

THE CLINICAL PSYCHOLOGIST



A publication of the Society of Clinical Psychology (Division 12, American Psychological Association)

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PRESIDENT'S COLUMN

Home



By David F. Tolin, Ph.D., APBB



Autumn always makes me think of home. And this year, autumn has a double meaning for me, as it also signals that I am nearing the end of my term as President of the Society at the end of this year. It's got me thinking about what a professional "home" ought to be.

Home should serve our needs. As clinical psychologists, we should be able to rely on our professional home to give us information about the best that our science and practice have to offer. Of course, we have always had our flagship journal, *Clinical Science and Practice*, as a great source of information. We are also taking some new and bold steps this year - as a major example, the Committee on Science and Practice, headed by Evan Forman, along with our Web Subcommittee, headed by Damion Grasso, is about to unveil a completely new format for how we disseminate ESTs to practitioners and the public. Our web site (www.div12.org) will shortly provide you not just with a list of ESTs, but also training manuals, links to training opportunities, journal articles, therapy videos, and more. It's intended to become a "one-stop shopping" site for everything you need to get started with a particular treatment. We're also about to open a Clinician's Directory, in which our practicing members can let the public know that they belong to the Society. Those practitioners who are skilled in ESTs will have the opportunity to make that publicly known as well; this is the first directory of which I am aware in which consumers looking for a particular treatment will be able to find a practitioner in their area who practices it.

Home is also a place where we feel welcome, with a sense of camaraderie and shared purpose. It's a source of professional identity. I'm a member of many professional societies; perhaps you are too. But first and foremost, I identify myself as a clinical psychologist. And the Society of Clinical Psychology is where the clinical psychologists go to exchange ideas, debate issues, and collectively try to shape the field and move our discipline forward. There is no other professional organization that can lay claim to that. We've been working hard to invite more people into our home this year. Over the last decade, our Society's ranks have been decreasing, despite no change in the number of clinical psychologists in APA (Tolin, 2012). Under the leadership of Marc Hillbrand, our Membership Committee is working to reverse that trend by attracting and retaining a new crop of students and early career psychologists through a series of social networking events around the country and at various conferences.

Home should also energize you. It should be stimulating, and make you want to get involved. We have exciting things going on, and people are engaging. As one example, a group

(Continued on page 2)

President's Column (*continued*)

of us have been working over the year on a proposal for a new classification system for ESTs. The original criteria for ESTs (Chambless et al., 1998), developed 20 years ago, were highly influential, but several valid critiques have been made of the system. The criteria are overdue for an update. More to come on this later, but in brief, we propose to develop a system that parallels that proposed by the APA Task Force on Evidence-Based Treatment (Hollon et al., 2014), yet aiming for more

rapid dissemination of results. The outdated classifications of “probably efficacious” and “well established” will be replaced by specific recommendations using a modification of the GRADE system (e.g., Guyatt et al., 2008), which has been adopted by many other prominent healthcare organizations. In collaboration with Section 3 (Society for a Science of Clinical Psychology), the Society has addressed weaknesses in APA’s system for approving sponsors of continuing education pro-

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GRAPHIC DESIGN

Jason Crowtz



grams, and APA seems to be listening. We're initiating several Special Interest Groups, under the able direction of Natalia Potopova, for our members to have more focused discussions about specialized topics, including application of evidence based treatments in practice, teaching of clinical psychology, and being a clinical supervisor.

And, sadly, sometimes people leave home. Our Administrative Officer, Lynn Peterson, will be retiring at the end of the year. Lynn has been with our Society since 1995, and for many of us her name has become synonymous with Division 12. Lynn has handled every administrative aspect of the Division, from scheduling board meetings to managing the listserv to preparing budgets to chasing down the Sections for their tax returns... the list goes on and on. She has also, over the years, had to contend with some colorful personalities and egos (who, us?), and has done so in a truly masterful fashion. I, for one, know that I could not have accomplished much during my term as President had she not been there to guide me. She leaves some very big shoes to fill, and she will be missed.

Thank you all for the privilege of serving this wonderful Society.

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CONGRATULATIONS



The Society of Clinical Psychology congratulates **John Linton, Ph.D.**, for being appointed the **Associate Vice President for Health Sciences** and **Campus Dean** of the **West Virginia University School of Medicine**.

Dr. Linton has been a leader in psychological education and training, and has shown exemplary dedication and leadership at WVU. We're proud of you, John!

The Quality of Empirically Supported Treatment Studies

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Muyu H. Lin, Fangfang Shangguan,
and Nicola Petrocchi

Boston University, Department of
Psychological and Brain Sciences

Objective: *The list of empirically-supported treatments by the Division 12 of the APA has generated a great deal of controversy. Using a method recommended for meta-analytic studies, we examined the methodological quality of 18 studies that formed one of the original lists of empirically supported treatments for adult disorders.*

Method: *Two independent raters evaluated these studies using an established quality rating tool.*

Results: *The two raters showed moderate and acceptable agreements. The quality standard was judged to be strong for 9, moderate for 8, and weak for only 1 of the 18 studies.*

Conclusion: *The methodological quality of the studies examining the efficacy of empirically supported treatments is generally high.*

KEY WORDS: EMPIRICALLY SUPPORTED TREATMENTS, QUALITY OF STUDIES, RISK OF BIAS, CLINICAL TRIALS.



In 1995, the Division of Clinical Psychology of the APA published a Task Force on Promotion and Dissemination of Psychological Procedures (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The goal of the Task Force was to identify effective treatments for particular disorders based on current evidence, and to make recommendations on more effective ways to disseminate these approaches. For this purpose, treatments were classified into the categories “well established treatments,” “probably efficacious treatments,” and “experimental treatments.” A particular treatment was classified into the category “well-established” if either one of the following two criteria were met: (1) at least two experimental clinical trials, conducted by different investigators, demonstrating the efficacy of treatment (the treatment must have been either equivalent to an already established treatment or superior to pill, psychological placebo, or to another

treatment); or (2) a large series of single case design studies demonstrating efficacy of the treatment. Furthermore, the intervention had to be specified in treatment manuals, and characteristics of the client samples must have been clearly delineated.

In the original 1995 report, the Task Force published the criteria for selecting the treatments and a preliminary list of treatments that met these criteria. As noted by Chambless and Ollendick (2001), this list was initially constructed to allow the survey of clinical directors to demonstrate that treatments meeting these criteria could be identified. In a subsequent report, the Task Force expanded the list, which included 18 trials that were conducted with adult populations (Chambless et al., 1998). The list was further expanded in 1998 (Chambless et al., 1998; Chambless & Ollendick, 2001) and is now updated on a continual basis on APA’s Division 12 website. Most of the controversy surrounding the purpose, selection procedure, and methodological evaluation of the studies erupted with the publication of the first and second publication of the empirically supported treatment (EST) list (Chambless & Ollendick, 2001; Crits-Christoph, Frank, Chambless, Brody, Karp, 1995).

High-quality clinical trials are widely accepted in medicine as the gold standard for assessing treatment efficacy. Although, as discussed below, there is good conceptual agreement about what constitutes a well-conducted trial, ambiguity about the state of empirical research still exists and creates a significant problem for training and practice in the mental health fields (Westen, Novotny, & Thompson-Brenner, 2004). Therefore, an objective evaluation of the methodological quality of the clinical psychotherapy trials that form the basis for the list of empirically supported treatments is a crucial missing piece in this ongoing debate.

The issue of methodological quality of studies is a well-known problem in the evaluation of clinical trials (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012; Hróbjartsson, Boutron, Turner, Altman, & Moher, 2013; Lundh, & Gotzsche, 2008; Moher, Tetzlaff, Ricco, Sampson, & Altman, 2007; Moher, Liberati, Tetzlaff, Altman, 2009; Thomas, Ciliska, Dobbins, & Micucci, 2004). Commonly discussed quality assessment methods in meta-analyses are the Jadad scales (Jadad et al., 1996), the Cochrane

Collaboration Risk of Bias Tool (Lundh & Gotsche, 2008), and the Effective Public Health Practice Project Quality Assessment Tool (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012). Although the Jadad scales are frequently used measures in pharmacological trials, they show a number of weaknesses (Lundh & Gotsche, 2008). For example, the scales place greater focus on the quality of reporting than on methodological quality. Moreover, they do not address blinding of therapists or intention-to-treat analysis, and they show low inter-rater agreement.

The Consolidated Standards of Reporting Trials (CONSORT) statement has been widely adopted by most major medical journals. However, the CONSORT checklist is designed to primarily assess studies of pharmacological or medical interventions, failing to adequately assess the psychotherapy literature. For example, the checklist does not examine aspects specific to psychotherapy trials, such as adherence to the treatment, and quality and credibility of comparison treatments.

The development of the Cochrane Collaboration Risk of Bias Tool (CCRBT) represents a shift away from the assessment of methodological quality of included studies using scales, and towards an evaluation of the risk of bias in the results of each study through a domain-based evaluation. The CCRBT examines the generation of the allocation sequence, concealment of the allocation sequence, blinding (of participants, personnel, and outcome assessment), incomplete outcome data, selective outcome reporting, and other biases (Higgins et al., 2011). This tool, however, is associated with low inter-rater agreement rates because of the subjective nature of several domains (Hróbjartsson, Boutron, Turner, Altman, & Moher, 2013).

In contrast, the Effective Public Health Practice Project rating system (EPHPP, Thomas et al., 2004) showed higher inter-rater reliability than CCRBT while assessing similar aspects of a trial (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012). Therefore, the most suitable measure to examine quality of psychotherapy trials to date appears to be the EPHPP, which examines selection bias, study design, confounding variables, blinding, data collection methods, drop-outs, intervention integrity, and appropriateness of analysis to the study question.

Based on these considerations, our objective was to examine the methodological quality of studies that

comprise the list of ESTs using the EPHPP rating system. We specifically focused on the second publication of the EST list (Chambless et al., 1998).

Methods

Quality Assessment of Studies

To evaluate the quality of the studies, we used the Effective Public Health Practice Project rating system (EPHPP, Thomas et al., 2004). Two trained independent assessors judged the quality of each trial using the following domains (Thomas et al., 2004): (1) selection bias; (2) study design (i.e., to what extent trials were randomized and/or controlled); (3) confounders; (4) blinding; (5) data collection methods (i.e., self-report, assessment, physiological measures); (6) withdrawals and drop-outs; (7) intervention integrity; and (8) appropriateness of analysis to study question.

For each domain, a score of “Strong,” “Moderate,” or “Weak” was assigned according to quantitative standards issued by the EPHPP; then domain scores were used to generate a global score for each trial that ranged from 1 to 3, with 1 being the best score (Thomas et al., 2004). For example, controlled trials in which assessors and participants were both blind to condition received a score of “strong” on the blinding domain, whereas trials in which neither assessors nor participants were blind to condition received a score of “weak” on the blinding domain. Then, following EPHPP guidelines, a global quality score was computed based on the number of domains with “weak” scores. The global score for each trial could range from 1 to 3, with 1 being the best score and reflecting no “weak” domain ratings; 2 reflecting one “weak” rating, and 3 reflecting two or more “weak” ratings (Thomas et al., 2004).

Results

Reliability Assessment of Ratings

Each study was independently judged by two assessors, who received extensive prior training by the first author. Because the variance of ratings was occasionally 0 on some EPHPP domains, we calculated intra class correlations (ICC) for the various dimensions and kappa for the global ratings. ICC were 0.63 for the rating of blinding, 0.66 for selection bias rating, 0.88 for withdrawals and dropout ratings and 1.0 for the rating of confounders and data collection methods. The kappa of the global rating was 0.53. These data suggest

that the two raters showed moderate agreement. After all studies were assessed, consensus was reached through discussion among assessors where there was disagreement.

Quality of Studies

Details of the study characteristics are shown in Table 1. The trials in this table show a fair degree of heterogeneity in terms of target disorder, sample size assessment methods, and trial methodology. All treatments were relatively brief with 20 being the maximum number of sessions. Table 1 also shows a summary of the results at post-treatment and follow-up.

Table 2 depicts the consensus quality ratings of the studies. The quantitative standard of the studies was strong for 9, moderate for 8, and weak for only 1 of the 18 trials. The only trial with a weak rating was a study on specific phobia published in 1969 by Bandura and colleagues. This was also the oldest study from this list. Note that all studies were strong with regards to intervention integrity and analytic plan. Therefore, these two EPHPP criteria were not listed in Table 2.

Discussion

To examine the methodological rigor of the studies comprising the EST list, we used meta-analytic methodologies to examine the quality of clinical trials. This information is important in the ongoing controversy surrounding ESTs, because studies with poor methodology provide little support for the efficacy of an intervention, even if the treatment shows strong effects.

In general, we found strong support for the methodological quality of the studies that examined the efficacy of the treatments identified by the Division 12 Task Force. More specifically, we found that only 1 of the 18 trials received a weak rating. This particular study was published in 1969 by Bandura and colleagues, which was the oldest study from this list. The methodological qualities of the other studies were all rated as moderate (8 studies) or strong (9 studies) when using a conservative rating system. The independent raters showed high agreement in their ratings. We conclude that the trials comprising the EST list are generally of high methodological quality. The main limitation of our study was that the evaluation of the studies was limited to the studies of the original Task Force report. The clinical trials literature has improved considerably since the Task Force report was published, and it

is likely that the quality of newer studies has further improved. Moreover, important questions about the mechanism of the treatments and possible moderators have not been addressed.

Despite the empirical support for ESTs, dissemination efforts have been disappointing. An early Task Force report showed that in 1995, over 20% of doctoral training programs did not provide even minimal coverage of empirically validated treatments in didactic courses, and internship programs usually did not require trainees to be competent in any of these treatments before completion of the program (Crits-Christoph et al., 1995). Although the situation for PhD programs seems to have improved, the situation is still dismal for other training programs. To the best of our knowledge, little has changed since the publication of a large national survey of 221 training programs that included training for psychiatrists, PhD- and PsyD-level psychologists, and social workers. This study showed that only 20% of PsyD and 21% of social work programs, the 2 disciplines with the largest number of students, required didactic or clinical supervision in CBT, which was identified by the survey as the most common form of evidence-based therapy (Weissman et al., 2006). Whatever the reason for the lack of dissemination of ESTs, it does not seem to be a result of a poor quality of the trials that examined the efficacy of these treatments.

Author Note

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(References continued on page 12)

Table 1: Description and results of studies

Study	Target problem	Sample size (without dropout)	Assessments	Treatment groups	Number of completers	Frequency/ duration of each session	Post-treatment	Follow-up
DiMascio et al., 1979.	Depression	81	RDS, HRS	Interpersonal Therapy (Psychotherapy)	12	16 sessions/ 1h each	S.I. on RDS & HRS. S.I. on anxiety/depression and apathy symptoms.	
				Amitriptyline/ Pharmacotherapy	8	16 sessions/ 0.5h each	S.I. on RDS & HRS. S.I. on Sleep, anxiety/depression and apathy symptoms.	
				Psychotherapy + Pharmacotherapy	16	16 sessions/ 1h each	Most overall improvement on RDS & HRS. Most overall improvement on all the symptoms.	
				Nonscheduled	7	16 sessions/ 0.5h each	Unknown	
Elkin et al., 1989.	Depression	239	BDI, HRSD, HSCL-90 T, GAS.	CBT	37	20 sessions/ 50mins each	% HRSD \leq 6: 51%. % BDI \leq 9: 65%.	
				IPT	47	16-20 sessions/ 50mins each	% HRSD \leq 6: 55%. % BDI \leq 9: 70%. Superior to PLA-CM in higher depression cases.	
				Imipramine & Clinical management (IMI-CM)	37	16 sessions/ 60mins 1st, 30mins remaining	% HRSD \leq 6: 57%. % BDI \leq 9: 69%.	
				Placebo-Clinical Management (PLA-CM)	34	16 sessions/ 60mins 1st, 30mins remaining	% HRSD \leq 6: 29%. % BDI \leq 9: 51%.	
Jacobson, 1996.	Depression	152	BDI, LIFE-II, HRSD, W.P.R.	BA (behavioral activation)	56	20 sessions	No significant differences between the treatments on either the BDI or the HRSD. None of our follow-up analyses uncovered differences between groups. CT did not lead to decreased re-lapse, or better long-term functioning in terms of depressive symptoms, than did either of the component treatments.	(6mon): The three treatments did not differ either in the overall impact of therapy through the 6-month follow-up or in changes in depressive symptoms over the first 6 months after posttest.
McLean, 1979.	Depression	196	DACL, BDI, EPQ	Psychotherapy	37	10 sessions/ 60 min each (range 8~12 sessions)	Favorable outcome in Behavioral therapy:(a) the BDI, (b) social and (c) mood component scores, and (d) complaints, (e) goals, and (f) average satisfaction.	(3mon): Depression rate: 50% in BT group; 75% in psychotherapy and drug therapy groups; Favorable outcome for BT group: social and mood variables, (12mon): Significantly lower in self-rating and clinician rating of anxiety for therapist-directed exposure.
				Relaxation training	38	10 sessions/ 60 min each		
				BT	40	10 sessions/ 60 min each		
				Drug therapy	39	11 weeks. Starting with 75 mg, then to fixed dosage of 150 mg/day over a 10-day period, at the end, 25 mg/ day. a single daily dose at bedtime.		

Quality of EST Studies (continued)

Table 1 (continued)

Study	Target problem	Sample size (without dropout)	Assessments	Treatment groups	Number of completers	Frequency/duration of each session	Post-treatment	Follow-up
Bandura et al., 1969.	Specific Phobia (animal)	48	Six attitude scales on encounters with snakes, B.A.T., Fear Arousal Accompanying Approach Responses, A.F.P.	Systematic Desensitization	12	4h 32mins total	% Terminal approach task: 25% Unable to locate exact numbers	
				Symbolic modeling	12	2h 46mins total	% Terminal approach task: 33%	
				Live Modeling + Guided Participation	12	2h 10mins total	% Terminal approach task: 92%	
				Control group (no treatment)	12		% Terminal approach task: 0%	
Ost et al., 1991.	Specific Phobia (animal)	34	SQ (Klorman), SQ (Watts), C.R., B.T.	One-session therapist-directed exposure	17	M=126.2 min, SD=30.5 min	Behavioral score: significantly decrease for therapist-directed exposure. Significantly lower in self-rating and clinician rating of anxiety for therapist-directed exposure.	(12mon): Behavioral score: significant decrease for therapist-directed exposure.
				Manual based self-directed exposure	17	M=282.8 min, SD=157.5 min, (M= 80.4 min per session)		
Barlow et al., 1989.	Panic Disorder	56	HADS, STAI-T, CSAQ, FO, S.M.A., BDI, S.M.D., PRS, SSS, LES.	Exposure and Cognitive (E&C)	15	15 sessions	% of High endstate: 46%. Superior to WL on Hamilton Anxiety score. % panic free: 85%. N.S. on Self-monitored anxiety, depression and pleasant mood.	(6mon): N.S. between post-test and follow-up in any test
				Applied Relaxation (R)	10	15 sessions	% of High endstate: 50%. Superior to WL on PRS and Hamilton Anxiety score. % panic free: 60%. N.S. on Self-monitored anxiety, depression and pleasant mood.	(6mon): N.S. between post-test and follow-up in any test.
				E&C + R	15	15 sessions	% of High endstate: 46%. % panic free: 87%. N.S. on self-monitored anxiety, depression and pleasant mood.	(6mon): N.S. between post-test and follow-up in any test.
				WL	20	Phone contact once/2-3 weeks	% of High endstate: 0%. % panic free: 36%. N.S. on self-monitored anxiety, depression and pleasant mood.	(6mon): N.S. between post-test and follow-up in any test.
Clark et al., 1994.	Panic Disorder	64	P.C.S., P.F., P.D., BAI, HARS, G.T.A., AA, SA, BA, AF, SF, BF, BSQ, AC, BSI, BDI	CT	16	10.5 sessions/ 58mins each	% of High endstate: 80%. % panic free: 90%. Superior to WL on 19 panic/anxiety measures. Superior to WL on BDI. Superior to R on 10 panic/anxiety measures. Superior to IMIP on 9 panic/anxiety measures.	(3mon): CT was superior to R on 10 panic/anxiety measures. Superior to IMIP on 9 panic/anxiety measures. (6mon): Superior to R on 6 panic/anxiety measures and BDI. (15mon): Superior to IMIP and R on 6 panic/anxiety measures.
				Applied Relaxation (R)	16	10.3 sessions/ 57mins each	% of High endstate: 25%. % panic free: 50%. Superior to WL on 12 panic/anxiety measures. Superior to WL on BDI.	
				Imipramine (IMIP)	16	10.5 sessions/ 24mins each	% of High endstate: 40%. % panic free: 55%. Superior to WL on 8 panic/anxiety measures. Superior to WL on BDI.	(6mon): Superior to R on 4 panic/anxiety measures and BDI.
				WL	16		Unclear	

Table 1 (continued)

Study	Target problem	Sample size (without dropout)	Assessments	Treatment groups	Number of completers	Frequency/ duration of each session	Post-treatment	Follow-up
Borcevec et al., 1987.	GAD	42	HADS, S.A.S., Zung, STAI-T, FQ, CSAI, RRAQ, D.GA.	CT	16	12 sessions/ 60-105 mins each	S.I.on HADS,CSAI, daily anxiety episodes, STAI-trait, FQ, Zung, etc.	(6mon): N.S. in between groups comparison.
				Nondirective Therapy	14	13 sessions/ 60-105 mins each	S.I.on HADS, CSAI, daily anxiety episodes, etc.	
Butler et al., 1991.	GAD	57	BAI, STAI, LEEDS, S.R.9, HAS, A.R.9, BDI, DysAS, CC, SPQ, FNE	CBT	19	10.7 sessions/ 1h each	Superior to WL on 6 anxiety scales. Superior to WL on 5 cognition scales. Superior to WL on 3 depression scales. Superior to BT on 3 anxiety scales, 1 depression scales, and 2 cognitive scales.	(6mon): Superior to BT on 3 anxiety scales, 1 depression scales, and 5 cognitive scales.
				BT	18	10.6 session/ 1h each	Superior to WL on 1 anxiety scale. Superior to WL on 1 depression scale. Superior to WL on 2 depression scales.	
				WL	19			
Agras et al., 1989.	Bulimia Nervosa	77	P.F., A.P., EDI, E.A.T., S.A.L., BDI, HDS, STPI	CBT	22	14 session/ 1h each	Purge Frequency $\downarrow p < 0.001$. Abstinence rates: 56.3%. BDI(Compared with WL) $\downarrow p < 0.05$. Weight $\uparrow 0.48\text{kg}$.	(1mon): Purging $\downarrow 80\%$. (6mon): Abstinence $\downarrow 59\%$.
				Self-monitoring group	19	15 session/ 1h each	Purge Frequency $\downarrow p < 0.1$. Abstinence rates: 23.5%. BDI (Compared with WL) n.s. Weight $\uparrow 3.49\text{kg}$.	(1mon): Purging $\downarrow 50\%$. (6mon): Abstinence $\downarrow 18\%$.
				CBT + Response prevention condition	17	16 session/ 1h each	Purge Frequency $\downarrow p < 0.04$. Abstinence rates: 31.2%. BDI(Compared with WL) $\downarrow p < 0.05$. Weight $\uparrow 1.64\text{kg}$.	(1mon): Purging $\downarrow 50\%$. (6mon): Abstinence $\downarrow 20\%$.
				WL	19		Purge Frequency n.s. Abstinence rates: 5.8%. Weight $\downarrow 2.01\text{kg}$.	(1mon): Purging $\downarrow 50\%$.
Thackwray et al., 1993.	Bulimia nervosa	47	BDI, BPB, Weight, EDI, RSCS, RAS	CBT	39	8 sessions/ 60 min each	Post-treatment abstinence rate: CBT (92%), BT (100%), NSMT (69%).	(6mon): Abstinence rate: CBT (69%), BT (38%), NSMT (15%), $p < .05$. Binge-purge episodes: significant increase in NSMT.
				BT		8 sessions/ 60 min each	BDI: significant reduction in all three groups.	
				Nonspecific self-monitoring treatment (NSMT)		8 sessions/ 60 min each		

Table 1 (continued)

Study	Target problem	Sample size (without dropout)	Assessments	Treatment groups	Number of completers	Frequency/ duration of each session	Post-treatment	Follow-up
Hill et al., 1993.	Smoking	94	S.F., E.C.MO, N.T., G.H.R., S.E.	BT only	22	12 sessions/ 90 min each	Abstinence rate: no differences between the four groups at treatment end, or at any of the subsequent follow-up periods.	(12mon): Three times as many quitters in the three behavioral groups versus the physical exercise only condition. When three BT groups were combined, significantly higher abstinence rate in the BT groups. No differences between the three groups receiving behavioral treatment were found at 12 months.
				BT & nicotine gum	22	12 sessions/ 90 min each, gum for 3 months/6.8 pieces per day		
				BT & physical exercise	18	12 sessions/ 60 min(BT) & 45 min walking each		
				physical exercise only	20	12 sessions/ 45 min walking each		
Stevens & Hollis., 1989.	Smoking	587	P. A. S	skills	184	3 sessions/ 2 hours each	Monthly: lower rate of relapse in skill group.	(6mon): Drive for thinness subscale: significant changes for CBT only, no significant changes for NSMT. (12mon): Thiocyanate concentrations (SCN): decrease in skill group
				discussion	205	3 sessions/ 2 hours each		
				no-treatment	198	no sessions		
Keefe et al., 1990.	Rheumatic pain	99	CSQ, AIMS, M. I., M.P.	pain coping skills	32	10 sessions/ 90 min each	Significantly lower levels of pain and psychological disability in the pain coping skills training group.	
				arthritis education	36	10 sessions/ 90 min each		
				control	31			
Parker et al., 1988.	Rheumatic pain	83	SCL-90-R, BDI, CSQ, MPQ	cognitive-behavioral pain management (CB)	29	a 5-day comprehensive pain management, once/ 1~3 month support group		(6mon): More increase in CSQ for CB. (12mon): More increase in CSQ for CB.
				attention-placebo (AP)	26	a 5-day basic RA education program, once/ 1~3 month support group		
				control(CN)	28	no sessions		
Azrin et al., 1980.	Marital discord	66	P.M.H., Locke-Wallace (revised), PC	Reciprocity counseling	28	4 sessions	Locke-Wallace scale improved 13 points. Number of problems ↓ 47%. Self-rated happiness% ↑ 19%.	(1mon): Self-rated happiness% ↑ 27%. (6mon): self-rated happiness% ↑ 26%.
				Discussion-type counseling	27	4 sessions	Locke-Wallace scale improved 2 points. Number of problems ↓ 22%. Self-rated happiness% ↑ 2%.	

Table 1 (continued)

Study	Target problem	Sample size (without dropout)	Assessments	Treatment groups	Number of completers	Frequency/ duration of each session	Post-treatment	Follow-up
Jacobson et al., 1984.	Marital discord	36	DyaAS, PPC, SOC	BE(Behavioral Engagement)	9	12 sessions/60-90 min each	Only BE and CO: significant increase in the ratio of positive/ positive plus negative behavior. The three versions of BMT were equally effective in promoting marital satisfaction, and in reducing the frequency and intensity of presenting complaints. Only BE lead to significant increases in the frequency of positive behavior as a result of therapy.	(3mon): BE couples: deterioration on all measures. BE couples: less change in problem reduction and problem elimination. BE couples: improvement rate dropped to 44%. (12mon): CPT or CO: treatment gains maintained. CPT or CO: continued to reduce and eliminate problems CO and CPT: improvement rates of 78%, higher than at posttest
				CPT(communication/ problem-solving training)	9 Malfunction	12 sessions/60-90 min each		
				CO(complete treatment package)	9	12 sessions/60-90 min each		
				WL	9	no sessions		
				AT(modification of dysfunctional thoughts)	43	20 sessions		
				CT(cognitive-behavioral therapy)	50	20 sessions		

Note:

Superior to = Target treatment had greater improvement (more symptom reduction);

↓ = decrease;

↑ = increase;

S.I. = significant improvement/increasing;

N.S. = No significant difference;

AA - Agoraphobic Avoidance;

AC - Agoraphobic Cognitions;

AF - Agoraphobic Fear;

A.F.P. - Appraisal of Fear Proneness;

AIMS - the Arthritis Impact Measurement Scales;

A.P. - abstaining from purging;

A.R.9 - 9-point assessor rating;

BA - Bloody/injury avoidance;

BAI - Beck Anxiety Inventory;

B.A.T. - Behavioral Avoidance Test;

BDI - Beck Depression Inventory;

BF - Blood/injury fear;

BPB - Binge-purge behavior;

BSI - Bodily Sensations Interpretations;

BSQ - Body Sensations Questionnaire;

B.T. - Behavioral test;

BT - Behavior Therapy;

CBT - Cognitive Behavioral Therapy;

CC - Cognition Checklist;

C.R. - Clinician rating;

CSAI - Cognitive/Somatic Anxiety Inventory;

CSQ - Coping Strategies Questionnaire;

D.GA - Daily diary on general anxiety level;

DACL - Depression Adjective Check List;

DyaAS - Dyadic Adjustment Scale;

DysAS - Dysfunctional Attitude Scale;

E.A.T. - the Eating Attitudes Test;

E.C.MO - expired carbon monoxide levels;

EDI - Eating Disorders Inventory;

EPQ - the Eysenck Personality Questionnaire;

FNE - Fear of Negative Evaluation Scale;

FQ - Fear Questionnaire;

G.T.A. - General tension and anxiety by assessor and patient;

GAS - Global Assessment Scale;

G.H.R. - Global health ratings;

HADS - Hamilton Depression Rating Scale;

HARS - Hamilton Anxiety Rating Scale;

HDS - Hamilton Depression Scale;

HRS - Hamilton Rating Scale;

HRSD-Total - The 17-item Hamilton Rating Scale for Depression;

HSCL-90 T - Hopkins Symptom Checklist (Total);

LEEDS - Leeds Scales for the Self-Assessment of Anxiety and Depression;

LES - Life Experience Survey;

LIFE-II - Longitudinal Interval Follow-up Evaluation II;

Locke-Wallace (revised) - Locke-Wallace Marital Adjustment Scale (revised);

M.I. - Medication intake interview;

M.P. - Motor pain observation;

MPQ - McGill Pain Questionnaire;

N.T. - Nicotine tolerance;

P. A. S - Proportion of abstinence from smoking monthly and at 1 year follow-up (confirmed by cotinine test);

P.D. - Panic-related distress/disability by assessor and patient;

P.F - Panic frequency by assessor and patient;

P.F.- Purge Frequency (self-monitored);

P.M.H. - reported general marital happiness expressed as a percentage;

PC - Problem Checklist;

P.C.S. - Panic/anxiety composite score;

PPC - Presenting Problem Checklist;

PRS - Psychosomatic Rating Scale;

RAS - Rathus Assertiveness Schedule;

RDS - Raskin Depression Scale;

RRAQ - Reactions to Relaxation and Arousal Questionnaire;

RSCS - Rosenbaum Self-Control Rating Scale;

S.A.S. - Overall severity rating of anxiety symptomatology;

S.E. - Self-efficacy to resist the surge to smoke;

S.F. - Smoking frequency;

S.M.A. - Self-monitoring anxiety;

S.M.D. - Self-monitoring depression;

S.R.9 - 9-point self-rating;

SA - Social Avoidance;

SA.L - Serum amylase levels;

SCL-90-R - Symptom Checklist-90-Revised;

SF - Social fear;

SOC - Spouse Observation Checklist;

SPQ - Subjective Probabilities Questionnaire;

SQ (Klorman) - Spider Questionnaire (Klorman);

SQ (Watts) - Spider Questionnaire (Watts);

SSS - Subjective Symptom Scale;

STAI - State-Trait Anxiety Inventory;

STPI - State-Trait Personality Inventory;

W.P.R. - Weekly psychiatric ratings;

Zung - Zung Self-rating of anxiety Scale.

Table 2: EPHPP Quality Ratings of Studies

Study	Target problem	Selection bias rating	Design rating	Confounders Rating	Blinding rating	Data collection methods rating	Withdrawals and drop-outs rating	Global rating
DiMascio et al., 1979	Depression	Moderate	Strong	Strong	Moderate	Strong	Weak	Moderate
Elkin et al., 1989	Depression	Moderate	Strong	Strong	Strong	Strong	Moderate	Strong
Jacobson, 1996	Depression	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong
McLean, 1979	Depression	Weak	Strong	Strong	Moderate	Strong	Moderate	Moderate
Bandura et al., 1969	Specific phobia	Weak	Strong	Weak	Strong	Strong	Strong	Weak
Ost et al., 1991	Specific phobia	Weak	Strong	Strong	Moderate	Strong	Strong	Moderate
Barlow et al., 1989	Panic disorder	Moderate	Strong	Moderate	Moderate	Strong	Moderate	Moderate
Clark et al., 1994	Panic disorder	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong
Borcevec et al., 1987	GAD	Weak	Strong	Strong	Strong	Strong	Moderate	Moderate
Butler et al., 1991	GAD	Moderate	Strong	Strong	Strong	Strong	Strong	Strong
Agras et al., 1989	Bulimia	Moderate	Strong	Strong	Strong	Strong	Moderate	Strong
Thackwray et al., 1993	Bulimia	Weak	Strong	Strong	Moderate	Strong	Strong	Moderate
Hill et al., 1993	Smoking	Weak	Strong	Strong	Moderate	Strong	Strong	Moderate
Stevens & Hollis., 1989	Smoking	Moderate	Strong	Strong	Strong	Strong	Strong	Strong
Keefe et al., 1990	Rheumatic pain	Moderate	Strong	Strong	Strong	Strong	Strong	Strong
Parker et al., 1988	Rheumatic pain	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong
Azrin et al., 1980	Marital discord	Moderate	Strong	Strong	Moderate	Weak	Strong	Moderate
Jacobson et al., 1984	Marital discord	Moderate	Strong	Strong	Strong	Strong	Strong	Strong

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Notes to a Young Clinical Psychologist: Words of Wisdom from Stefan Hofmann, Ph.D.

 Starting with this issue, we are extraordinarily excited to introduce a new section entitled Notes to a Young Clinical Psychologist. In this new section, we ask leaders in the field of clinical psychology to reflect back and share their early experiences as a young clinical psychologist, to trace their steps from young professional to leader in the field, and to offer advice and words of wisdom to the new generation of clinical psychologists just now entering the field. We were delighted that for our inaugural appearance of this column, we were able to sit down with **Stefan Hofmann, Ph.D.**, who offered the following notes to young clinical psychologists.

Who were some of your most important mentors in clinical psychology, and what was special or unique about their impact on your professional development?

Hofmann: I have been influenced by too many people to list them all here – most of them did not even know that they influenced me. Some of those who are aware of their mentor status are David Barlow, Aaron T. Beck, Anke Ehlers, and Walton T. Roth. Dave Barlow mentored me in becoming a critical scientist/practitioner; Tom Roth trained me in psychophysiology, and Anke Ehlers mentored me in experimental methods. I also consider Aaron T. Beck to be a formative figure in my later development that began after my time as a Beck Scholar. All of these mentors had a unique style but all shared a commitment to rigorous scientific methods and critical thinking.

What do you know now that you wish you knew when you were first starting your career in clinical psychology?

Hofmann: I wish I had understood earlier the meaning of the following quotation, often attributed to Henry Kissinger: “Academic politics are so vicious precisely because the stakes are so small.” Unfortunately, this not only applies to peers within the same cohort, but it is also true for the interactions with more senior colleagues who might feel threatened by more junior investigators. You live and learn. Rather than

harboring resentment and anger, it is important to let go of these feelings and to move on.

What have been some of the greatest challenges or obstacles to your career as a clinical psychologist?

Hofmann: In order to do good and meaningful research, you need money, and money is a scarce resource. Grant reviewers are often reluctant to fund high-risk/high-reward grant proposals and instead fund the project that is very similar to the one that was funded before. I also did not realize how much politics factor into scientific decision-making. It is important not to take rejection from funding agencies or journals personally and not to let politics sabotage scientific goals or spoil the fun in research.



Stefan Hofmann, Ph.D.

Rejection is common, especially when proposals or studies challenge the existing paradigm. However, we need people who do this and push the envelope. Otherwise, there can be no progress in clinical science. Fortunately, perseverance often pays off.

What advice would you give to young professionals just now beginning a career in clinical psychology?

Hofmann: Choose a subject area that excites you, because you will live with it for a long time. Don't be afraid to expand your horizon, but don't get distracted by the latest fashion. Don't be intimidated by any useful new tools, methods, techniques or strategies. Learn and use them if they serve your research agenda, no matter how complicated they are. Don't be a lone wolf. Scientific progress is a collaborative process. Be generous, honest, and fair. Work with people who share your passion, especially those who have expertise in areas you are less familiar with. Be a good team player and avoid working with overly egocentric and

(continued on page 19)



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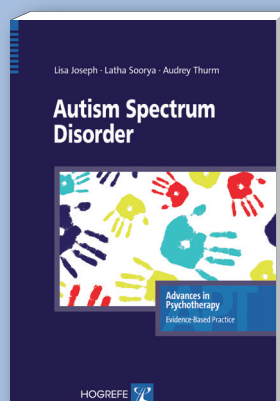
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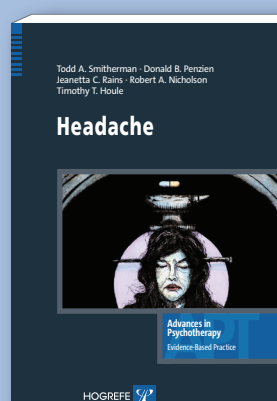
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*Todd A. Smitherman,
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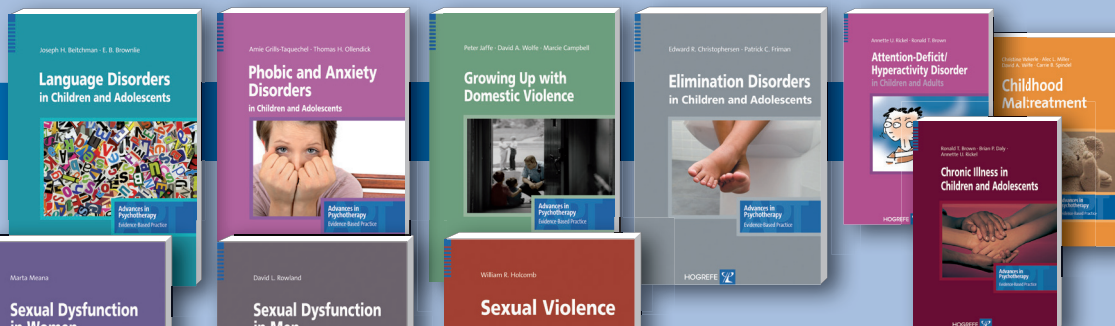
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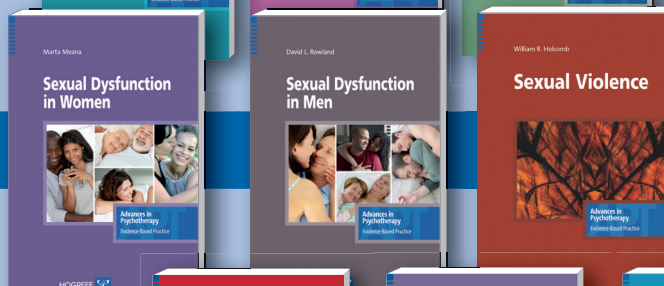
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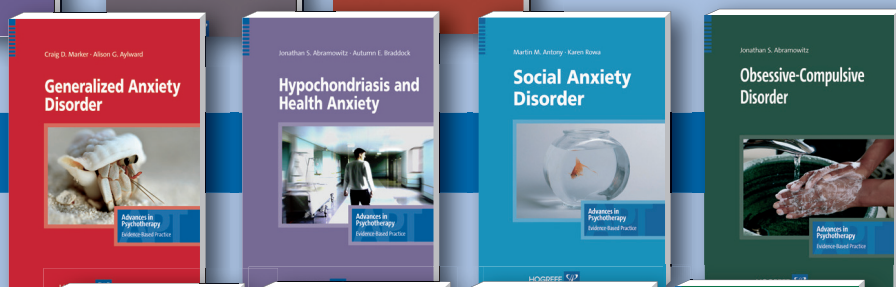
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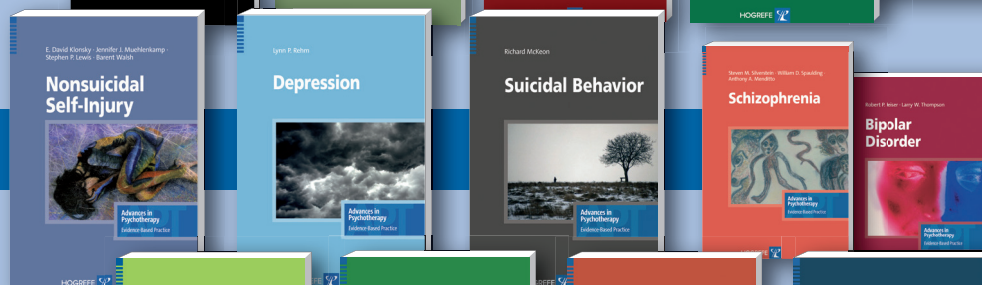
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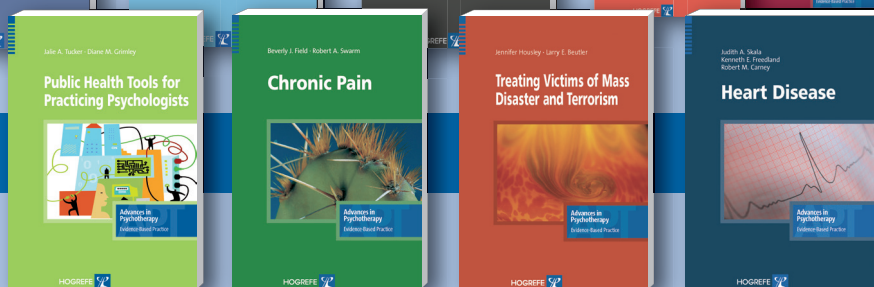
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narcissistic people (which may be difficult to avoid at times). Never ever lie or misconstrue the truth. The goal of doing clinical studies is to understand human nature and to enhance well-being. If this is not your goal, you are in the wrong field.

How can young clinical psychologists make a meaningful impact?

Hofmann: Young clinical psychologists have the distinct advantage of being young and energetic. More senior people are often hesitant to start a new research program because they know how much work it would entail. Our field also tends to classify scientists into particular categories, and it is difficult to move into a new field once you made a name for yourself in a particular area. Young scientists have the distinct advantage of being able

to move more freely into new disciplines. In addition, naivety about the amount of work involved can be a huge advantage. My advice is: follow your passion and don't be afraid to take risks.

What do you see as the most important new areas on the horizon for the field of clinical psychology that are in need of focused attention?

Hofmann: It is time to finally leave behind the never-ending struggle between the various "psychological schools" and "theoretical orientations." Theory is important, but the focus should be on treatment mechanisms and theoretical models that bridge the gap between science and practice. This can be – and will be – achieved by closely working with our neighboring disciplines, especially neuroscience and social sciences. 

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Please note that the editor and the Publication Committee of Division 12 reserve the right to refuse to publish any advertisement, as per the advertising policy for this publication.

Submission deadlines for advertising and announcements:

Winter issue: January 3

Spring issue: April 1

Summer issue: July 1

Fall issue: October 1





CALL FOR NOMINATIONS:

Theodore Millon Award in Personality Psychology

About the American Psychological Foundation (APF)

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

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

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

Description

The **Theodore Millon Award in Personality Psychology** recognizes outstanding early or mid-career psychologists engaged in advancing the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement.

Program Goals

The Theodore Millon Award in Personality Psychology:

- Recognizes individuals' outstanding contributions to the science of personality psychology as described above.

Eligibility Requirements

Nominees must:

- Be a professional psychologist working in personology, personality theory, personality disorders, or personality measurement
- Have demonstrated scientific accomplishment in one or more of these areas

Amount

One \$1,000 award

Evaluation Criteria

Nominations will be evaluated on magnitude of contributions to the award criteria, relative to the stage in the individual's career

Nomination Requirements

- Cover letter outlining nominee's contributions to target areas
- Abbreviated current CV
- Up to two supporting letters of recommendation

Submission Process and Deadline

Submit a completed application online at <http://forms.apa.org/apf/grants/> by November 1, 2015.


Inquiries should be directed to the Division 12 Central Office at 303-652-3126 or div12apa@comcast.net

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

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

Growing Pains of Professional Development: Understanding Self-Sabotaging Behaviors in Clinical Psychology Graduate Students

Sheena Glover, M.A., DeAna Gray, B.S., & Aikaterini Tsapanidou, B.A.

 Within the clinical psychology doctoral program there is an emphasis for each student to meet all the necessary milestones so that they may become a professional. As we advance through the training phases, a pattern emerges where a number of students are no longer able to keep up with the increasingly intense curriculum. Research on attrition rates has established that students are more likely to dropout during the first semester or the first year. The most common factors for dropouts within graduate programs are due to limited financial resources and academic difficulties, however attrition rates can also increase during the rigorous process of the dissertation development at the doctoral level (Hermanowicz, 2003). All too often, students who are unable to cope with the stressors that accompany such a program will compromise their academic progress by resorting to self-sabotaging actions. This article attempts to highlight the parallel processes of the stages of emerging adulthood and the transformative experiences of doctoral students. Lastly, we examine how self-sabotaging behaviors can be minimized through the utilization of personal psychotherapy.

Developmental Implications

A 2012 nationwide survey of Social Science doctorate recipients showed that the median age was 32.4 years old, suggesting that students undergoing a doctoral degree enter into the graduate program at approximately twenty-six years of age (National Science Foundation, 2012). In the same survey more than 35% of the doctoral students fell under the 26-30 year old age range and another 35% under the 31-35 year old age range. The implications of the developmental stages serve as a metaphorical representation of the challenging years of doctoral program. More importantly, they can serve as

facilitating points when we find ourselves in the midst of transitions.

It has been established by Arnette (2004), that emerging adulthood occurs between the ages of eighteen and twenty-five. We can't help but acknowledge a plethora of similarities between the features of the life stage suggested by Arnette (2004) and the types of challenges faced by a psychology graduate student as proposed by Baker and Pifer (2011). Research by Baker and Pifer (2011), suggests that as we enter the new training program with pre-existing identities, we attempt to identify what our new role and responsibilities are as students and integrate them with our own identity. Thus, an *identity exploration* occurs at both a personal and professional level. In this initial stage of the doctoral program, students rely heavily on the structure that is being provided to them (e.g., coursework, deadlines, and easily identifiable objectives). This is a *self-focused age* whereby we develop the awareness and expertise needed for "adulthood" which would be equivalent to becoming a competent professional. Following this stage is the *age of feeling in-between*, which is when the practicum training begins, and the student is learning to adapt to the interchangeable roles of "student" and "clinician." In the *age of possibilities*, students have not specialized their skill sets thus removing any barriers for exploring infinite career possibilities. As we approach the latter phases of the program, we move away from the structured demands of coursework into a more self-initiating period such as writing dissertation proposals.

As we enter the internship year, a unique set of challenges arises especially while cultivating a more professional platform. In trying to familiarize ourselves with, and respond successfully to, the new responsibilities we may feel "confused, even overwhelmed" (Guinee, 1998, p. 616). We gradually learn how to take risks and wait for more guidance when it is appropriate. The developmental task at hand is individuation, and the challenges that can prolong this process are diverse in nature. During this time, we are prone to self-examination, which can produce doubt and internal conflicts.

Self-Sabotage Behavior & Personal Psychotherapy

Hurley-Wilkinson (2002) defines self-sabotage as "a combination of thoughts, feelings and actions that

act as barriers to our success by working against our own self interests” (self-sabotage section, para. 2) Self-sabotaging consists of both deliberate and non-deliberate behaviors, which may be rooted in internalized insecurities that manifest into maladaptive behaviors such as passive aggression, denial, lying, plagiarisms, and avoidance. Due to the intensity of the program, students may engage in counterproductive actions that can impact their academic and professional career. As the practicum years commence students are expected to transition from a “dependent trainee to a competent, independently functioning professional” (Guinee, 1998, p. 617). Practica provide direct contact with clients who are looking to students for answers and ‘cures’ to their problems, which can be overwhelming for students. Further, student clinicians are not necessarily expecting to be triggered by their clients’ experiences. This can be quite taxing on the human psyche, and may leave some feeling lost, angry, confused, and even scared. When these emotions are not appropriately addressed, students may resort to self-sabotaging tendencies such as procrastination, turning in late assignments, chronic tardiness, or dropout altogether.

A means by which students can help themselves combat the emergence of self-sabotage is through personal psychotherapy. Kumari (2011) and Murphy (2005) both conducted qualitative research that investigated the impact of personal therapy on psychology trainees and concluded that the engagement of personal therapy may aid in the preparation of professional therapist. Moreover, it was perceived to be a positive and beneficial experience for graduate students in the field of psychology. Grimmer and Tribe’s (2001) empirical research on the efficacy of personal psychotherapy amongst psychology trainees suggested improvements in self-esteem, social life, and work function. Lastly, research conducted by Norcross, Strausser-Kirtland, and Missar (1988) outlined six positive outcomes, including: improvement of mental and emotional functioning, lessening of emotional stress that often results from this profession, enhanced understanding of personal dynamics, and sensitization of the interpersonal responses and needs of the clients.

The implementation of personal psychotherapy is integral to the psychology graduate student. Norcross (2005) stated that through personal psychotherapy students are able to achieve a great sense of self-awareness and psychological maturation, which

will increase their abilities to more effectively treat their clients. Furthermore, those who participate in personal psychotherapy experience the process of therapy as a client, and experience, first-hand, the highs and lows of the therapeutic journey. Thus, it’s imperative that such awareness be given the space to develop in order to integrate an effective therapeutic process for our clients, while simultaneously developing the armor needed to combat the feelings and expectations that our clients may hold during their own therapeutic journey.

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BECOME A DIVISION 12 MENTOR

Section 10 (Graduate Students and Early Career Psychologists) has developed a **Clinical Psychology Mentorship program**. This program assists doctoral student members by pairing them with full members of the Society.

We need your help. Mentorship is one of the most important professional activities one can engage in. Recall how you benefited from the sage advice of a trusted senior colleague. A small commitment of your time can be hugely beneficial to the next generation of clinical psychologists.

For more information about the mentorship program, please visit www.div12sec10.org/mentorship.htm, and visit www.div12.org/mentorship to become a mentor today!





CALL FOR NOMINATIONS:

Theodore Blau Early Career Award

About the American Psychological Foundation (APF)

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

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

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

Description

Honoring the memory of clinical psychologist and former APA President, the **Theodore Blau Early Career Award** recognizes the accomplishments of early career professionals working in clinical psychology. Such accomplishments may take many forms including:

- Promotion of the practice through professional service
- Innovation in service delivery
- Novel application of applied research methodologies to professional practice
- Positive impact on health delivery systems
- Development of creative educational programs for practice
- Other creative activities that advance the service of the profession

Program Goals

The Theodore Blau Early Career Award:

- Recognizes individuals for their work in clinical psychology at an early career stage
- Encourages continued growth & contribution to clinical psychology

Eligibility Requirements

- Nominations accepted from self or others
- Nominees no more than ten years post-doctoral degree

Amount

One \$4,000 award annually

Evaluation Criteria

Nominations will be evaluated on:

- Nominee's demonstrated accomplishments and promise in the field of clinical psychology

Nomination Requirements

- Nomination cover letter outlining relevant contributions
- Abbreviated current CV
- Up to two supporting letters of recommendation

Submission Process and Deadline

Submit a completed application online at <http://forms.apa.org/apf/grants/> by November 1, 2015.

Inquiries should be directed to the Division 12 Central Office at 303-652-3126 or div12apa@comcast.net

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SECTION UPDATES

Jonathan S. Comer, Ph.D.—Editor

Section IV: Clinical Psychology of Women

Submitted by Elaine Burke, Psy.D.



Our section met on August 23, 2014 during the APA conference. One issue that was discussed was how to increase recruitment especially among early career psychologists and graduate students. Some ideas include establishing a mentoring program, encouraging them to contribute to the newsletter, and involving social media.

Dr. Kalyani Gopal (past president) is hosting the first Human Trafficking Conference sponsored by a psychologist. It will be held in October in Chicago.

Our most recent newsletter included our first peer-reviewed article. There will be a continuation of the theme of supervision. Some ideas for future themes are health and women, and international and immigration issues regarding women. The section would like to provide opportunities for students to submit work in the newsletter.

There were several action items to be followed up after the meeting. Our president (Natalie Porter) will discuss ideas related to recruitment with our membership chair Vivian Tamkin. Lekeisha Sumner (secretary) and Natalie Porter will discuss the implementation of a mentoring plan. Elaine Burke will work on the development and implementation of future newsletter themes.

Section VI: Clinical Psychology of Ethnic Minorities

Submitted by Cheryl Boyce, Ph.D.



Section VI and its members have continued to bring forth knowledge on effective treatments for racial/ethnic minority populations to Division 12, APA and the field.

At the recent APA convention, a symposium co-sponsored with Division 12, 17, 29, 35, 44, 51, and APAGS explored: “What’s the Evidence That Treatments Are Effective for Ethnocultural Groups? Progress and Challenges.” In a successful session, Section VI members and leaders in health disparities and mental health treatment presented an evaluative review of the evidence on mental health treatments for African Americans (Dr. Alfee Breland-Noble, Georgetown University Medical Center), Latinos (Dr. Guillermo Bernal, University of

Puerto Rico), Asian Americans (Dr. Nolan Zane, UC Davis) and Native Americans (Dr. Beth Boyd, University of South Dakota).

Emerging and innovative models exploring risk and resilience factors which can inform future mental health treatments were also highlighted in the session: “Innovative Models with Evidence to Reduce Racial/Ethnic Health Disparities and Risk” co-sponsored with Divisions 1, 8, 17, 34, 35, 44, 51, 54, and APAGS. Multidimensional, conceptual models for the role of stress, the HPA axis and discrimination factors were presented by Dr. Gail Wyatt of UCLA, past president of Section VI. While data for new prevention strategies among African Americans in rural settings was shared by Dr. Velma Murry of Vanderbilt University. Dr. Alfee M. Breland-Noble, immediate past president of Section VI, provided thoughtful comments as to the promise and need for the intersections of culture and evidenced-based treatments.

For the second year, our Division 12 Section VI student representatives collaborated with Drs. Alfee M. Breland-Noble (Chair of the APA Division 12 Section VIII Disparities and Diversity Task Force, Ashley Butler (Member of the Division 12 Section VIII Disparities and Diversity Task Force) and Division 35 student representatives to coordinate a conversation hour for the APA Annual Convention. Titled “Navigating your Training as a Woman of Color: A Conversation Hour and Safe Space,” the focus of the hour was to engage in a productive dialogue about the difficulties encountered while seeking training across all stages of career development. Participants shared tips, validated experiences, and moved toward building a community of support for issues addressed. Continuing last year’s successful event, this year’s conversation had 15-20 participants, comprised of students and early career psychologists from various fields of psychology. Lively conversation and tips were followed by sharing contact information to continue the support provided within the session. We are hoping to continue the conversation in following years to support the success of ethnic minority women in the field. This event represented our effort to meet the APA goal of collaboration across divisions with two sections of Division 12 and members of Division 35 represented on the planning team.

Additionally, the section co-sponsored a session on Ethics, “Raising Our Voices: Updates from Ethnic Minority Psychological Associations on the APA Ethics Code”. Each of the major ethnic minority associations



addressed the applicability of the APA Ethics Code to their ethnocultural group.


Mentoring remains active with the section with a joint discussion hour at the convention on specific challenges facing women and ethnic minorities in careers in psychological science and practice. For the second year, Section VI student representatives collaborated with Dr. Ashley Butler (Division 12, Section 8) and Division 35 student representatives to coordinate a conversation hour for the APA Annual Convention. "Navigating your Training as a Woman of Color: A Conversation Hour and Safe Space," was designed to engage in a productive dialogue about the difficulties encountered while seeking training across all stages of career development. Participants shared tips, validated experiences, and moved toward building a community of support for issues addressed. Continuing last year's successful event, this year's conversation had 15-20 participants, comprised of students and early career psychologists from various fields of psychology. Lively conversation and tips were followed by sharing contact information to continue the support provided within the session. The conversations and mentoring will continue to support the success of ethnic minority women in the field from the section through the networking facilitated by this student representative lead initiative.

Finally, dissemination activities have continued from the efforts of Dr. Fred Leong (Michigan State University (MSU)), with the assistance of Dr. Guillermo Bernal (UPR) and Nicole Buchanan (MSU) who organized the 2013 MSU Symposium on Multicultural Psychology which focused on "The Clinical Psychology of Ethnic Minorities: Integrating Research and Practice". This is another example of activities from the presidential initiative which centered on "Disseminating Our Science to Expand Our Influence". This conference, which was part of the biennial MSU Symposium on Multicultural Psychology, was held October 25-26, 2013 at Michigan State University. The goal of the 2013 MSU Symposium was to provide a review of the current state of the field and to formulate research needs and identify directions for integrating research and practice in the field of ethnic minority clinical psychology. Leading researchers in the field were invited as speakers including members of section such as Dr. Alfiee Breland-Noble and Dr. Cheryl Anne Boyce. The invited presentations from the conference are scheduled to be published as a volume in the CMPR APA/MSU Symposium Book Series. In addition, the presentations were all videotaped and will be available for sale from Microtraining, an imprint of Alexander Stress Press soon (<https://www.academicvideostore.com/microtraining>) to provide dissemination to the field on clinical psychology and ethnic minority factors relevant for science and practice.

academicvideostore.com/microtraining) to provide dissemination to the field on clinical psychology and ethnic minority factors relevant for science and practice.

Section VII: Emergencies and Crises


Submitted by Marc Hillbrand, Ph.D.

 Section VII has presented a rich array of programs at the 2014 American Psychological Association Convention in Washington, DC. Anders Goranson, Psy.D., gave the Presidential Address, "The Myth of 'Just Snapped': A Risk Assessment Overview of the Sandy Hook Elementary School Shooting" and chaired the symposium "Veterans and Violence - Myths, Realities, and Innovations". Dale E. McNiel, Ph.D., was awarded the Section VII Lifetime Award and gave a talk entitled "Advances in Training in Assessment of Acute Risk of Violence to Self and Others". There was a symposium entitled "Suicide Risk in Active Duty Soldiers and Veterans: What's been Learned from Iraq and Afghanistan?" Phillip Kleespies, Ph.D., Chair. It included presentations by David Rudd, Ph.D., "Assessing Suicide Risk in Active Duty Military Personnel", Peter Gutierrez, Ph.D., "Assessing Suicide Risk in U.S. Military Veterans: Lessons Learned from the Current Conflicts", and David Jobes, Ph.D., "Active Duty Military and Veteran Suicide Risk: Perspectives from a Collaborative Clinical Approach", James Griffith, PhD, discussant.

It was possible for Section VII to present these programs in spite of the reduced number of convention hours assigned to the Sections starting in 2014. This was thanks to the APA Collaborative Programming Initiative. We are using the same strategy for the APA 2015 Convention and look forward to contributing programs on topics such as violence and suicide among the severely mentally ill.

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, Ph.D.

 The Association of Psychologists in Academic Health Centers (APAHC) continues to thrive with an energetic and creative Board, as well as numerous volunteers who help manage the day to day needs of the

Section Updates (*continued*)

organization. President Ronald T. Brown, Ph.D., ABPP continues to lead the APAHC Board and all initiatives.

The APAHC 7th National Conference will be held in Atlanta, GA, February 5-7, 2015, with the theme: "Academic Health Centers in the Era of Interprofessionalism: Multifaceted Contributions of Psychology." Keynote speakers include current APA President, Dr. Nadine Kaslow, who will address psychologist's roles in patient centered medical homes. Additional speakers represent various key organizations including ASPPB, APPIC, VA Office of Mental Health Operations, and many others. We continue to sponsor the Early Career Boot Camp, a poster session, and an opening reception. Both CoA site visitor and self-study workshops will precede the conference. Clinical Health ABPP exams can also be arranged during this time! Check website information at: <http://www.div12.org/section8/index.html>

APAHC continues a productive relationship with the AAMC (The Association of American Medical Colleges) with a variety of projects and the opportunity to impact medical training as well as the involvement of psychologists in medical school settings.

APAHC continues to enhance resources available on our website at: <http://www.div12.org/section8/>, including those related to teaching, writing, conducting research, and grant writing in the Behavioral Sciences. APAHC members place high value on the resources provided as a membership benefit. Of note, Drs. Ed Christophersen and Zeeshan Butt developed the *Promotions Primer* with a focus on career advancement and academic promotion. This resource was also highlighted through a recent publication in the *Journal of Clinical Psychology in Medical Settings*,

December 2012, Vol 19 (4), 349-352: "Introducing a Primer for Career Development and Promotion: Succeeding as a Psychologist in an Academic Health Center."

APAHC is proud of including a student member on the Board, with Laura Daniels, M.A. (from East Carolina University), as our first representative. Student members are invited to seek training in the peer review process through a mentoring process for the *Journal of Clinical Psychology in Medical Settings*. APAHC has also recently re-invigorated a Consultation Program, co-lead by Drs. Zeeshan Butt and Cheryl Brosig-Soto. Experienced consultation is available to APAHC members regarding career development, dealing with institutional or workplace opportunities, challenges, and barriers, and other professional development issues of concern.

Members continue to benefit from valued APAHC publications, including the *Grand Rounds* newsletter, and our flagship journal: *Journal of Clinical Psychology in Medical Settings*. APAHC welcomes new members, including student members. Membership dues are low and this is a great way to add to the benefits offered as a Division 12 member. For further information about APAHC/Division 12 Section 8, please check our website at: <http://www.div12.org/section8/index.html> or contact me directly at Sharon.Berry@childrensMN.org.

The entire APAHC community extends their best wishes to the Division 12 Administrative Officer, Lynn Peterson, who has served remarkably in this role for over 18 years and will retire at the end of 2014. You are the heart and soul of this division, and the historian for all that has transpired during the past two decades. We will miss you but wish you all the best in your next adventure! 📺

SOCIAL MEDIA AT THE SOCIETY OF CLINICAL PSYCHOLOGY

Follow Division 12 on **Twitter**:
twitter.com/SCPdiv12

Like Division 12 on **Facebook**:
www.facebook.com/pages/Society-of-Clinical-Psychology-Division-12-of-APA/155569667748



2014 APA Conference Photos

Jonathan S. Comer, Ph.D.—Editor

Society Snap Shots: Photos of Division 12 from the 2014 APA Annual Convention

Jonathan S. Comer, Ph.D.

The American Psychological Association held its annual convention in Washington, D.C. this past summer, and the Society of Clinical Psychology (Division 12) was on hand with members, students, early career psychologists, and eminent psychologists from across North America. Division 12's award ceremony took place on August 7 and we are pleased to report that an enjoyable time was had by all. Participants enjoyed cocktails, appetizers, a display of student posters, and of course, the presentation of awards. Below are a few snap shots of award winners and attendees from that evening. We look forward to seeing you at the next APA annual convention in 2015. Smile! 📷



CALL FOR AWARD NOMINATIONS

AWARD CRITERIA & PROCESS

No voting member of the Division 12 Board of Directors will be eligible to receive awards from the Division while serving their term.

Candidates can be simultaneously considered for multiple awards, although a psychologist may receive only one Division 12 award in any given year.

Nominations must include a CV and at least one letter of endorsement. Self-nominations are permitted and should include one external endorsement.

Please submit nomination materials to:

Awards Committee Chair
APA Division 12
PO Box 1082
Niwot, CO 80544-1082

Deadline: November 1, 2015

Inquiries should be directed to the Division 12 Central Office at 303-652-3126 or div12apa@comcast.net

SENIOR AWARDS

Award for Distinguished Scientific Contributions to Clinical Psychology

Honors psychologists who have made distinguished theoretical or empirical contributions to psychology throughout their careers.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology

Honors psychologists who have made distinguished advances in psychology leading to the understanding or amelioration of important practical problems and honors psychologists who have made outstanding contributions to the general profession of clinical psychology.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology

Honors psychologists who have made remarkable contributions to the understanding of human diversity and

whose contributions have significant promise for bettering the human condition, overcoming prejudice, and enhancing the quality of life for humankind.

Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology

Honors psychologists who display excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty. It will recognize those individuals who have been outstanding in supporting, encouraging and promoting education and training, professional and personal development, and career guidance to junior colleagues.

MID CAREER AWARD

American Psychological Foundation Theodore Millon Award

The American Psychological Foundation (APF) Theodore Millon, Ph.D. Award will be conferred annually (from 2008 through 2012) to an outstanding mid-career psychologist engaged in advancing the science of

personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. A review panel appointed by APA Division 12 will select the recipient upon approval of the APF Trustees. The recipient will receive \$1,000 and a plaque. Nominees should be no less than 8 years and no more than 20 years post doctoral degree.

EARLY CAREER AWARDS

David Shakow Early Career Award for Contributions to Clinical Psychology

Given for contributions to the science clinical psychology by a person who has received the doctorate within the past seven years and who has made noteworthy contributions both to science and to practice. Up to \$500 for travel to the APA Convention is awarded.

Theodore Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology (given jointly with APF)

Honors a clinical psychologist for accomplishments and promise in clinical psychology. Accomplishments may include promoting the practice of clinical psychology through professional service; innovation in service delivery; novel application of applied research methodologies to professional practice; positive impact on health delivery systems; development of creative educational programs for practice; or other novel or creative activities advancing the service of the profession. Nominees should be no more than ten years post doctoral degree. Amount of the award is \$4000.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology

This award will be conferred annually to an early career psychologist who has made exemplary contributions to diversity within the field. Such contributions can include research, service, practice, training, or any combination thereof. Nominees should be no more than seven years post doctoral degree.

GRADUATE STUDENT AWARDS

Recipients of the Division 12 graduate student awards must be matriculated doctoral students in clinical psychology (including pre-doctoral interns) who are student affiliates of Division 12. Nominations should include a copy of nominee's curriculum vitae and two letters of support detailing the nominee's service contributions to the profession and community. Recipients of

the awards receive a plaque, a \$200 honorarium contributed jointly by Division 12 and Journal of Clinical Psychology, and a complementary two-year subscription to JCLP & JCLP: In Session. The Division 12 Education & Training Committee will determine the award recipients.


Distinguished Student Research Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made exemplary theoretical or empirical contributions to research in clinical psychology. Clinical research contributions can include quantity, quality, contribution to diversity, and/or innovations in research.

Distinguished Student Practice Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made outstanding clinical practice contributions to the profession. Clinical practice contributions can include breadth and/or depth of practice activities, innovations in service delivery, contribution to diversity, and/or other meritorious contributions.

Distinguished Student Service Award in Clinical Psychology

Honors a graduate student in clinical psychology who has made outstanding service contributions to the profession and community. Service contribution can include development of creative educational programs or other novel activities in the advancement of service, contributions to diversity, working to increase funding for agencies, volunteer time, working on legislation regarding mental health, general mental health advocacy; as initiating outreach to under served communities or substantive involvement in efforts to do such outreach. 



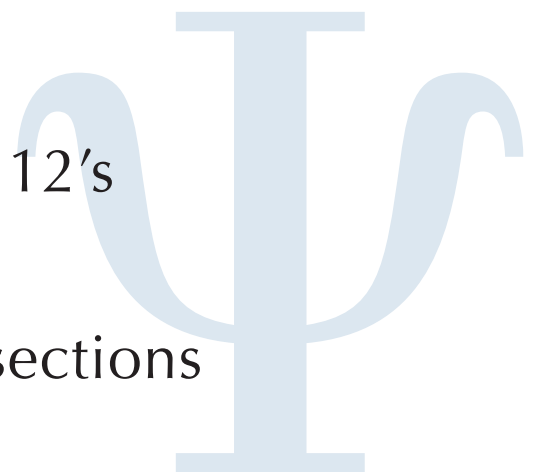
JOIN A DIVISION 12 SECTION

Division 12 has eight sections covering specific areas of interest.

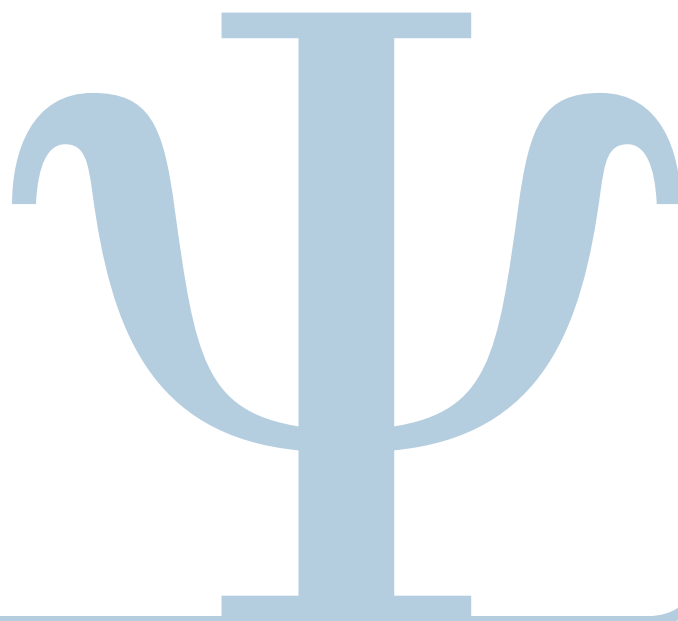
- Clinical Geropsychology (Section 2)
- Society for a Science of Clinical Psychology (Section 3)
- Clinical Psychology of Women (Section 4)
- Clinical Psychology of Ethnic Minorities (Section 6)
- Section for Clinical Emergencies and Crises (Section 7)
- Section of the Association of Medical School Psychologists (Section 8)
- Section on Assessment (Section 9)
- Graduate Students and Early Career Psychologists (Section 10)

To learn more, visit Division 12's
section web page:

www.div12.org/division-12-sections



To learn more about the
Society of Clinical Psychology,
visit our web page:
www.div12.org



Instructions to Authors



The Clinical Psychologist is a quarterly publication of the Society of Clinical Psychology (Division 12 of the American Psychological Association). Its purpose is to communicate timely and thought provoking information in the broad domain of clinical psychology to the members of the Division. Topic areas might include issues related to research, clinical practice, training, and public policy. Also included is material related to particular populations of interest to clinical psychologists. Manuscripts may be either solicited or submitted. Examples of submissions include: position papers, conceptual papers, data-based surveys, and letters to the editor. In addition to highlighting areas of interest listed above, *The Clinical Psychologist* includes archival material and official notices from the Divisions and its Sections to the members.

Material to be submitted should conform to the format described in the sixth edition of the Publication Manual of the American Psychological Association (2010). An electronic copy of a submission in Word format should be sent as an attachment to e-mail. Brief manuscripts (e.g., three to six pages) are preferred and manuscripts should generally not exceed 15 pages including references and tables. Letters to the Editor that are intended for publication should generally be no more than 500 words in length and the author should indicate whether a letter is to be considered for possible publication. Note that the Editor must transmit the material to the publisher approximately two months prior to the issue date. Announcements and notices not subject to peer review would be needed prior to that time.

Inquiries and submissions may be made to editor
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