Psychotherapy

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BULLETIN

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PRESIDENT'S COLUMN

William B Stiles, Ph.D.
Glendale Springs, NC

Division 29 is declining in membership and aging, but thriving financially, thanks to a successful journal.

First, Division 29 membership has been declining at a rate of about 6% per year since a peak of about 7000 members in 1994. The number of full members who paid their dues was 1781 in 2011, 1683 in 2012, and 1540 up to May in 2013. In addition, there were 120 student members and 12 affiliate members in 2011, 204 and 26 in 2012, and 94 and 21 so far in 2013 (more about these categories later). As context, although overall APA membership has been holding steady at about 150,000 for the last 10 years or so, those who are members of at least one division has dropped from over 80,000 to about 60,000 during that period, though a few divisions have been growing.

Second, a series of surveys across 30 years by John Norcross and his collaborators has found that Division 29's mean age has been rising at the rate of about 6 months per year: 45.6 in 1981; 51.4 in 1991; 56.6 in 2001; and 63.0 in 2012. Of course, each individual member's age rises by 12 months per year, so we have lost some older members and added some younger members to partially counterbalance our individual aging.

Third, we are in great shape financially. Our main sources of income are dues from members and royalties from our journal, *Psychotherapy*. Although income from dues alone no longer covers our costs, journal royalties have been increasing and have contributed about twice as much as dues to our income over the last few years.

If membership, mean age, and income continue to change at the current rates, then in 40 years, by 2053, Division 29 will have fewer than 200 members whose average age is 83 and enough income from royalties so that every member can have a $5,000 research grant every year. Even if it doesn't quite come to that, the trends deserve attention.

The Division 29 Board (elected officers and domain representatives) have been addressing the declining membership in several ways. We make special efforts to welcome APA members who indicate interest in Division 29 on the checklist that comes with the annual APA dues statement. In a program organized by Annie Judge (Anniejudge@aol.com) and Meg Tobias (mrtobias@loyola.edu), we are this year offering 500 free student memberships. We are investing in a new mentoring program designed for early career professionals, designed by a group chaired by Susan Woodhouse (woodhouse@Lehigh.edu). Contact those Board members for further information.

We are discussing a substantial broadening of criteria for affiliate membership in the Division. Affiliate members need not be APA members. They pay dues, and they receive *Psychotherapy*, and *Psychotherapy Bulletin*, and they can participate in all activities of the division except that they cannot vote or run for elected office. The number of affiliate members is currently small, at least partly because our bylaws are currently rather restrictive, for example, requiring non-American affiliates to have a doctoral degree in psychology from an institution listed in the National Regis-

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ter/ASPPB designation program. This register will be phased out over the next few years, so our bylaws on this point must be revised anyway. At its October meeting, the Division 29 Board will discuss extending eligibility to any professionals who are entitled to practice psychotherapy within their jurisdiction. The proposal that emerges will be brought to the membership for a vote, so watch for further news. And if you have opinions or suggestions that you would like considered in the discussion, please let me or some other Board member know by the beginning of October.

Our rising income presents another set of issues. As one response, we have developed and expanded a program of awards and small grants meant to recognize and advance important work on psychotherapy. As a member, you are eligible and invited to apply. Details are posted at:http://www.divisionofpsychotherapy.org/members/awards/ We continue to support work promoting professional communication and advocacy, and we are able to support new initiatives, such as the mentoring program mentioned earlier.

Importantly, the Division's income from royalties may not remain so high. Most journal income comes from subscriptions that offer institutions, such as universities, electronic access to packages of journals. Income to individual journals is allocated by formulas that assess use of each journal (e.g., downloading of specific articles) within the package. *Psychotherapy* is a well-used journal and is well served financially by this system. But the journal publishing industry is in flux as institutions object to paying high subscription costs for material that was written, in substantial part, by people who work in those institutions. Various models of open access are being proposed and tried, and it is uncertain whether what emerges will maintain our current income. So the Division is using some of its current income to build a reserve.

But the trends raise fundamental questions. Should we resist the trend towards a smaller older membership? Or should we accept these trends as inevitable? Division 29 has not been meeting as a group for over a decade; only the Board meets. Is this an effect—or a cause—of the Division being less central in members' professional identity? Should the Division be doing more for its membership? Should the membership be doing more? If so, what should it be doing? If you have reactions or suggestions, write to me or any other Board member (contact information in the front of *Psychotherapy Bulletin* and on the Division website). Or, if you would like to be more actively involved in the Division, please write and describe your interest.

EDITORS' COLUMN

Lavita Nadkarni, Ph.D.
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This issue of the *Bulletin,* riding the waves of a successful APA Convention in Honolulu, Hawaii, allows Division 29 members the opportunity to fondly recall colleagues seen and presentations heard, and consider avenues for greater involvement in the Division. It was a pleasure to meet current and future Division 29 members at the Convention booth, and thanks go to Annie Judge for organizing the booth and to the many Division 29 members for being welcoming and informing Convention participants about the Division. Thanks also to Tracey Martin, who was a regular fixture at the event! You will find the Presidential column engaging and fostering of thought and action.

This issue of the *Bulletin* is filled, as usual, with excellent articles we know you will enjoy and find useful. We have an array of topics in this issue of the *Bulletin,* all of which we hope will be of interest, particularly to students. Given that many of our students are working on internship applications, we are pleased to offer three timely and compelling articles on the internship match, ranging from a personal reflection to helpful hints to an empirical review of the last 15 years of internship match results. This issue includes two thought-provoking explorations of factors related to therapeutic outcomes, and an important piece on providing mental health services to our military service members. We are proud to have several contributions from students, in addition to those about internship—a collection that speaks to the broad scope of graduate training and interests—including a helpful article on ethical issues related to social media, an important discussion about implications for practice with first generation college students, and the abstracts from our student award winners. Finally, the Washington Scene contribution, as usual, includes up to date information related to psychology and politics.

We are absolutely thrilled that we continue to receive quality articles from students. This is a promising sign for our Division and our field. We encourage all readers to please continue sending us your ideas, questions, comments, suggestions, and submissions to the email addresses provided below.

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Integrating Research and Practice: Some Results of the Two-Way Bridge Initiative

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At the 1932 meeting of the American Psychiatric Association, Thomas French stood before his colleagues and discussed possible links between the contributions of Pavlov and Freud. It was perhaps one of the earliest attempts to integrate different approaches to therapy. Since that time, interest in psychotherapy integration has moved from a latent theme in the field to an actual movement. However, although the Pavlov-Freud comparison is often viewed as an attempt to link theoretical approaches, it also reflects a more latent theme, namely the integration of research findings with clinical observations. And while the therapy integration movement has primarily focused on bridging the gap between different theoretical schools of thought, there is now the renewed and growing interest in integrating research and practice.

Closing the Gap Between Research and Practice

The Society for the Exploration of Psychotherapy Integration (SEPI) was formed in 1983 to help facilitate clinical and research work that could provide a rapprochement across different theoretical schools of thought. Some three decades later, another important need has arisen in the field, namely how therapists can meet the growing pressures for accountability coming from professional organizations, governmental agencies and insurance companies. Who will respond to the challenge of determining which therapies work? Will it be by therapy researchers? Practicing clinicians? Both working in collaboration? As both a researcher and clinician, I believe that effective therapy must be rooted in *both* clinical observation and empirical verification. After much discussion, the Steering Committee of SEPI has expanded its mission to facilitate the collaborative efforts of both researcher and clinicians in meeting this important challenge.

Also recognizing the importance of closing the gap between research and practice, two Divisions of the APA—Division 12, the Society of Clinical Psychology, and Division 29, Psychotherapy—have joined forces to establish a collaborative initiative to build a two-way bridge between research and practice. Much has been written about the importance of disseminating research findings to the practicing clinician. However, information needs to be transmitted both ways, in that more needs to be done in the area of disseminating clinical observations to the researcher. In doing so, practicing clinicians will be able to have a more salient voice in helping to chart the direction for psychotherapy research—based directly on clinical observation and need.

In order to provide researchers with information on how those empirically supported treatments that have been based on clinical trials actually fare in clinical practice, surveys of practitioners that have used these interventions were

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conducted. As the initial foray into this area, three clinical problems were studied: panic disorder, social anxiety disorder, and general anxiety disorder. In as much as CBT has received most of the research attention in treating these clinical problems, the survey was directed toward CBT practitioners. In addition to the first three surveys, surveys on clinical experiences in using empirically supported treatments for posttraumatic stress and obsessive compulsive disorder have also been recently completed, and will be written up for publication.

In responding to the three separate surveys, participants were asked to indicate which of several variables listed under each of the following general categories had limited their successful use of CBT in reducing symptoms of panic, social anxiety, and general anxiety, respectively:

- Patient's symptoms related to the disorder
- Other patient problems or characteristics
- Patient expectations
- Patient beliefs about the disorder
- Patient motivation
- Social system (home, work, other)
- Problems/limitations associated with the CBT intervention method
- Therapy relationship issues

The three surveys were administered on line, and took approximately 10 minutes to complete. Participants were told that much like the Federal Drug Administration (FDA) continues to receive feedback from practitioners after a drug being approved, this two-way bridge initiative was designed to provide clinicians' feedback to researchers on their experiences in using an empirically supported treatment in practice. They were also told that the survey was sponsored by both the Psychotherapy and Clinical Psychology divisions of the APA, and that their responses would be anonymous.

Selected Findings of the Two-Way Bridge Surveys

The results of these surveys, which will be published in the journal *Behavior Therapy*, are far too extensive to report here. However, some of the highlights for the panic, social anxiety and GAD surveys, which involved 338, 276, and 260 participants respectively, can be noted.

One of the significant barriers to symptom reduction in the treatment of these three clinical problems reported by a large percentage of clinicians consisted of chronicity (57%, 62%, and 72% for each of the surveys, respectively). Relatedly, severity of symptomotology was also reported to be problematic in successful intervention, although somewhat less so in the case of panic disorder (36%, 64%, and 61%).

Another major obstacle to symptom reduction noted by more than a majority of the participants consisted of the problem of patient motivation (60%, 61%, and 60%). Since the CBT intervention for these clinical problems involved exposure, often resulting in the experience of anxiety, there appears to be the risk of the patient terminating prematurely. A problematic expectation on the part of patients is that the therapist will do all the work to make things better (53%, 51%, and 65%). Relatedly, practicing clinicians reported problems in patients' inability to do the clinical work (often exposure) between sessions (70%, 55%, and 52%). A patient expectation that appears to play a significant role in their participation of the intervention noted by therapists is when patients expect that they will be free of all anxiety (54%, 38%, and 56%). Another related and problematic belief observed by clinicians that interferes with successful CBT was patients' belief that their medication played a significant role in symptom re-

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duction, especially in the case of panic disorder (52%, 31%, and 37%).

Although most of what has been highlighted in the CBT research literature has been the importance of the therapeutic technique, practicing clinicians working with these three clinical problems reported that the therapy relationship nonetheless plays an important role. As acknowledged by participants in these surveys, problems in symptom reduction occur when the therapeutic alliance is not strong enough (36%, 30%, and 49%). This may very well be related to the problems of minimal motivation and reluctance on the part of the patients to work between sessions. Moreover, a fair number of clinicians acknowledge that when the therapy was less than successful, the patient did not feel his or her distress was sufficiently understood by them (33%, 22%, and 42%). A smaller percentage of therapists themselves confess that their own personal negative feelings toward the patient may have interfered with the treatment (17%, 12%, and 28%).

There were a few other characteristics that were reported as indicating a poor prognosis in the treatment of panic disorder, social anxiety and general anxiety disorder with CBT, including instances where the patient also had a personality disorder (55%, 51%, and 64%) and when there existed functional impairment (39%, 35%, and 38%). In addition, a very significant factor that can interfere with successful treatment is when the patient's social system (e.g., family) reinforces or supports the patient's clinical problem (61%, 51%, and 58%).

The complete findings of these surveys will be published in a special section of the journal *Behavior Therapy*, together with an introductory overview written by the committee that has spearheaded this initiative, and a commentary by Dianne Chambless and Tom Ollendick. The papers are as follows:

Goldfried, M. R., Newman, M.G., Castonguay, L. G., Fuertes, J. N., Magnavita, J. J., Sobell, L. C., & Wolf, A. W. (2014). On the dissemination of clinical experiences in using empirically supported treatments. *Behavior Therapy.*

Wolf, A. W., & Goldfried, M. R. (2014). Clinical experiences in using cognitive-behavior therapy to treat panic disorder. *Behavior Therapy.*

McAleavey, A. A., Castonguay, L. G., & Goldfried, M. R. (2014). Clinical experiences in conducting cognitive-behavioral therapy for social phobia. *Behavior Therapy.*

Szkodny, L. E., Newman, M. G., & Goldfried, M. R. (2014). Clinical experiences in conducting empirically supported treatments for generalized anxiety disorder. *Behavior Therapy.*

Chambless, D. L. (2014). Can we talk? Fostering interchange between scientists and practitioners. *Behavior Therapy.*

Ollendick, T. H. (2014). Closing the research-practice gap: Commentary on the two-way bridge initiative. *Behavior Therapy.*

The two additional surveys on PTSD and OCD, which were conducted by Lauren Szkodny and Nick Jacobson, together with their Penn State mentor Michelle Newman, and also me. The results of these surveys will be written up for publications shortly. The objective of this initiative is both to offer researchers with important, clinically based variables to study, but also to inform clinical colleagues and trainees about some of the difficulties in translating research-supported treatments into practice.

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Intervention Frequency, Working Alliance, Dropout, and Outcome in Brief Psychotherapy: A Nonlinear Relationship Model

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A recent special issue in the journal, *Psychotherapy,* considered the past 50 years of psychotherapy research on what has been called the "outcome problem" (volume 50, 2013): we *know that* psychotherapy works but not clearly enough *how* different treatment orientations and assessment methods effect change. Early hypotheses focused on therapist orientation, presuming that adherence to a model of therapeutic action, such as psychodynamic or cognitive-behavioral, would predict better outcomes; however, mounting evidence over several decades has shown no significant differences in overall outcomes among different models of therapeutic intervention (Wampold, 2001). If psychotherapies based on different understandings of etiology and therapeutic action show similar results, these general treatment type labels may be masking the influence of specific process variables.

Another possible explanation for the equivocal findings of comparative psychotherapy studies is that they may incorrectly presume a linear relationship between therapist intervention (i.e., the "dose" of therapy within sessions) and positive outcome markers, such as symptom reduction or client retention. A recent meta-review (Webb, DeRubeis, & Barber, 2010) found the effect of therapist adherence on outcomes to be nearly zero and noted that research may be overlooking the possibilities of nonlinear relationships between therapist interventions and outcome.

Relatedly, meta-reviews of therapist factors and their relationship with process and outcome variables concluded that therapist inflexibility in the use of manualized interventions contributed to poor alliances (Ackerman & Hilsenroth, 2003) and higher dropout rates (Roos & Webart, 2013). In studies reviewed between January 2000, and June 2011, Roos and Webart (2013) summarized that clinicians "using extensive and early interpretations and confrontations are perceived as unsympathetic and hostile" by clients who ultimately drop out of psychotherapy, and that unsatisfied clients also "express disappointment about not receiving enough information, validation, and support," experiencing their psychotherapists as "unsympathetic, passive, and indifferent" (pp. 395-396). These studies suggest there may be an effective, moderate "dose" of therapeutic intervention, one that reflects a therapist's flexible use of theory-specific interventions required to develop and manage the alliance and work towards good overall outcome, and that has not been identified in analyses that assume linear relationships among these three variables.

The aim of this pilot study was to further investigate the relationships among

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psychotherapist intervention frequency, working alliance, client dropout, and outcomes in an archival sample of brief outpatient psychotherapy. Three hypotheses were considered that evaluated self-reported working alliance and outcome conditions across a range of psychotherapy orientations for clients both completing and prematurely terminating 30-session, manualized protocols. Outcome was established for completed treatment cases based on reliable change scores of self-report symptom measures (called good and poor outcome) and on client description of dissatisfaction with the psychotherapy or psychotherapist early in treatment, where no post-treatment symptom measures were available (called dropout). Hypothesis 1 predicted that a model including "moderate" psychotherapist intervention frequency and client-rated working alliance scores would show a significant positive relationship with therapeutic outcomes in completed cases (*n*=28 completed treatment cases). Hypothesis 2 predicted a curvilinear relationship between early treatment technique frequency and alliance, such that "high" and "low" frequency of interventions would be significantly negatively correlated with working alliance (tested on the total sample of *N*=44). Hypothesis 3 predicted that "high" and "low" frequency of psychotherapist interventions early in treatment would also show a significant positive correlation with treatment dropouts (tested with the total sample of *N*=44).

Method

Participants

This study utilized archival data from an ongoing hospital-based psychotherapy research program using the following inclusion criteria (see Samstag, Muran, Wachtel, Slade, Safran, & Winston, 2008): adult clients meeting criteria for Cluster C Personality Disorder or Personality Disorder NOS according to DSM-III-R; no recent substance abuse, destructive impulse control problems, or active suicidal behavior; and no recent use of psychotropic medication.

Clients. Clients (*N*=44) included in the study had a mean age of 38.96 years (*SD = 7.75*). A slight majority was female (56%), and most were not currently married (71%). Clients were predominantly college educated or higher (65%), White (85%), and presently employed (81%). Primary Axis I diagnoses included depression (63%) and anxiety (25%); primary Axis II diagnoses included mostly Cluster C or Personality Disorder Not Otherwise Specified (PD NOS) with Cluster C features (79%).

Clients accepted into the research program were randomly assigned to one of five manualized, 30-session, once weekly therapies. These included two types of dynamic (Laikin, Winston, & McCullough, 1992; Pollack, Flegenheimer, & Winston, 1992), a cognitive-behavioral (Turner & Muran, 1988), a supportive (Pinsker & Rosenthal, 1988), and a relational psychotherapy (Safran & Muran, 2000). Cases were randomly assigned across treatment types according to therapist availability: dynamic I = 23%; dynamic II = 25%; supportive = 10%; cognitive-behavioral = 21%; and relational = 21%. The sample included *n*=12 good outcome, *n*=16 poor outcome, and *n*=16 premature dropout cases (4 cases from the original good outcome condition were not included due to unavailable session data).

Psychotherapists. Psychotherapists were recruited from the Department of Psychiatry at Beth Israel Medical Center. The *N*=34 psychotherapists in the study had a mean age of 38.54 (*SD = 8.86*)

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years, with a mean of 7.65 (*SD = 9.34*) years clinical experience. A majority was female (61%) and all were White. Education levels were as follows: 37% Ph.D., 34% M.D, and 29% M.A./M.S.W.

Measures

***Psychotherapist Adherence and Technique*:** The Comparative Psychotherapy Process Scale (CPPS; Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005) is a 20-item, observer report measure assessing the extent to which each of 20 distinct therapist techniques is characteristic of a session. It includes a subscale of 10 characteristically psychodynamic techniques (PI subscale), such as "the therapist addresses the patient's avoidance of important topics and shifts in mood," and a subscale of 10 representative cognitive-behavioral techniques (CB subscale), such as "the therapist interacts with the patient in a teacher-like (didactic) manner." Each item is rated on a 7 point Likert scale (0= "not at all characteristic"; 6="extremely characteristic"). Intervention frequency is computed by adding scores on the individual items for each session, resulting in a continuous measure of technique frequency and treatment adherence. To compare means for hypotheses 2 and 3, cases were divided into quartiles based on descriptive statistics of technique frequency: the middle 50% of cases were defined as "moderate frequency," while the highest and lowest quartiles were categorized as "immoderate frequency." These definitions are, therefore, sample dependent. However, the literature contains no defined range or evidence-based norm for frequency of therapist intervention on which to base such designations. Overall, the CPPS has shown good psychometric properties, including excellent internal reliability (.93), good inter-rater reliability (.82), and good convergent validity with other therapist technique measures (.71-.90; Hilsenroth, et al., 2005). Means and standard deviations for therapist intervention frequency by outcome category were as follows: good outcome (*M*=20.30, *SD*=5.58), poor outcome (*M*=22.07, *SD*=7.56), and dropout (*M*=21.23, *SD*=2.73).

Working alliance: The Working Alliance Inventory Short Form (WAI-12; Tracey & Kokotovic, 1989) was derived from the original Working Alliance Inventory (WAI: Horvath & Greenberg, 1986). It assesses the extent to which therapist and client report agreement on the tasks and goals of therapy, as well as on the quality of the affective bond between them. It is a 12-item, Likert scale measure, with items rated on a 1 (Never) to 7 (Always) scale. Both the client- and therapist-rated Short Forms have demonstrated excellent convergent validity with the original 36-item WAI across each of the three subscales (.88-.97; Busseri & Tyler, 2003). Means and standard deviations for working alliance ratings by outcome category were as follows: good outcome (*M*=5.50, *SD*=0.78), poor outcome (*M*=5.19, *SD*=1.07), and dropout (*M*=4.13, *SD*=1.07).

Psychotherapy Outcome: Inventory of Interpersonal Problems (IIP-64; Horowitz, Rosenberg, Baer, Ureno, & Villaseur, 1988); Symptom Checklist Revised (SCL-90R; Derogatis, 1983). The IIP-64 is a 64 item self-report measure assessing level of distress in interpersonal situations. Alden, et al. (1990) report internal consistency estimates of .72-.85 for the eight subscales. The SCL-90R is a 90 item self-report assessment of the presence and severity of psychological symptoms. It has also demonstrated good psychometric properties, with internal consistency estimates ranging from .79-.90, and test-retest reliability from .78-.90 (Derogatis, 1983). For all study hypotheses, outcomes were

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measured using Reliable Change (RC) scores (Jacobson & Truax, 1991), which average total pre- and post- scores on the IIP-64 and the SCL-90R to compute a more comprehensive rating of therapeutic change. Positive change was defined as either improvement (RC<1.96) or recovery (RC>1.96).

Procedure

Typed transcripts of the first 15 minutes of three randomly selected sessions within the first third of treatment (prior to session 10; see Samstag, et al., 2008) were coded by two trained graduate-level psychology students using the CPPS. Coders were blind to the study hypotheses, patient outcomes, and assigned treatment type. Training on the CPPS was conducted by the first author of the study according to the manual developed by Stein, Pesale, Slavin, and Hilsenroth, (2010). Forty transcripts (33% of the total) were double-coded to evaluate ongoing inter-rater reliability, which was found to be good to excellent for all CPPS items (.66-.95; Fleiss, 1981).

Results

Hypothesis 1: Tested using a multiple regression model, including the "moderate" frequency of early treatment therapist interventions and client-rated working alliance scores as a predictor of completed treatment outcomes, hypothesis 1 demonstrated a statistically non-significant effect (B=1.247, t(25)=1.988, p=.058). The effect size, f^2=.045, was also very low.

Hypothesis 2: A comparison of means between "moderate" and "immoderate" use of psychotherapist techniques early in treatment and client-rated WAI scores showed no statistically significant differences in working alliance scores by therapist intervention frequency, although there was a low to moderate effect size in the negative direction (t(42)=.975, p=.335, d=.296).

Hypothesis 3: Support for hypothesis 3 was demonstrated, although contrary to what was predicted. In a chi-square analysis, moderate levels of overall therapist interventions significantly *negatively* predicted treatment completion (χ^2=4.454, p=.035), with a moderate effect size (ϕ=.318). This indicates that therapists who were relatively active or relatively inactive in their intervention frequency early in treatment retained their patients to completion significantly more often than therapists who were "moderately" active.

Discussion

Recent meta-analytic studies and reviews have demonstrated no relationship between treatment adherence frequency and outcome (Webb, DeRubeis, & Barber, 2010), what has been called the "outcome problem" in comparative psychotherapy research studies, and a negative relationship between treatment adherence frequency and alliance (Ackerman & Hilsenroth, 2003). These results suggest two possibilities: first, that psychotherapist flexibility in response to clients is a key feature of alliance development, treatment retention, and overall outcome (Roos & Webart, 2013), and second, that a linear relationship between psychotherapist intervention frequency and outcome may not accurately fit the data. In an attempt to address the outcome equivalency problem in psychotherapy, the current pilot study tested a non-linear model of the relationships among psychotherapist intervention frequency, working alliance, treatment retention and outcome in a sample of good outcome, poor outcome and dropout clients and their psychotherapists in brief psychotherapy. Additionally, as psychotherapy treatment type labels may mask specific interventions within sessions, we assessed the frequency of psychodynamic and cognitive-behavioral interven-

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tions as consistent variables across a range of treatment types.

We found that a relatively "moderate" frequency of psychotherapist interventions (compared to "low" and "high" frequencies) predicted lower client-rated working alliance, with an effect size in the low-moderate range. The small sample size is likely the reason that this relationship was not supported statistically in hypothesis 2. Interestingly, we also found that psychotherapists who intervened with "moderate" frequency had significantly more clients terminate prior to session 10 than did psychotherapists who were "immoderate" in their intervention frequency (i.e., those who intervened either much more or less frequently than average early in treatment). While this second finding (hypothesis 3) is contrary to what we hypothesized, the results offer partial support for the argument made by Webb, DeRubeis, and Barber (2010), that psychotherapy research using linear dose-effect models of therapist intervention may have overlooked important processes. The results of hypothesis 1 indicated there was no meaningful relationship between "moderate" psychotherapist interventions and outcome, moderated by the working alliance.

It may be that our operationalization of "low," "moderate," and "high" intervention frequency captured an existing nonlinear relationship between psychotherapist intervention frequency and two of our three dependent variables, working alliance and dropouts, but that "moderate" intervention frequency did not reflect clinical flexibility. Instead of a "moderate" level of interventions capturing a just right level of psychotherapist activity, "low" and "high" intervention frequency may, instead, be an indication of a psychotherapist's ability to flexibly and sensitively adjust responses to the particular needs of the client, resulting in a greater number of clients who complete treatment. Post-hoc analyses were completed as a way to shed light on this explanation but we found no meaningful relationships between psychotherapist years of experiences, Psychodynamic or CBT interventions, or ratios of Psychodynamic to CBT interventions with working alliance, outcome or dropout rates. Clearly, more work evaluating psychotherapist flexibility in response to particular clients needs to be done.

The present study included several limitations that must be kept in mind when interpreting the results, but that also highlight the need for further research. The use of 15-minute segments of psychotherapy transcripts may have missed important therapy processes related to working alliance development and outcomes. Furthermore, a lack of norms for the frequency of psychotherapist interventions resulted in a sample-dependent definition of "moderate" and "immoderate" intervention frequency that will need to be tested in other psychotherapy samples. A larger sample with repeated assessments of working alliance and other sub-outcome markers would have allowed for hierarchical linear modeling, which may have been able to reduce the error incurred in defining such categories on the basis of one sample. Our decision to use commonly utilized psychodynamic and CBT interventions as a way to compare this psychotherapist variable across different treatment orientations and thereby address a problem in the existing in terms of general therapy labels masking specific in-session processes, may also have been considered a methodological limitation with respect to other, theory-specific manualized techniques not being measured here. Further research into

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non-linear models, including case studies, that attempt to explain the relationships among the frequency of specific, theory-driven psychotherapist interventions, working alliance development, treatment retention, and overall therapeutic outcomes is needed in order to better explain what works for whom in brief psychotherapy.

NOTICE TO READERS

References for articles appearing in this issue can be found at the end of the on-line version of Psychotherapy *Bulletin* published on the Division 29 website.

Keys to a Successful Internship Application 'Season': Preparation, Self-care, Collaboration, and Self-awareness

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We are two doctoral candidates in a counseling psychology Ph.D. program who recently matched at university counseling centers (UCCs). Upon reflecting on the internship process, we recognized that a foundation of preparation, self-care, collaboration, and self-awareness helped maximize our efforts and allowed us to even find some enjoyment during "internship application season." We recognize that these four strategies may not fit for everyone; however, we hope this article provides guidance around what the process entails and encourages you to reflect on how to best approach your own internship applications.

Preparation – Given the dual realities of the necessity of completing an internship to move forward with our careers and the current internship imbalance, it becomes clear how much is riding on successfully matching. As it can be easy to overlook necessary steps when under pressure and facing deadlines, we found advanced preparation and organization made the process more intentional and less stressful. In this section, we provide a brief chronological overview of recommendations based on our training and preparation, as well as things we wish we had known.

Prior to application year:

- Reflect on your first practicum setting. In what ways was this placement a good fit for you and why? What would have made it better? Tailor your next practicum toward being well-suited to your dream internship site. For example, most UCCs prefer applicants who have prior UCC practicum experience. Planning your practica accordingly is important to be competitive for hospital and other internship settings as well. By the time you are looking at prerequisites for specific internship sites, it may be too late to gain a certain type of experience.
- Begin tracking your hours as soon as you start accruing them. APPIC just released an hours tracking system that deposits hours directly into AAPI. Tallying hours requires an extensive amount of time and mental energy, but the process is much simpler if you track weekly or daily.
- Update your curriculum vita (CV) each semester to minimize your workload later. Check out CV templates of current and former interns to find the best ways to organize your information.

Summer before application deadlines:

- Register for the Match News and obtain copies of the Internship Handbook.
- Polish your CV and receive feedback from peers and advisors.
- Prepare a list of strengths and areas for growth to be included in the training director's (TD) letter by reviewing prior supervisor evaluations.

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We devised five development categories (counselor, supervisee, professional, multicultural, and ethical) and listed strengths, growth edges, and direct quotes for each. We recommend this assignment whether it is required in your program or not. It can help the TD write a more personal letter for you, especially if the TD is not someone you have worked with extensively.

- Prepare drafts of the four essays and be prudent in your choice of editors. In order to make decisions that best represent you, ask people who know both you and the type of site well to read your essays.
- Order transcripts and send out requests for recommendation letters EARLY. Be sure to check the sites' websites to see how many letters are requested and who should author those letters (recent clinical supervisor, supervisor in a particular setting, etc.).
- Begin researching sites and start a spreadsheet. Include factors you find important (e.g., stipend, special rotations, location). Tracking all of this information along with comments about what you like about the site makes writing the cover letter much easier. We recommend only applying to sites where you meet all of their specified criteria.
- After your sites are selected, start working on cover letters right away. This "first impression" is perhaps the most important part of the application, as it provides an opportunity to make your case for being an excellent fit with the site. Note and use the site's language in your letter. What would you bring to this site? How does their training meet your professional goals?

Fall semester – Getting ready to interview:

- Practice interviewing. Phone/Skype interviews usually last 30 to 60 minutes. Applicants have a limited amount of time to answer each question with depth and introspection. This is also an opportunity to troubleshoot potential technical challenges before the actual interviews (e.g., check lighting and sound for Skype; reception on the phone). Practice in-person interviews with different people.
- Prepare questions. Intern selection committee members we have spoken with have remarked how important it is to share what you love about their site as well as to ask questions that show you have done your homework about their training program. Develop 15 to 20 questions in case you have extended time to ask questions.
- Create an interview scheduling spreadsheet. Some sites list their interview and open house dates and format in advance on their website, which can help you determine busier times for interviews and traveling.
- Create an internship ranking spreadsheet to rank sites on criteria such as service activities, site environment, training activities, location, and gut reaction.

Self-Care – Self-care is vital to the internship application process and it is best to start early. One professor assigned a semester-long self-care project that helped us build a habit of practicing and reflecting on self-care activities. These activities can vary and it is important to determine what you need for balance. For example, a mindfulness meditation practice can provide stillness for our overworked minds, while a movement-based activity such as yoga

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or running can help after sitting at a desk all day. We will share some reflections on our experiences implementing self-care throughout the internship process:

- So often we can forget about joy and its importance in our lives when we are so focused on the task at hand. Joy refuels and re-energizes us, and scheduling time to share joy and a meal goes a long way. Schedule downtime with your peers during internship application season.
- Spend time with friends or a hobby outside of academia. It is easy to get "tunnel vision" during the internship application process, and spending time with activities and people outside of your program can provide much-needed perspective.
- During interviews, we experienced difficulty with multi-tasking because internship interviews demanded substantial time, focus, and energy, as well as proper rest and care between interviews. Minimize external obligations during this time. Talk with your supervisors early in Fall semester about the time you may need to take off during December and January for interviews.
- After interviews conclude, the ranking and waiting periods begin. During the written and interview portions of the application, there is so much to do that it can leave little idle time. This period of waiting and ranking can provoke anxiety; thus, it is a helpful time to increase your self-care activities.
- Match day is another opportunity for infusing self-care into the process. Our cohort scheduled a get-together for the day after match day. Most of us took the day off for match day and scheduled a self-care activity like a massage. It can be important to reflect in advance on what you are likely to need or want most that day, regardless of the Match outcome.

Collaboration – Building a spirit of collaboration and teamwork throughout our program was another crucial component to reduce the stress. Many of us are forced to compete with one another for practicum sites, assistantships, and other opportunities. However, this should not stop us from learning how to work collaboratively in a supportive team setting. In our internship process, this included sharing of ideas and information in addition to emotional support.

- We began this process early on, by meeting with the prior year's intern cohort from our program shortly after match day to glean information about what they found helpful and what they wished they had known. We paid it forward after we matched by passing along information to the following year's students.
- The summer before applications were due, our cohort organized weekly meetings, created an agenda for each meeting, and assigned homework between weeks, primarily focusing on preparing our written materials. In addition, we discussed strategies regarding letters of recommendation, counting hours, and selecting sites.
- We also benefitted from collaboration in selecting our sites. Once you have a tentative list of sites in which you are interested, run your list by supervisors and faculty who may know more about the sites. Talk to contacts who completed internships at the sites on your list, including alumni, peers, supervisors, and faculty.
- Before interview invitations rolled in, we each set up our own interview

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criteria spreadsheets. Collaboration can be helpful during this time because it provides an opportunity to talk through ideas and reflect on what criteria are most important to you in ranking an internship site.

- We began preparing for interviews during the internship course our program offers once our written applications were complete. Although it felt awkward at first to answer interview questions on the spot in front of the class, it helped us learn quickly how to merge spontaneity, reflection, and professionalism. We alternated practicing interview questions, giving feedback in dyads and the large group. We also conducted mock interviews in person, on the phone, and via Skype.

Self-Awareness – Self-awareness is a fourth key component to internship success, but is rarely spoken about in our experience. Self-awareness includes observing the self and noticing the impact we make on our relationships, noticing and reflecting on our "blind spots," and the ability to make ourselves vulnerable when appropriate. Just as we start to develop a habit of self-care as early as possible, it is also important to cultivate self-awareness throughout our time in our program. When we start internship applications, we must be prepared to be present, engaged, and reflective while managing stress. Below are some opportunities for self-awareness that we noticed during the process:

- If you engage in a practicum where you may eventually apply for internship, it is important to think about how you are presenting yourself as a clinician as well as a supervisee.
- Consider asking different people to read different essays. A recent clinical supervisor may be best to review your theoretical orientation essay. Your advisor may be the best choice to read your research essay. Keep in mind that having a few of the "right" people read essays may be more beneficial than having many people read them and offer conflicting feedback.
- Before the dust settles on the written application process, the waiting period for interview invitations begins. Intern applicants can join the Student Doctor Forum, which updates the days and times that internship sites send out interview invitations. It may be important to reflect on the pros and cons in order to make an informed decision about whether to join the network. Although the network provides updates in real time, applicants may feel compelled to refresh the network thread constantly, which can add unnecessary anxiety.
- Interview scheduling can be a hectic part of the process, and notification can happen at any time (including weekends). Some sites call to schedule and you may have to engage in phone tag to schedule an interview. Other sites have moved their scheduling system online in order to provide ease of scheduling to applicants. Weigh the options and talk with former applicants about what they wished they had known during this process. For example, one former applicant shared she was surprised to open a rejection email minutes before beginning a therapy session with a client, and struggled to stay present. Another applicant decided it felt less stressful to check her email regularly in order to maximize her interview date options, as most scheduling systems operate on a first-come, first-served basis.
- Before asking any questions, read the site's website and the APPIC

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website multiple times. Reflect on your values and what is important to you in a site, and look for these things on the website before asking a question. Asking a busy training director a question that is answered on the website can quickly turn a first impression sour.

- Prepare to make yourself somewhat vulnerable during internship interviews. We were frequently asked questions about clients who challenged us, multicultural and clinical mistakes, conflict with supervisors and peers, etc. The selection committee wants to know how we might fit with their site and what it might be like to work with us. Think deeply about these kinds of interview questions and practice them with others so you can learn how you are presenting yourself and how you are balancing "vulnerable yet appropriate."
- In-person interviews and open houses can range in length from a one-hour meeting to an all-day event. It may sound like common sense, but being warm to support staff as well as other applicants is important. Selection committees are observing how applicants connect with others beyond the selection committee to get a sense of how applicants might fit interpersonally into the center and with other interns. Staff members have also been known to give feedback to selection committees, and how applicants treat them may be viewed as a way to gauge how applicants interact with others when they are not perceiving themselves as being in the spotlight.
- Use your questions as a way to show what is important to you on internship as well as a way to glean information for ranking. It can be helpful to set up follow-up phone conversations with the training director and/or current interns (15 to 30 minutes) if you still have more questions after the interview. Speaking with training directors can give you a sense of how you might interact together. Talking with current interns can give you a reality check about the internship, as they will often share both positive and challenging aspects of the site. Although they can feel more like peers, remember that you are still being 'interviewed.'
- The interview process can feel like a whirlwind for many applicants and it can be easy to forget your impressions and details of interviews surprisingly quickly. Take notes during the interviews. Jot down your gut reactions and what you noticed about your experience with each site right away.
- The ranking process can induce new anxiety in applicants because submitting rankings feels so final. However, we strongly encourage applicants to attend to the ranking process every day for a few weeks before rankings are due. Allowing yourself that longer time period to engage with it gives you some days to step away from it and then come back after letting it simmer. Decisions should come from intuition, values, and interests.

The internship application process can evoke a variety of emotions, but we hope our perspectives on the four keys to success during internship application season will be useful to you as you begin preparations. Remember that you have worked hard to get to this stage of the process: Being authentic and confident can assist you in finding an internship that fits best for you. Reflect on your experiences, share how you have grown, and enjoy the process!

DIVISION 29 PSYCHOTHERAPY

Of the American Psychological Association (APA)

CALL FOR NOMINATIONS

Distinguished Psychologist Award

The APA Division of Psychotherapy invites nominations for its 2014 *Distinguished Psychologist Award,* which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

Deadline is January 1, 2014. All items must be sent electronically. Letters of nomination outlining the nominee's credentials and contributions (along with the nominee's CV) should be emailed to the Chair of the Professional Awards Committee, Dr. William Stiles, at stilewb@miamioh.edu

CALL FOR NOMINATIONS

Division 29 Award for Distinguished Contributions to Teaching and Mentoring

The APA Division of Psychotherapy invites nominations for its 2014 *Award for Distinguished Contributions to Teaching and Mentoring*, which honors a member of the division who has contributed to the field of psychotherapy through the education and training of the next generation of psychotherapists.

Both self-nominations and nominations of others will be considered. The nomination packet should include:

1) a letter of nomination describing the individual's impact, role, and activities as a mentor;
2) a vitae of the nominee; and,
3) three letters of reference for the mentor, written by students, former students, and/or colleagues who are early career psychologists. Letters of reference for the award should describe the nature of the mentoring relationship (when, where, level of training), and an explanation of the role played by the mentor in facilitating the student or colleague's development as a psychotherapist. Letters of reference may include, but are not limited to, discussion of the following behaviors that characterize successful mentoring: providing feedback and support; providing assistance with awards, grants and other funding; helping establish a professional network; serving as a role model in the areas of teaching, research, and/or public service; giving advice for professional development (including graduate school postdoctoral study, faculty and clinical positions); and treating students/colleagues with respect.

Deadline is January 1, 2014. All items must be sent electronically. The letter of nomination must be emailed to the Chair of the Professional Awards Committee, Dr. William Stiles, at stilewb@miamioh.edu

Our Time to Serve – Treating the Newest Generation of Military Service Members

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Since the terrorist attacks on the United States on September 11, 2001, over 2 million American service members have been mobilized to Iraq and Afghanistan in Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) and most recently Operation New Dawn (OND) which encompasses military activities in Iraq after August 2010. This sustained mobilization, the largest since the Vietnam War, has created unique challenges related to the tempo, duration, and combat circumstances for the current generation of military members. Service members are facing multiple deployments with relatively short interim periods between deployment, a tempo that may potentially exacerbate the effects of combat deployment for service members and their families.

Although most service members demonstrate remarkable resilience in response to a combat theater deployment, many do not. In a large study of Iraq and Afghanistan veterans entering the Veterans Affairs (VA) health care system, 37% received a mental health diagnosis; 22% were diagnosed with posttraumatic stress disorder (PTSD), 17% with depression, and a considerable percentage with dual diagnoses (Seal et al., 2009). Multiple deployments result in relatively higher risk for anxiety, depression, alcohol use, and acute stress (Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004). Despite the prevalence of mental health concerns, post-deployment mental health services are underutilized in military populations in part due to fear of stigmatization (i.e., appearing weak or being treated differently by leadership), concerns about harming one's career, and other barriers to care (Hoge et al., 2004; Wright et al., 2009).

Despite these concerns, rates of mental health care utilization among service members are on the rise, placing greater demands on the healthcare system. An estimated 35% of military personnel serving in Iraq seek mental health care within the first year after combat (Hoge, Auchterlonie, & Milliken, 2006). An increasing number of service members and veterans are expected to pursue healthcare in the civilian sector, in part because the military healthcare system is overwhelmed and understaffed (American Psychological Association, 2007; U.S. Department of Defense Task Force on Mental Health, 2007). Hence, even mental health providers outside of the military health system, particularly the next generation of providers, need to enhance their "cultural competency" and become better informed about the challenges that are salient for this newest wave of service members. What should providers be attuned to when working with service members and veterans in the post-OIF/OEF era? How might greater understanding of these conflicts and of the evolving military culture be important in providing effective treatment?

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The Separation of Military and Civilian Communities

Because the current U.S. military is an all-volunteer service, a large segment of the general population (mental health providers included) has not experienced the threat of having a loved one deploy. This can create a greater cultural divide – leaving service members feeling disconnected from the civilian world and especially from civilian providers. Service members often report a sense of being misunderstood and disconnected from the civilian community (Demers, 2011). At a minimum, civilian providers need to create a safe therapeutic environment, which includes refraining from pressuring service members to share their deployment experiences before they are comfortable and providing support and validation once deployment experiences are disclosed. Providers also need to make special effort to become familiar with rudimentary military terms including ranks, organizational structure, and basic operations (refer to DeVries, Hughes, Watson, & Moore, 2012; Freeman, Moore, & Freeman, 2009; appendices of Snyder and Monson, 2012).

Navigating the balance between military and civilian life can be particularly challenging for those in the reserves. National Guard/Reserve troops have been mobilized to Iraq and Afghanistan to a far greater extent than in previous conflicts (Defense Science Board Task Force, 2007). Evidence suggests that National Guard/Reserve troops may be at a greater risk for post-deployment mental health problems. Indeed, in one study reservists returning from a tour in Iraq reported more than double the rate of mental health problems compared to active duty service members (Milliken, Auchterlonie, & Hoge, 2007). Unlike active component service members, reservists demobilize following a deployment and lose the day-to-day support from their unit peers. They often return to civilian communities that lack military awareness and the reservist may feel unappreciated or unrecognized for his/her service. They may also experience additional barriers (e.g., legal or geographic) to accessing mental health care services. Finally, they often face challenges of transitioning back to full-time civilian employment after a long deployment (Defense Science Board Task Force, 2007), which may be further complicated by a strained economic climate and a relatively high rate of unemployment. When working with National Guard/Reserve members it is important to explore their unique challenges in balancing their military and civilian roles.

The Changing Face of the Military

The overall composition of the military has changed dramatically over the past few decades. One of the most notable changes is the increasing number of women in uniform. Women's involvement in military operations is evolving rapidly – with a growing number of women being exposed to combat despite not being able to serve officially in front-line combat roles (Street, Gradus, Giasson, Vogt, & Resick, 2013). This effect will likely increase as a result of recent efforts toward extending the combat roles of women. There is mounting evidence that women service members have unique needs and face different challenges compared to their male counterparts. Mental health providers need to understand and respond to the psychological challenges facing service members, particularly women, in the military, including military sexual trauma, combat exposure, body dissatisfaction, and intimate relationship distress (for an overview of evidence-informed practice with women service members and veterans see Ghahramanlou-Holloway, Cox, Fritz, & George, 2011).

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Related to the increase in the number of women in the armed services, there is also an increase in dual military couples and more service members with children, highlighting the importance of adopting a family systems perspective when considering various treatment options (Snyder & Monson, 2012).

As a whole, the U.S. military is also growing in diversity. Military members from the current conflict are older on average than service members of previous conflicts (with an average age of 28 years), and most service members fall between the ages of 22 to 30 years. Minorities make up almost one third of the active duty forces, but they are disproportionately comprised of enlisted members as opposed to officers (Office of the Deputy, 2012). Additionally, with the repeal of the "Don't Ask, Don't Tell" act, service members may now serve openly in the military regardless of their sexual orientation. However, accompanying the increased diversity in racial/ethnic and sexual orientation is also a greater risk for discrimination, harassment, or victimization. (For more information regarding military issues related to the repeal of "Don't Ask, Don't Tell" see Department of Defense, 2010). Characteristics such as age, sex, race/ethnicity, and sexual orientation should be considered when working with any population, but they are particularly salient when working within the military population. Clinicians should explore the unique impact of these factors for the service members or veterans with whom they are working.

Building on Strengths

Despite the widespread assumption that deployment is related to negative outcomes, service members can also experience positive personal, familial, and work-related gains as a result of their service. Both research and practice need to take a more comprehensive conceptualization and approach with military service members. Treatment should be both problem focused and strength based (Park, 2011). Military members generally demonstrate a tremendous amount of resilience in the face of adversity. The military culture instills and enhances numerous fundamental positive intrapersonal and interpersonal qualities. In many ways service members and their families are a robust and healthy group (Cozza, Chun, & Polo, 2005).

The military has its own set of beliefs, ideals, and expectations that are central for mission readiness. Beginning with boot camp, the military member's civilian identity is transformed into a military identity. The military culture promotes courage, discipline, duty, honor, and commitment to their comrades, unit, and the nation (Demers, 2011). The focus is on the wellness of the group rather than the individual, promoting self-sacrifice and loyalty. Service members also learn to suppress their emotions and to depersonalize events, which is adaptive in combat situations but can be problematic when returning home. Deployment can provide a greater appreciation and new perspective on life, resulting in personal growth and rediscovery of one's self. Some have described this transformation as "posttraumatic growth," which includes improvements in the quality of relationships, optimistic outlook regarding the future, positive self-perception, greater appreciation of life, and greater depth of spiritual beliefs (Gallaway, Millikan, & Bell, 2011).

The assets of service members deserve to be recognized and promoted. Their commitment to the military has often resulted in acquiring skills and gaining life experiences that will benefit them in

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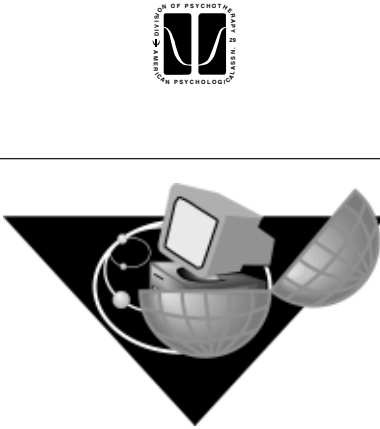
school, jobs, and their community. They often exhibit organization, structure, and dependability; furthermore, they have educational opportunities to acquire new skills. Providers can help service members recognize their unique assets and utilize their potential as leaders in their communities. Some characteristics (e.g., self-sufficiency, toughness, and emotional detachment), while necessary and adaptive in the deployment setting, can become barriers to mental health treatment once the service member returns home. Providers should help service members use their deployment-related assets to their advantage while recognizing when these characteristics might interfere with post-deployment reintegration or with effective use of mental health resources.

Despite the overall resilience of our newest generation of service men and women, psychological injuries exceed the number of physical injuries or deaths. These adverse effects extend beyond the individual service members themselves; for example, a high percentage of those seeking behavioral health services will have problems with family reintegration (Sayers et al., 2009). However, it is important to resist over-pathologizing this resilient population and, when pathology exists, to avoid a sole focus on posttraumatic stress disorder (PTSD). One should consider broader diagnostic possibilities, including traumatic brain injury, substance abuse, depression, relationship distress, occupational problems, and family dysfunctions (Sammons & Batten, 2008). Providers also need to be particularly vigilant in suicide risk assessment, because service members are at a greater risk for suicide than their civilian counterparts (Department of the Army, 2012). Although many will seek care in government agencies, others will seek care in civilian settings or from a civilian provider within the military health system. Clinicians in the community must now embrace the responsibility of better understanding the military culture and explore the unique challenges faced by service members and their families in order to provide effective treatment. It is now our time to serve.



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ETHICS IN PSYCHOTHERAPY

Ethical Issues and Social Media

Alexandra Karas
University of Denver Graduate School of Professional Psychology

Ethical implications are important to consider when using social media, including Facebook, Twitter, and Instagram. This paper is written from the point of view of a master's student in Forensic Psychology, and focuses on the possibility that the use of social media may be perceived by clients as a form of self-disclosure. Given that the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010) does not have specific guidelines for psychologists related to the use of social media, psychologists and graduate students may be uncertain about using social media and unclear about what is ethically appropriate and what is not.

As of October 2012, Facebook has become a social outlet for over a billion people (Zuckerberg, 2012). It is an important way for people to stay in contact with friends, family, coworkers, and others (Petrashek, 2010). Before beginning my first year in the forensic psychology Master's program at the University of Denver, I assumed that it would be unprofessional to continue participating in Facebook given my new work in psychology. I also wanted to protect my personal information from future clients. However, as I complete the end of the first year of the Master's program, it has become apparent how helpful Facebook is for keeping in contact not only with family and friends, but also fellow classmates. The students in our program created a private group on Facebook and use it to communicate with each other on a regular basis (often using our smartphones for immediate responses), including asking each other questions, and sharing information about the program. Despite the conveniences of Facebook, questions remain about the ethical implications involving clients and social media.

Facebook has a privacy setting where only your "friends" can view your profile information. However, according to Petrashek (2010), some basic information that you list about yourself (e.g., profile picture and geographical location) will remain public. This could give away details that you may not want clients or others to see. Most of the other information on your page can be set to private, but there are certain settings that may reveal personal details if you are unaware of them. For example, the URL link for your Facebook page may contain your full name despite the fact that you removed your last name from your profile. Your name can also be found in the search bar listed as someone's family member. For example, if you listed the names of your relatives on your Facebook page, you can be searched and your full name can pop up as "John Smith's daughter." All of these settings can be changed in order to make your information private, however a lot of people may be unaware of them (Petrashek, 2010).

These privacy settings may not seem like a serious matter, but if you think of your personal information being accessible to the public as a form of disclosure, it becomes less clear as to what is appro-

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priate. This is especially important for clinicians who work with forensic populations. In the forensic program, I have learned that giving out personal information can be quite problematic. According to Berg (2007), personal information that is posted online can be misused for criminal purposes. Petrashek (2010) adds that "this mixture of excessive disclosures, criminals, and police is certain to produce frequent constitutional issues in the near future" (p. 1507). This speaks to the unclear expectations of privacy and the problems that could arise as a result of social media usage.

Of course, personal disclosure can be problematic not just for the student or the psychologist, but for clients as well. The focus of psychotherapy and assessment is supposed to be on the client, not the therapist, and the nature of the therapeutic relationship can be negatively compromised if too much information (or inappropriate information) about the therapist is revealed.

A few points to consider in relation to engaging in social media also include the temptation to search for a client on Facebook. According to Jent et al. (2011), a study conducted with 302 psychology graduate students found that 27% admitted to searching their clients on social media for various reasons. What if you have a client on probation and you see on Facebook that they are violating probation somehow? If your employer requires you to report that client, what are the implications for the client and your therapeutic relationship with them? What are the implications involved in discovering this information via social media? And what if the information that was posted was fabricated (as may be especially true for adolescents according to Jent et al., 2011)?

Another social media site that poses possibilities for disclosure is Twitter. Twitter is slightly different than Facebook because it is more similar to a journal. It is mostly composed of posting comments, which are called "tweets," on a person's individual page for their "followers" to read. It is similar to Facebook in the sense that there is the option to post pictures and share articles; however, it is more of an outlet to post tweets or daily observations. This can be concerning for psychologists and students since it can provide a window into their personal thoughts and opinions that, again, can be a form of unwanted disclosure to clients or potential clients. Twitter can also be made private to only allow specific people to follow an individual's page, but Twitter also has a setting whereby others can "re-tweet" another person's tweet, thus potentially sending it well beyond the intended audience in a way that may be impossible to erase. In addition, Twitter involves not just communicating personal thoughts and opinions, but also revealing what a psychologist "follows" including magazines, comedians, actors, TV shows, musicians, and so on, thus revealing additional personal information to clients and potential clients.

The latest social media outlet that has become popular is Instagram, which is used for uploading pictures with a smart-phone. There is the ability to "follow" other people on Instagram in order to see when they post new pictures. There is also the ability to "like" someone's picture and post comments to it. Instagram poses the same ethical problems as Facebook and Twitter in that it can be viewed as a form of disclosure. This is especially true when posting personal pictures such as family photos, or places that you may have visited. Similar to Facebook and Twitter, Instagram provides the option to make your page private. However, if you use a hash tag on a picture, it will link it with all the

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other pictures on Instagram that have that same hash tag. A hash tag is basically putting a number sign in front of a word (e.g., #sunshine), thus, allowing people to see who posted that picture. Kolmes (2012) reported that, in a study of 332 psychotherapy clients, 70% admitted to finding personal details about their therapists on social media sites and Google. Thus, this author suggested that the informed consent process is where clinicians should discuss with their clients the ethical considerations surrounding internet use and how it may affect the relationship.

When psychologists and graduate students engage in social media, they should make it a common practice to inform clients about this, and should discuss the possibility of how this might impact the therapeutic relationship. In addition, being aware of privacy issues inherent in various forms of social media, and setting strong privacy settings is important. Moreover, it might be useful to consider having professional accounts that are separate from personal ones, perhaps even using different names for each. Social media has become part of daily life; psychologists and students should be aware of the various ethical issues involved and take steps to protect both themselves and their clients.

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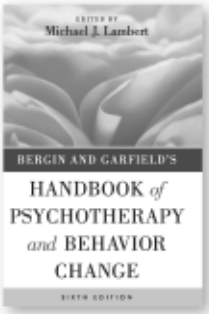

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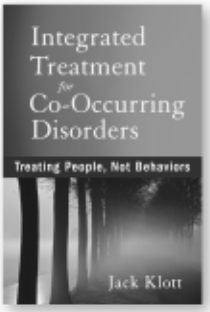

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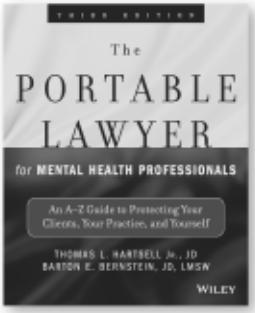

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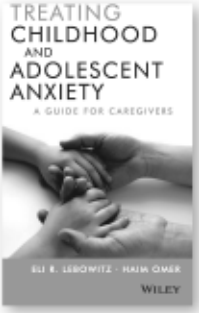

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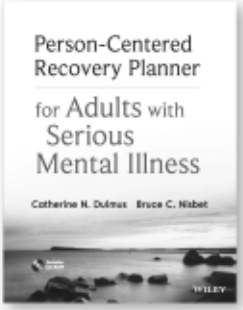

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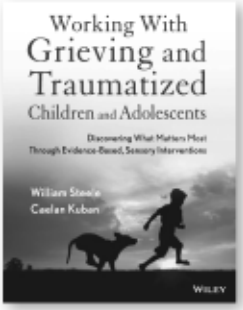

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WILEY

Understanding First-generation College Students: Implications for Practice

Shalena Heard, M.Ed.
Lehigh University

Campus support services, such as college and university counseling centers providing psychotherapy, continuously face the challenge of meeting the needs of a diverse student body (Mehta, Newbold, & O'Rourke, 2011). One subgroup of this population is *first-generation college students* (FGCS), defined as students who come from a family in which neither of the parents or guardians graduated from college (Mehta et al., 2011). As of 2010, the National Center for Education Statistics (NCES) reported that FGCS composed almost 50% of the population within higher education (U.S. Department of Education, 2010). FGCS may enter college with various disadvantages related to academic preparedness (Hertel, 2002; Mehta et al., 2011), readiness, exposure, financial need (Ramsey & Peale, 2010; Ting, 2003), beliefs in their ability to succeed in college, and/or community background (Hertel, 2002; Madyun, 2011; Mehta et al., 2011; Próspero & Vohra-Gupta, 2007; Stewart, Stewart, & Simons, 2007). Though previous studies have examined barriers impeding FGCS success (e.g., Coffman, 2011; Hertel, 2002), it is also important to identify protective factors that promote success. The purpose of this column is to highlight the barriers and protective factors impacting FGCS success, and to provide concrete recommendations for providing psychotherapy to this growing population.

Ethnic and Racial Disparities in First-generation College Student Success

The cultural differences between college students of varying ethnic and racial backgrounds have been highlighted as also worthy of assessment (e.g., Chavous, 2002; Moschetti, & Hudley, 2008; Wartman & Savage, 2008; Walpole, 2007). For instance, Chavous (2002) noted a limited focus on racial comparison in college student research and Walpole (2007) suggested that the intersecting identities of FGCS be examined because ethnicity and race, gender, and class should not be independently considered. Though a great deal of FGCS literature has focused on ethnic and racial minorities solely (e.g., Bryan & Simmons, 2009; Gloria & Rodriguez, 2000; Owens et al., 2010), studies that have compared ethnic and racial minority and White groups have reported differences, which suggest that factors such as community context and self-efficacy are important. Therefore, prior studies that have focused on negative outcomes and risk models (e.g., Hertel, 2002) may reflect erroneous assumptions about ethnic and racial minority FGCS, overlooking important strengths and resiliencies that could be further studied, nourished, and celebrated.

Implications for Therapy with First-generation College Students (FGCS)

The following recommendations have been synthesized from a number of studies conducted with FGCS of varying

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ethnic and racial identities, which can be useful for clinicians working with FGCS in academic settings. These suggestions are intended to encompass the cultural specific needs of FGCS as a group, and some are specific to the needs of ethnic and racial minority FGCS and White FGCS.

Acknowledging intersectionality – All clinicians may benefit from exploring multiple factors that comprise the development and experiences of their FGCS client (e.g., ethnicity, race, community environment, self-efficacy, pre-college involvement).

Avoid making assumptions – Despite the number of challenges facing FGCS and ethnic and racial minority FGCS specifically (Coffman, 2011; Hertel, 2002; Mehta et al., 2011), clinicians should not carry these assumptions into therapy. Many FGCS are motivated, resilient, and successful so allowing them to share their story may debunk assumptions and stereotypes.

Facilitate self-efficacy development – FGCS of various ethnic and racial identities may benefit from exploring their level of self-efficacy in multiple aspects of their life (e.g., social, academic), having those experiences validated by the clinician, and helping them generalize their sense of efficacy to task-specific contexts (Cervone, 2000; Schunk & Meece, 2005).

FGCS programs – College and university counseling center clinicians are encouraged to advocate for FGCS by consulting with college/university administrators on how to develop programs that accommodate the intersecting (e.g., race, first generation status, SES) and shared identities of FGCS (Coffman, 2011). Clinicians should also become familiar with existing federal programs designed for FGCS such as Upward Bound, Talent Search, and Student Support Services (U.S. Department of Education, 2013), which are solid examples of how to provide multisystemic support to FGCS.

Familiarity with FGCS research – The term and cultural identity of FGCS is becoming more prevalent, however, many people are still unfamiliar with FGCS. Clinicians are encouraged to become familiar with research studies that report a number of factors that support FGCS success, as well as the challenges they face. For instance, Hurtado et al. (1996) found that in-college experiences are more predictive of college adjustment than personal background variables (e.g., SES, FGCS status) for ethnic and racial minority students. For White FGCS, previous studies have linked parental support with higher self-efficacy (Bandura, Barbaranelli, Caprara, & Pastorelli, 2001), and community service engagement with higher college adjustment (Ting, 2003). It is vital for college and university counseling center clinicians to be aware of these ethnic and racial differences in college adjustment when providing psychotherapy with FGCS.

Conclusion

In sum, there is much to be learned about FGCS and how their individual backgrounds influence their college experience. It is recommended that clinicians consider within-group variability by ethnicity, race, and other important identity variables (e.g., gender). Creating programs that enhance cultural competence, promote leadership development, and prepare students to work in a diverse global economy can potentially increase students' self-efficacy, life satisfaction, and overall college experience. Therefore, clinicians are encour-

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aged to advocate for culturally appropriate programs and strategies that support and increase the retention and success of FGCS.

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AMERICAN PSYCHOLOGICAL FOUNDATION

Call For Nominations

DIVISION 29 EARLY CAREER AWARD

About the American Psychological Foundation (APF)
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APF encourages applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the Division 29 Early Career Award
This program supports the mission of APA's Division of Psychotherapy (Division 29) by recognizing Division members who have demonstrated outstanding promise in the field of psychotherapy early in their career.

Amount
One $2,500 award

Eligibility Requirements & Evaluation Criteria
Nominees should demonstrate and will be rated on the following dimensions:
- Division 29 membership
- Within 7 years post-doctorate
- Demonstrated accomplishment and achievement related to psychotherapy theory, practice, research or training
- Conformance with stated program goals and qualifications

Nomination Requirements
- Nomination letter written by a colleague outlining the nominee's career contributions (self-nominations not acceptable)
- Current CV
- Nomination must be submitted as a single PDF document

Submission Process and Deadline
Submit a completed application online at **http://forms.apa.org/apf/grants/** by **January 1, 2014**.
Please be advised that APF does not provide feedback to applicants on their proposals.
Questions about this program should be directed to Samantha Edington, Program Officer, at **sedington@apa.org**.

STUDENT FEATURE

To Those Who are Applying for Internship This Year

Maggie Perry, M.S.
Loyola University Maryland

I applied for internship last year and I didn't match. My life went on. I believe I'll be a better psychologist because of it.

Despite the risk I run for sounding unrealistically optimistic, let me offer you my experience and what I've learned this year "not matching" for internship. I hope my story inspires you to use your internship application year as a catalyst for increased growth, self-awareness, and confidence.

To summarize my graduate school experience briefly: I worked as hard as I could. I did well in my classes; I accrued many hours and received great feedback at my practica sites about my clinical skills. Those experiences included diverse populations that matched the types of internship sites to which I applied. I defended my dissertation (with edits) during June prior to applying for internship and presented my research at an APA convention; I was a teaching assistant for several classes at my program's university and then held lecturing positions at two other universities teaching undergraduate psychology courses. I was actively involved in my state association, co-chairing an annual graduate student convention, serving on two committees, and presenting at an annual conference… the list goes on. It was, and still is, my life goal to become a psychologist and I pursued each of these activities enthusiastically. I'm sure you can identify with some or all of these experiences.

To summarize my internship application experience briefly: I received a great deal of rejection from those who only knew me on paper, and a great deal of support from those who knew me in real life. I applied to 17 sites that fit my interests and skills. I was not geographically limited. The Psy.D. program I attend has match rates that have been higher than the national average for several years. I chose my sites and wrote my essays and cover letters early. Several of my professors and my DCT reviewed my materials, gave me positive feedback, and wrote me great letters of recommendation. I felt very good about my hard work and we all felt confident that I would get many interviews.

It didn't happen.

Between Thanksgiving and Christmas I received 14 rejection letters and 3 interviews. It was difficult. I cried and sought support. Then, I pumped myself up for the interviews I did have. I generally enjoy interviewing and I practiced my answers with several classmates, friends, and professors. I am told that I have a warm interpersonal demeanor. I was certain there was nothing in my teeth those days. After my interviews, I again felt confident about my performance and confident that I would match.

It still didn't happen.

I say all these things to show you that I truly was a "good candidate"—and I truly didn't match. There are not enough accredited internship openings for all of the good candidates. In many ways it is

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a game of numbers, and some of us will have bad luck.

One of my professors is a friend of a former internship training director at a site where I was rejected and my professor asked him for feedback on my behalf. In his response, he explained that there were about 40 applications for every position, so that there were many more people who looked like good people to interview than the site could possibly manage. He emphasized that, due to the significant disparity between the number of applicants and the number of internship slots in general, being asked for an interview didn't always have to do with the applicant's qualifications.

While this may sound anxiety provoking, I hope it brings relief. I hope it drops the pressure you have about crafting your graduate school experience to place at an internship site. Most of the internship advice I heard from others or read on websites focused on things like whether it was more important to accrue additional hours or work on your dissertation, as if acquiring an internship was part of a merit based system that just requires the right effort channeled at the right opportunity. As someone who did everything that everyone told me to do, I can tell you that, no matter what you do, there is still no guarantee you will match. The reality is that there aren't enough openings for everyone. Certainly put forth your best effort throughout your training and in your application. But also, be sure you study and pursue the activities you are passionate about, and don't let yourself be too preoccupied by comparison with others. Recognize that this is an unpredictable process, and be ready to use this as an opportunity to build your strengths despite the obstacles. Specifically, I would offer the following advice as a guide to help build your resilience:

Build and utilize your social support
Helpers (like most of us) don't typically like to need help. During this process, you'll need to surround yourself with people who believe in you and let yourself receive the support, especially from those who understand the internship process. During more than one tough week this year, I talked to my advisor every day and leaned on his support, as well as the support of many others in my program, to maintain my perspective. In my career as a psychologist, I expect to have more than one tough day or week. This process taught me to whom I could turn for help and how to best get what I need.

Focus on your progress to build your internal motivation
I lectured in my undergraduate course on the morning of Match Day prior to checking my email to see my results. I could have cancelled the class, but it helped me to be there. Giving the lecture reminded me of what I learned over the course of graduate school and I reaffirmed to myself that I had professional skills, no matter what my email would say that day. Later that day, and in the days to come, I read and reread my letters of recommendation and various feedback forms that I had received in clinical supervision over the years. I chose to believe what those who had seen my professional skills have said, rather than what one email would have me believe. Rather than allowing this experience to burn me out, I have used this process to increase my internal drive for success.

Clarify your goals and values
It's easy to start comparing yourself to others during graduate school, especially the internship process. Take time prior to applying to remind yourself why you decided to earn your doctor-

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ate, what your goals are, what you've done to achieve those goals so far, and what you still need to do. When you feel yourself tempted to compare, remind yourself of those goals. Remember that your journey may meander in different ways than you expected, and in ways that differ from the experience of others, but that doesn't mean that you won't ultimately achieve your goals. Because of this process, I've learned how to maintain my vision while becoming flexible about my path.

In closing, I want to share another email I received from one of my professors after I didn't match. I hope it will offer you hope and perspective, as it did for me.

> "Though what you're experiencing right now is, very appropriately so, a huge deal, it will become just a "blip" to reflect upon in a few years from now. Everyone has had (or will have) tough points in their academic and professional careers. I know of many very esteemed and talented physicians, psychologists and other professionals who have not matched for training positions, not passed licensing boards or the bar, lost jobs or even lost their licenses to practice either temporarily or permanently... and they have all landed on their feet and continued with great careers. I know this is probably not all that comforting now, but these experiences often turn out to have more of a "gold lining" than a "silver lining" after the dust settles. What I mean by this is that, as the expression goes, "when one door closes, another one opens"... and often that second door is much better than the first." (printed with permission)

I leave you with the saying, "it's not about what happens, but what you do with it." Whether you match or you don't match this year, I encourage you to use the internship application process to focus on your own progress, to build and utilize your social support, and to clarify your goals and values. You will be better for it, and eventually the "luck" will come.

Call For Nominations

APF DIVISION 37 DIANE J. WILLIS EARLY CAREER AWARD

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Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people's lives.

APF encourages nominations from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the APF Division 37 Diane J. Willis Early Career Award

The APF Division 37 Diane J. Willis Early Career Award is named after Dr. Willis, to honor her life-long advocacy on behalf of children and families. Dr. Willis's work cuts across many areas including clinical child, pediatric, developmental and family psychology. Through her publications, clinical work, and mentoring/teaching she has changed policy at the local, national and international level. She has advocated for children's rights at the United Nations, developed programs on prevention and early intervention for Native American children living on reservations, and established services promoting the wellbeing of children with developmental disabilities, chronic illness, and those who have suffered from maltreatment.

The APF Division 37 Diane J. Willis Early Career Award supports talented young psychologists making contributions towards informing, advocating for, and improving the mental health and well-being of children and families particularly through policy.

60 YEARS 1953 - 2013 AMERICAN PSYCHOLOGICAL FOUNDATION

Program Goals

- The APF Division 37 Diane J. Willis Early Career Award
- Advances public understanding of mental health and improve the well-being of children and families through policy and service.
- Encourages promising early career psychologists to continue work in this area.

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- psychologists with an Ed.D., Psy.D., or Ph.D. from an accredited university
- no more than 7 years postdoctoral

Evaluation Criteria

Nominations will be evaluated on:

- Conformance with stated program goals and qualifications stated above
- Magnitude of professional accomplishment in advancing public understanding of mental health and improves the well-being of children and families through policy and service.

Nomination Requirements

- Nomination letter outlining the nominee's career contributions
- Current CV
- Two letters of support
- Nomination must be submitted as a single PDF document

Submission Process and Deadline

Submit a completed application online at **http://forms.apa.org/apf/grants/**
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Please be advised that APF does not provide feedback to grant applicants or award nominees on their proposals or nominations.

Please contact Samantha Edington, Program Officer,
at sedington@apa.org with questions.

FEATURE

An Analysis of the Match Crisis in Clinical Psychology Internships: A 15 Year Perspective

Thomas O. DuVall, M.A., Doctoral Candidate, Fielding Graduate University
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Lawrence S. Dilks, Ph.D., Training Director, Counseling Services of Southwest Louisiana
Burton Ashworth, M.A., Doctoral Student, Fielding Graduate University
Jacqueline Bourassa, B.S., McNeese State University

Clinical psychology graduate students face a daunting task as they search for an internship. The number of applicants has risen steadily over the years, but the number of internship positions has not kept pace with the need. Despite years of training and preparation, a significant number of applicants will face the disappointment of not "matching" to an internship site. This imbalance has been identified as a crisis in the field of psychology that affects not only students, but also the profession as a whole.

The internship selection process, referred to as the "Match," proceeds in two phases. The initial phase (Phase I) has the largest number of potential placements for the upcoming internship year. Chances for matching are dependent on a variety of conditions such as: site accreditation, requirements, student interest, geographic limitations, and financial considerations. Students who do not secure an internship placement in Phase I may participate in a second round (Phase II) consisting of unfilled or newly available placements.

The Association of Psychology Postdoctoral and Internship Centers (APPIC) reported that for the 2013 Match cycle the number of applicants increased by 1%, and the number of available internship positions increased by 6%, which sounds promising. However, a record number of applicants (4,481) participated in the 2013 Match. At the end of Phase I, 1,387 students had not secured an internship. This is an alarming number, as only about 5% of students secure an internship in Phase II (APPIC, 2012).

With the addition of 6 new slots, there were 156 Phase II positions. However, 9 positions were withdrawn and 8 positions were not filled through the Match (i.e., no rankings for these slots were submitted by the internship program). Thus, although 6 positions were added, there was a net decrease in available Phase II slots rather than a gain. Sites do not fill open internship slots for a variety of reasons. Perhaps the most commonly cited reason is loss of funding. In other cases, there may be a perceived shortage of qualified candidates after Phase I;

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however, the disproportionately high ratio of applicants to positions calls this presumption into question. To further guard against this potential problem, APPIC Match Policies state that all unfilled positions from Phase I must be offered in Phase II. Removal of an unfilled position from Phase II for reasons other than loss of funding requires APPIC approval (APPIC, 2013).

While the imbalance has intensified, it is not a new problem. Over three decades ago researchers called attention to the predicted "nonplacement" rate of 14% by 1978 (Tuma & Cerny, 1976). In reviewing the statistics from 54,173 applications (Association of Psychology Postdoctoral and Internship Centers, 2013) over the last 15 years (Table 1), the data revealed 10,318 applicants failed to match during the span from 1999 to 2013, with an additional 3,906 applicants categorized as unplaced. The applicant-to-position imbalance has risen from 16% to 24%, with a peak rate of 27% in 2012. The recent nonplacement rates have remained substantially higher than that 14% rate that was a noted cause for concern. Many years have passed since 1978 and the dilemma has yet to be resolved.

The creation of new internship placements is paramount in addressing the current supply and demand issues facing professional psychology. Prior to implementing interventions, clinicians and researchers are trained to assess the presenting problem and to determine if the issue is more representative of an outlier or a symptom of a larger pattern of concern. It is clear that the time for intervention has come. Efforts to determine the possible causal relationships for the shortage without steps toward immediate intervention are likened to trying to pinpoint the origins of suicidal intent prior to securing a patient's personal safety.

All parties involved (e.g., academic institutions, APA, APPIC, internship sites, students) agree that the problem is complex and simple solutions will not suf-

Table 1.
APPIC Match Rates from 1999 to 2013

YEAR	IMBALANCE	UNMATCH	UNPLACED	TOTAL
1999	16.0%	17%	6.7%	23.7%
2000	14.5%	18%	6.8%	24.8%
2001	13.7%	18%	8.0%	26.1%
2002	10.4%	15%	7.5%	22.5%
2003	14.3%	18%	6.6%	24.6%
2004	16.1%	20%	6.7%	26.7%
2005	18.6%	21%	8.0%	29.0%
2006	20.1%	23%	7.7%	30.7%
2007	22.0%	25%	7.2%	32.2%
2008	18.6%	21%	7.1%	28.1%
2009	20.2%	24%	5.9%	29.9%
2010	20.2%	23%	5.6%	28.6%
2011	24.6%	21%	7.1%	28.1%
2012	27.0%	22%	8.2%	30.2%
2013	24.0%	19%	8.1%	27.1%

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fice. In 2007, the American Psychological Association (APA) Education Directorate released a report triggered by the 2007 Match data. This data highlighted the greatest imbalance between applicants and internship positions since the inception of the APPIC computerized system in 1999. One in every four students failed to secure an internship position. The outcome of the 2007 Match represented a 10% increase in unmatched applicants when compared to Match Day 2002. Some of the primary problems identified in 2007 are still cited as impediments in current efforts to resolve the situation, such as the cost of developing and maintaining training programs, increased admission and enrollment of students, and a focus on practicum hours rather than competencies (American Psychological Association, 2007).

A number of efforts were initiated by various constituents to address the problem. First, APA called for greater accountability and transparency in academic programs and advocated for additional training dollars. Second, APPIC continued to make Match data available through its website and worked to bring attention to the imbalance crisis. Third, the American Psychological Association of Graduate Students (APAGS) worked to disseminate information and dispel myths regarding the Match process and the internship imbalance (American Psychological Association, 2007).

While these have been important first steps, the imbalance has continued to grow. More recent efforts to remedy the situation have included the release of a toolkit design to aid the development of new internships (Council of Chairs of Training Counsels, 2010) and APA (2012) grant funding to expand the number of accredited internship positions and programs. Others (Grus, McCutcheon, & Berry, 2011) have advocated: (a) uniform minimum requirements for Match eligibility (e.g., comprehensive exams completed/passed); (b) movement toward universal accreditation as the standard for professional psychology education and training; (c) placing greater responsibility with training programs; and (d) conducting workforce analyses to address the needs within the profession for providers with particular skills and consideration of emerging societal issues. There are also calls for creative solutions involving local professionals, such as the development of consortiums.

Community-based psychologists across the U.S. have begun efforts to address the immediate need for internship programs in psychology. There are a growing number of pre-doctoral internship programs developing from the consortium model. The formation of a consortium is created through the collaborative efforts of practicing psychologists and other multidisciplinary professionals, such as physicians, nurses, and members of law enforcement. The consortium model pools expertise and financial resources to partner for the development of ethically sound pre-doctoral internship programs that offer a transitional experience from academia to the professional practice of psychology. Maybe the most overlooked aspect of the consortium model in professional psychology is that is rooted in the community and provides seasoned professionals a vehicle to impart knowledge while making a contribution to the profession.

There are a number of internships operating through the consortium model. For example, the Arizona Psychological Association developed the Arizona Psychology Training Consortium, an organization utilizing the psychological community throughout the state of

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Arizona. This organization helps increase internship opportunities (Arizona Psychological Association, 2011) and potentially increases the number of psychologists who will remain in the area to provide services after graduation. Similarly, the Lone Star Psychology Residency Consortium (LSPRC) was developed to increase the training opportunities available in Texas. The LSPRC brings together academic departments, community agencies, and independent practitioners to provide internship training. In Louisiana, a newly developed consortium, the Southwest Louisiana Pre-Doctoral Internship Consortium, has brought together a range of training opportunities to increase professional services available to the community while advancing training opportunities in Louisiana. This site introduced internship placements in the southwestern part of the state, where previously none were available.

The internship imbalance has reached crisis proportions. Although there are no easy solutions, application of creative approaches and involvement of the psychological community could potentially alleviate the shortage. In particular, the consortium model utilizes local entities that not only provide training opportunities, but also reduce costs by pooling resources and providing much needed services, often in underserved areas. As a profession, we have an ethical obligation to collegial cooperation and advocating for the care and development of our own. We have long known about the internship imbalance crisis. We have identified areas to be addressed, as well as the challenges to addressing the shortage. Perhaps by shifting the focus to the local level, we will continue to creatively implement solutions in the present as the debate continues on the growth management issues of our profession's future.

WASHINGTON SCENE

Even Incremental Change Takes Time

Pat DeLeon, Ph.D.
Former APA President

SAMHSA's FY' 2014 Budget: It is always instructive to review the budget priorities of those federal agencies which address the needs of our profession's beneficiaries. The Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) noted that her FY' 2014 budget "prioritizes essential investments in mental health and substance abuse infrastructure and innovation as the nation comes to terms with its long-standing neglect of these public health issues. I believe this request reinforces SAMHSA's efforts to help the nation understand and act on the knowledge that behavioral health is essential to health—that emotional health and freedom from substance abuse are necessary for an individual, a family, a community or a nation to be healthy." Her total budget request is $3.572 billion, including $130 million to support the President's plan to protect America's children in the wake of the tragic events of December 14, 2012 in Newtown, Connecticut. Approximately $63 million is targeted for states to work with providers to increase enrollment and to maximize third party reimbursements for substance abuse and mental health services. An additional $21 million is to identify and bring to scale evidence-based practices to promote mental health and to prevent and treat mental illness. Funding is also requested to implement the National Strategy for Suicide Prevention and to begin a new program focused on trauma and women, Grants for Adult Trauma Screening and Brief Intervention. $130 million will ensure young people and the adults who work with them know how to recognize mental illness and find a clear pathway to care. This includes funding for Project AWARE (Advancing Wellness and Resilience in Education), providing Mental Health First Aid training, and fostering comprehensive state-school-community partnerships to prevent violence, promote mental health, and facilitate referrals to treatment.

The Administration firmly believes that individuals and families cannot be healthy without positive mental health, freedom from addiction, and the absence of abuse of substances. Prevention, treatment, and recovery support services for behavioral health are essential components of health service systems and community-wide strategies that work to improve health status and lower costs for individuals, families, businesses, and governments. The presence of substance abuse and mental illness exacerbates the cost of treating co-morbid physical diseases and results in some of the highest disability burdens in the world.

SAMHSA's vision:

- Behavioral Health is essential for health.
- Prevention works.
- Treatment is effective.
- People recover from mental and substance use disorders.

Being aware that the sense of shame and secrecy associated with mental illness and addiction prevents too many Amer-

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icans from seeking help, President Obama directed the Secretaries of the Departments of Health and Human Services and Education to launch a national dialogue about mental illness with young people who have experienced mental illness, members of the faith community, foundations, and school and business leaders. SAMHSA collaborated with public and private partners to facilitate this National Dialogue on Mental Health in order to raise awareness and reduce negative attitudes. APA's Norman Anderson and Give An Hour's Barbara Van Dahlen were invited to participate in this historic White House Conference.

Barbara's Reflections: "On June 3, President Obama held an unprecedented event at the White House: a National Conference on Mental Health. The day-long gathering featured speeches by both the President and Vice President, as well as a series of panels—one of which, moderated by Secretary of Health and Human Services [HHS], Kathleen Sebelius, I had the honor of serving on. The attendees for the conference included members of consumer and advocacy groups, representatives of the major mental health associations (American Psychological Association, American Psychiatric Association, National Association of Social Workers), and several celebrities, including Glenn Close and Bradley Cooper, who came because they care about ending the stigma associated with mental illness. This was a premier event that took months to coordinate. It brought together all of the stakeholders—from within the government and from communities across the country—with the goal of raising our nation's consciousness about the mental health issues that affect one in four Americans. Oddly, while the White House was packed with TV cameras and journalists on June 3, the event itself received very little national coverage…. There has been no follow up and seemingly no interest about an issue that affects us all—directly or indirectly—at some point in our lives. According to the National Institute of Mental Health, an estimated 26.2% of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year. And, mental disorders are the leading cause of disability in the United States and Canada."

One particularly exciting initiative in the SAMHSA budget highlights a program for which Senator Mark Begich introduced the authorizing legislation—the Mental Health First Aid (MHFA) bill. MHFA helps the public identify, understand, and respond to the signs of mental illness and addiction disorders. Specifically, the program teaches: the warning signs and risk factors for schizophrenia, major clinical depression, panic attacks, anxiety disorders, trauma and other common mental disorders; crisis de-escalation techniques; and provides trainees with a 5-step action plan to help individuals in psychiatric crisis connect to professional mental health care. Since violence is not limited to college and school campuses, the audience for the training includes emergency services personnel and other first responders, police, human resource professionals, teachers and school administrators, faith leaders, parents, veterans, etc. Widespread dissemination of the Mental Health First Aid curriculum is expected to reach 750,000 individuals who work with youth, including how to talk to adolescents and families experiencing these problems so they are more willing to seek treatment. SAMHSA funding, combined with that from the Departments of Education and Justice, will be used to support competitive grants with the goal of making schools and communities safer and providing mental health literacy training, along the

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model of traditional First Aid projects for physical accidents.

Three of SAMHSA's strategic initiatives are closely aligned with APA priorities that Katherine Nordal has discussed at her annual State Leadership Conferences over the past several years:

- Ensuring that the behavioral health system (including states, community providers, and peer and prevention specialists) fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).
- Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities. And of special interest to APA President Don Bersoff,
- Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

Having been supportive of the Minority Fellowship Program (MFP) since its inception in 1973, I was pleased to learn of SAMHSA's request for $5 million to provide stipends to graduate students in order to increase the number of culturally competent behavioral health professionals who would provide direct mental health and/or co-occurring substance abuse services to underserved minority populations. Currently, minorities represent 30% of the nation's population and are projected to increase to 40% by 2025; yet only 23% of recent doctorates in psychology, social work, and nursing were awarded to peoples of color. SAMHSA intends to utilize the existing infrastructure of the MFP to expand the focus to support master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy, and nursing and thereby increase the number of providers who are available to provide clinical services to the underserved, at-risk children, adolescents, and populations transitioning to adulthood, in an effort to increase access to, and the quality of, behavioral health services for this age group.

Change Always Takes Time: In 2006, the Institute of Medicine (IOM) released its report "Improving the Quality of Health Care for Mental and Substance-Use Conditions." The IOM concluded: "Improving our nation's general health and the quality problems of our general health care system depends upon equally attending to the quality problems in health care for mental and substance-use conditions…. Dealing equally with health care for mental, substance-use, and general health conditions requires a fundamental change in how we as a society and health care system think about and respond to these problems and illnesses. Mental and substance-use problems and illnesses should not be viewed as separate from and unrelated to overall health and general health care." Each year more than 33 million Americans use health care services for their mental and substance-use illness (M/SU). Treatment can be effective. M/SU problems and illnesses occur with a wide array of diagnoses and varied severity, with many people requiring only a short-term intervention to help them cope successfully. However, as with general health care, despite what is known about effective care for M/SU conditions, numerous studies have documented a discrepancy between M/SU care that is known to be effective and the care that is actually delivered. One land-

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mark study demonstrated that people with alcohol dependency were found to receive care consistent with scientific knowledge only about 10.5% of the time. The IOM called on institutions of higher education to "facilitate the development and implementation of core competencies across all M/SU disciplines (and) place much greater emphasis on interdisciplinary didactic and experiential learning and bring together faculty and trainees from their various educational programs"—one of the underlying tenants of the Patient Protection and Affordable Care Act. Similarly, the Secretary of HHS should "provide leadership, strategic development support, and additional funding for research and demonstrations aimed at improving the quality of M/SU health care." The 21st century will be an era of patient-centered, interdisciplinary, integrated care which is significantly impacted by the unprecedented advances occurring within the communications and technology fields (i.e., EHRs and comparative effectiveness research) which readily allows cross-diagnostic, cross-population, and cross-provider objective comparisons.

Over the years, I have always wondered why it seems that even beneficial change takes so long to accomplish. Harvey Fineberg, President of the IOM, recently proffered a highly relevant and thoughtful observation in JAMA—"The Paradox of Disease Prevention: Celebrated in Principle, Resisted in Practice." "Why is prevention such a difficult sell? This puzzling question surfaces daily in clinical practice and public health, and it intrudes on policy makers wanting to make scientifically sound, evidence-based policy decisions. Because prevention is so deeply embedded in US culture, the relative neglect of preventive medicine seems paradoxical." This is a critical issue that Senator Inouye and his colleagues grappled with for over four decades. As the treatise notes, there are many possible explanations for prevention's low priority: future success is invisible, there is a lack of clinical drama, the long delay before concrete rewards appear, commercial conflicts of interest, and statistics have little emotional effect upon individual lives. Perhaps the key is that "incentives for prevention are often misaligned in a system designed to treat disease after it occurs. A key policy goal in health reform is to better align financial incentives with superior care, often including prevention. Too often still, the benefits of prevention do not accrue to the payer. Until incentives are aligned with health and not just diagnosis and treatment, true health care reform will be delayed…. In the end, prevention is truly worth the investment to make a difficult sell just a little easier and to put everyone on the road to a healthier future." Yet, as Barbara pointed out after the historic White House event, there is "seemingly no interest about an issue that affects us all—directly or indirectly—at some point in our lives." Without question, the SAMHSA FY' 2014 budget request is most timely.

Transformational Change: This spring, Lt. General Patricia Horoho, U.S. Army Surgeon General, testified before the U.S. House Appropriations Committee describing the Army Medicine story. "Since 1775, America's medical personnel have stood shoulder to shoulder with our fighting troops, received them at home when they returned, and stand ready today when called upon to put their lives on the line to care for our wounded Soldiers. While the wounds of war have been ours to mend and heal during a period of persistent conflict, every day our Soldiers and their Families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; are

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treated in state-of-the-art fashion when prevention fails; and are served by an extraordinarily talented medical Force. We are at our best when we operate as part of a Joint Team. It is our collective effort—Army, Air Force, and Navy—that saves lives on the battlefield…. Our Army is charged with being prepared to face tomorrow's challenges, remaining relevant for the future ahead of us."

"The reality is that after more than a decade of war, our Military and our Nation face a time of significant changes and challenges. Army medicine is impacted by both the National healthcare conversation and the direction of the Military Health System…. The Army Medicine 2020 strategy is a Call to Action that contains the vision, strategic imperatives and way ahead for Army Medicine to move from a healthcare system to a System for Health…. By moving from a disease model to a health model, we can impact health on a National level. The health of the military and the health of the Nation are not separate discussions…. This is a Call to Action—Healthcare in the United States is at a turning point, and the Military Health System has an opportunity to lead the Nation away from the status quo."

"In 2012, the Army lost 183 soldiers to suicide. These tragic losses affect all those left behind, including fellow Soldiers, Families, and communities…. We must eliminate the perceived stigma of asking for help. This is not simply an issue isolated to the medical community to recognize and resolve…. Our challenge regarding military suicides is to move forward in a coordinated, multifaceted, and National approach. It will take a team effort…. Army Medicine is advancing a culture shift by encouraging every Professional Soldier to develop a mindset that drives them to optimize their own health in order to improve performance and resiliency. There must be an effective way to change mindsets, not just dictate behaviors. As Army Medicine continues to open the aperture, we must look at where health is truly influenced. Long term success in Army Medicine lies in our ability to effectively impact the 'Lifespace.' It is in the Lifespace where the choices we make impact our lives and our health. We understand the patient healthcare encounter to be an average interaction of 20 minutes, approximately five times a year…. The health of the Total Army is essential for readiness and prevention is the best way to health. Prevention—the early identification and mitigation of health risks through surveillance, education, training, and standardization of best public health practices—is critical to building and sustaining health and resiliency in Army populations and is the foundation for military success."

Behavioral Health. "The longest period of war in our Nation's history has undeniably led to physical, mental and emotional wounds to the men and women serving in the Army—and to their families. The majority of our Soldiers have maintained resilience during this period. However, the stresses of increased operational tempo are evident in the increased demand for Behavioral Health Services and increased suicide rate…. While physical injuries may be easier to see, 'invisible wounds' such as mild traumatic brain injury, depression, anxiety, and post traumatic stress (PTS) also take a significant toll on our Service Members. And yet, to the individuals who suffer from these wounds, and those who care for them, they are anything but invisible. One of the most challenging areas of wartime medicine is PTS treatment. We have discovered that with the right treatment, most will go on to live productive, fulfilling lives.

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Military research shows that 15% of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans develop PTS. PTS is treatable; 80% of those with PTS have remained on Active Duty. Army Medicine continues to move the model of behavioral healthcare delivery outside of the brick and mortar MTFs [military treatment facilities] through behavioral health initiatives, such as Embedded Behavioral Health (EBH). We demonstrated success by looking at ways to bring healthcare and education to the foxhole, which allows us to increase accessibility, visibility, and ultimately trust, while decreasing the stigma and time spent away from the unit."

"Behavioral health problems, mild traumatic brain injury, and suicide, while often described as 'invisible wounds of war,' are not unique to a theatre of combat or to the military population—they are National issues. As a Nation, there are opportunities for us to partner and to lead the way in breaking the silence—to encourage those who struggle with behavioral health issues to receive help. The Army and Army Medicine are actively engaged in reducing stigma and upholding our responsibility to raise national awareness regarding mild traumatic brain injury and mental health conditions including PTSD. We anticipate the need for mental health services will only increase in the coming years as the Nation deals with the effects of more than a decade of conflict."

"We must never lose sight of the fact that the most important unit in the Army is the Family unit. Our Families, including those outside of the nuclear family setting, have demonstrated unprecedented strength and resilience, quietly shouldering the burdens of our Nation's wars…. Army Medicine is currently setting the conditions to better understand the Army Family both within and outside of conventional patient care settings. Impacting the Lifespace of our Army Families will not only improve the strength, performance, and readiness of the Soldier, but also establish an example for our Nation on a way forward to improve the health of communities…. Our military families—the children of our men and women in uniform—have a different story to tell compared to their peers outside of the military. I want the story of the military Family to resonate throughout the Nation's history as an example of resilience—demonstrating the powerful impact that can be felt when we invest not only in the Soldier, but in the individuals, old and young, who support our heroes." [General Horoho is the first woman and first non-physician to serve as DoD Surgeon General.]

Reflections on Retirement — One of Psychology's True Visionaries: "HA! When I decide to retire, I will disappear. I have no desire to hang on past that time. My youngest graduated from medical school Saturday and he is headed to Emory University to begin his seven year neurosurgical residency. My oldest and her husband are both practicing physicians here in town (OB and ID respectively), my middle daughter was awarded her master's degree in nursing two weeks ago and is starting to teach in an RN program locally, and my youngest daughter is a master's degree social worker employed by one of the large general med-surg hospitals locally where she is the ICU/ER social worker. I will simply ride off into the sunset and turn everything over to the next generation (Jim Quillin)."

Aloha.

CONGRATULATIONS TO THE DIVISION 29 AWARD WINNERS!

Donald K. Freedheim Student Development Award
Alexey Tolchinsky, George Washington University
For his paper: Acute Trauma in Adulthood in The Context of Childhood Traumatic Experiences

In this paper I will present the case of Paul, who survived an assault as a young adult, resulting in a traumatic brain injury and post-traumatic epilepsy. Paul's reactions to this traumatic event in adulthood are considered in the context of his earlier traumatic experiences, his psychodynamic conflicts and his characteristic defense patterns. Transference and countertransference will be considered from the viewpoint of psychodynamic therapy with a traumatized patient who has been in a complex, dependent relationship with one of the perpetrators. Paul's progress in therapy will be reviewed, including his realization of the profound impact of trauma on his life and his strong will to work though his issues.

The Mathilda B. Canter Education and Training Award
Mallaree Blake-Lodestro, Adler School of Professional Psychology
For her paper: The Impact of Bug Chasing on the Spread of HIV

The population of men who have sex with men (MSM) has approximately 30,500 newly HIV infected men annually (Centers for Disease Control and Prevention [CDC], 2012). Despite extensive prevention efforts and funding, HIV among the MSM community is still spreading and becoming a growing concern. This increase may be linked to a newly emerging subculture called "bug chasers," defined as HIV-negative gay men who actively seek out to be voluntarily infected with HIV (Groy & Parsons, 2006). For the general MSM community, this subculture is opposing prevention messages, which emphasize safe sex and aversion to HIV infection, as they perform unprotected sexual practices in hopes of becoming HIV positive, or seroconverting. The field of psychology must work to better understand bug chasing and its social impact on a variety of levels and systems in order to support and educate bug chasers on the reality of HIV and modify prevention efforts to tackle this social issue. This paper addresses how and why bug chasers actively pursue HIV infection and the impact of HIV on the life of an individual and community. A discussion surrounding the pathological potential of bug chasing behavior and the role of mental health in this phenomenon is also included.

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The Jeffrey E. Barnett Psychotherapy Research Paper Award
Lily A. Brown, M.A., Department of Psychology, University of California, Los Angeles
For her paper: CBT Competence in Novice Therapists Improves Anxiety Outcomes

Objective: This study explores the relationships between therapist variables (CBT competence, and CBT adherence) and clinical outcomes of computer-assisted CBT for anxiety disorders delivered by novice therapists in a primary care setting.

Methods: Participants were recruited for a randomized controlled trial of evidence-based treatment, including computer-assisted CBT, versus treatment as usual. Therapists (Anxiety Clinical Specialists; ACSs) were non-expert clinicians, many of whom had no prior experience in delivering psychotherapy (and in particular, very little experience with CBT). Trained raters reviewed randomly selected treatment sessions from 176 participants and rated therapists on measures of CBT-competence and CBT-adherence. Patients were assessed at baseline and at 6, 12, and 18 month follow-ups on measures of anxiety, depression, and functioning, and an average reliable change index was calculated as a composite measure of outcome. CBT-competence and CBT-adherence were entered as predictors of outcome, after controlling for baseline covariates.

Results: Higher CBT-competence was associated with better clinical outcomes whereas CBT-adherence was not. Also, CBT-competence was inversely correlated with years of clinical experience and trended (not significantly, though) down as the study progressed. CBT-adherence was inversely correlated with therapist tenure in the study.

Conclusions: Therapist competence was related to improved clinical outcomes when CBT for anxiety disorders was delivered by novice clinicians with technology assistance. The results highlight the value of the initial training for novice therapists as well as booster training to limit declines in therapist adherence.

The Diversity Award
Joan DeGeorge, University of Massachusetts – Amherst
Individual Differences in Psychotherapy Change Among Ethnic Minority Patient

There is limited research on ethnic minorities in psychotherapy, particularly with regard to the process of change. Most existing studies subscribe to a "uniformity myth" in which individual differences across and within minority groups are often masked or ignored because of an assumption of shared characteristics and experiences. The primary aim of this study is to address the gap in research on individual differences in psychotherapeutic

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change across a large sample of adult patients ($N = 2,272$) of varying ethnicity who received psychotherapy across various naturalistic settings. The treatment settings all participate in a national practice-research network, administering the same outcome measure (the Treatment Outcome Package) at regular intervals throughout treatment. Latent class growth curve modeling was used to examine whether patients of a particular ethnicity (viz., Caucasian, Hispanic, African-American) have multiple change trajectories over time. We then explored whether patient characteristics (e.g., age, gender, patient socioeconomic status) predicted membership in one or another group, as defined by the trajectories. Several different trajectories emerged for each ethnicity and change in panic symptoms were predicted by some patient demographics. Knowledge of change trajectories, as well as predictors of latent class membership, will help to identify individuals' change prognosis, which, in turn, can help to facilitate the development of sensitive and helpful interventions.

DIVISION OF PSYCHOTHERAPY 29 · NSSAL AMERICAN PSYCHOLOGICAL

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DIVISION 29 PSYCHOTHERAPY

Of the American Psychological Association (APA)

CALL FOR NOMINATIONS

Editor of *Psychotherapy Bulletin*

The Publication Board of the APA Division of Psychotherapy is seeking nominations (including self-nominations) for the position of Editor of the *Psychotherapy Bulletin*. Candidates should be available to assume the title of Incoming Editor January 1, 2014, for a three-year term. During the first year of the term, the incoming editor will work with the incumbent editor.

The *Psychotherapy Bulletin* is an official publication of the Division of Psychotherapy. It serves as the primary communication with Division 29 members and publishes archival material and official notices from the Division of Psychotherapy. The *Bulletin* also serves as an outlet for timely information and discussions on theory, practice, training, and research in psychotherapy.

Prerequisites: Be a member or fellow of the APA Division of Psychotherapy
An earned doctoral degree in psychology
Support the mission of the APA Division of Psychotherapy

Responsibilities: The editor of the *Psychotherapy Bulletin* is responsible for its content and production. The editor maintains regular communication with the Division's Central Office, Board of Directors, and contributing editors. The editor is responsible for managing the page ceiling and for providing reports to the Publication Board as requested. The editor must be a conscientious manager, determine budgets, and administer funds for his or her office. As an *ex officio* member of the Publication Board, the editor attends the scheduled meetings and conference calls of the Division's Publications Board. An editorial term is three years.

Oversight: The Editor of the *Psychotherapy Bulletin* reports to the Division of Psychotherapy's Board of Directors through the Publication Board.

Search Committee: Nominations should be submitted to Jeffrey Barnett, Psy.D., ABPP for consideration.

Nominations: To be considered for the position, please send a letter of interest that addresses your relevant experience, goals for serving in the position, and statement of ability to fulfill the duties of the position for the three-year term, and a copy of your curriculum vitae no later than September 15, 2013 to: Jeffrey Barnett, Psy.D., ABPP, Publications Board Chair, electronically to jbarnett@loyola.edu. Inquiries about the position should be addressed to Dr. Jeffrey Barnett at jbarnett@loyola.edu as well and/or to the incumbent editor, Dr. Lavita Nadkarni at lnadkarn@du.edu.

DIVISION 29 PSYCHOTHERAPY

Of the American Psychological Association (APA)

CALL FOR NOMINATIONS

CHARLES L. BREWER DISTINGUISHED TEACHING OF PSYCHOLOGY AWARD

About the American Psychological Foundation (APF)
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people's lives.

APF encourages applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the Charles L. Brewer Distinguished Teaching of Psychology Award
The Charles L. Brewer Distinguished Teaching of Psychology Award recognizes significant career contributions of a psychologist who has a proven track record as an exceptional teacher of psychology.

Amount
- $2,000 award, all-expense paid round trip, and plaque presented at the APA convention
- Awardees are invited to give a special address at the APA convention

Eligibility Requirements & Evaluation Criteria
Nominees should demonstrate and will be rated on the following dimensions:
- Have demonstrated achievement related to the teaching of psychology
- Exemplary performance as a classroom teacher
- Development of innovative curricula and courses
- Development of effective teaching methods and/or materials
- Teaching of advanced research methods and practice in psychology
- Administrative facilitation of teaching
- Research on teaching
- Training of teachers of psychology
- Evidence of influence as a teacher of students who become psychologists

Nomination Requirements
- Nomination cover letter outlining the nominee's contributions to the teaching of psychology
- Current CV and bibliography
- Up to ten supporting letters from colleagues, administrators, and former students

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CHARLES L. BREWER DISTINGUISHED TEACHING OF PSYCHOLOGY AWARD, continued

- An appendix of no more than two to three supporting documents
- A one to three page statement of teaching philosophy from the nominee
- Nomination must be submitted as a single PDF document

Submission Process and Deadline
Submit a completed application online at **http://forms.apa.org/apf/grants/** by **December 1, 2013**.

Please be advised that APF does not provide feedback to grant applicants or award nominees on their proposals or nominations.

Questions about this program should be directed to Samantha Edington, Program Officer, at *sedington@apa.org*.

NOTICE TO READERS

References for articles appearing in this issue can be found at the end of the on-line version of Psychotherapy *Bulletin* published on the Division 29 website.

DIVISION 29 PSYCHOTHERAPY

Of the American Psychological Association (APA)

CALL FOR FELLOWSHIP APPLICATIONS

Nancy L. Murdock,
Chair, Fellows Committee

The Division of Psychotherapy is now accepting applications from individuals who would like to nominate themselves or recommend a deserving colleague for Fellow status with the Division of Psychotherapy. Fellow status in APA is awarded to psychologists in recognition of outstanding contributions to psychology. Division 29 is eager to honor those members of our division who have distinguished themselves by exceptional contributions to psychotherapy in a variety of ways such as through research, practice, and teaching.

The minimum standards for Fellowship under APA Bylaws are:

- The receipt of a doctoral degree based in part upon a psychological dissertation, or from a program primarily psychological in nature;
- Prior membership as an APA Member for at least one year and a Member of the division through which the nomination is made;
- Active engagement at the time of nomination in the advancement of psychology in any of its aspects;
- Five years of acceptable professional experience subsequent to the granting of the doctoral degree;
- Evidence of unusual and outstanding contribution or performance in the field of psychology; and
- Nomination by one of the divisions which member status is held.

The Division of Psychotherapy criteria for election to the category of Fellow are:

- Attainment of the category of Member of The Division of Psychotherapy.
- Five years of qualifying experience in the field of psychotherapy.
- Demonstration of evidence of unusual and outstanding contribution or performance in the field of psychotherapy. *Please see the division website for more details on the Division criteria* *www.divisionofpsychotherapy.org/members/fellows*
- Nomination to the category of Fellow by The Division's Committee on Fellows, such nomination to be conducted in accordance with extant Bylaws and Association Rules of the American Psychological Association.

Fellowship Applications

There are two paths to fellowship. For those who are not currently Fellows of APA, you must apply for **Initial Fellowship** through the Division, which then sends applications for approval to the APA Membership Committee and to the APA Council of Representatives. The following are the requirements for initial Fellow applicants:

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CALL FOR FELLOWSHIP APPLICATIONS, continued

- Completion of the Uniform Fellow Blank;
- A detailed curriculum vitae;
- A self-nominating letter (which should also be sent to your endorsers);
- Three (or more) letters of endorsement of your work by APA Fellows (at least two must be Division 29 Fellows) who can attest to your qualifications for fellowship;
- Send your vita and self-nominating letter to each endorser.

Division 29 members who have already attained Fellow status through another division may pursue a direct application for Division 29 Fellow by sending a curriculum vitae and a letter to the Division 29 Fellows Committee, indicating specifically how you meet the Division 29 criteria for Fellowship.

DEADLINE FOR SUBMISSION: The deadline for submission to be considered for 2014 is DECEMBER 15, 2013.

Initial nominees (those who are not yet Fellows of APA in any Division) must submit the following electronically using APA's on-line system:

(a) cover letter, (b) the *Uniform Fellow Application*, (b) a self-nominating letter, (c) three (or more) letters of endorsement from current APA Fellows (at least two Division 29 Fellows), and (d) an updated CV.

Please visit APA's website for more information on the electronic submission system: http://apa.org/membership/fellows/

Current Fellows of APA who want to become a Fellow of Division 29 need only send a letter to attesting to their qualifications with a current CV to Nancy L. Murdock (see below), the Fellowship committee chair.

For questions about the submission process, or for guidance and advice about the application and forms, please contact:

Nancy L. Murdock, Ph.D.
Chair, Division 29 Fellows Committee
murdockn@umkc.edu
Phone:816.235-2495

Incomplete applications or applications submitted after the deadline cannot be considered for this year.

Please feel free to contact Nancy Murdock or other Fellows of Division 29 if you think you might qualify and you are interested in discussing your qualifications or the Fellow process. Also, Fellows of our Division who want to recommend deserving colleagues should contact Nancy with their names.

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CALL FOR FELLOWSHIP APPLICATIONS, continued

Fellowship Criteria • Division 29 Psychotherapy
Fellow status in APA is awarded to members in recognition of significant, outstanding, and lasting contributions to the profession of psychology. Division 29 is eager to honor those members of our division who have distinguished themselves by exceptional contributions to psychotherapy in a variety of ways to include researcher, psychotherapist, teacher/trainer, scholar, theorist, etc.

The minimum standards for Fellowship under APA Bylaws are:

1. The receipt of a doctoral degree based in part upon a psychological dissertation, or from a program primarily psychological in nature;
2. Prior membership as an APA Member for at least one year and a Member of the division through which the nomination is made;
3. Active engagement at the time of nomination in the advancement of psychology in any of its aspects;
4. Five years of acceptable professional experience subsequent to the granting of the doctoral degree;
5. Evidence of unusual and outstanding contribution or performance in the field of psychology; and
6. Nomination by one of the divisions in which member status is held.

Attaining Fellow status in Division 29 requires that the individual has achieved national or international recognition from one's colleagues for contributions to the field of psychotherapy.

Contributions may be through any of the following individually or in combination:

1. Excellence in Practice of Psychotherapy. Those who have demonstrated excellence in the practice of psychotherapy which is evident by national standing. This can include innovative models or programs of practice, applications of scholarship to programs of practice, publications that impact practice, training, etc.

2. Teacher/Trainer/Mentor. Those who have demonstrated excellence and a national reputation as a teacher, trainer, or mentor of psychotherapists, to include the development of innovative models with a wide ranging impact.
3. Scientific Work. Documented research in the area of psychotherapy or related areas that impact the practice of psychotherapy such as neuroscience, psychotherapy process, outcome, training, etc.
4. Theoretical and Treatment Advances. Those who have contributed to the field with the development of theory, methods, and techniques of psychotherapy.
5. Leadership, Advocacy, Scholarly Application. Those who have demonstrated leadership in the advancement of the art, science, and policy of 5.

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psychotherapy or innovative programs of training, practice or administration.

Evidence of Criteria Used by Nomination Committee
The following are offered as examples of the range of activities that may be considered when being nominated for Fellow but are in no way to be considered exhaustive:

1. Published scholarly articles in professional journals that are considered important in the field.
2. Author of books and texts in the field of psychotherapy or related areas in that have important impact on the field of psychotherapy.
3. Demonstrated a high degree of involvement in the advancement of psychotherapy at the national level.
4. Developed a theory of psychotherapy that is widely considered important to the field.
5. Developed approaches to psychotherapy that are widely considered important to the field.
6. Produced innovations in the practice of psychotherapy such as models of practice that address novel problems or the needs of special populations in the delivery of mental health services.
7. Administered a novel or excellent program for training psychologists in psychotherapy or related areas.
8. Demonstrated evidence of service that is distinguished.
9. Demonstrated evidence of scholarly work that advances the field such as editor of an influential journal or special editions.
10. Made contributions that advance the status of psychotherapy as a healing art and science.
11. Exhibited excellence in serving as a mentor in the field.
12. Demonstrate a program of research that advances the field.

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.org

DIVISION 29 SOCIAL HOUR – AUGUST 3, 2013

2013 APA Convention – Honolulu, Hawaii

Libby Williams, Matty Canter, Jerry Koocher, Ray DiGiuseppe, and Linda Campbell, speakers for the Division 29 symposium, "History & Future of Division 29"

Division 29 President Bill Stiles with Dr. Les Greenberg, winner of the Division 29 Distinguished Psychologist Award

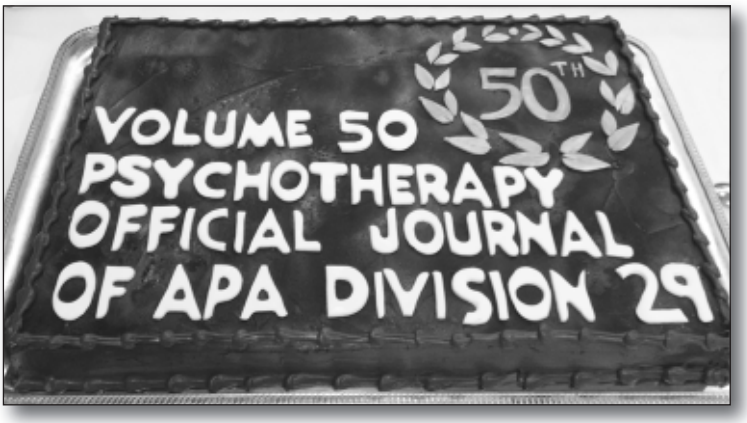
Division 29 President Bill Stiles with Dr. Laura Brown, winner of the Division 29 Award for Distinguished Contributions to Teaching and Mentoring

Division 29 President Bill Stiles with 2013 Rosalee Weiss Lecturer Dr. Jeffrey Barnett

Division 29 President Bill Stiles and Dr. Matty Canter with Mallaree Blake-Lodestro, winner of the Division 29 Mathilda B. Canter Education and Training Student Paper Award

Joshua Swift, recipient of the Norine Johnson Psychotherapy Research Grant for $10,000 with Division 29 President Bill Stiles

Celebrating the 50th
Anniversary of the Division's journal, *Psychotherapy*



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The Division of Psychotherapy

The only APA division solely dedicated to advancing psychotherapy

MEMBERSHIP APPLICATION

Division 29 meets the unique needs of psychologists interested in psychotherapy.

By joining the Division of Psychotherapy, you become part of a family of practitioners, scholars, and students who exchange ideas in order to advance psychotherapy.

Division 29 is comprised of psychologists and students who are interested in psychotherapy. Although Division 29 is a division of the American Psychological Association (APA), APA membership is not required for membership in the Division.

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As a member, you have access to our Division listserv, where you can exchange information with other professionals.

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MEMBERSHIP REQUIREMENTS: Doctorate in psychology • Payment of dues • Interest in advancing psychotherapy

Name _____ Degree _____

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PSYCHOTHERAPY BULLETIN

Psychotherapy Bulletin is the official newsletter of Division 29 (Psychotherapy) of the American Psychological Association. Published four times each year (spring, summer, fall, winter), *Psychotherapy Bulletin* is designed to: 1) inform the membership of Division 29 about relevant events, awards, and professional opportunities; 2) provide articles and commentary regarding the range of issues that are of interest to psychotherapy theorists, researchers, practitioners, and trainers; 3) establish a forum for students and new members to offer their contributions; and, 4) facilitate opportunities for dialogue and collaboration among the diverse members of our association.

Contributors are invited to send articles (up to 2,250 words), interviews, commentaries, letters to the editor, and announcements to Lavita Nadkarni, PhD, Editor, *Psychotherapy Bulletin*. Please note that *Psychotherapy Bulletin* does not publish book reviews (these are published in *Psychotherapy*, the official journal of Division 29). All submissions for *Psychotherapy Bulletin* should be sent electronically to lnadkarn@du.edu with the subject header line *Psychotherapy Bulletin*; please ensure that articles conform to APA style. Deadlines for submission are as follows: February 1 (#1); May 1 (#2); August 1 (#3); November 1 (#4). Past issues of *Psychotherapy Bulletin* may be viewed at our website: www.divisionofpsychotherapy.org. Other inquiries regarding *Psychotherapy Bulletin* (e.g., advertising) or Division 29 should be directed to Tracey Martin at the Division 29 Central Office (assnmgmt1@cox.net or 602-363-9211).

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