RESPONDENTS' OPPOSITION EXHIBIT 18

FEATURE

Changing gears

Russ Newman looks back over his APA tenure and ahead at psychology's continuing challenges.

December 2007, Vol 38, No. 11
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5 min read

Having served for the past 14 years as executive director for professional practice, Russ Newman, PhD, JD, is leaving APA to become provost and vice president for academic affairs at Alliant International University in California. The *Monitor* asked Newman about his work on behalf of professional psychology and his new leadership role at Alliant.

What has changed for practicing psychologists since you became executive director of the Practice Directorate in 1993?

Our health-care system continues to deteriorate. Many health-care professionals find it increasingly difficult to practice, and too many consumers are unable to get the psychological services they need.

Managed care was introduced as nothing more than a cost-saving mechanism that, true to its historical roots, has valued profits over patients. Ironically, it failed to even accomplish real cost containment. When I first became executive director of the Practice Directorate, we specifically focused on obstacles to practice arising from the advent of the managed-care industry. In recent years, we have also focused on cultivating opportunities for practitioners beyond traditional mental health services, particularly in the health arena.

Despite our badly broken system, we've seen some positive developments. Building on a strong foundation of traditional psychotherapy and assessment, practitioners are diversifying their practices by expanding into new practice areas. Licensed psychologists continue to broaden their professional opportunities and roles, for example, by gaining legislative authority to prescribe psychotropic medication, by collaborating with other health-care professionals to provide comprehensive services, and being utilized for their expertise to solve behavior-based problems with individuals, groups, organizations, communities and even nations.

Meanwhile, there is growing public awareness of the link between psychological and physical health and greater understanding that lifestyle and behavior are important factors in health and illness. Employers in particular are recognizing the effects of lifestyle and behavior on both their employees and their bottom lines. People are more willing to seek treatment as the stigma against mental health care has lessened. On the federal legislative front, we're on the threshold of achieving full parity, a decade-in-the-making critical move toward ending discrimination in the health-insurance market against individuals with mental health disorders.

What does the future look like for practitioners?

Problems with the U.S. health-care system seem likely to continue in the short run, while unpredictable health reforms cause continuing flux in the system. During that period of flux and beyond, psychologists will need to emphasize their ability to address lifestyle and behavior issues, health promotion and prevention, as well as the importance of dealing with disease management. This is particularly true in our nation, where the six leading causes of death are related to behavior.

Psychologists who continue to diversify their practices and provide culturally competent services to underserved individuals and communities are likely to find the greatest professional opportunities.

What were some of the Practice Directorate's greatest successes during your tenure?

Several of these achievements include:

Creation of the American Psychological Association Practice Organization. APA faces limitations in advocating for practitioners given its tax status as a 501(c)3 organization. In 2001, we launched the APA Practice Organization (APAPO), a 501(c)6 affiliate of APA, to enable us to engage in advocacy and political activity that the 501(c)3 APA is unable to do.

Managed-care litigation. For more than 10 years, we've joined with state psychological associations to successfully wage battle in the courts against abusive managed-care practices, such as fee cuts in breach of psychologists' contracts, no-cause termination, and "phantom panels" that harm psychologists and their patients. The APAPO remains involved in a nationwide class action lawsuit that has yielded $15 million in settlement payments so far, along with substantial managed-care company policy changes.

Gaining the health and behavior codes. The implementation of these new billing codes in 2002 represented a milestone in recognizing and reimbursing psychologists for their services delivered to individuals with a physical health diagnosis but no mental health diagnosis. It has also enabled psychologists to get reimbursed on an 80/20 co-payment basis rather than the 50/50 co-payment for mental health services.

Public education about the value of psychology and psychological services. Our ongoing public education campaign, launched in 1996, has helped inform the public about timely issues including the warning signs of youth violence, resilience, dealing with war and other sources of stress, and the mind-body connection. The campaign reach has been impressive. Millions of people have seen and heard our messages in newspapers, magazines, brochures, on television and radio.

Outreach to the corporate sector. Given the importance of employers in the health-care system, the directorate has incorporated a focus on the employer community during my tenure as executive director. Our Psychologically Healthy Workplace Program is one of our most successful ventures in this area.

What has been your greatest disappointment?

One disappointment involves recognizing the reality of the limited influence any single health profession has in seeking to "fix" a badly broken health-care system. We need to guard against having unrealistic expectations about how much leverage even the health professions together have in dealing with the likes of the insurance and employer communities. It took close to 10 years with parity to convince Congress that the needs of people with mental health problems should take priority over the interests of insurance companies and employers. I am disappointed that change has not been faster and more visible.

What will you miss about working at APA?

Psychology has a rich heritage in its diversity of professional orientations and interests. I will miss working with the many constituencies that comprise the practice community, including leaders in our state, provincial and territorial associations and practice divisions. It has been difficult work at times when groups have differing priorities that need either to be reconciled or reprioritized, but it is gratifying to see what we have been able to accomplish by pulling together.

What will you do at Alliant?

Having practiced psychology and worked with practitioners for more than two decades, it is clear to me that the education and training needs of practitioners are changing. Not only are marketplace changes requiring new kinds of training, but shifting demographics and increasing globalization are significantly affecting training needs for future professionals.

I'll be working at Alliant to help ensure that psychologists and other professionals are well equipped to provide contemporary, culturally competent services in an increasingly international environment. I also expect to cultivate opportunities for collaboration between disciplines--for example, the psychology and business schools--to help prepare students fully for successful practice of their profession, whether it be psychology, forensics, business or education.

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STATE LEADERSHIP CONFERENCE

A year that brought pain, but also progress

Russ Newman summed up notable events for psychology since the last State Leadership Conference.

By JENNIFER DAW
Monitor Staff
May 2002, Vol 33, No. 5
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3 min read

Most everyone in the United States agrees that the events of Sept. 11 have shaped our future in ways we could never have foreseen.

Psychologists, certainly, are keenly aware of the changes in people's attitudes through their work with clients and their own changed perspectives.

"The terrorist attacks had a profound effect on us as individuals, as a profession, as a community and a nation," said Russ Newman, PhD, JD, APA's executive director for practice, at the keynote presentation at the 2002 State Leadership Conference. "We've all been touched by these events. Life will never be the same again." As a result of the attacks, people have a new found desire to be resilient in the face of continuing challenges and seem more open to psychological process and self-discovery than before, he said.

Now more than ever, Newman added, psychology has "an opportunity and a responsibility to contribute in one of the most important events of our time."

He praised the field for the work already done--its rapid mobilization to become part of the response to Sept. 11, saying psychologists were "on the front lines, reaching beyond consulting rooms and offices and into the community." Sixteen state psychological associations were involved in APA's Disaster Response Network and the American Red Cross efforts.

Though they pale in comparison to the magnitude of Sept. 11, many other significant events have occurred in the field since the last State Leadership Conference, said Newman, such as:

A historic victory on the prescription privileges (RxP) front. Newman gave a special commendation to New Mexico's Elaine LeVine, PhD--whose work at the state capital for RxP kept her from attending the conference--and Mario Marquez, PhD, both of whom were instrumental in the recent legislative win for psychologists. (See April *Monitor* (/monitor/apr02)). Newman said New Mexico could begin a domino effect in many of the 13 states that have introduced RxP legislation.

An increased concern about phantom managed-care panels. California passed a law against the practice, in which managed-care provider lists are incorrect or out-of-date, promising providers that aren't really available. The Virginia Association of Clinical Psychologists lawsuit against Blue Cross/Blue Shield of the National Capital Area "is likely to be the first courtroom challenge to phantom panels," Newman said.

Measured progress on patients' rights legislation. On the federal level, parity supporters have vowed to renew efforts, and talk of discussions between President Bush and Sen. Ted Kennedy (D-Mass.) seems promising. Newman said APA will continue to make the Mental Health Equitable Treatment Act--which passed the Senate and was shelved in a conference committee this year--a legislative priority. The act calls for equal insurance coverage for mental health and physical health. On the state level, New Jersey and West Virginia passed health plan liability laws, which allow patients to hold managed-care companies legally accountable for their decisions. Five additional states have achieved mental health parity--Rhode Island, Kansas, Illinois, Delaware and Arizona.

Preparation for the Health Insurance Portability and Accountability Act (HIPAA). Psychologists will have to comply with HIPAA privacy rules by 2003. (See related story (/monitor/may02/primer)) Newman promised attendees they'd "all know more about HIPAA next year than they ever wanted to know."

Development of the APA Practice Organization Practitioner Portal, set to launch at the Annual Convention in August. The portal is an Internet-based resource that will provide practitioners with the information and tools they need to manage their practices.

Continued work on the International Classification of Functioning, a classification system based on human functioning, rather than disease, is strong, with APA driving the work on an ICF manual for providers.

Newman called for all psychologists to come together like never before to show the public how psychology makes a difference in their lives. "There are as many front lines as there are communities," he said.

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PROFESSIONAL POINT

Seeking 'zero trauma'

By Dr. Russ Newman, APA Executive Director for Practice

January 2004, Vol 35, No. 1
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4 min read

In a recent column, I wrote about the important role for psychology and psychologists in helping people build resilience in today's increasingly stressful and challenging world. I want to follow up on that theme by focusing on a related issue of building resilience in our profession in an increasingly stressful and challenging health-care world.

Without question, practicing psychologists in today's health-care system face many obstacles. Although there seems to be a growing consensus in the country that a market-driven, managed-care approach to health care clearly is not working, there is no consensus as to how to build a better system. Reform, while perhaps starting to appear on the horizon, continues to be unclear and is likely to be mired in presidential campaign politics for at least another year. Many other forces also contributing to unpredictability in the health-care arena are likely to remain for some time to come. While we continue to work to address obstacles in the system, the process is slow and painstaking in the absence of comprehensive reform.

On one level, building individual resilience could certainly help individual psychologists weather the challenges posed by the broken health-care system and the fits and starts we can expect of reform. What might be more useful, though, is looking at resilience from the perspective of the profession as a whole. A September 2003 *Harvard Business Review* (Vol. 81, No. 9) article offers a framework for corporations and organizations to enhance their resilience in the wake of turbulent times. Perhaps this framework can be applied to the profession of psychology as well.

According to Gary Hamel and Liisa Valikangas, authors of the article--"The Quest for Resilience"--strategic resilience for corporations is less about responding to a crisis or about bouncing back from a setback and more about "having the capacity to change before the case for change becomes desperately obvious."

In effect, strategic resilience builds an ingrained agility and flexibility that enables a company to be "constantly making its future rather than defending its past." Reorganization, reengineering or downsizing become unnecessary as evolutionary change takes

place in ongoing incremental steps consistent with a goal of "zero trauma" for the company.

Given the degree of flux (if not turmoil) anticipated to continue in the health-care system as Congress and the country struggle to find solutions, the agility and flexibility envisioned by strategic resilience may benefit our profession. Being ahead of the change curve rather than behind it may help psychology toward the goal of "zero trauma," or at least reduced trauma, in the wake of continuing health-care reform.

Implementing strategic resilience in an organization (never mind a profession) is not without its challenges. The Hamel and Valikangas article describes four specific challenges: the cognitive challenge, the strategic challenge, the political challenge and the ideological challenge.

The cognitive challenge is described as the denial, nostalgia and arrogance that prevent recognition and appreciation of what is changing in the surrounding world and how it is likely to affect the company, or in this case the profession of psychology. It results in absolute surprise when the company discovers one day that it can no longer function successfully in the changed world. The counter to this debilitating denial is perhaps best described by Jim Collins in his book, "Good to Great" (HarperCollins, 2001), which looks at what distinguishes good companies from great companies--the need to confront the brutal facts of reality prior to decision-making.

Strategic resilience also requires having alternative plans to implement. The strategic challenge is the difficulty inherent in developing new alternative strategies to replace old strategies that no longer work. Embracing ongoing experimentation of new ideas, new approaches and new strategies is key to overcoming this challenge.

Perhaps the most difficult challenge--the political challenge--is the ability to divert resources away from old programs and strategies to new ideas and approaches. Despite the difficult political process inherent in reallocating resources, to be successful today, companies must, according to Hamel's strategic resilience model, invest in "what could be" and not just "what is."

The final challenge, the ideological challenge, involves moving away from exclusive reliance on optimization. Doing more, better, faster and cheaper is no longer enough to guarantee success, or even survival. An increasing wave of change requires as much emphasis on getting *different* as it does on getting better. Perpetual renewal is as important as building the foundations for operational efficiency.

If our profession can master these challenges, perhaps we will be in a better position to withstand what lies ahead. Perhaps we will be able to achieve "zero trauma." And, perhaps we will be in a better position to make our future, rather than only defending our past.

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PROFESSIONAL POINT

'Right to sue' remains at heart of debate

By Dr. Russ Newman APA Executive Director for Practice

July/August 2001, Vol 32, No. 7
Print version: page 44
4 min read

There has been much federal legislative activity so far this session concerning managed-care reform, and the White House has shown that it wants to get in on the action. Of course, no amount of political activity guarantees that, at the end of the day, a strong patient protection bill will become law. As in the last few years, the right of patients to sue negligent managed-care companies remains at the heart of the policy battle and the key to successful reform.

Almost immediately after the 107th Congress was seated, Sens. John McCain (RAriz.), Edward Kennedy (DMass.) and John Edwards (DN.C.) introduced a patient protection bill with an HMO (managed-care company) accountability or "right to sue" provision. In the House, Reps. Greg Ganske (RIowa) and John Dingell (DMich.) introduced companion legislation. While the accountability language in these bills was a variation of language previously included in the Norwood-Dingell bill, it was clearly the strongest proposal ever put forward in the Senate, which, in contrast to the House, has been slow to embrace patients' right to sue.

Increased accountability

In a nutshell, the McCain-Ganske bill provides for lawsuits in both federal and state courts. If enacted, the bill would create a new federal cause of action against managed-care plans for inappropriate decision making related to such issues as enrollment or plan coverage. In essence, these new causes of action would cover the types of decisions presently covered by ERISA actions. But unlike ERISA actions, which currently only allow recovery for the economic value of the denied benefit, the proposed new federal action includes unlimited economic and non-economic damages. In addition, the bill creates a new civil assessment of up to $5 million if it can be shown that the managed-care plan displayed "bad faith" in its administrative decision making.

At the state level, the bill ends ERISA preemption of state-based personal injury or wrongful death causes of action for managed-care decisions that involve medical judgment, i.e., "medically reviewable decisions." Negligent medical necessity or utilization review decisions are examples of the types of actions by managed-care plans that could be legally challenged if this bill were to

become law. Managed care's present immunity to challenge for many such actions due to ERISA preemption has been a major obstacle to holding managed-care companies accountable. The bill leaves it to state law to determine allowable economic and non-economic damages. Punitive damages also would be available where a plaintiff could show that the managed-care plan acted with "willful or wanton disregard" for the rights or safety of others. Importantly, the bill includes damages for mental injury (as well as physical injury), something that other proposals have, unbelievably, omitted.

Counterproposal

While many in Congress support strong patient protection with an adequate right to sue, not everyone favors it. Sens. Bill Frist (R-Tenn.), James Jeffords (IVt.), and John Breaux (DLa.) are introducing legislation that limits patients' right to sue. The Practice Directorate succeeded, along with other mental health organizations, in making sure that the definition of injury contained in this bill includes "significant mental illness or disease," not just physical injury. Yet under the Frist-Jeffords-Breaux bill, patients could only sue for denials of care in federal court (no state cause of action) for unlimited economic damages plus up to $500,000 for non-economic damages adjusted for inflation, and patients would be barred from seeking any punitive damages. While the Frist-Jeffords-Breaux bill includes most of the patient protections included in McCain-Kennedy apart from the right to sue, it is clearly intended as a more conservative counterproposal to holding managed-care companies more fully accountable. Congressman Charlie Norwood (RGa.), longtime champion of a patient's right to sue, describes the liability section of the Frist-Jeffords-Breaux legislation as fatally flawed, with legal loopholes and hurdles that will prevent most victims from being able to successfully file suit.

It would seem, then, that the stage is set for a political battle through the spring (and perhaps into the summer) over a patient's right to sue a negligent managed-care company. Any real reform of the current market-driven managed-care approach to health care depends on the degree to which managed-care plans are held accountable for profit-driven corner-cutting. Some bills in play would hold managed-care companies accountable; other bills would not. Attempts at patient protection without sufficient means of enforcement risk creating a "fig leaf" statute that adds little to legal reform that is simultaneously occurring in the courts, albeit slowly, as the common law whittles away at ERISA preemption. In the end, however, the courts will not be able to fashion a complete fix on their own. A strong right to sue law passed by Congress is also necessary.

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LETTERS

Letters

July/August 2007, Vol 38, No. 7
Print version: page 4
5 min read

Health-care reform

Regarding Russ Newman's column "Moving beyond reform (/monitor/may03/pp) " in the May *Monitor*, we certainly agree that good mental health care means integrating mental and physical health, concentrating on prevention and teaching behavioral change for health promotion. But it is very clear to us that these things cannot be accomplished in the current fragmented, privatized health-care system. To preserve and expand the professional work psychologists do, we need a health-care system that will cover everyone.

Unfortunately Newman's interpretation of the phrase "moving beyond reform" seems to mean that psychologists should find ways to do psychological work outside of the health-care system. This sounds to us like not moving beyond reform, but avoiding the problem. While finding new areas to do our work may be the way to go for some psychologists, it is decidedly not what our profession as a whole needs. We would like to see the Practice Directorate support psychologists who want to continue to provide psychotherapy in their private practices. The best way to do this is to join with other national organizations in working to replace the current health-care system with one that provides health care for all-i.e., a single payer system, such as traditional Medicare, with no managed care.

Psychologists need to stand up for access, affordability and universal inclusiveness in health care, not only for the sake of our patients and our society, but for the preservation of the work that we do.

Marianne Jackson, PhD
Brooklyn, N .Y.

RESPONSE FROM RUSS NEWMAN

Helping psychologists make unique contributions outside the health care system should not be in place of working within it, rather in addition to it. Additional opportunities for practitioners are particularly important now, when a badly broken health-care system makes reliance on third-party payment problematic. And because of the severity of the system's difficulties, transforming health care in this country, more than just reforming it, must be a priority for Congress. The Practice Directorate works in coalition with many other national organizations in an effort to convince Congress of this.

It is not yet clear, however, how Congress will attempt to tackle the problem, or which legislative approach will have the greatest chance of accomplishing the goals of increased access, affordability and universal coverage. Therefore, it is critical that psychology focus its efforts on assuring psychological services are included and valued, irrespective of what approach Congress pursues. To prematurely commit to one particular model or ideology runs the risk of marginalizing our voice in the many different discussions and debates that will inevitably occur on the way to successful congressional action.

In the meantime, the Practice Directorate continues to confront those obstacles that interfere with the successful practice of psychology. We are working closely with state psychological associations to take action on rate cuts by managed care plans. We are developing strategies and materials for individual psychologists to use in dealing with third-party payers. We have successfully sued major managed care companies and won victories for patients and psychologists. We helped stop a five percent Medicare rate cut slated for 2007 and are continuing to work to get Congress to roll back the nine percent cut initiated by CMS. And we have played a key role in advancing a full mental health insurance parity bill that we are optimistic will pass this year.

While these actions alone will not fix the broken health care system, they can provide help for psychologists doing psychotherapy in their private practices, as well as in the public sector.

Russ Newman, PhD, JD
APA Executive Director for Professional Practice

As a Massachusetts-based APA member, I am distressed that the *Monitor* has joined the hype about our state's new "universal" health insurance law. This bill is, in fact, a cruel hoax that, if emulated in California and elsewhere, will turn the clock way back on efforts to provide American citizens with universal access to comprehensive, affordable, quality care. The United Nations, after all, has declared health care as an inalienable human right, recognized as such by every other industrialized nation in the world.

The fundamental premise of the law is that health insurance is an obligation of each individual, who is to be punished if he or she does not buy it. Never mind that thirty-somethings earning under $40,000 annually would wind up paying 20 percent of their before-taxes income on a plan that won't cover all health needs, can "cherry pick" healthy people without pre-existing conditions (or even bad DNA) and declare as medically unnecessary whatever the corporate bottom-line needs to exclude (e.g., intensive psychotherapy or certain preventive measures). The greater good is here defined as the runaway profits of insurance and psychopharmacology giants, whose immense lobbying power has for years defeated attempts to change our broken health-care system to the just and cost-effective models practiced by the rest of the civilized world.

It is troubling to see psychologists, who should understand the dynamics involved, fail to denounce the "victim blaming" that goes into the individual mandate plans. Sadder still to see our state and national organizations ignore the fight for a truly progressive health coverage system while focusing on narrow guild interests. As health care goes, so goes our entire profession.

Abram Chipman, PhD
Brookline, Mass.

Navigation neurons

In addition to the hippocampal cells that respond to spatial attributes described by Rachel Adelson in "Checking the coordinates (/monitor/mar07/checking)" (March *Monitor*), neural and physiological concomitants of spatial perception on a more macro scale have been studied in human volunteers. Take, for example, the eye movements by which we scan a scene and capture visual snapshots

that are connected to form a percept of the spatial environment. Although these saccades are triggered in frontal cerebral cortex and subcortical sites, they can be noninvasively recorded during complex visual and spatial tasks.

In clinical neurology, effects on visual and spatial attention have long been linked to neural damage in the parietal lobe. And in functional brain imaging by fMRI, visual attention has been associated with activation of frontal, parietal and striatal areas of the cerebrum. Brain imaging combined with a neuropsychological task suggests that a subgroup of children with attention-deficit hyperactivity disorder may have a subtle deficit in visual attention that may correspond with changes in activity in the opposite side of the brain. Such studies in human cognitive neuroscience provide a vital link to spatial cognition in clinical and applied psychology.

Robert Lavine, PhD
Washington, D.C.

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PROFESSIONAL POINT

Perennial battles on the Medicare front

By Dr. Russ Newman, APA Executive Director for Professional Practice

March 2007, Vol 38, No. 3
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4 min read

Confronting problems in the Medicare program remains a high priority for the Practice Directorate. In fact, hardly a year has passed since 1989, when psychologists were first included as independent providers in Medicare, that some element of the program did not need attention to assure access to psychological services that was intended when psychologists were added to the program. Removing unnecessary requirements for physician supervision of psychologists' services, extending access from outpatients to inpatients and fairly valuing services provided by psychologists (for example, psychological and neuropsychological testing) are just a few of the areas where we have focused our attention.

But perhaps the most important activity for preserving the program's integrity is our ongoing work to assure that Medicare commits sufficient resources to psychological services. While we have made progress in achieving parity in coverage for mental health services in portions of the private insurance market, the same is not true of Medicare. Including psychologists as full Medicare providers and then placing arbitrary limits on the extent to which their services are covered by comparison to physician services (health and behavior services are the only exception) seems to be less than "full" inclusion of psychological services. The latest round of Medicare reimbursement cuts provides more instances of placing mental health service providers at an unfair disadvantage. In addition to the scheduled 5 percent rate cut for all provider services, which was fortunately turned back by the last Congress just before it adjourned, the Centers for Medicare and Medicaid Services (CMS) has used its regulatory powers to implement yet another cut. This 9 percent cut is intended to offset an increase in dollars committed to support evaluation and management (E&M) services. The change was triggered by the former head of CMS, Dr. Mark McClellan, in an effort to encourage the provision of more E&M services, which he believed would enable Medicare providers to spend more time interacting with patients. E&M services involve functions such as establishing diagnosis and treatment options, and providing inpatient and outpatient consultation services. Unfortunately, CMS does not allow most non-physicians, including psychologists, to use the codes for E&M services.

The Practice Directorate has argued to CMS for years that psychologists are indeed well qualified to provide an array of E&M services. Yet the federal agency has simply been intractable on this issue. Litigation to force a change in CMS policy has been explored, but sufficient legal grounds to sustain a successful lawsuit were found lacking.

Legislation to direct CMS to make the change could solve the problem although, until recently, there was little congressional interest. Finally, some members have begun to appreciate the injustice in decreasing dollars to support psychological services to offset increasing dollars for E&M services. These legislators realize that psychologists in essence are being required to finance Medicare services that they are excluded from providing. As a result of growing congressional interest, CMS has agreed to meet with us to discuss the problem. The Practice Directorate will continue to press for psychologists' access to the E&M codes, while also asserting that reimbursement for psychological services should not be cut. One additional recent Medicare issue results from the newly created 1.5 percent bonus-incentive payment for providers who report certain quality measures, a provision included in the legislation that negated the 5 percent rate cut. Inclusion of this provision was virtually assured early in the legislative debate when organized medicine supported the "pay for reporting" scheme in return for Congress blocking the rate cut. According to the law, the quality measures to be used come from the CMS Physician Voluntary Reporting Program (PVRP), which includes physician quality measures but no non-physician measures.

Importantly, the physician measures are extremely basic process-oriented measures, such as whether certain screenings are conducted, certain symptoms evaluated or specific tests performed. The Practice Directorate will be working to see that any measures used for psychologists are similarly basic process-oriented measures that are not onerous to incorporate into routine practice. Additionally, we will closely monitor CMS's activity as this "pay for reporting" program evolves. While it is not unreasonable to expect psychologists, along with physicians, in Medicare to demonstrate that they are providing good quality care, it is a slippery slope from that point to the application of "pay for performance" measures motivated by economics rather than true patient care. Continuing to work to fix these problems with Medicare is critical for two reasons. First, only when beneficiaries have access to the psychological services they need can we have a strong Medicare program. Second, it is oftentimes true that as goes the Medicare program, so goes the benefits structure in the private market.

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PROFESSIONAL POINT

Repeating the past

By Dr. Russ Newman, APA Executive Director for Practice

March 2004, Vol 35, No. 3
Print version: page 33
4 min read

I have previously written in this column about the problems resulting from efforts to create a market-driven health-care system in this country. By "market-driven," I generally mean the notion that health-care services should be controlled by free-market forces rather than by government. Given Congress's recent efforts to further provide incentives for privatization in Medicare (i.e., let free-market forces influence how Medicare beneficiaries get services), perhaps it is worth looking again at what happens with a market-driven approach to health care.

This approach has been the prevailing one in the Republican-controlled Congress for approximately the last decade, beginning shortly after the demise of the Clinton Health Security Act proposal to overhaul the health-care system. Spiraling health-care costs were the target of this attempted reform and the market reform that followed.

According to free-market reform, letting competition flourish within health care would, in theory, rein in health-care costs. The theory predicts that with heightened competition for cost and quality, costs would decrease, and consumers would be well served. Specifically, poor quality health-care services would go unpurchased and disappear; health-care services that were too costly would do the same. Only good quality services at a reasonable price would remain--something all consumers would benefit from.

Profit over patients?

Unfortunately, competition and market forces have not had the desired effect on health care. Due to their unique characteristics, health-care services are not affected by free market forces the same way as other products and services. In most markets, for example, the same person decides whether to purchase a product or service, pays for it and derives a benefit. When someone other than the consumer chooses to buy the service and pays for it, market distortions result. This, of course, is exactly what happens with the country's third-party payer health-care system.

Another obstacle to an efficient, competitive health-care market relates to the benefits derived from health-care services. In markets that work according to free-market forces, all benefits of providing services are reflected in a company's revenues. But the societal benefits of good health care go far beyond monetary profits resulting from the delivery of services. If the health-care system relies strictly upon the market to determine availability of services, the inevitable result will be limited availability based only on profits, without regard to the societal benefits of health care. This is precisely the system that has evolved.

No competition for quality

The problems created in health care by an "imperfect" market have been further compounded by the decade-long influx of outside investment dollars into the health-care system. This includes venture capital used to start many health-care businesses and stock-related investments in publicly held health-care corporations. The interest of investors is more about return on investment than about quality health care.

The end result has been a health-care system with little, if any, competition for quality, intense competition for cost and a preoccupation with profits. Managed care--a concept since long before the 1990s but with no "takers"--caught on once cost-cutting and maximizing profit predominated. Ironically, except for a short-lived slowing in health-care cost increases in the late 1990s, neither the market-driven approach to health care nor managed care has solved the cost problem. Meanwhile, quality and access problems have increased.

An important implication of understanding these dynamics of health care is that managed care is not the problem, but rather a symptom of a market-driven health-care system. This suggests that the solution, then, is not just restraining managed care, although that helps. Rather, the solutions, in concept, revolve around mechanisms to ensure that quality is as important as cost. This could be done by an entirely government-controlled health-care system that removes market forces, although not a likely scenario in the current political climate.

Perhaps more likely would be just enough government involvement to correct for the uniqueness of health care and ensure that market forces incorporate both cost and quality. In effect, this would be like other regulated industries before Congress began to deregulate everything.

Unfortunately, one of the solutions is *not* likely to be increasing privatization in Medicare.

Allowing private insurance companies to compete with the government for Medicare beneficiaries is unlikely to solve current cost problems in Medicare. More likely is that, to maximize their profit, private companies will "cherry pick" the youngest and healthiest Medicare beneficiaries, leaving the oldest and sickest in Medicare and driving up program costs. There is likely to be considerable debate about the wisdom of these changes before they are scheduled for implementation. If implemented as the law is written, once again the country will witness a market-driven "solution" to problems in health care that will not solve the problem and will probably create a few more.

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PROFESSIONAL POINT

Staying the course in uncertain times

By Dr. Russ Newman, APA Executive Director for Practice

May 2003, Vol 34, No. 5
Print version: page 80
4 min read

Despite the time that has passed since the terrorist attacks, the past year has continued being influenced by the events of 9/11. Growing problems with this nation's health-care system have hardly been priorities in a Congress whose agenda understandably has been preoccupied with national security, terrorism, enemies abroad and the possibility of war. Add to that an economic climate marked by corporate scandal, a persistently declining stock market, the increasing possibility of a "double-dip" recession, employee layoffs and a hiring slump described recently in *The New York Times* as the worst in 20 years. In turn, state governments are grappling with their own economic woes, a situation more likely to result in resources being taken away from health care than it is to produce creative solutions for an ailing health-care system.

In these challenging and uncertain times, it is natural to begin wondering what we as a profession need to do differently, or how we need to change to respond to current circumstances. Yet, in times like these, adopting strategies to change course may not be the best approach. It may actually be that staying the course we have charted in recent years is a far more effective strategy. The theme of this year's State Leadership Conference (SLC), "Leading psychology forward: staying the course in uncertain times," was chosen to reflect a stance of resolve and confidence for our profession. That is not to say we should be without self-reflection and self-evaluation. Psychology leaders must demonstrate both perseverance and resilience in the face of significant challenges.

What does staying the course mean for our profession? First, we must continue pressing for mental health parity. We certainly have seen this at the state level over the past year with New Hampshire, West Virginia, Alabama and South Carolina either creating or expanding parity laws. At the federal level, we must ensure that people with mental health disorders are no longer the target of insurance discrimination in either the public or private sectors, and irrespective of what form the health-care system begins to take over the next decade.

Second, we must continue educating decision-makers and the public about the important role of psychological services in preventive care. No small number of health problems can be influenced through preventive lifestyle and behavior change--

cardiovascular disease, diabetes, obesity, HIV and some cancers are but a few examples.

Third, mental health and psychological services cannot continue to be kept so separate from physical health services in our health-care system. In our public opinion research from as early as 1995, people said they overwhelmingly recognize the link between psychological health and physical health. Yet with relatively few exceptions, our health-care delivery system refuses to recognize it. Although perhaps an ambitious goal, I can imagine a time when the public's current understanding that good psychological health is an important part of good physical health is replaced with the reverse--the recognition that good physical health is an important part of good psychological health.

Fourth, we must continue pressing to hold managed-care companies accountable for their actions, accountable for their decisions and accountable for their choice to put profits before patients. More to the point, any market-driven approach to health care must have accountability at its core or the system's concern for quality will not keep pace with its concern for cost.

Fifth, we must continue to assure that the value of psychological services is recognized by policy-makers and the public. Not only is this recognition necessary to be certain that psychological services are included in any health-care reform that occurs, it also is critical for preserving adequate reimbursement rates for psychological services of all types.

Finally, we must remain flexible in our ability to apply these objectives to whatever health-reform plans emerge as politically and practically viable proposals. While many reform proposals will be raised and some even debated by Congress, definitive action over the next two years is unlikely. Rather, a more likely scenario is that health reform will play a role in the upcoming presidential campaigns and election. During this process, we would be ill-advised to tie ourselves to any single version of reform. That is not to say we should be without voice as to what we believe is necessary for effective reform. But we must be prepared to ensure that psychological services are treated as an integral part of any reform plan.

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PROFESSIONAL POINT

The road to resilience

By DR. RUSS NEWMAN, APA Executive Director for Practice
October 2002, Vol 33, No. 9
Print version: page 62
4 min read

Resilience--the ability to adapt in the face of trauma, adversity, tragedy or even significant ongoing stressors--is receiving considerable attention of late. While not a new concept, the Sept. 11 terrorist attacks have underscored the importance and relevance of resilience to the present times. And given the public's apparently increased thirst for information related to resilience, the Practice Directorate's public education campaign is positioned to provide that information through the latest phase of the campaign titled, "The Road to Resilience."

Research on resilience

In an effort to tap the pulse of the post-9/11 nation, we conducted focus groups in Los Angeles, Indianapolis and Baltimore last October and November. Among the things we learned were that participants identified the presence of a chronic stress level, one that they described as present before the terrorist attacks and not just as a result of them. But it was also clear that this was a stress level noticeably increased since 9/11. Participants described a distinct sense that "the other shoe was about to drop." And they said this was made all the more difficult because they were already living with a chronic high level of daily stress resulting from pressures both at home and at work.

But without question, the strongest sentiment expressed by focus group participants was one of confidence and determination that people will "bounce back" from the initial emotional and psychological impact of the attacks. Resilience seemed to take on a new relevance for participants in their post-9/11 lives. More importantly, people expressed a clear desire to learn how to be resilient. They were not so much interested in just "coping with" or "dealing with" or simply "living with" change, stress and uncertainty as they were interested in being able to be resilient in the face of such challenges.

Armed with these focus group results and with a considerable body of research that demonstrates resilience is comprised of many behaviors and actions that can, indeed, be learned, we set off in search of a credible media partner to help with our campaign

efforts. The Discovery Health Channel fit the bill quite well, both in terms of their stature as a very credible source of health information and their interest in pursuing the topic of resilience. The result was a partnership that produced a documentary entitled, "Aftermath: The Road to Resilience," which aired on television Aug. 29 and Sept. 11.

Rather than an end result, the airing of the documentary actually marked the beginning of a grassroots outreach effort by the Directorate working in coordination with our members and with state and provincial psychological associations. A consumer brochure, co-produced by APA and Discovery Health that addresses how to take steps to build resilience, is available online and by calling (800) 964-2000. Psychologist-led forums, workshops and lectures are being planned for local communities.

Building strength

The topic of resilience seems to provide a solid foundation for educating the public about good psychological health. Not only can resilience be learned, research has shown that resilience is not an extraordinary thing but is rather ordinary and can be learned by most anyone. There is no one way for a person to be resilient and there is an array of behaviors, thoughts and actions found to be associated with resilience. As a result, individuals can put together their own strategies for building resilience, depending upon their individual strengths, styles and cultural differences.

Resilience can even apply to organizations faced with significant pressures and challenges. After all, turning adversity into opportunity--a potential byproduct of resilience--is critical for organizations to thrive in this day and age. Without question, building resilience here at APA is currently an important strategy as we deal with significant budget pressures and staffing shortages. In the Practice Directorate alone, for example, our staffing is currently down well over 30 percent owing to the recent voluntary staff buyouts and prior vacancies. This, plus significant budget cuts, have produced challenging times, to be sure. But if we can heed our own public education messages, draw on our strengths and build our resilience, we will most certainly "bounce back" from this difficult situation.

In any event, an optimum strategy for building resilience varies from one person to another. There is no single path that is universally suitable. We as psychologists are uniquely well-qualified to help guide individuals as they travel along their own personal road to resilience.

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PROFESSIONAL POINT

Consumerism: empowerment or illusion?

By Dr. Russ Newman APA Executive Director for Professional Practice
November 2006, Vol 37, No. 10
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4 min read

In the absence of any organized health-care reform effort by Congress, "consumerism" appears to be gaining traction in the health-care marketplace. This concept means different things to different people, but it usually means empowering consumers to make decisions about their health care rather than deferring to a "third party." It also generally entails providing consumers with information and decision-support tools, along with financial incentives, rewards and other benefits that encourage involvement in decisions about their health care.

"Consumer-driven health care" is, to date, the label most frequently attached to employer-sponsored benefit plan designs that attempt to incorporate principles of consumerism. An estimated six million individuals (of a potential 180 million) in the employer-based health system now participate in consumer-driven plans, but significant increases are predicted for the next few years. The jury is clearly still out as to whether these plans can lead to optimal, cost-effective care. It is important, nonetheless, for practitioners to understand what is happening with consumer-driven plans and how best to assure the inclusion of psychological services in whatever form consumerism takes.

Proponents see consumer-driven health care as a way to bring the power of informed consumer decision-making to health care in order to remedy the distorted purchasing decisions and uncontrollable inflation in a system where someone other than the patient is paying the bill. Some think consumer-driven health care offers a way of replacing managed care's efforts to limit the "supply side" of health care with incentives that influence and control demand for services.

The version of consumer-driven health care most often seen today relies on a health savings account (HSA) combined with a high-deductible insurance plan. In most instances, both the employer and employee contribute tax-free dollars that can accumulate from year to year. Money in the account can be used to pay for plan deductibles,co-insurance or co-payments, which the employee historically has paid with after-tax dollars. Money in the HSA can also be used to cover nonplan expenses recognized by the IRS as

"qualified medical expenses." The employee is responsible for all expenses up to the deductible, typically $2,000 or $5,000. In theory, this structure positions the employee to control decision-making about how to spend his or her health-care dollars and, importantly, to choose the desired health-care services.

Opponents of consumer-driven health care point to significant problems with HSAs. They are not curbing health-care costs. They are of no help to low-income or uninsured individuals. HSAs are built on fatally flawed assumptions about consumer behavior regarding health care. For example, people diagnosed with a life-threatening disease would not look to price as their first concern. People do not "shop" for emergency care. And research on cost-sharing shows that when people have to pay more out-of-pocket, they either delay or forgo treatment altogether.

Opponents of HSAs believe they will cause further fragmentation in the health insurance market. The healthiest individuals will gravitate to HSAs, while sicker people will remain in traditional insurance plans, causing premiums to rise and employers to stop offering plans. In the end, critics say, HSAs drive people out of the group insurance market and into an individual insurance market that is ill-equipped to handle the shift.

Even supporters of consumer-driven health care agree that the individual insurance market needs alteration if it is to be part of any effective health care system transformation. But they are also quick to point out that high-deductible plans with HSAs are far from the whole story with consumer-driven health care. Supporters say consumer-driven health-care is about changing incentives that influence all participants in the health-care system. It is intended to meld with other anticipated health-care reforms, such as increasing information technology, not to be implemented in isolation. And its ultimate focus is behavior change leading to wellness, prevention, early intervention and better disease management. It is here that psychology's unique expertise in the link between health and behavior must be primary as consumerism unfolds.

Whether consumer-driven health care can mature beyond the limited HSA version seen today and whetherit can have a positive impact is yet to be determined. Meanwhile, strong forces are converging that will likely propel its continuing adoption. Clear realization of a broken health-care system, baby boomers' demand for consumer empowerment, and employers desperately wanting to shift their responsibility for employee health care are all contributing to the growth of consumer-driven health care. Add the fact that those who oppose government control as a way to solve the health-care system's problems view the consumer-driven approach as the last opportunity to stave off a government-driven solution, and the stage is set for a development with which our profession must contend.

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PROFESSIONAL POINT

Rulemaking foreshadows demands for compliance

By Dr. Russ Newman APA Executive Director for Practice

May 2001, Vol 32, No. 5
Print version: page 74
4 min read

"HIPAA compliance" is a phrase that is just now beginning to become a part of our health-care lexicon. It is likely new enough that some may not have yet heard it, or those who have heard it may not know what it means. Most health-care professionals who have heard a definition are not yet aware of its implications for them. So let's start with the basics.

What HIPAA is

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, was a law sponsored by Sens. Ted Kennedy (DMass.) and Nancy Kassebaum (RKan.) that primarily extended the portability of employer-paid health insurance, restricted the use of pre-existing conditions and created a relatively small demonstration project to test the effectiveness of medical savings accounts. In addition, a lesser-known part of the law--a subtitle of the law termed Administrative Simplification--directed the secretary of Health and Human Services (HHS) to begin the process of adopting standards for electronically transmitting health information, securing that information and protecting the privacy of individuals to whom that information refers. The HIPAA rules are intended, when complete, to create a uniform set of standards for electronic data transmission that enable any entity to electronically communicate with any other entity in the health-care system regarding patient information. More to the point, it is hoped that when, for example, any third-party payer is able to receive and process a single uniform electronic claim submission, increasing administrative efficiency in the health-care system will begin to pay dividends in decreasing health-care costs.

Yet, the rules to implement the Administrative Simplification provisions of HIPAA are anything but simple, and the process of "simplifying" health-care transactions is far from settled. Little has yet been completed by way of rulemaking to accomplish HHS's goals. The only rules completed so far are those establishing the standards for the administrative transactions themselves, such as third-party claims processes. Neither the privacy nor security rules have yet been completed. But the first set of rules that have

been promulgated foreshadow the intensive response that will be required by the entire health-care industry to come into compliance when all of the rules are completed, that is, for parties in the health-care system to become HIPAA-compliant.

Health plans, insurance companies and other payers will need to modify their systems in order to receive the standardized electronic transactions. The provider community, including psychologists, will be required to use the standardized transactions only when electronic claims are submitted--right now a voluntary process for the most part. It is anticipated, however, that over time, more and more payers will move to an electronic claims process. Eventually, providers will have little choice but to use electronic claims and the standardized transactions if they wish to participate in the third-party payment process.

Privacy protections

The ability to successfully use such electronic data transmission will, of course, depend on the ability to have adequate security and privacy protections. Security rules have not yet been issued, even in proposed form. Privacy rules are much farther along. In December, the Clinton administration published final regulations on medical records privacy as required by HIPAA. The rule effectively distinguishes psychotherapy notes from other types of medical records and requires separate, specific and additional patient authorization for their release to insurers and managed-care companies. Importantly, the privacy rule prohibits an insurer or managed-care company from conditioning its coverage on a patient's authorization for disclosure of the separately protected psychotherapy notes. As a practical matter, then, only basic information, such as diagnosis, prognosis and treatment plan, is likely to be able to be shared with payers.

Although the privacy rule was issued as a final rule by the Clinton administration, current HHS Secretary Tommy Thompson has since re-opened the rule for another round of comments from the health-care community. APA's Practice Directorate is again providing comments to HHS in an effort to see that protections that have been included are retained, and to push for additional protections. One consequence of reopening the rule is that it is presently even more difficult to know just what it will take for the practice community to be HIPAA-compliant when all is said and done. We will continue monitoring the development of these HIPAA rules and as they begin to take shape in the coming months, we will be working to increase awareness and educate the practice community about what HIPAA requires.

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PROFESSIONAL POINT

Turning tragedy into triumph

By Dr. Russ Newman, APA Executive Director for Practice

January 2002, Vol 33, No. 1
Print version: page 32
4 min read

Without question, the country continues to process the events and experience of Sept. 11. We were a country initially not prepared to respond to the terrorist attacks on the World Trade Center and the Pentagon. Organized evacuation plans for such attacks were few and far between. One needed only to witness the 30,000 Washington, D.C., office workers all trying to leave the city at the same time to know we were unprepared.

But perhaps the more relevant lack of preparedness from a psychologist's perspective is the degree to which the country seemed psychologically unprepared for the events of Sept. 11 and subsequent threats of bioterrorism. Neither the 1993 bombing of the World Trade Center nor the 1995 bombing of the federal building in Oklahoma City, as tragic as each event was, can be considered the same type and magnitude of the terrorism we are now coping with.

In the immediate aftermath of the events of Sept. 11, psychology's contribution to the country's response was--or should be--a source of great pride for every psychologist. The APA Disaster Response Network (DRN), in collaboration with the American Red Cross, was deployed to the World Trade Center, the Pentagon, the Pennsylvania airplane crash site, as well as the Boston, Los Angeles and Washington Dulles airports. Also, a "marriage" of the DRN and the Practice Directorate's nationwide public education campaign coordinators network enabled a widespread community outreach to provide information to help the general public cope with the events, particularly how to respond to questions being asked by children. And, as our PracticeNet survey data are beginning to show, individual practitioners were clearly ready, willing and able to help their ongoing patients and clients in the wake of these horrific tragedies.

Since Sept. 11, psychologists have been helping people cope with loss, fear and uncertainty. They have been working to help replace prejudice with tolerance, while also being ready and available to treat post-traumatic stress disorder or other mental health problems the research tells us tend to develop after major disasters.

There is, however, yet another level on which psychologists can be instrumental in helping people, if not the entire country, move forward. One of my colleagues who experienced firsthand the devastating attack of the World Trade Center captured it best: "How do I find meaning in my life after an experience like this?" asked Wall Street psychologist Marilyn Puder-York, PhD, in a conversation shortly after the attack (see November *Monitor* (/monitor/nov01)). To better understand how we psychologists might help with this traditionally existential question now made pressing by currents events, I sought out a part of my own past training as a clinician--Victor Frankl's "Man's Search for Meaning"--to guide me. The search for the book itself proved surprisingly difficult; it was six weeks back-ordered on Amazon.com (http://www.amazon.com/) .

Eventually, I found a copy that included a preface from the author himself written in 1992. In the preface, Frankl responded to a question about the best-selling success of his book. "I do not at all see in the best-seller status of my book an achievement and accomplishment on my part but rather an expression of the misery of our time," said Frankl. "If hundreds of thousands of people reach out for a book whose very title promises to deal with the question of meaning to life, it must be a question that burns under the fingernails." Perhaps this comment is salient to the current run on his book.

More to the point, the section of the book on "logotherapy"--the term used by Frankl to refer to the interventions related to questions of meaning--offers some direction. He writes, "Even the helpless victim of a hopeless situation, facing a fate he cannot change, may rise above himself, may grow beyond himself. He may turn personal tragedy into triumph...and turn his predicament into human achievement."

As a part of the role psychologists must play following this tragedy, we must act as guides for the psychological journey of our country to find meaning in these events. We must use our knowledge, our research and our clinical skill to help turn personal tragedy into triumph and to turn our predicament into human achievement. It is both our opportunity and our responsibility. We must put aside our own personal and professional differences so that we do not shirk this responsibility or squander this opportunity. I am confident our profession will rise to the occasion. Many are counting on us.

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PROFESSIONAL POINT

Resilience and psychology: a healthy relationship

By Dr. Russ Newman, APA Executive Director for practice

July/August 2003, Vol 34, No. 7
Print version: page 26
4 min read

Ongoing threats of terrorism, economic woes, media coverage about SARS and lingering effects of war: These are just a few of the factors likely contributing recently to a sense of chronic stress among many Americans. As individuals face multiple stressors in all aspects of their daily lives--at work, school and home--we're finding that psychology has a valuable and timely resource to offer people of all ages and circumstances.

Following the traumatic events of Sept. 11, 2001, APA launched its "Road to Resilience" initiative, part of the association's ongoing public education campaign, "Talk to Someone Who Can Help." Many months later, a combination of research and experience continues to suggest that psychology's various efforts designed to help with building resilience resonate well with the public.

There is no profession better qualified to engage in this effort. As psychologists, we are well aware that resilience involves an ongoing *process* of adapting well in the face of adversity, trauma, tragedy, threats or other significant sources of stress. Not only is it a process, but building resilience is further complicated by the importance of personalizing the process. Each individual needs to develop a strategy for building resilience that works for him or her. People under stress, people suffering from depression or people with a serious mental illness all can benefit from building resilience, but there will be important differences in what helps each of these persons to build resilience. Who better than psychologists to help sort through the complexity and nuance underlying the process of developing resilience?

Further, the effects of fostering resilience go far beyond helping people to simply "feel good." Developing resilience skills not only helps reduce stress, but research has made it clear that it also makes people healthier, and may even help individuals live longer.

In his book, "Emotional Longevity" (Viking, 2003), APA CEO Norman Anderson, PhD, describes research that shows a connection between relationships and better health and longevity, and between optimism and good health and longevity. Importantly, relationships and optimism are probably the two factors most associated with resilience. Anderson also describes the connection between finding meaning in trauma or tragedy--yet another factor commonly associated with resilience--and longevity.

In addition to the significant beneficial effects of building resilience, our experience with the "Road to Resilience" campaign is that there are many different applications for efforts to build resilience. Our original application grew out of the aftermath of 9/11 and hearing from the public that they didn't just want to "live with" the increased stress and uncertainty brought on by the terrorist attacks. They wanted to "bounce back." Then, as war with Iraq approached, refocused resilience efforts enabled the development of public education campaign activities and efforts specifically targeted for "Resilience in a Time of War." This included four brochures for parents and teachers aimed at helping children in different age groups--preschool, elementary, middle school and high school. In April, with the end of the war, the campaign added "Homecoming: Resilience After Wartime" to help returning military and their families.

Psychologists throughout the country consistently found receptive audiences for psychology's messages about how to build resilience. For example, among the many successful local outreach efforts, psychologists worked with a local television station to record "Resilience Tips of the Day," gave presentations on resilience to local Red Cross chapters and community groups such as the Rotary Club, disseminated APA's materials geared for young children to local preschools and day care centers, and held community forums as well as support groups for military families.

Additional applications of the resilience materials are in the works. APA is collaborating with *Time for Kids* magazine on a special issue devoted to resilience slated for publication early this fall. Meanwhile, we're taking additional steps focused on building resilience in children. The Practice Directorate's 10th Annual Institute for Psychology in the Schools during the 2003 APA Annual Convention is titled, "Resilience: inoculating children from the inside out."

As a future phase of our resilience initiative, we are refocusing on the theme of workplace stress. Clearly, resilience applies to organizations faced with significant pressures and the related challenge of turning adversity into opportunity.

There are seemingly endless opportunities for psychology to become involved in efforts and activities to help people build resilience. To learn more about the "Road to Resilience" initiative and related APA materials, visit the Help Center, www.helping.apa.org (http://www.helping.apa.org) , and the "Public Education Campaign" section of www.apapractice.org (http://www.apapractice.org) .

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PROFESSIONAL POINT

The road to resilience

By DR. RUSS NEWMAN, APA Executive Director for Practice
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4 min read

Resilience--the ability to adapt in the face of trauma, adversity, tragedy or even significant ongoing stressors--is receiving considerable attention of late. While not a new concept, the Sept. 11 terrorist attacks have underscored the importance and relevance of resilience to the present times. And given the public's apparently increased thirst for information related to resilience, the Practice Directorate's public education campaign is positioned to provide that information through the latest phase of the campaign titled, "The Road to Resilience."

Research on resilience

In an effort to tap the pulse of the post-9/11 nation, we conducted focus groups in Los Angeles, Indianapolis and Baltimore last October and November. Among the things we learned were that participants identified the presence of a chronic stress level, one that they described as present before the terrorist attacks and not just as a result of them. But it was also clear that this was a stress level noticeably increased since 9/11. Participants described a distinct sense that "the other shoe was about to drop." And they said this was made all the more difficult because they were already living with a chronic high level of daily stress resulting from pressures both at home and at work.

But without question, the strongest sentiment expressed by focus group participants was one of confidence and determination that people will "bounce back" from the initial emotional and psychological impact of the attacks. Resilience seemed to take on a new relevance for participants in their post-9/11 lives. More importantly, people expressed a clear desire to learn how to be resilient. They were not so much interested in just "coping with" or "dealing with" or simply "living with" change, stress and uncertainty as they were interested in being able to be resilient in the face of such challenges.

Armed with these focus group results and with a considerable body of research that demonstrates resilience is comprised of many behaviors and actions that can, indeed, be learned, we set off in search of a credible media partner to help with our campaign

efforts. The Discovery Health Channel fit the bill quite well, both in terms of their stature as a very credible source of health information and their interest in pursuing the topic of resilience. The result was a partnership that produced a documentary entitled, "Aftermath: The Road to Resilience," which aired on television Aug. 29 and Sept. 11.

Rather than an end result, the airing of the documentary actually marked the beginning of a grassroots outreach effort by the Directorate working in coordination with our members and with state and provincial psychological associations. A consumer brochure, co-produced by APA and Discovery Health that addresses how to take steps to build resilience, is available online and by calling (800) 964-2000. Psychologist-led forums, workshops and lectures are being planned for local communities.

Building strength

The topic of resilience seems to provide a solid foundation for educating the public about good psychological health. Not only can resilience be learned, research has shown that resilience is not an extraordinary thing but is rather ordinary and can be learned by most anyone. There is no one way for a person to be resilient and there is an array of behaviors, thoughts and actions found to be associated with resilience. As a result, individuals can put together their own strategies for building resilience, depending upon their individual strengths, styles and cultural differences.

Resilience can even apply to organizations faced with significant pressures and challenges. After all, turning adversity into opportunity--a potential byproduct of resilience--is critical for organizations to thrive in this day and age. Without question, building resilience here at APA is currently an important strategy as we deal with significant budget pressures and staffing shortages. In the Practice Directorate alone, for example, our staffing is currently down well over 30 percent owing to the recent voluntary staff buyouts and prior vacancies. This, plus significant budget cuts, have produced challenging times, to be sure. But if we can heed our own public education messages, draw on our strengths and build our resilience, we will most certainly "bounce back" from this difficult situation.

In any event, an optimum strategy for building resilience varies from one person to another. There is no single path that is universally suitable. We as psychologists are uniquely well-qualified to help guide individuals as they travel along their own personal road to resilience.

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