affiliation with the APA in sponsoring these meetings means more to us as an organization than we can estimate. They are now are active partners in influencing behavioral health within the system nationwide.

Finally, my goal if elected will be to provide guidance to younger leaders in VA so that the next generation of psychology will be as strong and as effective as they need to be to successfully confront the challenges ahead of them. This must remain a high priority as more and more of our most senior people depart for the next phase of their careers.
Many have asked the questions: Just what do psychologists do? Why does the VA employ psychologists? And what added value do they bring to the healthcare arena? AVAPL is working on a project to help educate VA officials about how psychologists add value in the VA system, to answer the above questions, and more. Approximately once per month, a new Fact Sheet will be added to the AVAPL web site. You may want to print out these Fact Sheets or download them and send them via e-mail to your Chief of Staff, your Director, or anyone who might be wondering just what it is that psychologists do. To read these Fact Sheets online, simply go to www.avapl.org and click on the links.

AVAPL is looking for psychologists who are willing to create Fact Sheets. There are many areas of psychological service provided within the VA that are not currently included in the Fact Sheets series. It really doesn't take very long to complete a Fact Sheet, so please offer just 1-2 hours of your time to assist with this important project. If you would like to contribute a Fact Sheet, please contact:

Peggy J. Cantrell, Ph.D.  
VA Medical Center (MH-116A3)  
4801 Linwood Blvd.  
Kansas City, MO 64128  
Phone: 816.922.2681  
Fax: 816.922.4652  
E-Mail: peggy.cantrell@med.va.gov

To give you a sample, the next 4 pages will let you see the following:
- Fact Sheet 3 – Bipolar Disorder
- Fact Sheet 4 -- Cancer
- A list of various topics to address
- A generic template for ease of writing the information sheet
BIPOLAR DISORDER: PATIENTS CAN “LIVE A LIFE WORTH LIVING”

♦ Among VHA enrollees who received specialty inpatient or outpatient mental health services in FY 2000, approximately 9% were diagnosed with bipolar disorder
♦ Bipolar disorder affects approximately 2.3 million American adults per year
♦ Without effective treatment, nearly 20% of bipolar sufferers will commit suicide.

“This illness wreaks havoc with what makes us most human--our attitudes, our relationships, how we feel about ourselves, and our ability to trust our judgments about those closest to us” (Wehr, T.A.1)

Bipolar Disorder (formerly manic-depressive disorder) is a biologically based condition in which abnormalities in certain structures and functions of brain circuits cause extreme shifts in mood, energy, and functioning as well as severe psychosocial impairments.

Recent research supports the effectiveness of adding psychological interventions to pharmacotherapy to reduce rehospitalization, and improve overall psychosocial functioning and quality of life.2

Psychologists are trained in psychotherapeutic techniques that are beneficial for bipolar patients.3 It is important to include psychologists in treatment programs that target this population and in individual treatment plans of bipolar patients to ensure the most effective outcomes.

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CANCER: THE MOST FEARED OF DISEASES

Cancer is the second most common cause of death in the United States after heart disease. It is estimated that, ultimately, one out of every four Americans will die of cancer.1

♦ Since 1990, 12 million Americans have been diagnosed with cancer and 5 million have died.1
♦ Approximately 50,000 new cases of cancer occur in VA patients each year.2
♦ In FY 1998, the last time full reporting was complete, new cases of cancer in the VA accounted for nearly 10% of total unique patients accessing the VA for medical care in that year.3

The diagnosis of cancer often brings out fears unmatched by those elicited by other catastrophic illnesses. The effects are felt by patients, families and caregivers.4

Unfortunately, the psychological aspects of the diagnosis are often ignored and there is a lack of consistent psychosocial supports for patients with cancer.5

Cancer patients experience a variety of psychological symptoms including depression, stress and anxiety. Psychological interventions such as individual or group psychotherapy, family therapy, biofeedback, and pain management can significantly improve the quality of life for both patients and their families.6 Psychologists can help patients make important decisions regarding treatment options, teach appropriate coping strategies, and intervene in issues around noncompliance.

On a more positive note, an estimated 80% of all cancers could be prevented if people practiced healthier behaviors such as not smoking, good eating habits and exercise.7

Behavior change, a field in which psychologists have unique expertise, is one of the major weapons in the reduction of premature disease and deaths due to cancer. Psychologists are at the forefront in this field and behavioral research in this area is one of the top priorities for the National Cancer Institute.1

The Cartesian worldview separating mental and physical health is no longer suitable in healthcare today. Psychology is an important partner in the fight against this deadly disease and able to make vital contributions to the VA’s National Cancer Strategy through research and intervention.
Essential Healthcare for Veterans:
Psychologists Improve Lives

Possible Topics for AVAPL Fact Sheets

- Addictions
- Adult manifestation learning disorders
- Advance directives
- Amyotrophic lateral sclerosis
- Anger management
- Anxiety disorders/Panic
- Atypical dementias (Pick’s Lewy Body, etc.)
- Bereavement and loss
- Biomedical ethics
- Bipolar disorder
- Breast cancer/breast health clinics (done in some VA’s)
- Cancer
- Cerebrovascular disease risk and warning signs (TIA)
- Chronic obstructive pulmonary disease (sleep effects and chronic cognitive effects)
- Chronic pain
- CISD
- Competency evaluations
- Complimentary and alternative medicine (CAM)
- Coronary artery bypass grafts (CABG)
- Cost effectiveness of psychological services
- Death and dying
- Dementia/Alzheimer’s
- Depression
- Diabetes
- Diagnostic/psychological evaluations
- EAP
- Employment conflict arbitration and alternative dispute resolution
- Epilepsy
- Essential/familial tremor
- Exercise and psychological health
- Fibromyalgia
- Geropsychology
- Headache/psychological treatment
- Heart disease
- Hepatitis C
- HIV/AIDS
- Homeland defense/stress inoculation
- Homelessness/psychological impact
- Hospice consultation
- Hypertension
- Infectious diseases risk reduction
- Isolated memory loss (non-dementing cognitive change and dysfunction)
- Low vision/VIST
- Marital/couples therapy
- Medication compliance
- Memory evaluations
- Multiple sclerosis
- National importance and history of Psychology education in American healthcare
- Neurofibromatosis
- Obesity/eating disorders
- Organ transplant evaluations
- Organic brain syndromes
- Pain and its management
- Parkinson’s disease (really big –congress and gulf war exposures and effects)
- Personality disorders
- Phobia, anxiety attacks, and panic attacks
- Prisoner of war effects
- Prostate cancer (screening and counseling)
- Psychological tests available to veterans
- Psychology in research review and human subjects protection
- PTSD
- Relaxation therapy and meditation
- Repetitive strain injuries/carpal tunnel syndrome
- Schizophrenia (chronic mental illness)
- Sexual assault in the military
- Sexual dysfunction
- Sexual dysfunction therapies
- Sleep
- Smoking
- Smoking cessation/tobacco freedom
- Spinal cord injury
- Stress
- Telepsychology/telehealth
- Terrorism and stress
- Toxic exposures in military service
- Transplantation screening and outcomes
- Treatment contracts
- Veteran children at risk for substance abuse
- Violence and the workplace
- Vocational counseling and services (IT/CWT)
- Women’s health
Essential Healthcare for Veterans: Psychologists Improve Lives

[TEMPLATE]
ISSUE/DISORDER/PROBLEM: IMPORTANCE/PHRASE

♦ PREVALENCE
♦ STATISTICS-VA RELATED IF POSSIBLE

NEGATIVE CONSEQUENCES TO INDIVIDUALS, FAMILIES, AND/OR SOCIETY AS A RESULT OF THE ISSUE

DESCRIPTION OF THE TOPIC, ISSUE, DISORDER, PROBLEM

RESEARCH, OUTCOME STUDIES WITH PSYCHOLOGICAL INTERVENTION THAT IMPROVE OUTCOMES FOR THIS PROBLEM

STRONG CONCLUSION ABOUT THE IMPORTANCE OF PSYCHOLOGISTS BEING INVOLVED IN THE HEALTHCARE OF VETERANS REGARDING THIS PROBLEM/DISORDER

REFERENCES
REFERENCES
Do you belong to AVAPL?

No?

Then you must see the next page!!!
Top 10 Reasons to Join AVAPL

- AVAPL puts out newsletters 2-3 times per year that keep you informed.
- AVAPL has a web site that provides information of interest to VA psychologists. ([www.avapl.org](http://www.avapl.org))
- AVAPL sends its Executive Committee to promote VA Psychology’s interests with VA Headquarters administrators, the American Psychological Association (APA), and Congressional members/staffers during the mid-winter meeting.
- AVAPL co-sponsors with APA an annual VA Psychologist Leadership Conference that offers psychologists ideas, support, and a chance to network with VA colleagues and national psychology leaders.
- AVAPL hosts an annual VA Training Meeting at the APA Convention where VA psychologists with interests in training are able to learn about the recent training issues within VA and get questions answered.
- AVAPL hosted two free accreditation workshops for members presented by the APA Committee on Accreditation; one for accreditation of internship and postdoctoral programs, and the other for site visitor training. AVAPL maintains close relationships with those who are integral to the VA Training Mission.
- AVAPL hosts annual membership meetings at the American Psychological Association convention.
- AVAPL recognizes psychology leaders through the annual AVAPL awards program.
- AVAPL sponsors Special Interest Groups (SIG’s) that assist psychologists in their professional development in areas of interest to VA Psychologists.
- AVAPL provides a community of motivated, interested, talented, creative psychologists with whom to network.

AVAPL Membership Application Information

Please join us and take advantage of the many AVAPL benefits. Make copies of this information and membership application forms, share with the other psychologists at your station, and encourage them to join. There are three categories for AVAPL membership: Active, Affiliate, and Honorary. Membership criteria for each of these categories are as follows:

**ACTIVE MEMBER:**
Any psychologist who
i. is currently a supervisory psychologist, or
ii. is currently an acting supervisory psychologist, or
iii. is formally designated as responsible for the professional issues which ensure the integrity of the discipline of psychology (discipline concurrence in suitability for hire, credentialing and privileging, continuing education, or director of training for internship and/or post-doctoral training programs, where training programs exist), or
iv. is designated in an acting capacity and responsible as in (iii), or
v.  is a program manager responsible for directing the activities of clinical personnel, or
vi.  is an acting program manager responsible as in (v), or
vii.  directs the provision of psychological services within a facility, program, or clinic, or
viii. demonstrates professional leadership by such activities as holding professional elective office, committee membership which sets standards or policies for the profession, or significant involvement in accreditation and licensing/credentialing bodies

within the Veterans Health Administration of the U. S. Department of Veterans Affairs shall be eligible for election to active membership in AVAPL.  Active members in good standing shall be entitled to vote, to hold office, and to participate in all business and scientific meetings of AVAPL.  A person may remain an active member until the end of the membership year in which he/she ceases to function in one of the above roles.

HONORARY MEMBER:
Any former member of AVAPL shall be eligible for election to honorary membership.  In addition, honorary membership shall be available to other persons who have distinguished themselves in promoting the purpose of AVAPL and who are nominated for such membership by a member of the Executive Committee.  Honorary members shall be able to participate in the activities of AVAPL and shall receive all general mailings, but they may neither vote nor hold office.

AFFILIATE MEMBER:
Individuals who are not members of AVAPL may apply to the Executive Committee to be Affiliate Members of a SIG.  Affiliate Members of a SIG may not compose more than 49% of the total membership of the SIG and may not vote in matters concerning the SIG or be appointed as Chair of the SIG.

For your convenience, there are two ways to pay your dues this year.

Send the completed form and dues ($70 Active Member [$80 after December]; $30 Affiliate Member; no charge for Honorary Member) to:  Pam Fischer, Ph.D.
OKC Dept. of Veterans Affairs Medical Center
921 N.E. 13th Street (183A)
Oklahoma City, OK  73104

OR

Complete your membership form online and charge your dues to your credit card.  Just head over to AVAPL’s web site at http://www.avapl.org, and click on the Join/Renew button.  AVAPL has partnered with PayPal to provide you with the ability to charge your dues, and your transaction will be handled through PayPal's secure web site.

SIG MEMBERSHIP:  You may join as many SIGs as you want (at no extra charge).  Joining a SIG means that you will be included in the listserv for the SIG.  You can then participate in discussions and develop resource information for other psychologists who look to the leaders in that special interest area for professional development.  SIGs in Administration/Leadership/Advocacy, Primary Care and Behavioral Health, Geropsychology, Research, Training, and Addictions have already been initiated.  We are proposing the development of several more SIGs including Psychosocial Rehab, Seriously Mentally Ill, and Stress Disorders.

SIG DEVELOPMENT COMMITTEES:  Each of the SIGs is seeking volunteers to become members of its Development Committee.  This group will be the planning committee responsible for making the SIG functional.  Most of the Development Committee’s work will take place via a smaller listserv.
Association of VA Psychologist Leaders (AVAPL)
Application/Renewal for Membership

Name: ___________________________________________ Title: _________________________
Station: __________________________________________
Address: __________________________________________

Phone #: ___________________________________________ FAX #: __________________________________________
E-Mail: ___________________________________________

Preferred mode of communication from AVAPL: □ E-Mail □ U.S. Mail

I am applying/renewing (circle one) membership as

□ Active Member* □ Honorary Member* □ Affiliate Member*

*See definitions of membership status on previous page.

If applying/renewing as an Active or Honorary Member, please mark the Special Interest Groups (SIGs) that you wish to join. You may join as many SIGs as you want. Joining a SIG means that you will be included in the listserv for the SIG. If you wish to be included in a smaller listserv for the Development Committee of a particular SIG, please mark that column also. This group will be the planning committee responsible for making the SIG a functional group.

Current SIG’s

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<tr>
<th>Special Interest Group Name</th>
<th>I want to join.</th>
<th>I want to be on the Development Committee.</th>
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<td>Administration/Leadership/ Advocacy</td>
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<td>Primary Care/Behavioral Health</td>
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Proposed SIG’s

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<th>Special Interest Group Name</th>
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<th>I want to be on the Development Committee.</th>
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<td>Psychosocial Rehab</td>
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<td>Seriously Mentally Ill</td>
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<tr>
<td>Stress Disorders</td>
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If you are willing to nominate yourself to become a candidate for Chair of one of the proposed SIGs please note on this form and send a copy of your vita.

If applying for Affiliate Members status:

Which Special Interest Group do you want to join? Would you also like to become a member of that SIG’s Development Committee? □ YES □ NO