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BULLETIN

In This Issue

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PSYCHOTHERAPY BULLETIN

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PSYCHOTHERAPY BULLETIN

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PRESIDENT'S COLUMN

Ray DiGiuseppe, PhD
St. John's University, New York

The Division of Psychotherapy remains a strong, influential force within APA. In this column, I would like to focus on the strengths and recent developments that continue to make your division an active and successful organization. The Division recently received an expansion of the number of representatives to the APA Council, from two to three representatives. In the next Divisional election, you will have the opportunity to vote for a third council member, who will join John Norcross and Jean Carter in representing us on the APA Council. This increased representation will help us influence APA policy in ways that advance the interests of psychotherapy practitioners and researchers. Our allotment of representatives depends on the number of members we have and the allotment of representative votes that members place for the division in the annual APA election. Over the years, we have vacillated between two and three council representatives. Now that we have climbed back to three representatives, I encourage each member to take two actions that will keep the additional Council seat. First, encourage your friends, colleagues, and officemates to join the Division. More members can only help us get more seats on the APA Council. Second, when you receive the apportionment ballots from APA next year, give Division 29 all of your votes, or, give us a portion of your votes. Help us advance psychotherapy.

The Board has discussed changing the name of our Division. If you have noticed, a good number of Divisions of APA have changed their names over the years to include such titles as the Society of (Divisional Name). At its January meeting, the Board passed a motion to change the name of the Division to *The Society for the Advancement of Psychotherapy, a Division of the American Psychological Association*. An advantage of the name change will be to broaden our appeal and attractiveness to non-APA member psychologists or to non-psychologist psychotherapists who would be interested in joining the "Society." The entire membership will have the opportunity to vote for approval of this motion. We think the name change better reflects the varied activities of our membership and the mission of the Division. I hope that you will vote to approve the motion, but please vote. All voting will be done on the Division's website, or for your convenience, a paper ballot is included in this issue of the Bulletin.

The membership did vote to approve the motion to change the bylaws so that the minimum qualification for election to the category of Non-APA-member Affiliate shall be an earned an earned doctoral degree in Psychology or a professional credential that entitles the individual to practice psychotherapy independently. In addition, this motion stated that such non-APA-member Affiliates of the Division shall be entitled to all the rights and privileges of full members except that they are not eligible to vote in Division elections and they are not eligible to hold elected office in the Division. We believe that the name change mentioned above will increase this category of member.

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Our President-elect and Program Chair Rod Goodyear has put together a great program for the upcoming APA convention. We will have symposia on practice, research, and supervision in psychotherapy and on social justice that will be of interest to our members. Two changes to the upcoming APA convention have affected our Division's presentations. APA has set aside some program space for symposia that involve collaboration between several divisions. The goal is to have events that cover larger issues that will be of interest to a wide range of APA members. Rod has involved us in such cooperative presentations with other divisions on topics of mutual relevance. In addition, the APA has redesigned the system by which divisions are allocated presentation time slots. Although many divisions lost time slots, we were able to keep the same number of hours. Rod has assured me that we will be well represented at the APA convention, and we want to thank him for his work in ensuring a continuing strong Divisional presence during this time of change in the APA convention program planning. Also at the APA convention this year, our Early Career Domain Representative Rayna Markin will continue the successful "Lunch with the Masters" program. Please encourage any early career psychologists, graduate students, interns, and post docs to come have lunch and meet leaders in psychotherapy.

The busiest area of our Division is our Publications Board. This arm of the Division operates under the leadership of Jeff Barnett. The Publications Board has increased our web presence and has made proposals for enhancing the role of the Web Editor, as well as the functions and content of our webpage. In this time of social media and digital communication, a sophisticated web presence is crucial to an organization. Over the next year, look forward to significant changes and upgrades in our webpage that are underway by the Pub Board. Of course, our journal *Psychotherapy* continues to grow as a significant scholarly outlet for high quality articles on the theory, research, and practice of psychotherapy. *Psychotherapy* has hit two landmarks this year. It received a record number of submissions this past year, and achieved an increase in the journal's impact factor to its highest point ever. Mark Hilsenroth deserves a round of applause for providing us with great leadership. The Publications Board is also working with the Bulletin's new editor, Lynett Henderson Metzger, to increase the relevance of the *Psychotherapy Bulletin*. Lynett welcomes submissions from members to the *Psychotherapy Bulletin* for articles that will influence the field.

Working with Divisions 46 (Society for Media Psychology and Technology) and 56 (Trauma Psychology), we have been part of a consortium of divisions who received a small grant from APA to set up a system to review psychology-oriented device applications ("apps") that can be used in the delivery of psychotherapy practices. As digital and social media continue to proliferate in the world, more mental health services apps have appeared. However, there is no place for the professionals or the public to go to assess the quality of the available apps. We are setting up a system that will provide reviews by psychologists that will address the accuracy of the psychological content, usefulness for clients, and ease of use of apps. We already have a list of apps that we plan to review. However, it you have apps that you would like to see reviewed, or if you would like to serve as a reviewer, please email me at digiuse@stjohns.edu.

The areas of evidenced-based practice and research-support psychotherapies

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are always hot topics. A group of psychologists representing our Division, Division 12 (Society for Clinical Psychology), and the Association for Behavioral and Cognitive Therapies is reviewing the standards for research-based psychotherapies. I have been representing the Division in this group. We have been meeting regularly by phone and will be submitting a manuscript for publication to open up discussion of this issue.

Our Division continues to operate within our revenues or at a surplus. We are a financially healthy organization. Our Division is thriving, and I am pleased to serve its mission and its members. Please join me in continuing this mission by joining one of our committees or running for office.

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.

EDITORS' COLUMN

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Welcome to the 2014 *Psychotherapy Bulletin*! As the new Editor and Associate Editor, we want to express our heartfelt appreciation to the past Editors, Domain Representatives, and contributors who have helped make the *Bulletin* what it is today. We would like to personally thank outgoing Editorial Assistant Jessica del Rosario for her unfailing willingness to go beyond the call of duty in her service to the *Bulletin*, and outgoing Editor Dr. Lavita Nadkarni for her wit, wisdom, and tireless commitment to this publication and this Division.

It is, indeed, a pivotal time for both. A number of exciting changes are on the horizon as we work to increase our student membership and involvement, utilize technology and social media in creative and effective new ways, and, of course, maintain and build upon quality content for each of our quarterly issues of the *Bulletin*. We are fortunate, in this endeavor, to be moving forward with the invaluable assistance of Division Administrator Tracey Martin and the ongoing vision and leadership of Jeffrey Barnett and the entire Publications Board. In addition, we are pleased to be working with an amazing group of Domain Representatives and Contributing Editors, including: Armand Cerbone and Rosemary Adam-Terem (Public Policy and Social Justice), Jennifer Erickson Cornish (Ethics), Patrick DeLeon (Washington Scene), Jairo Fuertes and Beverly Greene (Diversity), Annie Judge (Membership), Rayna D. Markin and Kevin McCarthy (Early Career), Jesse J. Owen and Jennifer Callahan (Education and Training), George Stricker (Psychotherapy Integration), Barbara Thompson and Barbara Vivino (Psychotherapy Practice), Margaret Tobias (Student Features), and Susan S. Woodhouse and Cheri Marmarosh (Psychotherapy Research, Science and Scholarship).

In this issue, we welcome Ray DiGiuseppe, PhD, as Division 29 President; please read his inaugural President's Column for up-to-the-minute divisional news, including a summary of recent revisions to the bylaws, and some exciting changes on the horizon. In Washington Scene, Pat DeLeon continues to provide us with an insider's view of policy and practice at the national level. Several of our authors have focused on trauma for this issue, exploring diverse topics such as the relationship between distress, military experience, and trauma; deconstructing and reprocessing trauma-related nightmares; and risk factors for PTSD among burn survivors. We are excited to present a variety of articles of particular interest to students and early career professionals, including an empirical examination of

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applicant differences and "fit" with internship settings, a survey related to confidentiality practices in the use of client material among clinical training applicants, a student piece on ethical considerations in the treatment of eating disorders, and a light-hearted but thought-provoking piece on challenges facing a potentially "endangered species": the psychotherapy researcher. In addition, as always, flip through the *Bulletin* for grant and award opportunities, and visit our website (http://www.divisionofpsychotherapy.org/) for useful links and to learn more (and stay tuned for updates from Bradley Brenner in his new role as Internet Editor).

The key to our success is you. We welcome feedback for improving the *Bulletin*, along with any suggestions or concerns. We also invite high-quality content of interest to Division 29 members; if you have an idea for a submission for a future issue, please let us know.

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Examining Distress in Treatment-Seeking College Students With and Without Military Experience and Trauma Histories

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Since October 2001, more than 2.2 million military personnel have been deployed as part of the war in Afghanistan, known as Operation Enduring Freedom (OEF), and the war in Iraq, referred to as Operation Iraqi Freedom (OIF). These conflicts, the longest since the Vietnam War, have resulted in more than 6,500 fatalities, 48,000 injuries, and a new generation of American veterans suffering from psychological trauma and complex physical injuries (Frain, Bethel, & Bishop, 2010). With the passage of the post 9/11 Veterans Educational Assistance Act and an amendment to the Americans with Disability Act, it is expected that a large number of veterans will pursue a college education and some will seek counseling center services to cope with wartime experiences. Although the number of veterans who will seek counseling center services is difficult to predict, it has been hypothesized that the influx of returning troops may overwhelm the existing resources of many colleges and universities (Grossman, 2009). Early signs seem to confirm this possibility as the number of veterans or dependents using GI educational benefits from 2008 to 2012 nearly doubled from 540,000 to 945,000. While not all post-secondary institutions have seen surges in attendance, the number of men and women with military experience entering into campus life has dramatically impacted some geographical areas. As personnel levels continue to decrease in Afghanistan and Iraq, it is expected that even more colleges and universities will face issues related to increases in veteran attendance. Yet even with these actual and expected increases, there are many physical, psychological, bureaucratic, and social challenges that veterans must navigate in hopes of being successful in post-secondary institutions. Current evidence suggests that on a macro level these challenges are not being met, resulting in the lowest graduation rate of veteran students from four-year universities ever. While the national average for graduating from a four-year university is approximately 57%, graduation rates for returning veterans from the same institutions rests at an estimated 3% (Aud et al., 2010; Cunningham, 2012).

Current Study

Given the rise in the number of veterans returning from Iraq and Afghanistan,

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this study sought to determine the levels of distress reported by students with military experience seeking help at college counseling centers, particularly when compared to help-seeking students without military experience. Johnson et al. (2010) found elevated hostility and family concerns among counseling center clients with military experience compared to clients without military experience. Second, we investigated differences in distress between students with a military-related trauma and students who had experienced trauma but had no previous military experience. We believed that it would be useful to explore the potentially unique effects of military-related trauma as previous literature has suggested that individuals who have survived a military-related trauma may present differently than survivors of nonmilitary-related trauma. For instance, in a meta-analysis examining the association between anger and PTSD, the relationship was found to be moderated by military experience, with larger effects present for this population (Orth &[1] Wieland, 2006). Additionally, Deering, Glover, Ready, Eddleman, and Alacon (1996) offered preliminary evidence that there may be unique patterns of comorbidity in PTSD from different sources of trauma. Findings indicated that although similarities in trauma survivors undeniably exist, comorbid profiles may vary according to the type of trauma one has experienced. Thus, counseling center clients who have experienced a military-related trauma may manifest different mental health concerns than clients who have experienced trauma outside the military.

Hypotheses

For this study, we formulated two hypotheses. Hypothesis 1: We expected to replicate the findings of Johnson et al. (2010) and hypothesized that there would be greater hostility and family concerns among students with military experience compared to those without military experience. Hypothesis 2: We hypothesized that clients who had experienced a military-related trauma would report more distress than students who had experienced a trauma but had never served in the military.

Method

Participants

The present study utilized two data sets gathered by the Center for Collegiate Mental Health (CCMH). CCMH is a national practice-research network that pooled standardized data 97 centers in 2010–2011 (CCMH, 2011), and 120 centers from 2011–2012 (CCMH, 2012). Of the 59,571 students who provided usable data in the CCMH 2010-2011 dataset, 1,251 (2.1%) reported having military experience. Consequently, 1,251 of their peers without military experience were randomly selected to serve as a comparison group (see Table 1 for demographic information). Of the approximate 79,000 students who contributed data to the CCMH 2011-2012 dataset, 69,167 provided usable data regarding service in the military and 1,245 reported having military experience (1.8%). Thus, 1,245 of their peers without military experience were randomly selected as a comparison group.

Instruments

The Counseling Center Assessment of Psychological Symptoms (CCAPS-62) is a 62-item self-report questionnaire specifically designed to assess the mental health concerns of college students (Locke et al., 2011). Students are asked to rate each item on a 5-point scale where 0 = *Not at all like me* and 4 = *Extremely like me*. The CCAPS-62 measures psychological distress using eight subscales: Depression, Eating Concerns, Substance Use, Generalized Anxiety, Hostility, Social Anxiety, Family Con-

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cerns, and Academic Distress. The CCAPS-62 has been shown to have sound psychometric properties. Each of the subscales possesses adequate internal consistency, and preliminary evidence of convergent validity has been shown through significant Pearson product-moment correlations for each subscale with appropriate and well-established referent measures (e.g., the Beck Depression Inventory with the Depression subscale and the Alcohol Use Disorders Identification Test with the Substance Use subscale) (McAleavey, Nordberg, Hayes, Castonguay, Locke, & Lockard, 2012). Details about the development of the CCAPS-62 can be found in Locke et al. (2011).

The Standardized Data Set (SDS) was developed with input from more than 100 counseling centers and represents a set of questions typically asked of students seeking counseling services (CSCMH, 2009). The present study used the SDS to assess gender, race/ethnicity, traumatic experiences, and service in the military. The traumatic experiences question asks respondents to indicate which type(s) of traumatic event(s) they have experienced. Some examples of the 23 response choices include childhood sexual abuse, military combat or war zone experiences, and physical attack.

Results

The first hypothesis was that there would be elevated Hostility and Family Concerns scores among clients with military experience compared to clients without military experience. This hypothesis was tested using the combined 2010-2012 dataset, since Johnson et al. previously had examined a previous 2008 data set. The hypothesis was supported. The average Hostility and Family Concerns subscale scores were significantly higher for clients with military experience than their nonmilitary counterparts $F(1, 4261) = 71.85$, $p < .001$ and $F(1, 4261) = 47.25$, $p < .001$, respectively. Using the benchmarks presented by Cohen (1988), however, the differences between groups on the Hostility and Family Concerns subscale represent a small effect (i.e., .26 and .21, respectively; see Table 2). Table 2 shows the means and standard deviations, F statistics, and effect sizes (Cohen's *d*) for all eight subscales as they relate to military and nonmilitary personnel.

The second hypothesis predicted that clients who had experienced a military-related trauma would report more distress than students who had experienced a trauma but had never served in the military. Like the first hypothesis, this hypothesis was tested using the combined 2010-2012 dataset. The results of each component of the second hypothesis (i.e., CCAPS distress subscales) are reported below. The results of a multivariate analysis of variance revealed significant differences between survivors of a military-related trauma and individuals who experienced a trauma outside the military on some, but not all, of the CCAPS-62 subscales. Survivors of a military-related trauma reported significantly lower distress than those with a nonmilitary-related trauma on the Depression, Eating Concerns, Generalized Anxiety, Social Anxiety, and Family Concerns subscales. This finding runs contrary to the hypothesis that survivors of a military-related trauma would report significantly higher distress scores than survivors of a nonmilitary-related trauma. Table 3 depicts these results and includes effect sizes (Cohen's *d*). Using the benchmarks presented by Cohen (1988), the differences between groups for the Depression and Generalized Anxiety subscales represent a small effect (i.e., .44 and .39, respectively); the differences between groups for the Eating Concerns and Social Anxiety

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subscales represent a medium effect (i.e., .50 and .51, respectively); and, finally, the difference between groups for the Family Concerns subscale represents a large effect (i.e., 1.05; see Table 3).

Table 1: *Demographic Information From 2010 to 2012 Combined Datasets*

	Military (n = 2,496)		Non-Military (n = 2,496)	
African American/Black	259	10.9%	171	7.3%
American Indian or Alaskan Native	20	.80%	117	.70%
Asian American/Asian	83	3.5%	148	6.3%
Caucasian/White	1,634	68.7%	1,701	72.3%
Hispanic/Latino/a	198	8.3%	166	7.1%
Native Hawaiian or Pacific Islander	9	.40%	8	.30%
Multi-racial	92	3.9%	69	2.9%
Prefer not to answer	60	2.5%	32	1.4%
Other	25	1.1%	42	1.8%
Male	1,754	70.7%	881	35.5%
Female	715	28.8%	1,588	63.9%
Transgender	9	.40%	7	.30%
Prefer not to answer	4	.20%	8	.30%
Age	M	SD	M	SD
	29.04	8.30	22.63	5.46

Table 2: *2010-2012 CCAPS-62 Scores for Clients With and Without Military Experience*

Mean, SD, F statistic, and Effect Size

Subscale	Military (n=2,118)		Nonmilitary (n=2,145)			
	M	SD	M	SD	F	Effect Size†
Depression	1.56	.93	1.61	.94	3.30	.06
Eating	.89	.77	1.01	.89	21.02**	.14
Substance Use	.77	.86	.76	.87	.03	.01
Generalized Anxiety	1.56	.94	1.63	.93	4.93	.07
Hostility	1.25	.97	1.01	.85	71.85**	.26
Social Anxiety	1.71	.96	1.83	.96	15.18**	.12
Family Concerns	1.50	.99	1.29	.97	47.25**	.21
Academic Distress	1.86	1.02	1.86	1.03	.01	.003

**p < .01

† Cohen's *d*

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Table 3: *2010-2012 CCAPS-62 Scores of Military-Related and Nonmilitary-Related Traumas*

Mean, SD, F statistic, and Effect Size

Subscale	Military Trauma (n= 140)		Nonmilitary Trauma (n=141)			
	M	SD	M	SD	F	Effect Size†
Depression	1.45	.92	1.84	.86	13.58**	.44
Eating	.70	.68	1.09	.87	17.29**	.50
Substance Use	.92	.88	.78	.91	1.78	.16
Generalized Anxiety	1.61	.94	1.96	.90	10.54**	.39
Hostility	1.19	.92	1.38	.96	2.81	.20
Social Anxiety	1.45	.85	1.88	.88	17.84**	.51
Family Concerns	.99	.85	1.96	1.00	77.26**	1.05
Academic Distress	1.75	1.09	1.97	1.00	3.23	.21

Note. **p < .01

† Cohen's *d*

Discussion

Our first hypothesis, based on a previous study conducted by Johnson et al. (2010) on a previous CCMH data set, was that clients with military experience would report significantly more hostility and family concerns than clients without military experience. This hypothesis was supported in 2010-2012 dataset. The finding of elevated hostility in students with military experience is consistent with contemporary literature. In a recent survey by the Pew Research Center (2011), 47% of post 9/11 veterans reported that they have had frequent outbursts of anger and 32% reported times when they did not care about anything. These results are troubling, as the effect of returning veterans becoming overly angry or hostile can be detrimental to their individual psyche, their families, their communities, and society at large (Elbogen, Wagner, Fuller, Calhoun, Kinnear, & Beckham, 2010). Additionally, outbursts and general hostility may be indicative of signature conflict-related injuries, such as PTSD and TBI. However, it should be noted that it is also possible that individuals with greater hostility and more family concerns are particularly likely to enter the military. It should also be kept in mind that students who had experienced trauma in the military reported less hostility than students who had experienced trauma outside the military.

The elevation in family concerns was also consistent with recent literature, which has suggested the effects of military service during conflict are evident even upon a service member's return home, and consequences are experienced by both the service member and his/her family (Warchal, West, Grahm, Gerke, & Warchal, 2011). In fact, 83% of post-9/11 veterans have reported that their families have had to make a great deal of sacrifices since the September 11, 2001, attacks, and 48% have reported that they have experienced strains in their family relations since leaving the military (Pew Research Center, 2011).

We were surprised to learn that there were no elevations in rates of distress for students who had experienced a military-related trauma when compared to students who had experienced a nonmilitary-related trauma. At the same time,

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students who had experienced a nonmilitary-related trauma showed elevations in the areas of depression, eating concerns, generalized anxiety, social anxiety, and family concerns. We believe that there are a few possibilities as to why students who had experienced trauma within the military reported less symptomology than their civilian counterparts. First, there is a history of under-reporting symptomology in military populations for fear of decreased career opportunities and perceived stigma by peers and leaders (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). Thus, these findings could be a derivative of previous cultural and/or career concerns. A second possible interpretation of the finding that students who have experienced military-related traumas tend to have less elevated symptomology pertains to resiliency. Social resilience has been defined as the "capacity to foster, engage in, and sustain positive relationships and to endure and recover from life stressors and social isolation" (Cacioppo, Reis, & Zautra, 2011, p. 44). Resilience may moderate treatment-seeking behavior among students with military experience, and it may also facilitate counseling outcomes among students who do seek help. Yet another possible interpretation of the finding is that is indicative of the protective function inherent within the insulated military culture. In other words, many war-related traumas may be experienced and discussed in the group setting. This, coupled with the knowledge that military personnel often experience debriefings and immediate accessibility to treatment services following traumas, may also help to explain the lower elevations in reported symptomology when compared to civilian trauma survivors.

Clinical Implications

Overall, today's veterans constitute a unique population that faces unprecedented challenges. Due to a history of under-utilization, college counseling centers may need to target and even seek out veteran students who are struggling to integrate into post-secondary education settings through outreach programs that specifically address the needs and challenges of returning veterans (Church, 2009). Knowing that hostility and family concerns are disproportionately problematic in this population, outreach programs should be tailored to specifically address these concerns. Additionally, referrals to peer counseling groups and/or Combat2College campus programs [http://www.combat2college.org/] should be utilized in hopes of giving returning veterans a larger support network. Finally, using measures such as the CCAPS-62 to identify and normalize issues common for returning veterans may prove useful throughout treatment, in addition to indicating the need for the aforementioned referral sources.

References for this article can be found in the online version of the *Bulletin* published on the Division 29 website.

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Seeking the "Perfect" Match: An Empirical Examination of Applicant Differences According to Internship Setting

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Despite ongoing efforts to conceptualize and envision possible solutions to resolve the internship imbalance, the problem has continued to escalate (e.g., Baker, McCutcheon, & Keilin, 2007; Grus, McCutcheon, & Berry, 2011; Keilin, Baker, McCutcheon, & Peranson, 2007; McCutcheon, 2011; Rodolfa, Bell, Bieschke, Davis, & Peterson, 2007). The number of students entering the Association of Psychology Postdoctoral and Internships Centers (APPIC) match has increased over the past 10 to 15 years, steadily outpacing the growth of available internship positions (Hatcher, 2011; Larkin 2012). In the 2013 match, upward of 1,000 internship applicants went unmatched, for an overall match rate of 75% (see http://www.appic.org/Match/MatchStatistics/MatchStatistics2013Combined.aspx). Phase I of the 2014 match process suggests similar trends, with 77.1% of Ph.D. students and 69.0% of Psy.D. students having successful matched, leaving 801 participating applicants (20%) unmatched going into Phase II (see http://www.appic.org/Match/MatchStatistics/MatchStatistics2014PhaseI.aspx).

What may be overlooked as one considers these numbers is that not all internships are created equal in terms of their training value to interns with varying needs. The internship is a critical developmental step that serves as a training capstone experience and is often a time of intense and rapid professional growth (Collins, Callahan, & Klonoff, 2007). Completion of internship promotes integration of knowledge and aids in the successful transition from graduate training to emergence into the profession (Collins et al., 2007; Lamb, Baker, Jennings, & Yarvis, 1982). Thus, beyond matching, it is the securing of an internship that is consistent with identified training and career goals that is a vital aim to internship applicants (Stedman, 2007).

Recent reports offer internship applicants some empirical information about the characteristics associated with securing a match (Callahan, Collins, &

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Klonoff, 2010; Callahan, Hogan, Klonoff, & Collins, *in press*; Ginkel, Davis, & Michael, 2010); however, there are no empirical studies in the literature exploring whether there are characteristic differences among successfully matched internship applicants according to the type of internship setting. Identifying characteristics associated with successfully matched applicants across internship settings could be beneficial in (1) helping students identify how they may best prepare for the particular type(s) of internship that is most appropriate for their specific training needs and career goals, and/or (2) aiding students and their mentors in the subjective appraisal of readiness to competitively pursue internship at the type of site to which they are hoping to match. In light of the conceptual literature, we hypothesized that there would be characteristic differences among successfully matched interns according to internship site. However, we did not make any hypotheses regarding specific differences.

Method

The dataset for this investigation was constructed by compiling data gathered in two earlier internship match studies (Callahan et al., 2010; Callahan et al., *in press*), but has not been previously combined or analyzed in the manner presented in the current study. In light of space constraints, a comprehensive review of the methodologies employed in those studies will not be duplicated herein, but interested readers are encourage to consult the original sources for more information.

Results

Our primary goal was to examine whether there are meaningful differences among applicants matched to different internship settings: armed forces medical center ($n = 7$); child/adolescent psychiatry/pediatrics ($n = 182$); community mental health center ($n = 73$); consortium ($n = 81$); medical school ($n = 222$); prison or other correctional center ($n = 21$); private general hospital ($n = 64$); private outpatient clinic ($n = 43$); psychiatric hospital ($n = 38$); psychology department ($n = 27$); school district ($n = 18$); university counseling center ($n = 59$); veterans administration (VA) medical center ($n = 246$). A comprehensive table with data on all 14 types of sites can be found online (scroll to manuscript citation and click on "Supplemental Material" link at: http://psychology.unt.edu/ node/2377).

The comprehensive table contains averages and standard deviations for interns who were matched to each of the given types of sites, as well as the lowest, highest, and quartile values for each of the variables. This information may help students plan their training experiences to meet the expectations of the types of sites to which they intend to apply. For example, one might notice 75% of all interns who are matched to a VA setting for their internship have at least 694 intervention/assessment hours, 50% have at least 912 hours, and 25% have at least 1112 hours. A student who wants to complete an internship at a VA may want to make sure that he or she accrues at least 694 hours in order to be considered sufficient.

In addition to considering the volume of experiences that are typical for each of the sites, students should also consider the type of experiences that are reviewed favorably. For example, over 75% of interns who are matched to correctional facilities have had some previous practicum experience in a forensic setting. In contrast, few interns at any of the other settings have had a forensic setting practicum. Similarly, over 75% of interns who are matched to a university counseling center have had previous practicum experience in a university

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counseling center, while 50% of interns or less at each of the other internship sites have had practicum experience at a university counseling center. Also, hospital/medical clinic practicum experience seems important (50% of matched interns have had this experience) for most of the internship sites.

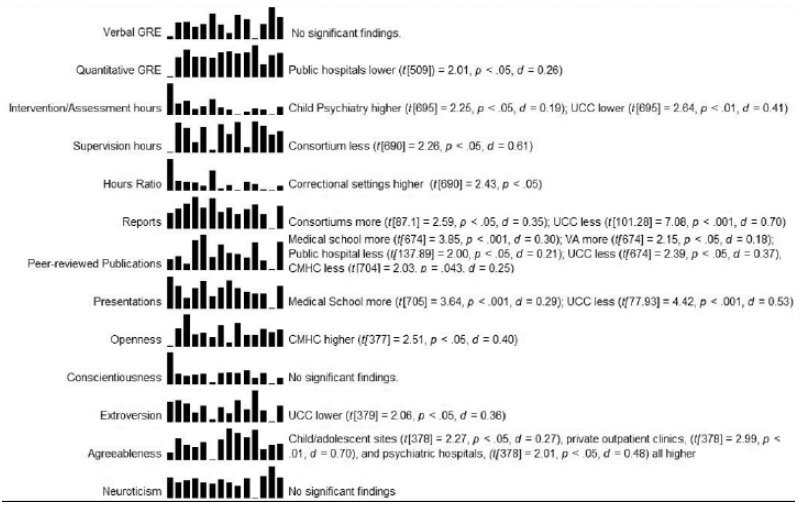

Figure 1
Results of pairwise comparisons on applicant characteristics by internship setting type. As noted in text, the armed forces medical center setting was not included in pairwise comparison due to insufficient sample size. Sparklines depict means on the variable of interest for each of the 14 internship setting types (left to right: 1 = Armed Forces Medical Center; 2 = Child/Adolescent psychiatry/pediatrics; 3 = CMHC; 4 = Consortium; 5 = medical school; 6 = prison or other correctional center; 7 = private general hospital; 8 = private outpatient clinic; 9 = psychiatric hospital; 10 = psychology department; 11 = school district; 12 = public hospital; 13 = UCC; 14 = VAMC). Note: due to unequal variances among groups being compared, visual representation in the sparklines may occasionally suggest a difference that is not confirmed by *t*-test.

Pairwise Comparisons

Direct comparisons of averages between the types of sites may also be useful in identifying characteristics salient to different types of sites. Figure 1 provides a summary of significant findings from these analyses and also presents corresponding sparklines that illustrate the mean score on each variable of interest within each internship setting. Although the sample size associated with armed forces medical centers ($n = 7$) was too low for inclusion, all other settings were considered in these analyses. Given our exploratory goal, and to avoid overlooking potentially meaningful differences, the results are presented both with and without family-wise error correction. To highlight those results that remain significant following Bonferroni correction ($\alpha = .003$), an asterisk follows the reported *p* value.

Quantitative GRE. Interns matched to state/county/public hospital settings had lower quantitative scores on the GRE compared to interns from the other sites, $t(509) = 2.01$, $p = .045$, $d = 0.26$.

Intervention/Assessment hours. While interns matched to sites that focused on children/adolescents were significantly

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higher than the average intern from other sites in their total intervention/assessment hours, $t(695) = 2.25$, $p = .025$, $d = 0.19$ interns matched to university counseling centers were significantly lower in their intervention/assessment hours, $t(695) = 2.64$, $p = .008$, $d = 0.41$.

Supervision hours. Consortium interns had significantly fewer supervision hours compared to other interns, $t(690) = 2.26$, $p = .024$, $d = 0.29$, and interns in correctional settings had significantly more intervention/assessment hours per hour of supervision compared to other interns, $t(690) = 2.43$, $p = .016$, $d = 0.61$.

Integrated reports. Consortium interns had written significantly more integrated reports compared to interns at other types of sites, $t(87.1) = 2.59$, $p = .011$, $d = 0.35$, and university counseling center interns had written a significantly fewer compared to other types of sites, $t(101.28)^1 = 7.08$, $p < .001$*, $d = 0.70$.

Peer-reviewed publications. Medical school interns had significantly more peer-reviewed publications, $t(674) = 3.85$, $p < .001$*, $d = 0.30$; VA interns also had significantly more peer-reviewed publications, $t(674) = 2.15$, $p = .032$, $d = 0.18$. In contrast, state/county/public hospital interns had significantly fewer peer-reviewed publications, $t(137.89)^a = 2.00$, $p = .047$, $d = 0.21$, as did university counseling center interns, $t(674) = 2.39$, $p = .017$, $d = 0.37$, and community mental health center interns, $t(704) = 2.03$, $p = .043$, $d = 0.25$.

Presentations. Medical school interns also had more presentations, $t(705) = 3.64$, $p < .001$*, $d = 0.29$, compared to other interns, while university counseling center interns had fewer, $t(77.93)^a = 4.42$, $p < .001$*, $d = 0.53$.

Personality characteristics. Interns matched to child/adolescent sites, $t(378) = 2.27$, $p = .024$, $d = 0.27$, private outpatient clinics, $t(378) = 2.99$, $p = .003$*, $d = 0.70$ and psychiatric hospitals, $t(378) = 2.01$, $p = .045$, $d = 0.48$, were all higher on agreeableness; community mental health clinic interns were higher on openness, $t(377) = 2.51$, $p = .013$, $d = 0.40$; and university counseling center interns were significantly lower in extraversion, $t(379) = 2.06$, $p = .040$, $d = 0.36$, compared to interns matched at other sites.

Discussion

As with previous research, this study attempted to demystify the process of internship match by investigating student characteristics, experiences and other variables that are relevant during the internship match process (Callahan, Collins & Klonoff, 2010; Callahan, Hogan, Klonoff, & Collins, *in press*). Given the multitude of elements that are considered when students apply to internship sites, there is a great need to investigate factors that influence the match process so that students can understand the process and plan their experiences accordingly.

Within the fourteen different types of internship settings, overall there were more similarities than differences in terms of the experiences and characteristics of successfully matched applicants. For example, there were no significant Verbal GRE score differences and all but one setting demonstrated similar Quantitative GRE scores. Similarly, most settings fell into a narrow range (2.11 to 2.58) for the intervention/assessment to supervision hours ratio, with only applicants matched to the prison or correctional setting evidencing a significantly higher ratio (3.12).

Although successfully matched applicants appear to be largely similar across settings, more subtle distinctions do suggest differing emphases in terms of the characteristics of successful appli-

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cants. As just one example, students matched to child/adolescent psychiatry settings tended to have higher internship/assessment hours. The only noted exception to this trend of subtle distinctions were students matched to university counseling centers, who appeared to have a cluster of differences from students matched to other settings (lower number of intervention/assessment hours, integrated reports, peer-reviewed publications, and presentations). This trend speaks to the need for students to understand the setting to which they hope to apply and focus on specific avenues that are important for students who tend to be matched to those settings.

In particular, several settings appeared to require previous experience in that respective setting. For example, at least 75% of students matched to either a university counseling center or a forensic setting having had previous practicum experience in a similar setting. Not only are students able to see which types of previous experiences are common for students matched to a particular setting, but they can also see the types of experiences that are common for several settings. For 10 out of the 14 settings (armed forces, child/adolescent, consortium, medical school, private general hospital, private outpatient clinic, psychiatric hospital, psychology department, public hospital and VA medical center), at least 50% of students who were matched had previous experiences in a medical/hospital setting.

Unfortunately, data from students matched to armed forces medical centers were not able to be included in the analyses due to insufficient sample size. However, visual inspection of the data associated with this setting (column one of each sparkline) suggests the possibility of potentially meaningful differences. In light of the small sample size, caution in interpretation is merited, but future research would be useful to specifically test hypotheses derived from this study that applicants who successfully match to armed forces medical centers may differ from other successfully matched applicants in a number of ways (i.e., they may be higher in conscientiousness, lower in openness, attain lower quantitative GRE scores, amass more intervention and assessment hours, and/or attain fewer supervision hours).

Finally, differences in personality variables were found between applicants matched to varying settings. As with clinical/research experiences, there appear to be more similarities than differences, although several sites have slight differences. In particular, the personality traits of openness, extraversion and agreeableness were noted differences between students in some internship settings. For example, students matched to child/adolescent psychiatry, private outpatient clinics, and psychiatric hospitals tended to have higher ratings of agreeableness. However, this relationship is complicated; students should not assume a unidirectional influence, where students are rated highly by an internship site and thus more likely to be matched because of their personality. Instead, students with certain personality traits might be more likely to apply to and highly rate certain internship settings during the match process. In addition, there could be a bidirectional relationship, where students with a specific personality trait are drawn to a setting, and that setting is more likely to desire that student because of that personality trait.

Limitations and Future Directions

As previously noted, the sample sizes associated with some of the settings were small. Specifically, armed forces medical centers, prison/other correc-

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tional, psychology department, and school district settings all had fewer than 30 matched applicants in this sample. Another limitation relates to the recruitment methods. Participants were recruited through directors of clinical training belonging to the Council of University Directors of Clinical Psychology (CUDCP), resulting in most participants (96.5%) being clinical psychology trainees. Future research investigating characteristics of matched students by internship setting with a sample that includes not only CUDCP, but also the National Council of Schools and Programs of Professional Psychology (NCSPP) and the Council of Counseling Psychology Training Programs (CCPTP) is needed for a more complete understanding.

With respect to the variables considered, it would be helpful if intervention/assessment hours indicated the variation in clinical hours (individual therapy, group therapy, child therapy, family therapy, assessment hours, etc.) accrued by students. As just one example, applicants to child/adolescent internship settings might desire information regarding how much clinical experience with children/adolescents is typical for a successfully matched intern in that setting.

Also, additional inquiries that more specifically focus on identifying changes evidenced by applicants who are unmatched their first year but successfully matched the second year they apply could also be beneficial.

Implications for students and mentors

Given the current concern over internship shortages, students may be understandably concerned as they plan and apply for the internship match (Baker, McCutcheon & Keilin, 2007). Accessing the comprehensive table we have prepared and reviewing the results of this study might provide students and their mentors with a tool to help in the formation of realistic, though still subjective, appraisals regarding readiness for internship. By reviewing trends of students who were successfully matched to various types of internship sites, especially at the beginning of doctoral training, students may select clinical experiences and practicum settings that are appropriately aligned with settings likely to foster their training needs and future career goals. In particular, with the data on quartile cut-offs, students can more objectively determine their strengths and identify gaps in their preparation prior to making a decision about applying for the match, so that if a need for corrective action exists, it can be enacted proactively.

Mentors and program faculty could also review this information and use it to inform program expectations and opportunities. Although program requirements regarding minimum clinical hours might not necessarily be changed, mentors can have empirically based conversations with students about the type of characteristics associated with successful applicants being matched to various settings. Similar conversations with collaborating local practica may also be useful, so that students have access to appropriate externships that can prepare them well to advance to their desired internship settings.

References for this article can be found in the online version of the *Bulletin* published on the Division 29 website.

[1] Because Levene's test for equality of variances was significant, the reported *t*-test statistic does not assume equal variances.

Confidentiality Practices of Trainees Applying for Clinical Training Positions: A Survey Study

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The ethical issues involved in writing about clients are complex and were the topic of a recent special section of *Psychotherapy*, Division 29's Journal (Samstag, 2012). The five papers in the series (Barnett, 2012; Blechner, 2012; Fischer, 2012; Sieck, 2012; and Woodhouse, 2012) identified a number of implications of a) obtaining consent from a client to present clinical material in a publication or conference, and b) of disguising the material, which are two options to consider according to the American Psychological Association's Ethical Principles of Psychologists and Conduct Code (2010; Standard 4.07). For instance, seeking consent might not be appropriate or possible with certain clients, and the extent to which clinical material is disguised and even "falsified" (Blechner, 2012) threatens the integrity of the material, presenting ethical dilemmas for clinical writers.

Although the clinical writing practices of experienced professionals have received considerable attention in the literature (e.g., Aron, 2000; Duffy, 2010; Gabbard, 2000; Kantrowitz, 2006), little is known about the practices of psychology graduate students, a surprising fact, given that graduate students are required to write about clients in the course of their training. Clinical writing at the graduate level is done in a number of different contexts, including: 1) direct clinical care (e.g., clinical reports and progress notes evaluated by supervisors), 2) specific academic requirements, such as for classroom assignments or clinical qualifying examination, and 3) as part of applications for clinical training positions (e.g., required externships and internships). Understanding the particular issues faced by clinical graduate students, and how they approach the preparation and use of clinical writing samples—particularly when they are required to share these materials with professional audiences outside of their home doctoral institution—is of great importance, both in terms of protecting client confidentiality and anonymity and evaluating current educational practices. Approaching a client about obtaining consent and appropriately disguising clinical material are sophisticated clinical skills for which graduate students may be ill prepared within current training curricula (Lewis, 2012, 2013; Samstag, 2013).

Students who are required to use clinical writing samples as a part of their training are faced with unique challenges compared to psychologists at later stages of their careers. Although many student writing assignments are written for an audience limited to professors of clinical courses or clinical supervisors, who are also mandated to follow rules of confidentiality and anonymity, clinical writing samples (e.g., intake reports, treatment summaries) are increasingly required as part of applications to training sites, exposing the material to a wider reading audience. The field must be cognizant of potential ethical dilemmas facing students.

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First, compared to experienced professionals, students will have considerably fewer choices in terms of appropriate clients from whom to seek consent, especially early in their academic careers. If truly informed consent is difficult or impossible to obtain for ethical or clinical reasons, disguising the material may be the student's only option when facing a clinical writing requirement.

The second issue refers to the kind of supervision the student receives about how to disguise clinical material. Since students must demonstrate proficiency in developing case formulations or diagnostic and treatment reports using accurate clinical data, understanding how material that has been altered, and possibly falsified, may compromise an evaluation of the student's training experience is of utmost importance. To date, there are no guidelines for clinical supervisors about how this should be done. Students, like professionals, may consult official guidelines for confidentiality outlined in the Health Insurance Portability and Accountability Act (HIPAA, 1996). However, HIPAA guidelines do not provide clarity around how to adequately protect client confidentiality: "removing all of the identifiers, which are typically found on a patient's medical chart, is not likely to de-identify a counseling or psychotherapy client because of the uniquely personal nature of the information that is the focus [of most reports]" (Duffy, 2010, p. 145).

Third, students may not have information from training sites regarding how the site will safeguard confidential clinical information—for instance, who will read the material (which is typically submitted electronically), where it will be stored, and when it will be destroyed. Uncertainty about these aspects of the application process and training requirements may lead to over-disguising or extensively falsifying information in the service of client protection, which, as mentioned above, threatens the integrity of the material submitted as an example of the student's clinical formulation ability.

Important questions remain about the relative competency of students in deciding whether and how clinical information should be altered in the documents they submit to training sites (Sperry, Hartshorne, & Watts, 2010). Others have described the inherent problems associated with using disguise as an approach to the maintenance of confidentiality (Duffy, 2010; Fisher, 2008), as clinicians, and especially clinicians-in-training, "cannot know in advance which details of the material will be significant in the case when considered by another clinician" (Blechner, 2012, p. 16).

The current study was designed as a pilot investigation to identify the issues faced by a sample of graduate students required to submit clinical writing samples as part of externship and internship applications, and to survey the current ethical practices of students who submitted such writing samples. Specifically, we sought to sample information about: (1) how different approaches to client confidentiality are taught in graduate training; (2) how students handled the protection of sensitive client information when preparing documents for submission to training sites; and (3) how students think about the maintenance of their clients' confidentiality when deciding how to address the protection of private information in these clinical writing samples.

Method

Participants and Procedures

Doctoral students in clinical and counseling psychology programs (PhD and PsyD) were contacted by e-mail through their Directors of Clinical Training

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(DCT), with an invitation to participate in an online survey investigating how students utilized clinical writing samples in their applications to clinical externship and internship sites. DCTS from 130 Clinical Psychology PhD and PsyD programs, and 65 Counseling Psychology PhD and PsyD programs, were contacted over a 3-month period with a request to forward a call for participation to their students; 3 DCTs indicated a refusal to participate. Students were eligible to participate if they were the age of legal consent, currently enrolled in either a clinical or counseling psychology doctoral program, and if they had at least one year of experience in applying to training sites that were external to their home doctoral institution (e.g., clinical externship or internship). Participants were provided with a secure link to a 32-item survey created by the authors (see Measure section), hosted by the secure data collection and storage website *Qualtrics*.

A total of 118 participants logged onto the site and *n*=86 eligible participants completed the survey; partial data for 19 eligible subjects who started but did not complete the survey were also included, for a total sample of *N*=105 doctoral students. All participants provided informed consent via electronic signature prior to completing the survey and were offered the opportunity to provide their e-mail addresses at the end of the survey for a chance to win one of two $50 gift certificates; their e-mail addresses were not linked to their survey responses, and no other identifying information was requested.

The final sample included *n*=78 (69%) clinical psychology, *n*=35 (31%) counseling students, divided into *n*=97 (86%) seeking PhD's and *n*=16 (14%) seeking PsyD's. The demographics of the sample were *n*=74 (82.2%) women with a mean age of 30 years (*SD*=4.7, range 24-55 years). The ethnic composition of the sample was *n*=69 (76.7%) Caucasian/White, *n*=9 (10%) Hispanic/Latino/a, *n*=6 (6.7%) African American/Black, with other ethnicities including Asian American (*n*=1; 0.8%) and Arab American (*n*=1; 0.8%) also represented. All participants reported that their current doctoral program was APA-accredited. Participants had an average of 203 hours of individual supervision (*SD*=153) and 194 hours of group supervision (*SD*=281) for all clinical work. Most of respondents (*n*=78; 92%) indicated that they had been successful in obtaining a clinical training placement for the upcoming training year.

Measure

The authors developed a 32-item survey specifically for the current study, with two items requesting open-ended responses from participants about the details of their decision-making process when preparing reports (see Results). The survey was divided into five general sections: (1) demographic information; (2) types of sites that students had applied to and type of clinical writing samples included in the most recent application cycle; (3) selection of specific approaches for confidentiality maintenance in the materials used; (4) communication with clients and/or to training sites about the use of clinical material used for application purposes; and (5) graduate training in confidentiality practices. The types of identifying clinical data that were asked about in the survey were developed both with reference to HIPAA's (1996) list of identifiers (e.g., client name, ethnicity, field of employment), as well as other potentially identifying information that would typically be included in a case formulation or description of psychotherapy (e.g., details of personality characteristics,

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client mannerisms, family history). Because participants were not required to respond to every item of the survey, results are presented both in frequencies and percentage of participants responding; no participant was removed from the study due to incomplete data.

Results

Results are presented first regarding applicant and training site details within the current sample, followed by the frequency and general type of clinical writing samples utilized by students. The specific practices of participants who submitted writing samples to external training sites are then examined, with participant responses to selected open-ended questions provided for additional qualitative detail.

Training Site Characteristics and Prevalence of Requests for Supplementary Material

Participants were primarily in the advanced stages of their doctoral program (4th year and beyond: *n*=74; 83.1%). Approximately half of the sample had experience applying to predoctoral internships in addition to formal practica/externships (pre-internship clinical training) (*n*=49, 49%). Over half of the sample reported that they had applied to either externship (*n*=35, 39.3%) or predoctoral internship positions (*n*=34, 38.2%) during the most recent training year (2013-2014). Participants most frequently reported that they had applied to academic medical centers (*n*=50, 42.4%), community mental health clinics (*n*=34, 28.8%), private psychiatric hospitals (*n*=33, 28%), Veterans Affairs Medical Centers (*n*=28, 23.7%) and university counseling centers (*n*=27, 22.9%). Seventeen participants (14.4%) indicated that they had submitted applications to other types of training sites, including state and forensic hospitals, psychoanalytic institutions, private practices, nursing homes, partial hospital programs, schools, and research centers.

The vast majority of participants reported that the training sites they applied to required some kind of clinical writing sample as a supplement to their standard application form (*n*=69, 78.4%); the most common materials requested included psychological testing reports (*n*=62, 52.5%), clinical case summaries (*n*=42, 35.6%), and psychotherapy assessment reports such as intake or discharge summaries (*n*=34, 28.8%). Many participants indicated that training sites requested supplemental materials that directly or indirectly asked them to discuss their clinical work and experiences, such as in essays related to personal or professional identity development (*n*=37, 31.4%), writing responses to clinical prompts (e.g., "describe a challenging case;" *n*=9, 7.6%), or papers written for academic course work (*n*=3, 2.5%).

Characteristics of Supplementary Material

The majority of participants who were required to include clinical writing samples in their applications indicated that they had submitted clinical documents completed at a former external training site (e.g., an intake report from a practicum site) (*n*=47, 69.1%); relatively fewer participants also reported using class assignments (*n*=6, 8.8%) or original documents created solely for application purposes (*n*=10, 14.7%). Clinical writing samples were most frequently about adult clients seen in individual psychotherapy (*n*=55, 79.7%), although adolescent (*n*=22, 31.9%) and child clients (*n*=19, 27.5%) were also frequently written about. Two participants (2.9%) reported that they had written about a fictional client in their submitted reports. Participants, therefore, most frequently reported that they had included

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existing, authentic clinical documents from their clients' medical records in their applications to training sites, rather than writing samples created solely for application purposes.

Consulted Resources for Supplemental Material Preparation

The majority of participants reported that their doctoral programs did not require them to have a mentor or supervisor approve their clinical materials for application purposes (*n*=56, 82.4%; an additional *n*=5 participants [7.4%] were unsure if this was a requirement). Nonetheless, many participants stated that they had relied on a variety of professional resources when preparing their writing samples for submission, with 43.3% of participants (*n*=23) indicating that they had consulted at least some form of professional confidentiality guidelines, including APA and HIPAA guidelines, guidelines provided by their home doctoral institution or the training site to which they were applying, or recommendations for applicants presented at state psychological association meetings.

When initially selecting which clinical writing samples to use, just over half of the participants indicated that they did not consult with anyone, instead making their decision independently (*n*=36, 52.2%). Participants who did seek input from others on which clinical writing samples to use most frequently asked for the assistance of peers (*n*=15, 21.8%), academic advisor or mentors (*n*=14, 20.3%), clinical supervisors (*n*=12, 17.4%), and/or DCTs (*n*=10, 14.5%). A smaller percentage of participants indicated that they had requested the assistance of family members or friends (*n*=2, 2.9%) or their personal therapist (*n*=2, 2.9%) when deciding which clinical writing samples to use.

Similar frequencies were found when students were asked about whom they consulted when editing and preparing their clinical writing samples for submission. While a little over half of participants reported that they prepared clinical documents without guidance from another person (*n*=40, 58.0%), others stated that their peers (*n*=14, 20.3%), clinical supervisors (*n*=12, 17.4%), academic advisors (*n*=12, 17.4%), and/or DCTs (*n*=10, 14.5%) assisted them in preparing and proof-reading their clinical writing samples prior to submission. Although family members and friends were again noted as providing help to some participants (*n*=6, 8.7%), personal therapists were not indicated as being a resource of help during the document preparation phase, and no participants indicated that they had solicited input from the client about whom they wrote. These results indicate that nearly 2 out of every 3 applicants submitted their clinical writing samples without soliciting the help or input of an experienced clinician or a representative from either their clinical training site or doctoral program.

Use of Omission and Disguise in Clinical Writing Samples

Participants were asked to indicate which clinical data they most often disguised or omitted for purposes of confidentiality in their clinical writing samples. Results are presented in Figure 1. Respondents most frequently reported that they had omitted details such as client name (*n*=48, 71.6%), specific place of employment (*n*=20, 30.3%), and job title (*n*=16, 23.9%); they were more likely to generalize, rather than present specific details, information about their clients' physical appearance (*n*=21, 33.3%), family history (*n*=16, 23.2%) and field of employment (*n*=16, 23.2%). Participants were most likely to include accurate and specific information about their clients' psychiatric

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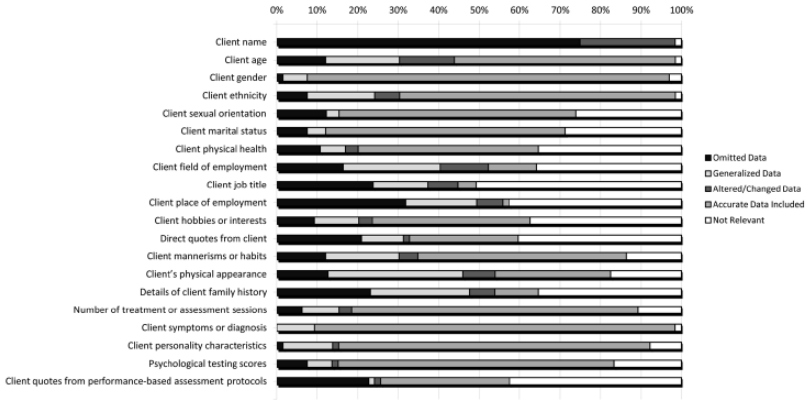
Figure 1. Method of disguise for specific clinical data in writing samples



symptoms (*n*=57, 89.1%) and treatment history (*n*=46, 70.8%), as well as their psychological testing scores (*n*=45, 68.2%). The details most frequently changed or altered included client name (*n*=15, 22.4%), age (*n*=9, 13.6%), and field of employment (*n*=8, 11.9%).

Participants were asked in an open-ended item to provide their reasoning in regards to the use of disguise or omission in their clinical writing samples. Many stated that they provided *general* rather than *specific* information with the explicit intention of protecting their client from being identified, stating, for example, a desire to "decrease the risk of the client being identified," to "ensure that the client would not be identifiable to anyone outside of [the] immediate site," and to "obscure the identity of the client." Several respondents expressed a desire to avoid significantly altering details of a case, with one participant stating that "it [seemed] better to disguise or omit; by altering it [seemed] to change the writing too significantly." Others indicated that they had intentionally altered certain clinical details in order to preserve confidentiality, stating that they "did so because [they] believed that the client's unique information or circumstances would make [them] easily identifiable," or that they "wanted the report to still be thorough, so [they] changed the information rather than delete it." Finally, respondents indicated differing attitudes toward limiting or expanding on the amount of clinical data included in their reports: While one respondent "tried to provide only as much information as was relevant to the report," another "added details to the report to make it longer that were not a part of the original report."

In sum, although participants reportedly used a range of approaches when de-identifying clinical documents, most frequently they reported either omitting potentially identifying details or simply retaining accurate information within their reports (see Figure 1). To a lesser degree, generalizing information and altering or changing clinical details were also used. Nearly half of all participants (*n*=31, 46.3%) reported that they had not directly informed application sites that they had in any way falsified their clinical writing samples in the service of confidentiality.

Use of Informed Consent

Participants were asked to indicate whether their clients had provided informed consent for the use of their materials for professional application

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purposes. Overall, the majority of participants indicated that they had access to the informed consent for treatment that their clients signed at the beginning of treatment (*n*=42, 63.6%), and that their clients clearly understood their status as a student in training (*n*=53, 80.3%). However, participants were less certain about whether their clients were aware that their clinical material could be used for the student's training applications, with many indicating that the extent to which their clients understood this possibility was "somewhat unclear" (*n*=21, 31.8%), "very unclear" (*n*=12, 18.2%), or " not clear at all" (*n*=19, 28.8%). For those respondents who utilized clinical writing samples about child or adolescent clients, the awareness of those responsible for providing consent was even less certain: only 4.5% (*n*=3) felt that this possibility was "very clear," while 19.7% (*n*=13) felt this was "not clear at all."

Participants were asked about whether or not they had considered approaching their clients to obtain informed consent for the use of their materials specifically for professional application purposes. Only 2 participants (2.9%) indicated that this possibility had been discussed in the context of their clinical supervision, and only 2 (different) participants reported that they had actually addressed the issue directly with their clients. Participants who did not discuss the use of clinical writing samples with their clients were asked to rank-order their reasons for not doing so (see Table 1), with results showing both practical concerns, such as no longer having contact with the client, as well as treatment-related concerns, such as fears that the request would feel coercive to the client or disrupt the treatment. In general, though participants reported that their status as a trainee was clear to their clients, the extent to which clients understood the implications of this in regards to the potential use of their information by the student for other training purposes was far less certain.

Participants were also asked in an open-ended item to provide information describing their reasons for not seeking informed consent from their clients for the use of their materials for application purposes. Although some respondents (*n*=2, 11.8%) stated that the idea of obtaining informed consent from their clients "never crossed [their] mind," others argued that the use of disguised information absolved them from having to obtain direct permission from their clients, stating for example that "[they] didn't think [they] needed to since all the information was disguised," and that "[the information] was not identifiable, and therefore did not require informed consent." Others indicated that permission for use of client data was included in the initial informed consent for treatment, or that permission to use a de-identified report had been granted by their clinical supervisor. Overall, participant responses reflected that seeking informed consent was less often considered as an ethical option when using client data, with clear preference given to the use of disguise in the preparation of clinical writing samples for applications sites.

The Use of Clinical Information in the APPIC Essays

Participants who applied to predoctoral psychology internships (*n*=49, 49%) were asked to indicate whether and how they had used clinical material in the four essays required as part of the Association of Psychology Postdoctoral and Internship Centers' (APPIC) Application for Psychology Internships (AAPI). The majority of respondents indicated that they had referred to clinical experiences

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Table 1

	Omitted Data	Generalized Data	Altered/Changed Data	Accurate Data Included	Not Relevant
Client name	71.60%	4.50%	22.40%	0%	1.50%
Client age	12.10%	18.20%	13.60%	54.50%	1.50%
Client gender	1.50%	6.10%	0%	89.40%	3%
Client ethnicity	7.60%	16.70%	6.10%	68.20%	1.50%
Client sexual orientation	12.30%	3.10%	0%	58.50%	26.20%
Client marital status	7.60%	4.50%	0%	59.10%	28.80%
Client physical health	10.80%	6.20%	3.10%	44.60%	35.40%
Client field of employment	16.40%	23.90%	11.90%	11.90%	35.80%
Client job title	23.90%	13.40%	7.50%	4.50%	50.70%
Client place of employment	30.30%	16.70%	6.10%	1.50%	40.50%
Client hobbies or interests	9.40%	10.90%	3.40%	39.10%	37.50%
Direct quotes from client	20.90%	10.40%	1.50%	26.90%	40.30%
Client mannerisms or habits	12.70%	19%	4.80%	54%	14.30%
Client's physical appearance	12.70%	33.30%	7.90%	28.60%	17.50%
Details of client family history	23.10%	24.60%	6.20%	10.80%	35.40%
Number of treatment or assessment sessions	6.20%	9.20%	3.10%	70.80%	10.80%
Client symptoms or diagnosis	0%	9.40%	0%	89.10%	1.60%
Client personality characteristics	1.50%	12.30%	1.50%	76.90%	7.70%
Psychological testing scores	7.60%	6.10%	1.50%	68.20%	16.70%
Client quotes from performance-based assessment protocols	22.70%	1.50%	1.50%	31.80%	42.40%

in at least one of the four essays, most frequently the Theoretical Orientation essay (*n*=31, 63.3%) and the Multicultural/Diversity issues essay (*n*=30, 61.2%); participants less frequently referred to clinical case material in their Autobiographical essay (*n*=4, 8.2%) and Research Experience essay (*n*=2, 4.1%). Details about the type of clinical information most frequently included in these essays are reported in Table 2. Unlike the preparation of supplemental clinical writing samples, internship applicants tended more often than not to include others in the editing and review process of their internship essays, with 28.6% of respondents (*n*=14) eliciting help from their academic mentors, 18.4% (*n*=9) requesting help from peers, 12.2% (*n*=6) obtaining input from their DCT, and 10.2% (*n*=5) requesting help from their clinical supervisors. Only 12.2% (*n*=6) stated that they did not receive help or input from anyone while preparing their internship essays. These findings suggest that students are more likely to solicit the input and assistance from experienced clinical professionals when preparing their four APPIC essays for internship applications, in comparison to their practices when submitting

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Table 2

Required Professional Ethics Course	63.60%
Clinical Practica Placements	55.10%
Clinical Supervision	50.80%
Other External Training Experiences	39.80%
Clinical Interviewing or Intervention Techniques Course	33.90%
Informal Peer Discussion	29.70%
Other	5.90%

original clinical reports more generally to clinical training sites.

Satisfaction with Education and Training on Confidentiality Issues

Participants were asked to discuss how various approaches to confidentiality practices in clinical writing had been discussed in their graduate training. The majority of participants (*n*=75, 63.6%) indicated that confidentiality issues had been discussed in the context of a required Professional Ethics course; further details on the source of education and training in the ethics of clinical writing are presented in Figure 2. Although nearly half of all participants felt that their programs had at least "adequately" addressed the benefits and limitations of changing client information in clinical reports (*n*=38, 44.2%), a majority reported that the pros and cons associated with utilizing composite cases were addressed "only briefly" or "never" (*n*=59, 69.4%). Nonetheless, participants largely felt that overall they were at least "somewhat familiar" with the confidentiality practices outlined within the APA Ethics Code (*n*=77, 91.7%) and HIPAA guidelines (*n*=95, 100%). Despite the clear paucity of discussion of confidentiality and clinical

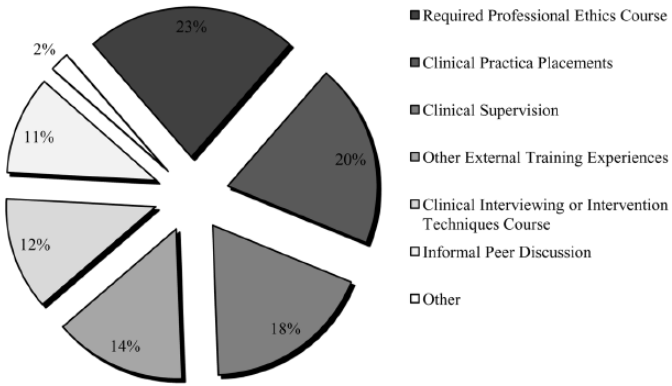

Figure 2. Sources of training and education on confidentiality issues in clinical writing.

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writing in the context of direct clinical supervision, students reported that the didactic training they had received on these issues, and their general familiarity with professional ethics codes, was "adequate" in preparing them on appropriate ethical practices.

Discussion

The current study is the first to our knowledge to survey the confidentiality practices of doctoral students who submit clinical writing samples as part of their applications to external training sites. Although our sample was limited in size and included participants from only APA-accredited programs, our results reveal important information about how students approach the maintenance of client privacy in the clinical writing samples they use for training application purposes. These data point to possible gaps in graduate school education and clinical training. The implications for training, as well as recommendations for the field, are discussed below.

Implications for Clinical Training and Education

One of the more concerning results to emerge from our data was the finding that the majority of student applicants did not consult any experienced clinician, supervisor, or professional resource (e.g., HIPAA or APA guidelines) prior to submitting their clinical reports to training sites, and when they did consult with others, it was usually their peers. This finding suggests that most of the time, students decide for themselves whether a clinical document has been sufficiently disguised. Thus, the extent to which clients' sensitive clinical information is protected, and the extent to which students' clinical proficiency skills may be obscured in the clinical documents that are typically sent to training sites via e-mail, is currently unknown.

These findings have additional implications for clinical supervisors. For instance, Thomas (2010) has argued that one of the roles of a clinical supervisor is to assume the role of "gatekeeper" for their student trainees, serving as both a model of good professional practices while ensuring that these practices are put into effect by the student. Other writers have considered supervision as a form of "intervention" (Bernard & Goodyear, 2014), designed not only to support the student in their training but to actively monitor professional functioning and development. Clinical supervisors must meet their students' training needs while protecting the needs of the clients with whom their students work, and sometimes there may be conflicts in these imperatives. The findings in the current survey suggest that guidelines for supervisors and graduate faculty regarding the dilemmas faced by graduate students required to demonstrate proficiency in clinical writing should be developed.

Although students in this survey reported frequently using omission, generalization, and falsification to disguise sensitive material in their clinical reports, there was little data suggesting that these changes had been made in a thoughtful or systematic way under the guidance of an experienced supervisor or faculty member. Students may not have sufficient knowledge or experience to manage the challenges of confidentiality maintenance in clinical writing or to understand the broader consequences of their available choices. Greater emphasis on the ethical issues associated with clinical writing must be included in clinical supervision and academic contexts in order to prepare students for appropriate ethical practices as independent professionals.

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Recommendations for Graduate Education

Although this was a preliminary pilot study, our results provide valuable information regarding the confidentiality practices and ethical decision making of students who utilize clinical writing samples as part of their applications to external training sites. These findings lead us to suggest a number of preliminary recommendations for those involved in the training of doctoral students:

1. Ethical considerations in clinical writing samples should be addressed early in graduate training, in the context of a required ethics course. This would ensure that students develop an awareness of confidentiality issues related to the use of clinical documents for professional and application purposes prior to encountering any formal requirements to submit these documents to training sites. Students could be provided with samples of de-identified documents that address the specific issues of omission versus disguise, and benefit from having a forum in which to discuss the question of when, whether and how to obtain informed consent directly from clients for clinical writing purposes.

2. Students should be required to have a faculty member at their doctoral training program approve all clinical materials submitted for externship and internship applications, and guidelines for how to disguise that material (or alternately, how to communicate that informed consent from the client was obtained) should be developed and incorporated into students' clinical training early in their academic careers. Input from both academic programs and clinical training sites should be considered in developing such guidelines, although doctoral programs are arguably in the strongest position to assume the lead in developing and implementing such measures. Such guidelines could, for example, be utilized within an early ethics course as study material, and later referred to during the application process to ensure that students have followed these guidelines prior to submitting any documents. Communicating these guidelines to clinical supervisors at external training sites—and ensuring that these standards also meet the confidentiality practices of the training institution—would provide greater awareness of these issues, and foster greater collaboration between those individuals most directly responsible for students' training and professional development in both academic and clinical contexts.

3. Training institutions who request clinical writing samples should provide information about how these materials will be handled, for what period of time they will be utilized, and how they will ultimately be disposed of after the application cycle has ended. Sites may also provide their own guidelines to applicants regarding which details to focus on in their clinical writing samples (e.g., the client's diagnostic conceptualization, interpersonal relationship history, or development of insight over course of treatment); such recommendations may assist students in reducing the scope of their clinical writing sample, and limit the number of potentially identifying details that they ultimately include.

4. In addition to education and training provided by doctoral institutions, clinical supervisors at external training sites should include discussions and training about how and when to obtain informed consent from clients

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for the use of their information for the clinical writing process. The high frequency of students in this survey who reported that they would feel too "embarrassed or shy" to ask their clients for permission, is illustrative of how useful the assistance and guidance of clinical supervisors could be. Obtaining informed consent from clients to publish or present clinical information is considered preferable among many professional clinicians (Fisher, 2008; Blechner, 2012) and is a skill that could be addressed during clinical training using the type of checklist developed by Sieck (2012), who provides a decision tree of when requests for informed consent from clients may be appropriate versus contraindicated within the treatment.

The current study is limited in terms of the representativeness of the graduate student population, which likely varies according to geographical location and type of program. A follow-up study investigating these issues with a larger sample of graduate students at various stages in training is needed to establish more broadly generalizable results. Additionally, it is recommended that future studies investigate the perspectives of clinical supervisors on the ways in which important issues related to client confidentiality—including supervisees' use of clinical documents for application purposes—are handled within the supervision process and supervisory relationship. Such studies will lead to more effective graduate training and more specific, relevant, and useful guidelines for students, supervisors, training site faculty, and graduate program faculty who utilize clinical documents for professional training purposes. Ultimately, all faculty, clinicians and trainees have the same desired outcome in mind: to provide clients with the highest level of care.

References for this article can be found in the online version of the *Bulletin* published on the Division 29 website.

Nightmare Deconstruction and Reprocessing for Trauma-Related Nightmares: An Integrative Approach

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PTSD Nightmares and Sleep Disturbance and Their Treatment

The increased prevalence of posttraumatic stress disorder (PTSD) among military personnel and veterans over the past decade has highlighted the challenges therapists face in treating the disorder in all patients—civilians as well as service members and veterans. Two signature symptoms of PTSD are nightmares and sleep disturbance. These symptoms occur in approximately 50% to 70% of individuals with PTSD (Spoormaker & Montgomery, 2008). Nightmares engender a fear of sleep and thus contribute to trauma-related sleep disturbance. The consequent build-up of sleep debt contributes to deficits in cognitive functioning and memory, emotional lability, and impaired motor function. Sleep-related intrusions predict reactivation of PTSD symptoms (Boe, Holgersen, & Holen, 2010; Picchioni et al., 2010) and may play a role in the development of comorbid anxiety, depression, and suicidality (Bernert & Joiner, 2007; Sjostrom, Hetta, & Waern, 2009). Given these considerations, specifically targeting nightmares may be an essential component of treatment for therapists to consider in working with individuals with PTSD.

Great strides have been made over the past decade in investigating PTSD treatments. Yet despite evidence of the role nightmares and sleep disturbance play in PTSD, these symptoms are not targeted by most evidence-based psychotherapies and often are refractory following treatment (Spoormaker & Montgomery, 2008; Krakow et al., 2002). Prolonged exposure and cognitive processing therapy have been found efficacious for waking PTSD symptoms (McLean & Foa, 2011; Monson et al., 2005) but do not target nightmares. Imagery rehearsal therapy (IRT; Krakow & Zadra, 2010), does target trauma-related nightmares and can be an effective tool for many patients (Casement & Swanson, 2012). However, with IRT the focus is on rescripting the nightmare; processing nightmare content is avoided. Such avoidance may reinforce fear of nightmares and misses the opportunity to process traumatic content.

Nightmare Deconstruction and Reprocessing

A newly adapted treatment, Nightmare Deconstruction and Reprocessing (NDR), has potential as a therapeutic tool for treating trauma-related nightmares. NDR combines exposure and emotional processing to reduce fear response; meaning-making and reprocessing to address grief, loss, guilt, shame, and moral injury; challenge of maladaptive beliefs to assist with reconsolidation of nightmare images and trauma memories; and rescripting nightmare content to facilitate mastery over the nightmares and waking life changes.

The first session consists of psychoeducation on PTSD, nightmares, sleep, and

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mental health; an overview of the model; assessing motivation for change; and practicing stress reduction techniques for use in session and for returning to sleep after a nightmare. In the second session, therapist and patient work collaboratively through three stages (adapted from Hill, 2004): (1) deconstruction and exposure, (2) meaning making and reprocessing, and (3) changes to the nightmare and in waking life.

The model was originally designed to progress through all three stages in one 75- to 90-minute session, which is repeated for several sessions as needed. It can be adapted so that deconstruction and exposure are covered in a 45- to 50-minute session, progressing to meaning making, reprocessing, and changing the nightmare in subsequent sessions. Following is a detailed description of the NDR stages using a de-identified case example* from a recent pilot trial (Spangler, Bowers, & Hill, 2012).

Case Example of NDR*

The participant, Rafa, was a 25-year-old Hispanic male U.S. Army veteran who was an undergraduate student at a large mid-Atlantic university. While serving in an infantry unit during his two tours in Afghanistan, he was exposed extensively to combat situations (firefights, mortar fire, and sniper fire). Since separating from the military, Rafa had experienced several periods of depression during which nightmare frequency and intensity increased. He had lost interest in his usual activities and felt irritable toward and isolated from family members, friends, and fellow students. He nevertheless was high functioning, with a good academic record and plans to graduate within the year. He was screened for exclusion criteria (psychotic symptoms, traumatic brain injury, suicidality, severe substance abuse or dependence, and prescription for Prazosin), and he signed the informed consent. Outcome measures included the Clinician Administered PTSD Scale and Attitudes toward Dreams Scale. Other measures were the Session Evaluation Scale from the Helping Skills Measure and a daily sleep and dream diary.

Treatment consisted of six 75- to100- min sessions over 3 weeks. The first session consisted of psychoeducation about nightmares and sleep disturbance in PTSD and an overview of NDR. I asked Rafa if he had recurrent nightmares or different nightmares with similar themes. Understanding an individual's nightmare pattern provides direction on how to proceed with the model. If, for example, a patient has recurrent, highly distressing nightmares that are a re-experiencing of a traumatic event, the therapist can ask for a less distressing dream to begin with, help the patient to become comfortable with deconstruction and gain mastery over the dreams, and then work with more distressing nightmares in subsequent sessions.

Rafa had multiple distressing dreams with military themes and content. I asked him to think about a dream to discuss in our next session. I also explained that if deconstruction of the images became too intense, we could pause and use relaxation techniques to help calm and center him. Because deconstructing nightmare imagery can be distressing, it is important to describe NDR beforehand and assess the individual's motivation for engaging in the treatment. Rafa seemed highly motivated, explaining that he wanted help with his disturbing dreams and was curious about the study.

Stage 1. In the next session, we worked through the NDR stages. Stage 1, which typically lasts 30-45 min, focuses on

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deconstructing 3 to 5 key nightmare images. This stage gives the patient the opportunity for detailed examination of nightmare images and serves an exposure function, which helps to extinguish the fear of nightmares. I asked Rafa to describe his nightmare in the first person, present tense (e.g., "In the dream, I'm walking around base"), in order to facilitate his re-experiencing the emotions in the nightmare. Rafa described the following dream (edited for brevity):

> I'm a police officer in civilian clothes. There are 3 others with us…. One is a woman…. We search a building [for] children being held in a gymnasium. The rest of the hallway is dark and looks like a hospital…We find bathtubs full of dead bodies and body parts....SWAT comes in, but it's a trap. I get into a firefight… I need a better weapon. As I search, I realize I'm on my bed.

I asked Rafa to pick 4 or 5 key images, and he named the civilian clothes, his female partner, the dead bodies, the SWAT team, and his weapon. The therapist can collaborate on this if the individual has difficulty identifying key images. Naming the images in chronological order helps to contextualize them and confirm the sequence of events. We deconstructed each image in order using the DRAW steps: (1) **D**escribe the image in as much detail as possible, (2) **R**e-experience feelings experienced with that image, (3) **A**ssociate to that image from past experiences, and (4) identify current **W**aking life triggers related to that image. Although not the first image, the SWAT team is provided as an example because it was the most intense image. To encourage a detailed description, I asked Rafa to describe the image as if I had no idea what a SWAT team does. He described them as heavily armed, dressed all in black, and moving stealthily through the building. The emotions he re-experienced related to the image were surprise and extreme vulnerability. He associated to several combat experiences during which his unit was surprised. He had no specific waking life trigger events, but rather a pervasive wariness and dislike of being surprised. Rafa was able to deconstruct the images without using relaxation techniques.

At this point, a summary of all deconstructed images helps the individual to begin making meaning of the nightmare, the focus of the next stage. Rafa's summary detailed how his civilian clothes felt inappropriate because he was on a mission. He was uncomfortable with his female partner because he felt he had to protect her rather than focus on the mission. The image of the bodies was distressing, but not horrifying, and was a reflection of what he had seen in combat and an omen of upcoming events in the nightmare. The SWAT team was the most emotionally intense image and reminded him of his distress at being surprised in combat situations. The weapon he carried was inadequate and contributed to his feeling vulnerable.

Stage 2. By the end of Stage 1, patients typically have a more nuanced understanding of the dream than they did at the start of Stage 1. Thus, Stage 2 begins with the therapist asking what the nightmare means based on the work done during deconstruction. Meaning making and reprocessing in this stage build on increased understanding by processing grief and loss, evaluating fear and anxiety, and challenging negative self-image related to guilt or moral injury. This is a two-step process: (1) collaborating with the patient in constructing a meaning of the nightmare and (2) guiding the patient through reprocessing his or her thoughts and feelings and, if necessary, challenging maladaptive beliefs and as-

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sumptions. The meaning may be related to current waking life issues, early life experiences, and/or existential issues. Typically, meaning making centers on the image causing the most distress. Reprocessing the image sets the stage for making changes to the nightmare. Depending on the patient's level of understanding, this stage takes 20-30 min and may require circling back to deconstructing the images.

Rafa's understanding of the nightmare at the end of Stage 1 was that it reflected his extreme discomfort with being surprised and related it to his unit being caught off guard and feeling the need to be more vigilant. This meaning made sense in that it focused on the most intense image, but it did not reflect any understanding of how Rafa's trauma history reflected his changed view of himself and his relationships since separating from the military. He viewed his female partner as needing protection, but was uncertain because of her role as a unit member. He felt unprepared for and overwhelmed by the SWAT team, which challenged his self-image as vigilant and physically superior and made him feel helpless. We discussed his feelings of helplessness and vulnerability and looked for instances in his waking life that could challenge those feelings. This reprocessing led Rafa to a fuller meaning of the dream and deeper understanding of himself. Elements of the nightmare made him feel conflicted about his roles as both protector and warrior. Indeed, he said that he felt like both a sheepdog and a wolf, and he was uncertain about how those roles were transferrable to the civilian world.

Stage 3. The goal is this stage is to help the patient to gain mastery over the nightmares and begin to reconsolidate the traumatic images into long-term memory. There are three key components to this stage: (1) detailed description of changes to the nightmare images based on the work done in the first two stages, (2) emotional engagement with the new images through behavioral rehearsal of changes to the nightmare both in session and before going to bed, and (3) making changes in waking life based on the meaning made and changes to the nightmare.

I asked Rafa how he would change the dream based on his new understanding. He said he would change the woman to a man so that he would not feel so protective and vulnerable, he would better arm himself, and they would be able to find the children being held hostage. As we rehearsed the changed dream sequence twice, I encouraged Rafa to focus on the feelings evoked by the new images. Rehearsal is repeated several times until the patient is fully engaged with the new images and comfortable with behavioral rehearsal. Practicing in session also provides a model for the homework of rehearsing the new images before bed.

In subsequent sessions, any new dream images or themes are deconstructed as before. During meaning making and reprocessing, the focus is on the new images and what the patient believes these changes might mean. New changes to the dream are made based on the patient's understanding of the changed images.

It may take several sessions of working with nightmares before the patient is ready to transition to waking life changes. These changes should be based on the meaning making, reprocessing, and changes made to the nightmare. Waking life changes might include: (1) specific behaviors, such as more interac-

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tion with a spouse or activities that help the individual feel less marginalized; (2) conducting a ritual to honor the dream, such as listening to a lost buddy's favorite song; and (3) continuing to work on the dream through journaling or talking with others.

Rafa brought a different nightmare to each session. His nightmares had several themes, including distress at being surprised and vulnerable, the presence of family or other civilians in military situation, and isolation from family and friends. We worked on the images in these nightmares over the remaining 4 sessions.

Post-treatment measures indicated that Rafa's PTSD symptoms decreased, he responded well to NDR, he maintained a very strong positive attitude toward dreams, and his sleep quality and duration remained good. The improvements on PTSD symptoms, as indicated by the decrease in CAPS score from 47 to 38, reflected a change from diagnosable PTSD to a subclinical level, including marked changes in avoidance and hypervigilance symptoms. These results indicate that NDR may be a useful alternative treatment for PTSD nightmares and sleep disturbance as well as addressing waking life symptoms.

References for this article can be found in the online version of the *Bulletin* published on the Division 29 website.

* **Editor's Note**: The participant described herein consented to the use of de-identified personal information in this article.

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Potential Ethical Dilemmas in the Treatment of Eating Disorders

Sarah Long, MS, LPC
University of Denver Graduate School of Professional Psychology

Mental health clinicians make decisions based on their respective ethical codes daily. Certain ethical standards, such as abstaining from sexual relations with clients, are clear. Other decisions, particularly those involving nuanced clinical judgment, can be more complex. Psychologists who treat clients struggling with an eating disorder frequently face common ethical dilemmas such as therapist competence, self-disclosure, and particular treatment challenges in non-urban locations. Due to the medical implications of eating disorders—including potential death—these psychologists often find themselves making treatment decisions that dramatically affect a client's physical and mental health. Such decisions must be guided by the *Ethical Principles of Psychologists and Code of Conduct* (Code; American Psychological Association, 2010). Determining whether to implement coercive tactics in treatment or palliative care for chronic eating-disordered clients requires careful evaluation and consideration of the psychological principles in the Code, particularly Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, and Respect for People's Rights. In addition, various standards of the Code should be consulted.

When providing services, psychologists are expected to work within "the boundaries of their competence" (Code, Ethical Standard 2.01). The ethical standard of competence (Standard 2 of the Code) has a variety of implications for those treating eating disorders. Because eating disorders greatly impact physical health, as well as mental health, they are especially complicated to treat. The American Psychiatric Association asserts that best standards of practice generally involve a treatment team consisting of a psychotherapist, medical provider, and dietitian (American Psychiatric Association, 2006). A therapist or psychologist with limited specialized training or knowledge of the medical ramifications, effect of nutritional deficiencies on cognitive functioning, and the complex underlying reasons of an eating disorder may likely be practicing beyond their "scope of practice." The clinician may also underestimate the importance of the treatment team, instead focusing solely on mental health concerns. Not only is this ineffective treatment, but a simplistic approach that can cause harm to the client.

In an effort to maintain competence while treating eating disorders, as well as ensuring nonmaleficence, it is crucial that psychotherapists working in this arena continually evaluate their influence on patients. Jacobs and Nye (2010) explain that "size, appearance, weight, dress, and overall presentation of one's physical self are fundamental statements we present to our patients and can be conceived of as indirect forms of self-disclosure" (p. 166). In order to practice as competent clinicians, eating disorder therapists need to consider and be willing to explore how transference and countertransference issues related to appearance may impact recovery progress and the therapeutic relationship.

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Overt forms of self-disclosure such as thoughts on diet, exercise, or personal struggles with an eating disorder (past or present) can also have a profound effect, potentially impeding a client's recovery. Therapists must be mindful about offering seemingly offhand comments or casual advice drawn from either personal experience or pop culture. It is not difficult to imagine a scenario in which a passing remark about the latest nutritional trend—"I know folks who swear by coconut oil" or "Quinoa worked wonders for that celebrity"—could be taken as tacit permission to engage in food rules and restricted eating, rather than focusing on the underlying therapeutic work. Far from being beneficial, this type of implicit or explicit endorsement of problematic thinking patterns or behavior may negatively impact the recovery process.

Disclosing one's own eating disorder and recovery could have an even greater impact than simple "nutrition advice." Similar to those working in the field of addiction treatment, many therapists specializing in eating disorders are themselves recovered (Barbarich, 2002). A recovered anorexic herself, Carolyn Costin is a well-respected professional in the eating disorder field. Costin (2010) explains "even though they (the therapist) think they understand what a client means or is going through because they have 'been there' it is critical that their understanding of each client is not being overly colored by their own personal experience" (p. 168).

Whether stating an opinion on the latest nutrition trend or disclosing personal recovery status, therapists must monitor and evaluate their comments, and their patients' perceptions of them, on an ongoing basis. Even if the therapist did not intend to cause harm, "if her patients experienced lowered self-esteem, body image and/or mood disturbances because of these interactions, the therapist's approach had to be reexamined" (Jacobs & Nye, 2010, p. 172). Before disclosing any personal thoughts on weight, nutrition, or past experiences, clinicians have an ethical obligation to evaluate the purpose of self-disclosure, as well as the potential benefit or harm to the client.

Treatment of eating disorders in rural settings presents particular ethical considerations. As stated above, because eating disorders involve both mental health and critical physiological factors, as well as considerable resistance to change, it is important for the clinician to have some training in standards of practice and effective treatment modalities. Unlike larger metropolitan areas, where numerous practitioners and treatment centers may offer relevant services, smaller locations often lack professionals who have specialized experience and training. Thus, it is likely that a therapist without adequate experience in eating disorders may work with a client with an eating disorder. For a clinician to maintain competency and do no harm, it is essential to recognize deficits, consult with more experienced practitioners, and pursue specialized training, even if this means driving long distances or utilizing online resources to obtain such consultation and training.

All psychologists contend with ethical decisions related to issues such as competency, multiple relationships, and self-disclosure; in addition, eating disorder treatment involves specific ethical dilemmas unique to this particular mental illness. Both Matusek & Wright (2010) and Vandereycken (1998) describe difficult ethical issues concerning informed consent, freedom of choice, autonomy, and the judgment of the patient's competence. These ethical quan-

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SUMMARY OF RECENT CHANGES TO THE DIVISION'S BYLAWS

Two proposed changes were voted on by the membership. Please note that changes in Division 29 Bylaws require a two-thirds majority of those voting.

1. The first item passed by a vote of 33 to 10 (77% in favor). This item included a number of changes. The main change simplifies and broadens the criteria for becoming an affiliate member of the Division, now specifying that:

Article II. Section E. The minimum qualification for election to the category of Non-APA-member Affiliate shall be an earned doctoral degree in Psychology or a professional credential that entitles the individual to practice psychotherapy independently.

A further change simplifies and clarifies the rights and privileges of Affiliates:

Article III. Section D. Non-APA-member Affiliates of the Division shall be entitled to all the rights and privileges of full members except that they are not eligible to vote in Division elections and they are not eligible to hold elected office in the Division.

In addition to these main changes concerning Affiliate membership, the item specified a number of housekeeping changes to the Bylaws, including grammatical corrections and removal of some detailed specifications of committee memberships, which have seldom been followed closely. The full text of the revised Bylaws is posted on the Division's website.

2. The second item failed because it did not attain the required two-thirds majority (22 to 21; 52% in favor). This item sought to modify the requirement that PRO and CON statements accompany all Bylaws changes. Because of this vote, the requirement is retained.

NAME CHANGE FOR THE APA DIVISION OF PSYCHOTHERAPY?

John Norcross & Jean Carter

In 2004, the Division 29 Board of Directors discussed the advantages and disadvantages of altering the formal name of the organization to the **Society for Psychotherapy: Division 29 of the American Psychological Association**. The Board voted in the affirmative to do so by a margin of more than 2 to 1. The Bylaws change was submitted to a vote of the membership, who also voted in favor but not by the required two-thirds. The bylaw proposal failed by two votes.

The issue has been periodically raised, and in Fall 2013, the Board asked that the matter be considered again.

Precedents. At present, 33 of the 55 APA divisions have formally changed their names to include "Society" (Divisions 1, 2, 8, 9, 10, 12, 13, 14, 17, 19, 23, 24, 26, 27, 30, 32, 34, 35, 36, 37, 40, 41, 43, 44, 45, 46, 48, 49, 50, 51, 53, 54, and 55). Eight of these are "Society of," 24 are "Society for," and one put "Society" after its name.

Reasons for the name change vary from division to division, of course, but the applications for name change almost always mention that the division was seeking to attract more non-APA members and to broaden its mission and identity. That is, they desire both the APA division affiliation and the broader appeal of a Society name. According to Ms. Sarah Jordon, no existing APA division has ever been denied permission by the Council of Representatives to modify its name.

Advantages. Have our cake and eat it too: maintaining the advantages of an APA Division while broadening our appeal, membership, and potentially dues revenue. Non-APA psychologists and non-psychologist psychotherapists would probably be more likely to join a Society, as opposed to an APA Division. More of our (already paid for) Journal subscriptions would be distributed and the impact of the Division strengthened. Joining the majority of other APA divisions that have already done so and that have reaped the attendant benefits. Sense of rejuvenating the organization.

Disadvantages. Expense of altering official documents and rebranding the division website. A name change may dilute the historical character of the Division and its close ties to APA. Potential for a new name that is too close to an existing organization, such as SPR, may lead to confusion or conflict. May alienate a few psychologists preferring the current name (although Ms. Sarah Jordan is unaware of any membership loss resulting from a division name change). Members of the society/association could not vote or run for office unless they also joined APA, or unless we changed membership.

Dear Division 29 Member:

You are receiving this email asking you to vote on a change to Article I, Section A of the Bylaws of Division 29 that was approved by the Division's Board of Directors February 2014 meeting. You are being asked to decide whether to change our name to "Society for the Advancement of Psychotherapy: Division 29 of the American Psychological Association (APA)" or keep our current name "The Division of Psychotherapy: Division 29 of the American Psychological Association (APA)."

A rationale for change or no change (pro and con statements as required by the Division's Bylaws) and your ballot can be found here:
http://www.divisionofpsychotherapy.org/name-change-for-the-apa-division-of-psychotherapy-review-pro-and-con-statement-and-proposed-bylaws-changes-here/

Please read the rationales and proposed change. Voting will be done on-line at the Division's website
http://www.divisionofpsychotherapy.org/vote-online-here-for-proposed-bylaws-changes/

You may also use this paper ballot should you be unable to use the on-line system. All votes must be in by April 15, 2014.

If you have any questions, please contact our central office at
assnmgmt1@cox.net

YOUR VOTE IS IMPORTANT – PLEASE PARTICIPATE NOW.

Thank you!

DIVISION OF PSYCHOTHERAPY
BYLAWS AMENDMENT TO CHANGE THE NAME OF THE DIVISION

- ❍ **YES — Change the name of the Division**
- ❍ **NO — Keep the current name of the Division**

Name (Printed) _____

Signature _____

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_____

_____

_____

Division29
Central Office
6557 E. Riverdale St.
Mesa, AZ 85215

daries include the use of coercive tactics (overt or covert); the imposition of treatment, up to and including enforced feeding; issues of competence, particularly among clients whose capacities may be compromised due to medical complications; and potentially differing levels of duties to minor and adult clients (Matusek & Wright, 2010).

When considering whether or not overt and covert coercive tactics should be implemented in treatment, a psychologist must consider several General Principles from the Code, including Nonmaleficence (Principle A) and Respect for People's Rights and Dignity (Principle E), which underscores the ethical tension between balancing client autonomy and a duty to protect at-risk clients. Principle E states: "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making." In addition, psychologists have a responsibility to "protect client's welfare when a clinician knows that a client poses an imminent risk of danger towards him or herself" (Matusek & Wright, 2010, p. 436).

These two ethical principles can be conflicting when applied to coercive treatment interventions such as involuntary hospitalization (for both adults and adolescents), tube feeding, monitoring bathroom privileges to prevent purging, exercise restriction, surveillance of mealtimes, enforced nutritional replacements, and blind weigh-ins. Enforcing compulsory treatment, whether on the level of outpatient or inpatient, is often in direct conflict with a client's wishes and therefore threatens autonomy. Many professionals argue that, with these types of interventions, it may be "more destructive and counterproductive for the client's autonomy to be usurped," leading to feelings of being out of control and therefore more drastic eating-disordered behaviors (Matusek & Wright, 2010, p. 439). It also threatens to rupture the therapeutic alliance and may decrease the likelihood of the client continuing treatment.

Conversely, others argue that the duty to protect and prevent imminent harm often warrants compulsory treatment. Eating disorders have the highest mortality of all psychiatric conditions (Matusek & Wright, 2010). To prevent a client from becoming medically compromised or dying, structure and close monitoring may be necessary. Malnourishment, coupled with the ego-syntonic nature of eating disorders, causes impaired reasoning and limits cognitive capacity. These distortions may result in a client's inability to break dangerous behavioral patterns regardless of intention, creating a potentially permanently harmful situation that itself may inhibit or prevent effective "autonomous decision making." Due to a likelihood of serious medical complications that may increasingly limit client competency, a clinician's duty to protect may override the presumption of client autonomy under these conditions.

Discerning the best course of action involves a complex decision-making process that examines the ethical dilemmas described above, as well as potential outcomes. In general, before a recommendation is made, several steps are necessary, including completion of a comprehensive health assessment on the part of the client; consideration of all practical treatment options and their likely effectiveness; and discussion with the client and his or her family or close

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support system. Specifically, the clinician should consider "at what point does an individual's disturbed relationship with food render her incompetent in making treatment decisions?" (Matusek & Wright, 2010). Two considerations that can help determine cognitive capacity, and therefore competence, relate to lack of insight related to the gravity of the "disorder and health status, as well as the presence of organic impairments" (Manley, Smye, & Srikameswaran, 2001). Related to health concerns, determining whether there is a "duty to protect" is dependent on immediate health risk, as well as longer-term physical risk. Because eating disorder patients have a high rate of suicide, suicidality should also be closely monitored (Matusek & Wright, 2010).

Whether working in an outpatient or inpatient treatment setting, clinicians working with eating disorders will make countless decisions regarding treatment interventions and the therapeutic process. Although the treatment of eating disorders presents unique challenges, as with all psychologists, practitioners in this area of specialization will face ethical issues involving self-disclosure, potential multiple relationships, competence (of both the clinician and the client), autonomy, and duty to protect. To prevent harm, respect client autonomy, and provide effective treatment within appropriate ethical boundaries, it is important that clinicians consult with other professionals and keep the ethical guiding principles and standards in the forefront of decision-making.

References for this article can be found in the online version of the *Bulletin* published on the Division 29 website.

EARLY CAREER

A Psychotherapy Researcher: Dinosaur or Chameleon?

Rayna D. Markin, PhD
Villanova University, Pennsylvania

The Golden Crown Sifaka is the smallest member of the lemur family from Northeastern Madagascar. He has a creamy white coat that is topped with a bright orange crown and a triangular face with small black eyes. These creatures live in groups of 5 or 6, care for their young, and form social groups dominated by females. Their habitat was first threatened by logging and bush fires, but the recent discovery of gold in the region has led to further destruction of forest to make room for the miners who eat lemurs, all leading to the Sifaka being labeled as an endangered species. The little lemur faces endangerment largely becomes of habitat loss, brought about by human greed and environmental carelessness.

While I am obviously not a Golden Crown Sifaka, I feel a certain connection to his kind. Similar to this small beady-eyed lemur, as a psychotherapy researcher, I too feel like an endangered species with little fertile ground on which to thrive. The combination of diminished funding for psychotherapy research and minimal academic jobs for psychotherapy researchers is akin to logging and bush fires, as such conditions lead to a climate in which psychotherapy researchers struggle to survive. As an Early Career Psychologist, I find myself in this paradoxical state of beginning my career in an area of research that has come to a startling halt. As Darwin might say, the survival of psychotherapy research rests on how "fit" the next generation of psychotherapy researchers is to survive and compete. Thus, Early Career Psychologists play an important role in whether psychotherapy research is to continue and thrive. This article explores threats to a psychotherapy researcher's survival and proposes some suggestions for counteracting extinction.

Why Does a Species Become Extinct?
There are three major reasons (among others) that species become extinct: habitat loss, climate change, and disease.

Habitat loss. Practically speaking, in order to survive as a psychotherapy researcher, you need a place from which to conduct your research, i.e., a home or habitat. As any Early Career Psychologist (ECP) who conducts psychotherapy research knows, there are few job announcements specifically seeking a psychotherapy researcher. As one prominent and respected colleague once told me, "Unless you have an fMRI machine, you will not get a job here." The lack of positions for psychotherapy researchers forces ECPs with an interest in this kind of work to venture into other areas of research to ensure their survival. As another mid-career psychotherapy researcher told me, "there is a feeling that no matter how much you publish, no one will hire you." In essence, the sure fire way of threatening a species survival is to eliminate its habitat.

The presence or absence of a thriving habitat for any species is closely tied to

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money. The lemurs are losing their habitat largely because humans found gold right under their noses. Psychotherapy researchers are losing their habitat largely because there is little funding currently available for their research. In a recent article in *Psychology Today*, Jeremy Safran writes eloquently about the NIMH's shift in grant funding away from psychological explanations and treatments to studies on the biological basis and treatment of emotional disorders. He writes,

> This is a perpetuation and expansion of a trend which has been taking place at NIMH for many years now, that privileges the biological over all other levels of analysis (e.g., psychological, emotional, social). It is one thing to hypothesize that psychological and emotional problems are associated with changes at the biological level (e.g., specific patterns of brain activity or levels of neurotransmitters) or that symptom remission is associated with biological changes. It's another to assume that the underlying causes of mental health problems are always biological in nature and that meaningful improvements in treatment will only take place when we can directly target the relevant brain circuitry. (Safran, 2013)

Particularly in this economic climate, universities look to hire candidates with a potential for major external funding. One does not usually find large grants for psychotherapy research, especially process and outcome research. The lack of a hospitable climate for psychotherapy researchers is mirrored in the practice community. In 2008, NBC News ran a story entitled, "In the Era of Pills, Fewer Shrinks Doing Talk Therapy" (Associated Press, 2008). This article cites a study that found a significant decline in psychotherapy among psychiatrists in the U.S., although the study did not look at rates among psychologists. The article attributes the expanded use of psychopharmacological drugs and the insurance company's preference for short-term visits as causes for this decline. Interestingly, this article goes on to state that the current preference for medication is in contrast to research suggesting that psychotherapy is superior to medication for some patients. In essence, despite research on the effectiveness of psychotherapy, there seems to be an "aura of invincibility around meds" (Associated Press, 2008). Psychotherapy researchers and clinicians both struggle to be seen as valuable (and fundable) at a time when biological explanations and treatments are in vogue.

Climate change and disease. All living creatures are deeply affected by their surrounding climate. Although the exact reason is still debated, leading theories suggest that climate change was a central reason behind the extinction of dinosaurs. More recently, polar bears, sea turtles, the giant panda, and elephants are among the species whose survival is in trouble due to climate change, according to the World Wildlife Fund (2014). The dearth of funding and job prospects for psychotherapy researchers have transpired within a change in our culture's climate.

Psychotherapy of all "brands" is essentially about introspection, whether one is reflecting on one's emotions, thoughts, and/or behaviors. The process of introspection is often a long and nonlinear one, requiring one to have *patience*. Psychotherapy calls for clients to forestall immediate gains and waddle in a sort of ambiguous and undefined place. In other words, while there may be *quicker* fixes, there is no quick fix, and change is most often internally driven rather than externally received. No mag-

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ical pill exists to instantly cure all of our ills. For instance, as a novice counselor, co-leading a substance abuse group, I vividly remember one group member who was given more medications than diagnoses, once proclaiming, "too bad there isn't a pill to stop me from drinking myself to death.[1]" In that moment, as an overwhelmed novice, I too wished there was some pill that could save this patient from himself. The wish to be saved and to be saved quickly has, arguably, never before created so much atmospheric pressure. The hard work, patience, and introspection required in psychotherapy are all antithetical to the fast paced, appearance based, externally reinforced, achievement-oriented climate in which we live. In other words, a culture that values external reinforcement and appearances more than internal self-definition, integrity, and introspection gives rise to a sort of cultural narcissism that does not readily lend itself to psychotherapy. Consistent with this, Nancy McWilliams (2011) writes "social theorists have argued that the vicissitudes of contemporary life reinforce narcissistic concerns. The world changes rapidly; we move frequently; mass communications exploit our insecurities and pander to our vanity and greed" (p. 177). It is within this cultural climate that the psychological basis and treatment of our emotional life struggles to compete with the promise of a fast acting and externally derived "pill."

Despite all the empirical evidence to the contrary, this cultural climate has given rise to a widespread disease in our society that causes many to believe that psychotherapy is useless, outdated, and a waste of time, especially when there is perceived to be a chemical solution to a psychological problem. Therapists themselves are not immune to this error. I once worked with a 31-year-old patient, with severe depression, who, after much convincing, finally agreed to see a psychiatrist and start antidepressant medication. When she reported positive gains from the psychopharmacological treatment, I expected her to stop the therapy. As a result, I preemptively started to discuss termination with her, when, with a confused expression on her face, my patient stopped me and said, "I do feel less depressed but this leaves me with another problem. If I'm not depressed, then who am I?" Apparently, there is no pill for self-identity.

How to Save an Endangered Species

How does a species save itself from extinction? As an ECP, am I fighting a losing battle sticking to psychotherapy research, rendering myself irrelevant? In thinking of how ECPs can survive the current cultural trend, I find some comfort in the famous misquotation, paraphrasing Charles Darwin, "It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is most adaptable to change" (see Matze, 2009). Three strategies for ECPs interested in psychotherapy research to manage change are: sticking together, conducting interdisciplinary research, and waiting the course.

Sticking together. Perhaps it is my background as a group clinician and researcher, but I tend to see strength in numbers. It is important that psychotherapy researchers, whether early-, middle-, or late- in their career, regardless of theoretical orientation, stick together. Unfortunately, scare resources tend to engender competition, as seen by the (in my opinion) counterproductive competitiveness that is seen today between "brands" of psychotherapy. In the fight for competitive and scarce funding, these are often pitted against each other in a contest of survival of the fittest, when, in fact, such a focus on psychotherapy brands probably under-

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estimates the common ingredients to all psychotherapy approaches that predict client change (Norcross, 2002, 2010; Wachtel, in press). Until I became involved with Division 29, as a dynamic therapist, I never actually sat down and had a conversation about psychotherapy with a "CBT person." Becoming involved in this Division has helped me to redefine myself not only as a psychodynamic researcher, but as a psychotherapy researcher. Division 29 represents a forum wherein psychotherapists of all theoretical orientations can come together under one roof to work together toward a common goal, i.e., preserving psychotherapy and psychotherapy research. In essence, to ensure our survival as psychotherapists (not just psychodynamic psychotherapists or cognitive behavioral psychotherapists, etc.) we must all stick together. You know the old expression—first divide, then conquer.

Perhaps for self-serving reasons, I believe an important function of the Division is to care for its "young" early career psychotherapy researchers. Accordingly, the Division offers ECPs a comprehensive mentoring program, opportunities in leadership, small grant funding, and conference programming and workshops. Moreover, Division 29 offers ECPs interested in psychotherapy research a group in which to belong, a community of likeminded individuals who understand and value each other's work.

Interdisciplinary research. This is no time to be a purist. We must adapt to our current environment and the changes around us to survive. This means that psychotherapy researchers like myself must step out of our corner and collaborate with researchers of related disciplines in developmental and social psychology, neuroscience, psychiatry, and other medical professions. However, for this strategy to be effective, I believe it must be genuine and not forced. For me, for example, my interest in attachment theory and pregnancy naturally lends itself to collaborating with developmental psychologists and researchers in the medical profession. The key is to not isolate ourselves but to collaborate with other like-minded colleagues in related disciplines.

Waiting the course. All things come full circle. Right now, the pendulum has swung in one direction; history (and gravity) suggests that, eventually, it has no choice but to swing back. In an article for *Psychology Today*, Robert Howes (2008), a practicing clinician, describes psychotherapy as "natural and organic," effective, relational, and having been around for a long time; thus, he argues, it is not likely to die out. Currently, as a society, we are flirting with the notion that we can somehow numb our emotional pain with drugs and circumvent our emotional life by focusing on our biological bases. Yet, at the end of the day, there is no drug for loneliness, trauma, self-other definition, or self-esteem. There is no drug that will allow you to look at yourself in the mirror or connect with others. Thus, there will always be a need for psychotherapy and psychotherapy research.

Conclusion

The lemurs have little "say" in their future survival and are largely at the mercy of forces beyond their control, such as the actions of humans. On the other hand, human beings obviously had no role in the extinction of dinosaurs. Rather, many scientists believe that these creatures simply ran their evolutionary course and could not adapt to a changing climate and other competing mammals. Unlike either of these species, the chameleon has survived for about 80 million years and changes color to adapt

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to its climate (i.e., temperature). Like the chameleon, for psychotherapy research to move forward and thrive, early career psychotherapy researchers must adapt to new environments and climates. We must come together as psychotherapy researchers under one large umbrella, while simultaneously reaching out to neighboring disciplines. I believe early career psychologists will largely define what it means to be a psychotherapy researcher in the future. Are we going to be dinosaurs or chameleons?[2]

References for this article can be found in the online version of the *Bulletin* published on the Division 29 website.

[1] All patient information has been di-identified and disguised (any identifying information has been changed or left out and the context of treatment altered) and any client quotations are paraphrased and not direct quotes.

[2] For more information on dinosaurs and chameleons please see http://paleobiology.si.edu/dinosaurs/info/everything/why.html and http://www.nwf.org/Kids/Ranger-Rick/Animals/Amphibians-and-Reptiles/Chameleons.aspx.

Find Division 29 on the Internet. Visit our site at www.divisionofpsychotherapy.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 of Psychotherapy (29)
American Psychological Association

Enter the Annual Division of Psychotherapy Student Competitions

The APA Division of Psychotherapy offers four student paper competitions:

- The Donald K. Freedheim Student Development Award for the best paper on psychotherapy theory, practice, or research.
- The Diversity Award for the best paper on issues of diversity in psychotherapy. The APA defines diversity as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status.
- The Mathilda B. Canter Education and Training Award for the best paper on education, supervision, or training of psychotherapists.
- The Jeffrey E. Barnett Psychotherapy Research Paper Award for the best paper that addresses psychotherapist factors that may impact treatment effectiveness and outcomes, to include type of training, amount of training, professional degree or discipline of the psychotherapist, and the role of psychotherapists' personal characteristics.

What are the benefits to you?

- Cash prize of $500 for the winner of each contest.
- Enhance your curriculum vitae and gain national recognition.
- Plaque and check presented at the Division 29 Awards Ceremony at the annual meeting of the American Psychological Association.
- Abstract will be published in the Psychotherapy Bulletin, the official publication of the Division of Psychotherapy.

What are the requirements?

- Papers must be based on work conducted by the first author during his/her graduate studies. Papers can be based on (but are not restricted to) a masters thesis or a doctoral dissertation.
- Papers should be in APA style, not to exceed 25 pages in length (including tables, figures, and references) and should not list the authors' names or academic affiliations.
- Please include a title page as part of a separate attached MS-Word or PDF document so that the papers can be judged "blind." This page can include authors' names and academic affiliations.
- Also include a cover letter as part of a separate attached MS-Word or PDF document. The cover letter should attest that the paper is based on work that the first author conducted while in graduate school. It should also include the first author's mailing address, telephone number, and e-mail address.
- All applicants must be members of the Division of Psychotherapy. Join the Division at www.divisionofpsychotherapy.org
- Applicant must specify for which award he/she is applying. Applicants can submit multiple papers for awards, but an individual paper may only be submitted for a single award.

Submissions should be emailed to:

Meg Tobias, M.S.
Chair, Student Development Committee, Division of Psychotherapy
E-mail: mrtobias@loyola.edu

Deadline is April 1, 2014

STUDENT FEATURE

Posttraumatic Stress Disorder Risk Factors Associated with Burn Injuries

Melissa M. Matos, MA
California School of Professional Psychology at Alliant International University, Los Angeles

The skin has been described as the largest organ of the integumentary system (Levenson, 2008). One condition affecting the skin organ is burn injuries. Serious or severe burn injuries have been described as a life-threatening state that challenges all of the integrating systems in the body (Sveen, Dyster-Aas, & Willebrand, 2009). Serious burn injuries are not rare and often occur from everyday circumstances that come unanticipated and without warning (Taal & Faber, 1998). According to Karter (2011), someone was injured in a fire every 30 minutes and a fire death occurred every 169 minutes in the United States in 2010. In addition, burn injuries appear to be more common among young children between the ages of 2 to 4 years, young adult males between the ages of 17 to 25 years, and older adults over the age of 65 (Flynn, 2010; Yu & Dimsdale, 1999).

The impact of burn injuries extends beyond that of visible difference and appears to be accompanied by a wide host of consequences. Financial burdens experienced by patients with burn injuries may occur from job loss associated with frequent absences due to medical treatment, and costs associated with medical surgery, rehabilitation care, and disability payments (Sadeghi-Bazargani et al., 2011; Yu & Dimsdale, 1999). Physical impairment is often reported resulting from burn pain which is intense and causes great discomfort and suffering, particularly during hospitalization and the dressing of wounds (Yu & Dimsdale, 1999). However, it is the psychological reaction to burn injuries, which perhaps may cause the greatest of impairment and distress. Patients suffering from burn injuries may experience depression, anxiety, and delirium associated with the physical experience of burn pain, as well as social withdrawal and negative body image due to visible differences (De Sousa, 2010; Sadeghi-Bazargani, Maghsoudi, Soudmand-Niri, Ranjbar, & Mashadi-Abdollahi, 2011; Yu & Dimsdale, 1999). In addition, patients with burn injuries appear to be at greater risk for developing symptoms associated with psychological trauma and Posttraumatic Stress Disorder (PTSD) such as re-experiencing of the incident via intrusive recollections, avoidance of reminders of the event, recurrent nightmares, memory and sleep disturbances, and phobic behavior (Lawrence & Fauerbach, 2003; Yu & Dimsdale, 1999).

Statement of the Problem

While the impact of psychological trauma and PTSD may have devastating effects on daily functioning and psychological well-being, early detection is associated with a positive prognosis (De Sousa, 2010; Yu & Dimsdale, 1999). However, patients with burn injuries are less likely to interact with healthcare professionals that are trained in psychological assessment, but rather are typically treated by medical staff who may lack experience in screening for psycho-

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logical issues in their patients (De Sousa, 2010). Medical practitioners such as plastic surgeons and rehabilitation specialists need to be made aware that improvement of patients' quality of life is not measured only by physical functioning, but by social and psychological factors as well; standards of care of patients with burns should include psychosocial rehabilitation as well as physical rehabilitation (De Sousa, 2010). Therefore, burn injury rehabilitation and plastic surgery medical teams need to be made aware of the PTSD risk factors associated with patients with burn injuries in order to screen and determine not only if psychiatric referrals are necessary, but also how to provide appropriate feedback concerning treatment outcomes (De Sousa, 2010).

PTSD and Burn Injuries

Prevalence and Onset

PTSD is a psychiatric condition occurring following exposure to a traumatic event which is characterized by persistent and intrusive re-experiencing of the event, avoidance of stimuli associated with the traumatic event, emotional numbing, dissociation, and hyperarousal (American Psychiatric Association [*DSM-IV*], 2000*; Lawrence & Fauerbach, 2003). Among patients with burn injuries, dissociation and a decrease in emotional responsiveness and feelings of detachment have been reported as occurring during the accident (Taal & Faber, 1998). According to the *DSM-IV*, PTSD has been found to be a common occurrence in patients with burn injuries, with prevalence rates reported as varying between 8% and 45%, while stress disorders in general has been reported as occurring in 18% to 33% of cases (El hamaoui, Yaalaoui, Chihabeddine, Boukind, & Moussaoui, 2002; Sadeghi-Bazargani et al., 2011). In a sample of 60 patients with burn injuries, 23% met criteria for PTSD, while in a sample of 43 adult inpatients at a regional burn center, 22% were diagnosed with PTSD (El hamaoui et al., 2002; Roca, Spence & Munster, 1992). Despite the high prevalence rates of PTSD among patients with burn injuries, "PTSD remains a neglected entity by practitioners and remains therefore under-diagnosed," according to El hamaoui and colleagues, who go on to note that "improvement of health and quality of life of these patients necessitates the earliest possible management" (2002, p. 649).

Symptoms must be present for one month to satisfy criteria for PTSD (APA, 2000). For most patients with burn injuries, PTSD-like symptoms may dissipate with time; however, for 5% to 25% of these patients, the symptoms become chronic (Lawrence & Fauerbach, 2003). In fact, evidence suggests that PTSD may have a tendency toward delayed onset in burn survivors, with onset usually occurring 3 to 6 months, and sometimes even a year, after the injury (Sadeghi-Bazarghani, 2011). Looking at a sample of burn survivors two weeks post-discharge from the hospital, Sadeghi-Bazarghani and colleagues (2011) found that 20% had a positive PTSD screening; after three months, this increased to 31.5%. Similar findings demonstrated a tripled prevalence of PTSD among burn survivors between the times of discharge and the 4-month follow up (Yu & Dimsdale, 1999). Further complicating the presentation of PTSD among burn survivors is the possibility that a substantial portion of patients may not meet full criteria for the diagnosis; however, the symptoms that are present may still significantly impact their quality of life (De Sousa, 2010). The nature of delayed onset and possible subclinical forms of PTSD among burn survivors illustrates the ne-

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cessity for increasing awareness of risk factors among medical staff, given that medical professionals are provided opportunities to observe and screen patients during 3- and 6-month follow up examinations.

PTSD Risk Factor: Age

Age has been shown to have an association with the development of PTSD among burn survivors. Sadeghi-Bazarghani and colleagues (2011) found that a younger age at that time of the traumatic event appeared to predict a higher PTSD score after burn injury. Comparatively, El hamaoui and colleagues (2002) found that younger age (M=15.8 years) at the moment of the burn (as well as explosion of gas containers for cooking purposes) also appeared to be related to PTSD. The element of age as a risk factor for PTSD may be due to the higher incidences of burn injuries among younger age groups, such as children and young adults. Another possible explanation has been the salient role of body image among younger age populations and the role of visible differences and physical appearance (Sadeghi-Bazarghani et al., 2011). It is then imperative for medical staff to take particular note of younger patients with burn injuries, not only screening for risk of developing PTSD, but also to closely listen to younger patients questions and concerns, and using appropriate and effective communication skills to provide feedback about treatment outcomes (De Sousa, 2010).

PTSD Risk Factor: Gender

The role of gender of burn survivors has been shown to be a potential predictor of risk factors for PTSD. Sadeghi-Bazarghani and colleagues (2011) found an association between PTSD and male gender in their study; however, they explained the higher prevalence of burn injuries among men as possibly accounting for these findings. Overall, additional findings have indicated that individuals with acquired facial trauma such as burn injuries are more likely to be female, and that most psychological symptoms after facial trauma are experienced more often by women, due to the higher prevalence of concerns associated with physical appearance and disfigurement (De Sousa, 2010). According to De Sousa (2010), facial trauma may lead to social withdrawal and isolation, and is often accompanied by anger toward the self or others as well as idealizing the pre-injury physical appearance. Previous findings indicated that 27% of patients with facial trauma developed PTSD seven weeks after the burn injury (Yu & Dimsdale, 1999). Therefore, female gender may function as a risk factor, contingent on the value the individual places on physical appearance and the level of distress resulting from visible differences.

PTSD Risk Factor: Coping Strategies and Social Support

Some models of PTSD postulate that adjustment to trauma is based on a series of factors, including resilience-recovery variables such as coping strategies and social support (Lawrence & Fauerbach, 2003). Coping has been described as behaviors that function to protect individuals from psychological harm from adverse experiences (Lawrence & Fauerbach, 2003). Coping strategies have been categorized as approach coping, which involves directly resolving the stressor, or avoidance coping, which attempts to avoid thinking about the stressor or associated affect (Lawrence & Fauerbach, 2003). An ambivalent coping style— that is, a coping style that combines both emotion avoidance with emotion approach—has been found to be a predictor of more severe PTSD (De Sousa, 2010; Lawrence & Fauerbach, 2003). In addition, lack of social support has been

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shown to function as a risk factor for PTSD among burn survivors (Lawrence & Fauerbach, 2003; Sveen, Dyster-Aas, & Willebrand, 2009; Yu & Dimsdale, 1999). Furthermore, high social support has been associated with both positive mental and physical health outcomes, such as lessening the impact of trauma exposure (Lawrence & Fauerbach, 2003). Similarly, the nature of the patient's social support functions as a variable, which influences psychological adjustment to facial trauma such as burn injuries (De Sousa, 2010). Medical staff, therefore, must assess for the presence and role of the patient's social support system, as well as observing the coping strategies utilized both by the patient and members of that support system, as potential risk factors for PTSD and health-related quality of life indicators.

Conclusion

For patients with burn injuries, the traumatic experience and suffering associated with serious burns may present with a wide host of physical and psychological challenges. In addition to intense pain associated with burn injuries, patients often experience psychological distress and trauma resulting from delirium during the hospitalization, physical appearance alterations, and medical treatment of wounds. Due to the traumatic nature of serious burn injuries, patients have been demonstrated to be at high risk for PTSD, particularly among young females with poor coping strategies and low social support (De Sousa, 2010; Lawrence & Fauerbach, 2003; Sadeghi-Bazargani et al., 2011; Yu & Dimsdale, 1999). The practitioners comprising the rehabilitation and plastic surgery team are responsible for providing a standard of care that helps maximize improvement in patients' quality of life. However, psychosocial rehabilitation is often overlooked as integral part of patient treatment, particularly in patients with burn injuries who appear at high risk for PTSD. Given the high prevalence of PTSD and trauma-related psychological distress among this population, plastic surgery and rehabilitation teams must increase awareness and psychoeducation regarding patient screening for psychological disturbances such as PTSD.

Successful treatment and management of PTSD is highly dependent on early detection. Given that medical practitioners may be among the few sources of social interaction to which burn survivors have access, it is critical that the medical team increase awareness of risk factors and training in screening for PTSD among patients with burn injuries. Furthermore, patients identified as presenting for risk factors for PTSD and psychosocial disturbances may require additional feedback regarding the influence of psychological factors on quality of life and treatment adherence (De Sousa, 2010). According to De Sousa (2009), "one of the most important contributions that the treating surgeon can make to the care of patients is to take time to closely listen to their unique concerns and those of their families" (p. 203). By increasing awareness, education, and training of assessment of risk factors for PTSD among medical practitioners, the rehabilitation and plastic surgery team is ensuring patient psychosocial rehabilitation and providing a much more holistic approach by which to improve client quality of life.

References for this article can be found in the online version of the *Bulletin* published on the Division 29 website.

[*] Diagnostic criteria from *DSM-IV* are used here for consistency with the cited research. The more recent *DSM-5* (APA, 2013) conceptualization of

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PTSD distinguishes between children under 6 years of age and others; includes a broadened definition of "exposure," including directly experiencing or witnessing actual or threatened death, serious injury, or sexual violence, as well as learning that one of these types of events happened to someone with whom there is a close relationship or (for those 6 years of age and older) extreme exposure to aversive details of such an event. Updated criteria require the presence of intrusive and avoidant symptoms, negative alternations in cognitions and mood, and marked alterations in arousal and reactivity. Duration must still be greater than one month; "with dissociative symptoms" has been added as a possible specifier; and "with delayed expression" has replaced "with delayed onset."

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.

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GRATITUDE

Linda Campbell, Ph.D.
Division of Psychotherapy APA Council Representative (2011-2013)

It has taken me six weeks from the end of my Council term for our Division to be able to write this note to you, our membership. Tracey tells me to "get with it" so I am doing so. We hear the phrase, "honor and privilege" all the time anymore but I truly have in my heart only gratitude to you for allowing me to represent you and I do know this position has been an honor and privilege.

Some years ago now, I received an invitation to apply for the *Psychotherapy Bulletin* Editorship. I had been editing the *Georgia Psychologist* and thought that must be the reason I received this invitation although to this day, I don't know that for sure. When I arrived at the appointed time for the interview, I had massive handouts and analyses of the direction the *Bulletin* could go. After about ten minutes of this, Carol Goodheart, who was on the P&C Board for the Division at the time, interrupted me and said, "Just tell us how you would make the *Bulletin* reflect who we are in the Division of Psychotherapy." I was jolted out of my planned presentation into a moment of spontaneity which, as those of you who know me know, rarely happens. I found myself feeling great assurance and confidence in saying, "Psychotherapy is the heart and soul of psychology. Our division is the home of psychotherapy within APA and should take the leadership on all matters that relate to psychotherapy in the association." Apparently my handouts were not persuasive but the P&C Board was persuaded that our Division should achieve this goal. Here we are, years later, and our Division has made many strides in taking a leadership role within APA. My part in making our Division what it is today is small. There are giants in the profession walking among us in the Division and I would be foolish to begin naming them but we all know that our Division is highly respected and holds a persuasive leadership role on Council, in all areas of governance in APA and, most importantly, in decision making.

I feel the greatest satisfaction in the fact that I and the Council Representatives with whom I have served, John Norcross and Norine Johnson, have been committed to keeping the membership involved in all decisions made regarding psychotherapy. This doesn't mean reporting back to you after all decisions are made. This means consulting membership and gaining an understanding of where you want our Division to go on all matters that affect us. Your voices can then be heard in the decision making, not just through information after decision making.

I leave you in the extraordinarily capable hands of John Norcross and Jean Carter who love this division just as I do. They will always magnificently rise to the occasion to represent and advance psychotherapy. I will steadfastly remain a loyal member and activist for our beloved Division of Psychotherapy.

WASHINGTON SCENE

The Evolution Towards Integrated Care

Pat DeLeon, Ph.D.
Former APA President

A Gradually Maturing Foundation: When the Final Report of the APA Ad-Hoc Task Force on Psychopharmacology, chaired by Michael Smyer, was submitted to the Council of Representatives in November, 1992 it anticipated that: "Practitioners with combined training in psychopharmacology and psychosocial treatments can reasonably be viewed as a new form of health care professional, expected to bring to health care delivery the best of both psychological and pharmacological knowledge. The contributions of this new form of psychopharmacological intervention have the potential to improve dramatically patient care and make important new advances in treatment." Interestingly, Anita Brown, who was one of the staff liaisons, eventually joined the U.S. Army in order to become one of the first 10 military prescribing psychologists.

Training/Policy: The Task Force developed its recommendations within a framework of three levels of training and practice in psychopharmacology: *Basic Psychopharmacology Education; *Collaborative Practice; and *Prescription Privileges (RxP). Collaborative Practice (Level 2) training requires a doctoral degree and reflects the knowledge base necessary to participate collaboratively with other health care professionals in managing medications prescribed for mental disorders and integrating these medications with psychosocial treatment. Training at this level includes more in-depth knowledge of psychoactive medications and drugs of abuse, as well as knowledge of psychodiagnosis, physical assessment, pathophysiology, therapeutics, emergency treatments, substance abuse treatments, developmental psychopharmacology, and psychopharmacology research. Training for collaborative practice competence includes coursework, practica, and internship experiences. From our policy frame of reference, this would provide the necessary training for a psychologist to "functionally prescribe" in conjunction with an appropriately licensed health care provider, such as a primary care provider, Advanced Practice Nurse, or psychiatrist, which would be similar to the role that clinical pharmacists are increasingly adopting today.

Administrative/Implementation: Bob McGrath, Director of the M.S. Program in Clinical Psychopharmacology and Certificate Program in Integrated Primary Care at Fairleigh Dickinson University, provided a listing of the 16 state psychology licensing boards which have formally addressed this evolution, focusing upon "the best interest of the client/patient." California, for example, notes—"There are many psychological conditions which manifest themselves in physical symptoms. There are physical problems which have psychological symptoms as well. The best interests of the patient demand that psychologists work closely with primary care physicians and psychiatrists who are prescribing medications to the patient of the psychologist. While a psychologist's responsibility may include involvement in limited aspects of a patient's medica-

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tions, the patient's physician is the only person who may lawfully prescribe and dispense the medication for the patient [August, 1998]." District of Columbia—"A psychologist may offer a medication recommendation to the prescribing physician about a patient he or she has evaluated when such recommendation is within the boundaries of his or her competence based on his or her education, training, supervised experience, or appropriate professional experience. It is then incumbent on the physician, based upon all of the evidence before him or her, which may include the recommendations of the psychologist, to decide what, if any, medication or medical treatment to prescribe [May, 1998]." Florida—"A Florida licensed psychologist may make recommendations for medications to physicians, including psychiatrists, as well as to other health care professionals, who are granted the authority to prescribe medications [July, 1998]." Prior to the enactment of their RxP law in May, 2004, Louisiana—"It is within the scope of practice of psychology to gain competence in the field of psychopharmacology. Psychologists who gain competence in psychopharmacology may provide consultations to professionals regarding psychotropic medications [July, 1999]." The other states which Bob referenced are: Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Tennessee, Texas, and Vermont. We would be interested in learning of similar developments in other states and public/semi-public systems such as Federally Qualified Community Health Centers and state mental health programs. This can be surprisingly controversial for some of our colleagues, as I learned in addressing the Pennsylvania Psychological Association. However, in case there is any question as to whether in-depth knowledge of medications is valued by our nation's health care system, the U.S. Department of Labor reports that, among workers employed in health care occupations (not including doctors and dentists, many of whom are self-employed), the nation's 266,410 pharmacists had the highest average wages—$104,260—in May 2008. And, with over 2.5 million people employed as registered nurses, that occupation is the largest among all health care occupations. Registered nurses' wages are typically the highest of occupations with employment numbered in the millions (including occupations not related to health care).

Visionary Leadership Within the VA: "Since it began offering paid postdoctoral fellowship positions in 1994 (with eight positions across the nation), VA's Office of Academic Affiliations has continued to emphasize the importance of postdoctoral education by continuing to increase the number of available positions. By the 2013-14 academic year, the number of postdoctoral fellowship positions increased to 348 located at 62 different VA facilities in the U.S. and Puerto Rico. In addition to the general clinical psychology fellowships, many of these positions now are in specialty areas such as neuropsychology and rehabilitation psychology, while others include emphasis areas that incorporate Geropsychology, HCV & HIV Treatment, Health Psychology with an emphasis on Primary Care-Mental Health Integration, PTSD & Trauma Treatment, Psychosocial Rehabilitation and Recovery, and Women Veteran's Needs. The number of positions should be even larger for the 2014-15 year" [Bob Zeiss, VA Office of Academic Affiliations, retired].

The senior nursing leadership within the VA recently proposed a national scope of practice such that individual state nursing practice acts would not limit their ability to provide quality care. As might have been expected, there was

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"push back" from medicine alleging a "public health hazard," specifically focusing upon whether nurse anesthetists (CRNAs) should be supervised by anesthesiologists (various state statutes differ on this requirement). Ken Pope reports that more than 60 physician groups have expressed "strong concerns" that this would effectively eliminate physician-led, team-based care within the VHA. Excerpts from Secretary Shinseki's response to interested Members of Congress: "VHA is proposing the authorization of full practice by CRNAs across the Department of Veterans Affairs (VA) health care system. This policy change will enable all VA CRNAs, not just those for whom the states currently allow, to practice to the full scope of their academic preparation and training. The policy will increase access to care and ensure continuation of the highest quality of care for our Nation's Veterans, and help meet the growing demands for health care services nationwide while standardizing the scope of practice for CRNAs across VA's health care system.

"CRNAs safely administer more than 34 million anesthetics each year to patients in the United States… using all anesthetic techniques and practicing in every possible setting. Over time, CRNAs have compiled a strong record of safety. That safety record is unchanged whether the anesthesia is provided by a CRNA working independently or by a CRNA working under the supervision of a physician. The available evidence does not substantiate that independent CRNA practice presents a threat to health and safety or in any way lowers the quality of anesthesia care…. Taking into account differences in patient and procedure complexity, the study revealed that patient outcomes did not differ between the states that did not require physician supervision and states that did…. Both studies confirmed that there were no measureable differences in quality of care or patient outcomes when anesthesia services were provided by CRNAs, Anesthesiologists, or CRNAs supervised by physicians. Current VHA policy recommends that CRNAs and Anesthesiologists work together in a care team model but does not require physician supervision of CRNAs. The proposed policy supports this team-based model of care that will fully utilize the knowledge, skills, and abilities of CRNAs. As a member of the anesthesia team, CRNAs will be able to lead anesthesia teams, consult with their physician colleagues, and will receive the same professional practice review, evaluation, and monitoring as all other anesthesia providers…. The overarching goal of VHA is to provide safe, effective and timely health care. The Undersecretary for Health is aware there are differing views with regard to physician supervision of CRNAs. To that end, VHA will engage in a rulemaking process which will afford all interested parties the opportunity to comment on the proposed policy change."

The Institute of Medicine (IOM): The National Academy of Sciences (NAS) recently celebrated its 150th anniversary, having been chartered by President Abraham Lincoln in 1863 to "investigate, examine, experiment, and report upon any subject of science." In 1970 the IOM was established by the NAS to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. APA's CEO Norman Anderson was recently elected to this distinguished body. One of the hallmarks of President Obama's landmark Patient Protection and Affordable Care Act (ACA) is an increasing emphasis on provider accountability and data-based decision making. Another is fostering

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interdisciplinary collaboration within integrated systems of care. Not surprisingly, members of the IOM, in their other capacities, have been instrumental in drafting and implementing the ACA.

This winter the IOM requested nominations for a forthcoming Consensus Study on "Psychological Testing including Symptom Validity Testing (SVT)." The committee will consist of 12 members with the three underlying objectives: *Perform a comprehensive review of psychological testing, including SVT (with emphasis on the MMPI-2, TOMM, Malingering Probability Scale, Structured Interview of reported Symptoms, Validity Indicator Profile, Structured Inventory of Malingered Symptomatology, the Rey's 15-Item-Test (FIT), and Portland Digit Recognition Test. *Determine the relevance of psychological testing, including the SVT, to disability determinations in claims involving physical or mental disorders; and *Provide guidance to help adjudicators interpret the results of psychological testing, including SVT. The study is being sponsored by the Social Security Administration with the goal of addressing and improving the agency's policies and processes related to disability claims. Experts in fields such as neuropsychology, psychiatry, psychology, cognitive rehabilitation, health care cost/benefit analysis, and health service systems are being sought. The committee will be exploring multiple questions under six subgroups: *Use of Psychological Testing, including SVT; *Testing Norms; *Qualifications for Administration of Psychological Testing, including SVT; *Administration of SVT Testing, including SVT; *Reporting Results; and *Use of Psychological Testing, including SVT, in the Disability Evaluation process.

Our Colleagues in Nursing and Pharmacy have long appreciated the importance of the IOM's deliberations to the quality of health care provided in our nation and to their professions' future. At the Uniformed Services University of the Health Sciences (DoD), I enjoy teaching a small health policy class for nursing and psychology graduate students. "Since the launch of the IOM in 1970, nurses have been members of the IOM with an even greater number having served on IOM boards, committees, forums, and roundtables. Since 1973, when the IOM began serving as the National Program Office for the Robert Wood Johnson Foundation (RWJ) Health Policy Fellows initiative, nurses have been part of this interdisciplinary program to participate in health policy formulation at the highest levels of government.

"Since 1992 the IOM has hosted the Distinguished Nurse Scholar-in-Residence program. Supported by the American Academy of Nursing, the American Nurses Foundation, and the American Nurses Association, this residential program has been supporting nurse leaders in playing a more prominent role in health policy development at the national level through a 1-year program of orientation (scholars join the RWJ Health Policy Fellows' orientation in the Fall) and study at the IOM. The scholar produces a report as a result of working on a current IOM initiative related to his/her area of expertise. This year's Distinguished Nurse Scholar-in-Residence for 2013-14 is Beatrice Kalisch, Director of Innovation and Evaluation and Titus Professor of Nursing at the University of Michigan. She brings extensive experience in quality of care and patient safety. She will also be working on the upcoming IOM study of diagnostic errors. The 2012-13 Distinguished Nurse Scholar-in-Residence, Marla Salmon—an IOM member and the immediate past Dean of the University of

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Washington School of Nursing—will continue her role as resident scholar. Her work is focusing on three areas of policy and scholarship: *Global nursing workforce capacity building; *Women's development aimed at enhanced educational and economic wellbeing; and *Social impact investment and microfinance as mechanisms for reducing barriers to women's education and subsequent sustained economic engagement" [Marie Michnich, former RWJ Fellow who served with Senator Bob Dole for three years]. The 2003 Scholar was Angelia McBride, a fellow Purdue University psychology graduate; the 2006 Scholar was Ada Sue Hinshaw, Dean of the Daniel K. Inouye USUHS School of Nursing, where I serve as a Distinguished Professor.

A frequent discussant for my class, Lucinda Maine, Executive Vice President of the American Association of Colleges of Pharmacy (AACP), shared her profession's appreciation for the long term importance of public policy involvement and the IOM. "IOM member J. Lyle Bootman, Dean of the University of Arizona College of Pharmacy and 2012-13 President of the AACP, challenged his members to 'Get to tables of influence' to insure that pharmacists' roles in improving health and health care could be maximized. He did not overlook the power of the IOM tables in implementing his own recommendation. With resources from AACP and other organizations, a fellowship was endowed in the IOM Anniversary Fellowship Program. Every other year in perpetuity a pharmacist from academia, practice or both will be selected to serve as the Pharmacy Fellow at IOM. Over two years they attend IOM meetings, work to support study committees, forums and other IOM groups. Dr. Sam Johnson, affiliated with the University of Colorado in Denver and a leader in pharmacogenomics at Kaiser's Rocky Mountain Health System, assumed the position of inaugural fellow in October 2012 and will complete his experience in October 2014. He describes his experience as nothing short of 'life changing.' It is clear that he has made an important imprint on the work of the IOM as well."

A Sea Change in Orientation: The conference agreement for the Fiscal Year 2014 Consolidated Omnibus Appropriations bill, which President Obama has now signed into public law, contains an intriguing directive for the Substance Abuse and Mental Health Services Administration. "The agreement provides for a new five percent set-aside for the Mental Health Block Grant. The set-aside is for evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, as proposed in Senate Report 113-71. It is expected that in implementing this set-aside, SAMHSA will collaborate with NIMH to develop guidance to States so that funds are used for programs showing strong evidence of effectiveness. It is expected that SAMHSA and NIMH brief the House and Senate Appropriations Committees on implementation status of this set-aside no later than 90 days after enactment of this act."

Those fortunate to attend the annual Practice Directorate State Leadership Conferences (SLC), which in my judgment are one of the highlights of the APA year, have recently been exposed to the vision of Art Evans, Commissioner of the Department of Behavioral Health and Intellectual disability Services for the City of Philadelphia. Art has been singularly focused on the transformation of the city's large behavioral health system. This involves hundreds of millions of dollars, hundreds of employees,

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tens of thousands of service recipients and ensuring a safety net for a city of 1.5 million people. The transformation of the behavioral healthcare system is focused on recovery and resilience outcomes and has required working at multiple levels and domains simultaneously. For example, the department has invested heavily in empirically supported treatments and has formed partnerships with clinical researchers such as Aaron Beck, M.D., and Edna Foa, Ph.D., to do large-scale implementations of evidence based practices. Simultaneously, Art and his colleagues have used financial incentives to improve provider performance, developing performance metrics for 90% of their service system. In addition to improving clinical service delivery, much of their focus has been on nonclinical strategies that they believe are essential to helping people achieve the best possible outcomes. Philadelphia has one of the most robust peer programs in the nation, training and deploying hundreds of people in recovery from mental health and addiction problems throughout their system from acute inpatient settings to assertive community treatment teams. Community work also includes working with members of diverse faith backgrounds who can support recovering people within their congregations and working with indigenous community leaders from immigrant groups to develop alternative pathways into treatment, as well as culturally-responsive support services. Art firmly believes that the next frontier for behavioral health is the adoption of a public health framework and strategies to address the psychological health of people.

Enjoyable/Intriguing Journeys: Since retiring from the U.S. staff after 38+ years with Senator Inouye, I have become increasingly intrigued by the experiences of colleagues who have "retired" from their previous employments. "If your Oregon tour schedule allows time I would be pleased to share coffee or a meal. I live in The Dalles, which if you check your map, is in the Columbia River Gorge. We are about 85 miles from Portland going East on I-84. It is probably the most scenic Interstate route in the nation and includes Multnomah Falls, Angel Falls, Bonneville Dam, etc., etc., etc. It is an easy, wonderful drive. We spend about eight months in The Dalles and four months in Yuma. We travel frequently. In retirement I travel, hunt, fish, volunteer on Veterans Issues, 4-wheel the desert southwest, and write. I am rewriting a book entitled '20th Birthday' which is a diary of my time in combat in Vietnam and its aftermath in my life. The first edition can be found on Amazon and Kindle. It is a good journey and lots of life continues after retirement when we are no longer defined by what we do but who we are" [Pat Stone, former APA Congressional Fellow]. Over the years we have also come to appreciate how personal the public policy world can be. Judith Glassgold, who is director of the APA Congressional Fellowship program and a former APA Congressional Fellow herself, reports that this year's Fellows Irina Feygina will serve with Senator Bennet focusing on environment, energy, and disaster relief issues while Joshua Wolff will be in the Policy Health Office of the Senate HELP Committee, working with Jenelle Krishnamoorthy, a former Congressional Fellow. Aloha.

Armand Cerbone, Ph.D.

During my five years as the Division's secretary, our Board transformed its structure to address the realities of heathcare in this country, new demands in psychotherapy education and research, and the press of a changing APA and membership. We added seats to provide greater participation in the leadership of the division while organizing each seat around revitalized values and mission.

We are now a much more diverse board than we ever were. We are more varied in age, race, ethnicity, expertise, and professional specialty. Our leadership now mirrors our membership in ways it never has. At the same time, our diversity is enriching our single-minded commitment to the advancement of psychotherapy as a science, discipline, and profession. This is evident in our deepening ties with leaders in psychotherapy research within and without APA and in our advocacy for patient access to quality care. We remain highly invested in getting as many well-trained, culturally competent psychologists as we can into a healthcare system that cannot meet present and coming demands for appropriately trained psychotherapists.

After three years as the Social Justice and Public Policy Domain Rep, I now seek the chance as President-elect to lead and shape and execute 29's pledge to improve access to care that is based on the best evidence available. I want to I extend our collaborations with divisions and professional groups that share this goal. Contacts are already in development. The emphasis in recent years to strengthen our research agenda and programs needs to continue. Expanding our efforts to position psychologists in the healthcare marketplace is also critical. Ensuring that everybody who seeks psychotherapy services or needs them can find a competent psychologist to provide them or to volunteer them or to advocate for them will remain a high priority.

Also, I would like to expand on our present Board teambuilding efforts. These include our triennial diversity training workshops and would create retreat-like discussions led by Domain reps of concerns, mission, and needs. Preferring product-oriented deliberations, I would expect our efforts to produce a consensus of agenda and initiatives that maximize our resources that would have meaning and value for our members.

I stand on a 30-year record of credible, effective, and trustworthy leadership in psychology. I have held a number of positions, both elected and appointed, at every level of governance in APA and in my state association, including the APA Board of Directors. I have co-authored major APA policies including those on same-sex marriage and families, and launched a successful presidential initiative for mandatory continuing education for psychologists in Illinois. I am a fellow of seven divisions, including Division 29, hold the ABPP diplomate in clinical psychology, and had received major awards from several divisions in APA, including a Presidential Citation for my work in LGBT psychology.

I wish to express here my great thanks and appreciation in being nominated to run for president elect of division 29. It is also with great humility that I ask for your vote. ■

Frederick T.L. Leong, Ph.D.

I am Professor of Psychology and Psychiatry at Michigan State University and Director of the Consortium for Multicultural Psychology Research. If elected, in addition to maintenance activities which are essential, my presidential project will be to design an integrated research and practice framework for promoting evidence-based practice in cross-cultural psychotherapy. I think that such a project is important given the increasing diversity of our client population. I am co-editor of a forthcoming volume on the topic entitled *Culturally Informed Evidence Base Practices for Ethnic Minorities: Challenges and Solutions* (APA Books). In 2006, I co-guest edited a special issue of *Psychotherapy* on *Culture, Race, Ethnicity in Psychotherapy*.

My major research interests in cross-cultural psychopathology and psychotherapy, cultural and personality factors related to work adjustment, and occupational stress cut across many Divisions. I am a Fellow of Divisions 1, 2, 5, 12, 17, 29, 45, and 52 of APA as well as APS, AAPA and the International Academy for Intercultural Research. I have authored or co-authored over 280 journal articles and book chapters and edited or co-edited 18 books, including the recent *APA Handbook of Multicultural Psychology*. I am the Founding Editor of the *Asian American Journal of Psychology* and was recently appointed as Associate Editor of the *American Psychologist*. According to Google Scholar, I have 7,419 citations to my research work and my h-index is 51.

In terms of my governance experience, I am Past President of APA's Division 45, the Asian American Psychological Association, and Division 12 Section VI of APA. I also founded the Counseling Division within IAAP and served as its first President. I am a recipient of the APA Award for Distinguished Contributions to the International Advancement of Psychology and the Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology from APA's Division 12. In 2013, I received the APA Award for Distinguished Service to Psychological Science. Within APA governance, I have served on the following boards and committees: CEHR, CIRP, CPTA, BSA, MFP, CEMRRAT2, and Membership (current board). Due to my breadth of experience I was appointed to the APA Good Governance Task Force (2010-2013).

Both personally and professionally, I believe in setting SMART goals: Specific, Measureable, Achievable, Results-focused, and Time-bound. As President-Elect, I would be formulating these SMART goals in consultation with the Board and others for completing my project. The time-bound aspects is a given since all Presidents serve three years on the Board. Due to time and space limitations, I will be able to share only a few of these goals which are in the early stages of formulation: (a) assemble a task force to prepare the integrated framework to be used to guide research and practice, (b) presenting the task force report at the 2016 convention, (c) use the task force report recommendations to guide and incorporate content into convention programming and other divisional activities, (d) publishing the task force report in either the *American Psychologist* or *Psychotherapy* or some other relevant journal outlet to be followed by press releases. ■

Barry Farber, Ph.D.

A quick biography: I received my BA from Queens College in 1968, a masters degree in Developmental psychology from Teachers College (Columbia University) in 1970, and my PhD in clinical-community psychology from Yale University in 1978. I've been a full-time faculty member of the clinical psychology program at Teachers College (TC) since 1979, beginning as an Assistant Professor and now as Full Professor. I was Director of Clinical Training at TC from 1990-2011, and along the way I also served two stints as Department Chair.

I'm a strong believer in the science-practitioner model and have been both a researcher and practitioner for over 35 years. My early research focused on the effects of psychotherapy on the therapist, including therapists' vulnerability to stress and burnout, and the nature of disclosure in psychotherapy (among clients, therapists, supervisees, and supervisors). More recently, I've studied the role of positive regard in therapy, as well as the nature of interpersonal disclosure across newer technologies and social networking sites (e.g., Facebook). Since 2012, I've served as editor of the *Journal of Clinical Psychology: In Session*. In addition to the time I spend on research, teaching, editing, and serving as Secretary of this Division (over the past three years), I've maintained a small private practice of therapy.

I've enjoyed serving as secretary of this Division over the past three years—getting to know better the needs and members of the Division and the ways of APA—and so am re-running for this office. My sense is that it's enormously important for Division 29 to continue to serve the multiple needs of the psychotherapy community, and to be heard and heard well among the many voices within APA. ■

Nancy L. Murdock, Ph.D.

I am honored to be nominated for the position of Secretary of the Division of Psychotherapy. I have been a member of the division for quite some time and highly value the integrative nature of our efforts to advance psychotherapy in multiple contexts. If elected, I promise to fulfill the duties of the secretary with enthusiasm and also to devote my energy to furthering the mission of the division in all ways possible. Division 29 is a unique and valuable meeting place for psychologists who are committed scholars and practitioners of psychotherapy and I look forward to possibly contributing to its continuance and growth. ■

Rosemary Adam-Terem, Ph.D.

I am running as a candidate for the Domain Representative for Public Policy and Social Justice. I would like to introduce myself and humbly ask for your vote.

I have been a practicing psychotherapist in Honolulu, Hawai's for over 20 years and have been active in our state psychological association (HPA) for even longer. I teach clinical classes occasionally as an adjunct faculty member at the University of Hawai's Psychology Department. I am a past president of HPA, where I also chair the Ethics and the CE/Convention committees. In APA, I was a Council representative (2005-7), served as member and co-chair of the Rural Health Committee, and currently serve on the Continuing Education Committee.

I was the Domain Representative for Public Policy and Social Justice (PPSJ) from 2010-2012 and have chaired the PPSJ Committee since then. I also chair the division's continuing education committee.

I feel that Division 29 is my "home" in APA. I know that our current president Ray Di Giuseppe is very enthusiastic about working for social justice, and our committee is looking forward this year to working more closely with him and the current PPSJ Domain Representative Armand Cerbone.

We see issues of social justice and public policy as central to the work of the Division in supporting psychotherapy, research, psychotherapists, and our clients. If elected, I would strive to work collaboratively within the Division with other Domains, and with other interested APA Divisions. There are many issues to address, not least of which are health disparities, access, and the evolution of the healthcare system and psychotherapy's place within it.

I would be pleased and honored to be elected to work with the Board on issues of importance to the psychotherapy community in the realm of public policy and social justice. ■

Stephanie Budge, Ph.D.

Stephanie Budge, PhD is an assistant professor of Counseling Psychology at the University of Louisville. She received her master's degree in educational psychology from the University of Texas at Austin and her PhD in counseling psychology from the University of Wisconsin-Madison. Her research focuses on psychotherapy process and outcome and lesbian, gay, bisexual, trans, and queer (LGBTQ) issues. She has received several grants and conducted numerous research studies that focus on emotional and coping processes for trans individuals. She was the first recipient of the American Psychological Association's Division 44 Transgender Research Award which resulted in the first publication on trans individuals in the *Journal*

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of Clinical and Counseling Psychology. She was also the first recipient of the Division 29 Charles J. Gelso Psychotherapy Grant, which resulted in the publication of two meta-analyses on the efficacy of psychotherapy for personality disorders. She currently serves as the associate editor for *Psychotherapy*, after having been on the editorial board for three years. She provides clinical trainings nationally and internationally related to trans issues, focusing on practitioners' self-efficacy, knowledge, awareness, and skills when working with the trans population. At the University of Louisville, she promotes LGBTQ activism on campus by providing workshops to students related to coping with difficulties coming out and navigating identity while adjusting to college. She currently serves as the advisor to the transgender student group, *Transformations* and chairs an ad-hoc committee committed to ensuring that bathrooms on campus are visibly friendly and accessible spaces for all students. For her activism efforts, she received the APA Division 17 LGBT Outstanding Community Contributions award from the Society for Counseling Psychology. She also currently works in private practice, specializing in work with LGBTQ clients. ■

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.

Libby Nutt Williams, Ph.D.

I was honored to be asked to run for Council Representative for Division 29. Division 29 is comprised of a great variety of individuals. However, there is one common element among Division 29 members—we are passionate about psychotherapy and would like to ensure that issues relevant to psychotherapy (practice, research, education, advocacy) are attended to at all levels of the APA.

My leadership in Division 29 began as the Early Career representative to the Board of Directors in 2005. I was then e-elected as the Membership Domain Representative (2008-2010). I became President of the Division in 2011. During my time on the Board, I remained focused on a few key issues: 1) clarifying our divisional identity, 2) strengthening the link between psychotherapy science and practice, and 3) promoting tangible evidence of our commitment to diversity and multiculturalism. I was proud to be part of the Division's strategic planning and delineation of seven guiding principles (see Williams, Barnett & Canter, 2013) and the adoption of our new Diversity Grant

In my professional work, I have been a dean at a public honors college for the last seven years and am a professor of psychology. My primary areas of research include psychotherapy process research, feminist multicultural counseling, and qualitative methodology. I am excited that my most recent book (the 3rd edition of the text *Counseling Psychology* with Charlie Gelso and Bruce Fretz) is coming out this April. My other recent book is the *Oxford Handbook of Feminist Multicultural Counseling Psychology* with Carol Enns (2012).

I care deeply about the Division and about our flagship journal *Psychotherapy*, and I would be delighted to be the third Council Rep for 29. I see leadership as service and would be happy to serve the membership of Division 29 again. Thank you for your consideration. ■

Jeffrey J. Magnavita, Ph.D., ABPP

It is an honor to be nominated for Council Representative of the Division of Psychotherapy of which I have been a member for over three decades. If elected to serve the membership of D29, I will continue to advocate for the advancement of psychotherapy and clinical science. I will endeavor to insure that psychotherapy continues to be recognized as the most effective treatment for most behavioral and mental health disorders, as well as relational disturbances. I previously (2010) served as the President of the D29, and during my term I am proud that a task force was created to explore and document the empirical evidence on the effectiveness of psychologists who practice psychotherapy. As a result, the division initiated a research award for investigators to explore this issue. Currently, I serve as the Vice-Chair of the *Clinical Practice Guidelines Advisory Steering Committee*

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and am the producer of the video series *Psychotherapists Face-to-Face*, featured on our website. I have also served APA in a variety of capacities over the years and look forward to the opportunity to advocate for psychotherapy as your representative on council. I am intimately aware of the challenges that face us while we deliver quality care, teach, and conduct research. I am full-time practitioner licensed in both Connecticut and Massachusetts. I have hospital and university affiliations and am a lecturer in Psychiatry at Yale. Psychotherapy is practiced by most psychologists but is not as accessible to many seeking treatment. While we are cognizant of the fact that psychotherapy is effective and should be a part of mental health and preventative care, there has been an alarming trend over-emphasizing pharmacological treatment. APA needs our council representatives to ensure that our voice is heard and the advancement of psychotherapy is represented in our evolving health care system. ■

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

DIVISION 29 PSYCHOTHERAPY

Of the American Psychological Association (APA)

CHARLES J. GELSO, PH.D., PSYCHOTHERAPY RESEARCH GRANTS

Brief Statement about the Grant:
The Charles J. Gelso, Ph.D., Psychotherapy Research Grants, offered annually to graduate students, predoctoral interns, postdoctoral fellows, and psychologists (including early career psychologists), provide three $5,000 grants toward the advancement of research on psychotherapy process and/or psychotherapy outcome.

Eligibility: All graduate students, predoctoral interns, postdoctoral fellows, and doctoral-level researchers with a promising or successful record of publication are eligible for the grant. The research committee reserves the right not to award a grant if there are insufficient submissions or submissions do not meet the criteria stated.

Submission Deadline: April 15, 2014

REQUEST FOR PROPOSALS

CHARLES J. GELSO, PH.D. GRANT

Description
This program awards grants for research projects in the area of psychotherapy process and/or outcome.

Program Goals
- Advance understanding of psychotherapy process and/or psychotherapy outcome through support of empirical research
- Encourage talented graduate students towards careers in psychotherapy research
- Support psychologists engaged in quality psychotherapy research

Funding Specifics
Three annual grants of $5,000 each to be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities. A researcher can win only one of these grants. (see *Additional Information* section below).

Eligibility Requirements
- Demonstrated or burgeoning competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The same project/lab may not receive funding two years in a row
- Applicant must be a member of the Division of Psychotherapy. Join the Division at www.divisionofpsychotherapy.org

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REQUEST FOR PROPOSALS, continued

Evaluation Criteria
- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Proposal Requirements for All Proposals
- Description of the proposed project to include, title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal. This will be a blind review so please exclude identifying information.
- Timeline for execution (priority given to projects that can be completed within two years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)
- No additional materials are required for doctoral level psychologists who are not postdoctoral fellows
- Graduate students, predoctoral interns, and postdoctoral fellows should refer the section immediately below for additional materials that are required.

Additional Proposal Requirements for Graduate Students, Predoctoral Interns, and Postdoctoral Fellows:
- Graduate students, pre-doctoral interns, and postdoctoral fellows should also submit the CV of the mentor who will supervise the work
- Graduate students and pre-doctoral interns must also submit 2 letters of recommendation, one from the mentor who will be providing guidance during the completion of the project and this letter must indicate the nature of the mentoring relationship
- Postdoctoral fellows must submit 1 letter of recommendation from the mentor who will be providing guidance during the completion of the project and this letter should indicate the nature of the mentoring relationship

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REQUEST FOR PROPOSALS, continued

Additional Information

- After the project is complete, a full accounting of the project's income and expenses must be submitted within six months of completion
- Grant funds that are not spent on the project within two years must be returned
- When the resulting research is published, the grant must be acknowledged
- All individuals who directly receive funds from the division will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st)

Submission Process and Deadline

- All materials must be submitted electronically
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours, which will provide you with an assigned application number. If you do not receive confirmation, your proposal was not received; please resubmit.

DEADLINE: APRIL 15, 2014

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Cheri Marmarosh at cmarmarosh@gmail.com), or the incoming Division of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at woodhouse@lehigh.edu), or Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net.

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT
for Early Career Psychologists

Brief Statement about the Grant:
The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually to Early Career Psychologists (within 10 years of earning the doctoral degree), provides $10,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes, including type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Eligibility: Early Career (within 10 years of earning the doctoral degree) Doctoral-level researchers with a successful record of publication are eligible for the grant.

Submission Deadline: April 15, 2014

Request for Proposals

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

Description
This program awards grants for research on psychotherapist factors that may impact treatment effectiveness and outcomes, including type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

Program Goals
- Advance understanding of psychotherapist factors that may impact treatment effectiveness and outcomes through support of empirical research
- Encourage researchers with a successful record of publication to undertake research in these areas

Funding Specifics
- One annual grant of $10,000 to be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see *Additional Information* section below).

Eligibility Requirements
- Early Career (within 10 years of earning the doctoral degree), Doctoral-level researchers
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years

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- The selection committee may choose not to award the grant in years when no suitable nominations are received
- Researcher must be a member of the Division of Psychotherapy. Join the division at www.divisionofpsychotherapy.org

Evaluation Criteria
- Conformance with goals listed above under "Program Goals"
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant's competence to execute the project
- Appropriate plan for data collection and completion of the project

Proposal Requirements for All Proposals
- Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal. This will be a blind review so please exclude identifying information.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

Additional Information
- After the project is completed, a full accounting of the project's income and expenses must be submitted within six months of completion
- Grant funds that are not spent on the project within two years of receipt must be returned
- When the resulting research is published, the grant must be acknowledged by footnote in the publication
- All individuals directly receiving funds from the division will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st)

Submission Process and Deadline
- All materials must be submitted electronically

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- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net
- You will receive an electronic confirmation of your submission within 24 hours, which will provide you with an assigned application number. If you do not receive confirmation, your proposal was not received. Please resubmit.

Deadline: April 15, 2014

Questions about this program should be directed to the Division of Psychotherapy Research Committee Chair (Dr. Cheri Marmarosh at cmarmarosh@gmail.com), or the incoming Division of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at woodhouse@lehigh.edu), or Tracey A. Martin in the Division 29 Central Office, assnmgmt1@cox.net.

AMERICAN PSYCHOLOGICAL FOUNDATION

AMERICAN PSYCHOLOGICAL ASSOCIATION DIVISION OF PSYCHOTHERAPY (DIVISION 29)

DIVERSITY RESEARCH GRANT FOR PRE-DOCTORAL CANDIDATES

The Diversity Research Grant for pre-doctoral candidates is established to foster the promotion of diversity within Division 29 and within the profession of psychotherapy.

The Division may award annually a $2,000 Diversity Research Grant to a pre-doctoral candidate (enrolled in a clinical or counseling psychology doctoral program) who is currently conducting research that promotes diversity, as outlined by the American Psychological Association (APA). According to the APA, diversity is defined as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status.

The Diversity Research Grant is expected to be used to support the completion of a pre-doctoral candidate's dissertation work. The grant may be used to fund: (1) supplies used to conduct the research; (2) training needed for completion of the research; and/or (3) travel to present the research (such as at a professional conference). The applicant must be a student member of Division 29 or commit to becoming a student member if the award is made. The recipient of the grant will be expected to present his or her research results in a scholarly forum (e.g., presentation at an APA Annual Convention, the Division 29 Journal, *Psychotherapy*, or other refereed professional journal) and acknowledge the award.

One annual grant of $2,000 will be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities. All grant recipients will be required to complete an IRS form W-9 before funds are issued.

A complete application must be submitted by email to <u>both</u> Diversity Domain Representatives:

Beverly Greene, PhD (bgreene203@aol.com) or
Jairo N. Fuertes, PhD (Jfuertes@adelphi.edu)

by midnight, April 15, 2014.
Incomplete or late application packets will not be considered.

The application must include:

- A 1-2 page cover letter describing how the applicant's work embodies the Division's interest in promoting diversity in the profession of psychotherapy and how the funding will be used to support the applicant's dissertation work;
- A 1-page document outlining a detailed budget;
- A 5-10 page research proposal (alternatively, a Dissertation Proposal may

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be submitted, preferably less than 30 pages not including references or appendices);
- 1 letter from the applicant's dissertation advisor or director of clinical training certifying that the applicant is currently in the process of completing research for the dissertation.

Once a complete application has been received (on or before the deadline), selections will be made using the following criteria:
- Consistency with the Diversity Research Grant's stated purposes;
- Clarity of the written proposal;
- Scientific quality and feasibility of the proposed research project;
- Budgetary needs for data collection and completion and presentation of the project;
- Potential for new and valuable contributions to the field of psychotherapy; and
- Potential for final publication or likelihood of furthering successful research in topic area.

Additional Information
- After the project is complete (do we specify the length of the project, 2 years for example), a full accounting of the project's income and expenses must be submitted within six months of completion.
- Grant funds that are not spent on the project within two years must be returned.
- When the resulting research is published, the grant must be acknowledged.
- All individuals who directly receive funds from the division will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31st).

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