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EDITORIAL STAFF

Editor: Jonathan S. Comer, Ph.D.
jocomer@fiu.edu

Assoc Editor: Kaitlin P. Gallo, Ph.D.
kgallo@mclean.harvard.edu

Editorial Asst: Lydia Chevalier, M.A.,
lcheval@bu.edu

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PRESIDENT'S COLUMN



“Let's Make SCP Great Again!”

**Bradley E. Karlin, Ph.D.,
ABPP**



There has arguably never been a more critical time for the field of

clinical psychology and, specifically, for the Society of Clinical Psychology (SCP), in light of recent professional developments. As I write this, my inaugural Presidential Column, on the eve of Super Tuesday and reflect on the present and future, I feel a sense of significant urgency and great opportunity to strengthen and grow SCP, building on, but expanding beyond, our rich history.

Developments within and outside of SCP urge that we focus on and invest internally in current members and in recruitment of new members. SCP, like many other professional membership organizations, has experienced significant declines in membership over the past several years, due to multiple factors. At a time when many are at a difficult choice point when considering writing their membership dues checks, and when there exist a spate of seemingly similar professional organizations, it is essential that we promote membership value and engagement among a broader array of members. In my candidate statement for SCP President, I wrote about hoping to “focus internally on the organization and bring fresh eyes, creativity, and vision to promote membership diversity, recruitment, and the value of the Society for a broader range of engaged members and leaders.” With the average age of SCP members just approaching the age of Medicare eligibility, it is essential that we make SCP an organization of early and mid-career psychologists, as well as more senior psychologists – and in so doing supporting and developing future leaders of clinical psychology.

For both the future of SCP and the field of clinical psychology, it is essential that we better connect with, be relevant to, and support early career and mid-

level psychologists, while also providing current value to and leveraging the senior members, luminaries, and leaders of clinical psychology within the Society. I would like to share some key initiatives – at organizational and programmatic levels – designed to achieve these important goals enthusiastically discussed and embraced by the SCP Board of Directors at the Mid-Winter Board Meeting in February.

Promoting membership value and engagement first requires that we address internal needs and opportunities, including how we connect and communicate with members (and prospective members). Below is a description of several strategic priority areas and activities at the organizational level that are designed to further engage and connect with existing and new members.

1) Inclusivity: Providing increasing opportunities for inclusivity and leadership among the broad membership of SCP is critical to the success of the organization. For SCP and the next generation of clinical psychology leaders to thrive, it is essential that we provide opportunities to members of varying backgrounds, perspectives, and experiences to develop and exercise leadership and engage in dialogue and discussion on key issues. I have already received enthusiastic messages from a number of members excited about being engaged – and engaging others. As part of the goal toward inclusivity and leadership, we have recently issued open calls for nominations for SCP committee and other leadership positions, with particular encouragement of nominations from early and mid-career psychologists, as well as others who may not have previously considered, or been considered, for leadership positions. I truly hope that many members respond to such direct calls – this is your organization and we need your input and individual leadership for SCP to thrive. In addition, we recently issued a special call for APA convention proposals specifically for students and early career professionals, which generated strong interest. And, Section 10 (Graduate Students and Early Career Psychologists) is planning a podcast on SCP's increasing focus on engaging and promoting leadership development opportunities for early career and student members.

2) Needs Assessment: In order for SCP to best serve the needs of and engage members – and thrive as a diverse and inclusive organization – it is important that we understand the needs of the membership and how SCP is meeting and could better meet members' needs. To be relevant, connected to, and supportive of our members, it is important that we have our finger more closely on the pulse of the membership. Accordingly, we are planning to conduct a membership needs assessment to identify members' needs, what

they value about SCP and SCP membership, and what might be done to promote the value proposition of SCP membership. This insight is essential for both recruiting and retaining members. Furthermore, such communication with the membership is likely to yield new insight, ideas, and creativity to aid both operational and strategic functions, including the development of a new SCP strategic plan in the future. I hope you will take a few moments to complete this important needs assessment when it is sent out in the near future and, in so doing, consider carefully how SCP is meeting your needs and suggest actionable recommendations for how we may increase membership value.

3) Mentorship Program: I am very excited to share with you plans we have for implementing a mentorship program in SCP – available to and potentially relevant to all members – which generated much interest and enthusiasm at the recent SCP Board Meeting. I have personally been involved in some mentorship programs (as both a mentor and mentee) that have been very successful and provided value and meaning on both sides of the mentor-mentee relationship. As part of the SCP Mentorship Program, a member (mentee) with a particular interest in receiving mentorship in a specific area would be paired with another member (mentor) with experience or expertise in that area. The program would be available for general mentorship in clinical psychology, as well as be organized by more specific interest areas (e.g., integrated care, evidence-based psychotherapies, working in academic medical settings, working with older adults, working in administrative, executive, or other “non-traditional” roles, establishing a practice, evidence-based assessment, working with specific minority populations, etc.). A mentorship program seems like a particular area of opportunity and fit within SCP given the rich experience of our members, both in terms of years of experience and the diversity of interests and expertise (as reflected, for example, by the 8 Sections in Division 12!). A mentorship program provides an ideal opportunity to bring together the younger and more senior members of SCP. And, with the average age of SCP members in the seventh decade of life (a decade in which Erik Erikson told us generativity is a major developmental focus), this seems like a natural opportunity. In fact, while there is hope that this could be a significant draw to younger mentees (both existing and new), this would be a program that could be directly relevant to and provide mentorship value to virtually all members regardless of age or professional experience, including members who may be interested in (1) expanding their clinical, scientific, or academic work, (2) exploring new fields, (3) pursuing second (or third!) careers, or (4) those just interested in promoting their connections, expanding their networks, or engaging in intimate intellectual discourse with other psychologists. Incidentally, my

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EDITORS:

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jocomer@fiu.edu

Associate Editor: Kaitlin P. Gallo, Ph.D.
kgallo@mclean.harvard.edu

Editorial Assistant: Lydia Chevalier, M.A.
lcheval@bu.edu

COLUMN EDITORS:

Ethics Column: Adam Fried, Ph.D.
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SECTION UPDATES:

2: Michele J. Karel, Ph.D. | michele.karel@va.gov
3: David Smith, Ph.D. | dsmith11@nd.edu
4: Elaine Burke, Ph.D. | eburke23@hotmail.com
6: Frederick Leong, Ph.D. | fleong@msu.edu
7: Marc Hillbrand, Ph.D. | marc.hillbrand@po.state.ct.us
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9: Paul Arbisi, Ph.D. | arbisi001@umn.edu
10: Natalia Potapova | natalia.potapova@email.wsu.edu

wife, who accompanied me to the SCP Mid-Winter Board Meeting, made a related (and poignant) comment to me that prompted me to mindfully reflect. As we returned to our hotel room following dinner with the Board, she (a change management and strategic communications professional – not a psychologist or member of a professional discipline) remarked how fortunate I was to have such a vast network of colleagues and with highly diverse interests (and this was just a subset of Board members she was basing this on!). A few moments later, I recognized that I had taken this somewhat for granted, as this is what I have known and experienced for many years. However, as she brought to my awareness, this is not the case for so many other professionals. We have an extremely deep well of intellectual resources that could make the Mentorship Program one of our most vibrant programs and bring us even closer together, and across Sections, as a professional organization. Let's leverage among the greatest and unique strengths of SCP – the considerable wisdom and experience of our successful and heterogeneous membership! We plan to gauge members interest in participating in a mentorship program in the forthcoming needs assessment described above, as well as inquire about potential areas of interest and expertise for mentees and mentors. If there is significant interest in such a program, we will plan to launch this later this year. I hope you will consider participating either as a mentor or mentee!

4) Existing and Prospective New Member Events:

With the support and leadership of the Membership Committee, we plan to implement a strategically developed and announced new and existing member event that would provide opportunities for meaningful networking and professional and leadership development. We are even exploring possibly incorporating speed mentoring, which some other organizations have held with great success, into the event. Such a member event would be preceded by a broad and strategic communications blitz to reach a large number of potential new members, as well as existing members. This would build on events SCP has held recently at ABCT and APA, as well as a Graduate Student Summit that was held a couple of years ago.

5) Strategic Communications and Outreach:


Strategic communications and outreach is an important component of SCP operations and is critical for successful retention and recruitment. It is essential that we communicate through the most relevant, appropriate, and high-yield channels, particularly those that are more likely to reach younger members and prospective members, including but not limited to social media. To accomplish this, we are exploring opportunities for low-cost, expert consultation and support in communications, branding, and marketing. In addition, we are exploring adding dedicated internal social media and communications capacity, building

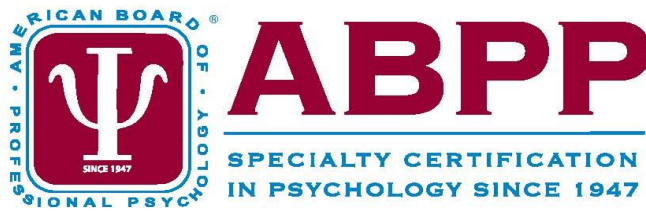
on the foundation established by SCP's Web Editor, Damion Grasso and others.

In addition to addressing key organizational needs and opportunities, we are excited to leverage programmatic level opportunities for the Society to be a content and thought leader in an emerging field in which there is no identified leader within professional psychology – namely, the field of dissemination and implementation. D&I is an emerging field of critical importance to bridging enduring gaps in science and practice and that fits very well with SCP's rich history and mission. For too long, we have focused so much in clinical science and practice on the "what" (i.e., specific treatments) and too little on the "how" (i.e., the process for how to get treatments into routine clinical practice). As the field of D&I has matured (and become increasingly empirically-oriented), research and experience has clearly shown that more active and sophisticated approaches to dissemination and implementation that account for facilitators and barriers at multiple levels of the organization or system can yield significant impact – much greater impact than reliance on traditional approaches that are more passive and one-dimensional (e.g., toolkits, clinical practice guidelines, etc.).

SCP is well poised to exert internal and external leadership in D&I at a time when many are seeking a home for dissemination and implementation within professional psychology. Moreover, D&I is a unifying area of opportunity, as it cuts across many different sub-fields within clinical psychology and within SCP, specifically. It is also a discipline that is of significant interest to many younger clinical psychologists, as well as to more seasoned clinicians and scientists within clinical psychology, including many treatment developers who yearn to see treatments that were the product of many years of labor realize their potential for impact. One of the greatest opportunities and privileges of my professional career has been to work to promote the broad dissemination and implementation of evidence-based psychological treatments for Veterans and to see the lives of many of our nation's heroes improve considerably when provided an opportunity to receive these treatments. I now work with various public and private systems to promote the broad dissemination and delivery of evidence-based psychotherapies and dementia care interventions.

I am energized to work together to advance these organizational and programmatic needs and opportunities. While the foregoing activities are priorities of my Presidential year, this endeavor will require a multi-year commitment and will continue with the strong support and leadership of President-Elect Michael Otto and the SCP Board.

It is an honor to serve as your president, a responsibility I take very seriously. I am committed to helping to advance the Society during this critical time and to working together to realize significant opportunities for us to make SCP great again! 



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Purging Disorder : A Brief History of Research on a New Eating Disorder

Pamela K. Keel, Ph.D.
Department of Psychology
Florida State University

 In 2005, the International Journal of Eating Disorders published, "Purging Disorder: An Ominous Variant of Bulimia Nervosa?" (Keel, Haedt, & Edler, 2005). To my knowledge, this represented the first use of the term "purging disorder" in the literature to characterize a syndrome marked by purging following ingestion of normal or small amounts of food in individuals who were not underweight. The absence of low weight meant that individuals could not be diagnosed with anorexia nervosa. The absence of large binge episodes meant that individuals could not be diagnosed with bulimia nervosa. The presence of purging precluded a diagnosis of binge eating disorder. As such, the condition fell beyond the bounds of recognized eating disorders in the DSM. Given the adage that "We study what we define" (Walsh & Kahn, 1997), I sought to move the field of eating disorders forward by introducing a name, a research definition, as well as data on the clinical significance and distinctiveness of this syndrome.

The title of the 2005 paper was an homage to a 1979 article by Gerald Russell, "Bulimia Nervosa: An Ominous Variant of Anorexia Nervosa" (Russell, 1979), in which he first introduced "bulimia nervosa" to name a binge-purge syndrome in patients who were not underweight. By 1980, "Bulimia" had been included in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III) (American Psychiatric Association, 1980). Although official recognition of purging disorder did not come as quickly or as decisively as it did for bulimia nervosa, the inclusion of "purging disorder" as a named syndrome among the Other Specified Feeding and Eating Disorders in the DSM-5 (American Psychiatric Association, 2013) represents a major advance in the field of eating disorders. This article provides an overview of my work on this condition as well as key findings that have emerged from research conducted by me and by others.

Although I would like to claim that I knew all along that I would be describing a new eating disorder, the truth is that I began this line of research somewhat accidentally. Based on a collection of research and clinical

experiences, I was frustrated by the requirement that eating episodes had to involve a large amount of food to be considered a "binge" in the DSM. In a 10-15 year follow-up study of bulimia nervosa, I found that many women were vomiting to control their weight but were no longer experiencing large binge episodes (Keel, Mitchell, Miller, Davis, & Crow, 2000).



Pamela K. Keel

Although the absence of binge-eating episodes indicated that they were in "partial remission," they did not seem to be meaningfully recovered to me. Around the time of this work, I began a clinical fellowship in the eating disorders unit at Massachusetts General Hospital and encountered patients who were purging but not binge eating. In the absence of evidence-based treatment for their symptom profiles, I attempted to adapt cognitive-behavioral therapy for bulimia nervosa to help them. However, I found myself struggling with the likelihood that these normal weight patients would gain weight as they undertook a regular pattern of eating and ceased vomiting – behavioral changes that are initiated immediately in treatment of bulimia nervosa. The psychoeducational information regarding the benefits of these behavioral changes for reducing the frequency of calorically-laden binge episodes did not seem particularly helpful given that my patients were not having binges according to the DSM. Finally, around this same time, I was recruiting participants for a study comparing bulimia nervosa to binge eating disorder. I was struck by the proportion of callers describing "binges" that did not involve a large amount of food and was alarmed that 70% of these callers were compensating for their episodes – most through self-induced vomiting. There are few things more frustrating than having people who volunteer for a study and excluding them because their eating disorder does not conform to the DSM's definition. Therefore my initial research was actually designed to improve the DSM's definition of bulimia nervosa so that it would be more inclusive of the problems I was seeing.

The first study tested the validity of the definition of binge-eating episodes as involving a large amount of food for a diagnosis of bulimia nervosa (Keel, Mayer, & Fischer, 2001). It seemed it shouldn't matter how much individuals ate before they purged given that

a person who felt compelled to vomit after eating 3 cookies was no less eating disordered than the person who felt compelled to vomit after consuming an entire package of cookies. (As a side note, this position is currently under active consideration for revising the definition of binges in bulimia nervosa in the upcoming International Classification of Diseases.) Indeed, it made little sense that a person who binged and purged twice a week would receive a full-threshold diagnosis whereas a person who purged multiple times per day but didn't binge would have a sub-threshold condition. This study focused on individuals who would have met DSM-IV criteria for bulimia nervosa, except that their binge-eating episodes were not large. These individuals had subjective binge episodes, in which they felt a loss of control over their eating and felt they had eaten too much, but did not eat more than others would eat under similar circumstances. We called the condition "subjective bulimia nervosa," fully expecting to find no meaningful differences in clinical significance between subjective bulimia nervosa and DSM-IV bulimia nervosa. In partial support of these expectations, we found no differences in current distress or global eating disorder severity. However, we found that individuals with DSM-IV bulimia nervosa were more impulsive. In retrospect, the unexpected finding made sense and was more valuable than our original expectations because 1) the finding linked impulsivity more directly to the presence of objectively large binge episodes in

bulimia nervosa than prior research had been able to, 2) the significant difference partially validated the DSM-IV definition of binge-eating episodes, 3) it had been ill-conceived to try to prove the null hypothesis with a small sample, and 4) if replicated, the result pointed to the possible existence of an alternative eating disorder presentation that might differ from bulimia nervosa on impulsivity and other factors that would make it a distinct disorder. This marked the transition to a new line of research in which I sought to examine the clinical significance and distinctiveness of purging disorder.

My next study sought to compare purging disorder to bulimia nervosa and healthy controls across a wider range of validators and included self-report and structured clinical interview assessments and 6-month follow-up assessments (Keel, Haedt, & Edler, 2005). Key findings were that purging disorder looked significantly worse across all measures of eating disorder and related psychopathology compared to controls and, again, looked similar to bulimia nervosa with the exception of key variables that were intuitively linked to the difference in binge episodes between groups. Purging disorder was characterized by lower levels of depression and anxiety, less hunger, and less disinhibition around food. The syndromes also demonstrated longitudinal stability. Women with bulimia nervosa were seven times more likely to continue to have bulimia nervosa as they were to have migrated

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to purging disorder, and women with purging disorder were more than ten times more likely to have purging disorder at follow-up as to have migrated to bulimia nervosa. Group differences in hunger and disinhibition also demonstrated longitudinal stability. If anything these differences grew more pronounced over follow-up. The differences in hunger and disinhibition fit with the clinical distinction between groups in amount of food consumed prior to purging. The difference in depression and anxiety seemed linked to differences in the frequency of loss of control over eating between groups. Although women with purging disorder could not have objectively large binge episodes, women with bulimia nervosa could have both objective and subjective binge episodes. As a consequence, loss of control over eating was more prevalent in bulimia nervosa than in purging disorder. A later integrated data analysis of samples across studies confirmed that frequency in loss of control rather than size of binge episodes was most closely tied to feelings of distress across syndromes characterized by purging (Forney, Bodell, Haedt-Matt, & Keel, in press).

This second study established the clinical significance of purging disorder while pointing to more distinctions between bulimia nervosa and purging disorder that were linked to their differences in eating behavior.

However, these data were based on two forms of self-report – questionnaires and interviews. Although participants had been quite open about their purging, it was difficult to set aside the nagging concern that we were only capturing differences in willingness to report candidly on eating behavior. Perhaps we were only capturing differences in positive self-representation biases. Building upon the self-reported differences, the next study examined a physiological correlate of bulimia nervosa posited to contribute to the presence of objective large binge episodes as a factor that should objectively distinguish purging disorder from bulimia nervosa.

In our third study, we examined cholecystokinin response to a standardized test meal in women with purging disorder, bulimia nervosa, and non-eating disorder controls (Keel, Wolfe, Liddle, De Young, & Jimerson, 2007). Our definition of purging disorder expanded to include all women who reported purging to control their weight or shape after normal or small amounts of food regardless of whether they experienced a loss of control over those eating episodes. Participants completed the same battery of self-report and interview assessments as used in our prior work and then came in for a second session in which we drew blood before and after they consumed a liquid meal to evaluate

their cholecystokinin response as well as their real-time experience of changes in hunger and fullness in response to food intake. We replicated all psychological findings from our prior study and extended these to demonstrate disorder-specific distress and impairment related to purging disorder in comparison to non-eating disorder controls (Keel, Wolfe, Gravener, & Jimerson, 2008). Further we established that disorder-specific distress was indeed higher in bulimia nervosa compared to purging disorder, underscoring the ego-dystonic nature of binge episodes compared to purging as central features of these disorders. Finally, we found that purging disorder and bulimia nervosa differed in their physiological and subjective responses to food intake (Keel et al., 2007). Women with bulimia nervosa had significantly lower subjective ratings of satiation and fullness and higher ratings of hunger compared to purging disorder and also demonstrated blunted cholecystokinin response to the liquid meal compared to purging disorder. Moreover, women with purging disorder experienced significantly greater increased in fullness and less hunger as well as more stomach ache and nausea compared to our control participants, providing initial clues to why they might experience a normal amount of food as intolerable.

Subsequent studies have attempted to better understand what factors contribute to the experience of normal amounts of food as being intolerable in purging disorder with the hope of identifying unique targets for intervention. We have expanded our list of physiological factors to examine leptin, glucagon-like peptide 1, peptide YY, and ghrelin. We have added an ad lib meal to behaviorally assess satiation in addition to our self-report assessments. In addition, my students have taken on dissertation studies employing ecological momentary assessment to capture real-time triggers and consequences of purging behavior (Haedt-Matt & Keel, 2015) and to examine the long-term outcome of purging disorder. This latter study involves recontacting participants from my original studies on purging disorder to describe course and

outcome and examine psychological and biological predictors of outcome at 10-year follow-up.

In addition seeing my students, Alissa Haedt-Matt and K. Jean Forney, obtain NIMH funding for their studies on purging disorder, I have been pleased to see other labs extend research on this important topic. A recent study out of Germany examined outcome of purging disorder compared to bulimia nervosa-purging subtype and anorexia nervosa with purging behavior (Koch, Quadflieg, & Fichter, 2013). Compared to anorexia nervosa, purging disorder demonstrated greater chronicity in maintenance of the same diagnosis from baseline compared to anorexia nervosa. In addition, women with purging disorder demonstrated a greater risk of premature death compared to women with bulimia nervosa. The crude mortality rate in bulimia nervosa was 1% at 5-year follow-up, compared to 5% for purging disorder. This indicates that 1 out of 20 women with purging disorder had died 5 years after entering treatment for their disorder, and the standardized mortality ratio was approximately 4, indicating a four-fold increase in risk of death compared to demographically matched population.

Population based epidemiological studies have established that the lifetime prevalence of purging disorders falls between 1-5% of women (Favaro, Ferrara, & Santonastaso 2003; Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006), placing its prevalence near that for anorexia nervosa and bulimia nervosa. Notably, these estimates come from studies in Italy and Australia. The most recent epidemiological studies of mental disorders in the US have been unable to capture data on purging disorder (Hudson, Hiripi, Pope, & Kessler, 2007; Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). Following the adage that we study what we define, structured interviews employed skip rules in which purging was only queried if participants endorsed low weight characteristic of anorexia nervosa or large eating episodes characteristic of bulimia nervosa. Conducting secondary analyses of

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an epidemiological study of college cohorts, we directly examined the impact of following such skip rules and demonstrated that 75-83% of symptomatic individuals were missed, the most common symptom combination resembled purging disorder. There was no difference in evidence of impairment associated with captured versus missed eating disorder diagnoses, and the time required to ask the missing questions increased assessment burden by a mere 1.8 minutes per participant! (Swanson, Brown, Crosby, & Keel, 2014).

In 2004, I was interviewed for an article in the New York Times titled, "Sorry. Your eating disorder doesn't meet our criteria" (Henig, 2004). In it, I commented, "It's very difficult to learn more about a problem if you never ask any questions about it." Thus, I encourage mental health professionals whether they are working in a research or clinical setting to include questions about purging to control weight or shape in their intake evaluations, particularly for high risk groups in which eating disorders are all too common. Data from my lab and others reinforce that purging disorder is a clinically significant disorder, characterized by distress, impairment, physiological alterations, and increased risk of death. Purging disorder does not appear to be an especially rare syndrome. Instead, it seems to have been overlooked for too long. ♣


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Jonathan S. Comer, Ph.D. - Editor

Ethical Issues in Participant Recruitment in Practice-Based Clinical Research

Adam Fried, Ph.D.
Fordham University

 Clinical research conducted in applied, practice-based settings, such as hospitals, community centers and clinics, provide valuable opportunities for researchers to identify and address traditional barriers to translating lab-based research to clinical practice (Atkins, Frazier & Cappella, 2006; DeFife, 2015). Such “real world” research can provide immediate applications that can have transformative effects on the provision of mental health services, providing relief to individuals suffering from mental illness. Research conducted in service settings requires careful planning, however, to address unique and complex ethical questions, especially with respect to the responsible conduct of research participant recruitment. While many of these ethical considerations have been empirically studied in medical research protocols (including clinical trials), there is a dearth of similar research and scholarship with regard to mental health and psychotherapy research.

Consider the following scenario. You are a client in a community mental health clinic receiving individual psychotherapy services, which you believe to be helpful. Your therapist recommends that you consider participating in a clinical research study that is currently being conducted at the clinic. The goal of the study is to better understand your mental health symptoms and includes lengthy and somewhat invasive psychological and medical assessments. You aren't sure you want to participate but you worry you will disappoint your therapist if you decline. You're also unsure whether your therapist considers the research an adjunct treatment to address your mental health symptoms, and by declining to participate, you worry you will be considered noncompliant and risk future services. You ultimately decide to participate.

This scenario reflects a number of the ethical considerations researchers must address when designing responsible recruitment methods in clinical research studies. The decision to participate in clinical research is likely motivated by a number of factors, including the prospect for direct benefit to improve one's condition and the opportunity contribute to scientific knowledge and possibly to help others suffering

from similar conditions. Informed consent provides individuals with the necessary information required to make an educated decision, while respecting an individual's right to make a decision about participation in research, treatment or assessment without coercion (Standard 8.02; APA, 2010). In this scenario, it is unclear whether the decision to participate is truly informed and voluntary. Namely, concerns about the perception of a possible discontinuation of service, even though not specified by the therapist and likely not part of the research protocol, may have motivated the decision. It is also possible that a different decision may have been reached if additional information had been provided, including a clear explanation of the nature and purpose of the research procedures, clarification that refusal to participate will not jeopardize the services that are currently being received, and clear explanations with respect to the differences between clinical care and research methods. [See Gyure et al (2014) for helpful recommendations regarding recruitment etiquette]

Influences on Research Decisions

When designing recruitment and consent procedures, it is important to remember that participants can experience pressure to participate from different sources. For example, in a study of adolescent decision-making to participate in clinical trials, Grady and colleagues (2014) found that one quarter of adolescents experienced pressure to participate from medical personnel, parents, and even research staff. Ethical recruitment techniques respect the self-determining rights of participants who possess adequate consent capacity to decide for themselves about participation.

Perceived and actual power differentials between patients and mental health researchers and providers may influence research participation decisions (Garland et al., 2008). Health care providers and researchers may be seen as authority figures, making it difficult for prospective participants to refuse suggestions or requests. Patients receiving care may also fear that participation in research is required for them to maintain their current health care services or that refusal to participate will result in a diminishment of services or other negative consequences (Fisher et al., 2002).

In addition to questions about the voluntary nature of consent, participants may be confused about what participation (or refusal to participate) may mean for their condition, especially when the experimental nature of the of the research is not clear. Researchers and individuals who refer prospective participants to clinical research should be aware that participants may view the research as a prescribed treatment (Stines & Feeny, 2008). This risk may be amplified in research conducted in treatment settings, such as hospitals and

community mental health clinics. Misunderstandings about the experimental nature of the research may also be compounded when the researchers are also providing clinical care.

Confusion about the Nature and Purpose of Research

Participants in clinical research may also hold erroneous and/or unrealistic beliefs about the research, including under or over-estimation of possible risks and benefits of research participation (Horng & Grady, 2003). For example, individuals recruited to participate in a study that seeks to understand different disease symptom presentations may believe that the study is designed to or holds the possibility of providing relief or even a cure. Relatedly, participants may also demonstrate erroneous beliefs that assignment to a research condition may be personalized based upon the participant's personal condition or medical needs (known as the therapeutic misconception; Appelbaum, Roth, & Lidz, 1982).

Finally, recruitment and research conducted by service providers requires careful planning and consideration to minimize conflicts between carrying out research

tasks and attending to the immediate clinical needs of participants through assessment and treatment. For example, findings from research in which clinicians who collaborated with investigators to conduct a psychotherapy study suggest that clinician adherence to research protocols during treatment sessions, including asking participants to fill out questionnaires or explaining research procedures, may be perceived to interfere with the therapeutic work (Castonguay, et al., 2010). Clinical research conducted in care settings must also take steps address possible confusion among individuals receiving services in terms of the primary role of the provider and purpose of the intervention.

Conclusion

Research conducted in practice-based settings provides a unique opportunity for investigators to address practical realities that may be critical to the effective translation of research findings into practice, but are often absent in traditional lab-based research protocols. This exciting line of research requires careful ethical planning to ensure that recruitment procedures are respectful, transparent and fair, taking into account the interaction between participant characteristics, consent setting and research methods.

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In particular, tailored ethical procedures should be considered for populations whose ability to consent (or decline participation) may be impacted by specific vulnerabilities, such as impaired consent capacities and/or social, economic or legal risks. ■■

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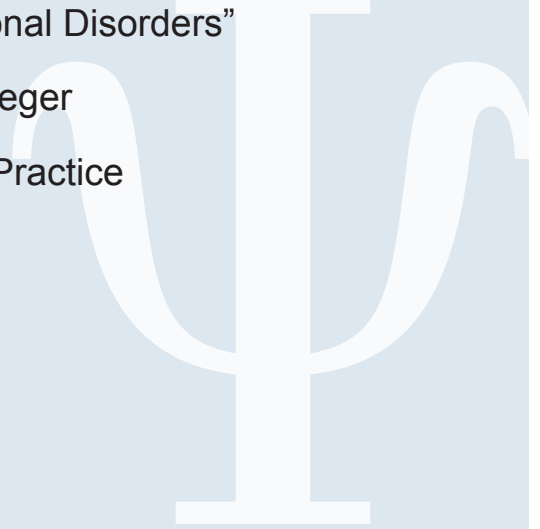
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Section VI: Clinical Psychology of Ethnic Minorities



The Clinical Psychology of Ethnic Minorities is pleased to share its new webpage: <http://www.div12.org/section-vi/>. Follow the link to learn more about the Section, its officers, membership benefits, and its social media outlets including Facebook, LinkedIn, and Blog.

The 2016 President of Section VI is Vincenzo G. Teran, Psy.D., a Staff Psychologist at Cambridge Health Alliance at the Harvard Medical School. Dr. Teran's presidential theme is, "Supporting the Ethnic Minority Psychologist Pipeline: Building Relationships and Fostering Personal and Professional Growth."

Section VI welcomes its new 2016 Officers. Omar Gudino, Ph.D., ABPP, an Assistant Professor in the Department of Psychology at the University of Denver, is the 2016 President-Elect. Mengchun Chiang, Ph.D., Faculty at William James College, is now Secretary. Ms. Thania Galvan, a doctoral student at the University of Denver, is joining Ms. Michelle Fong and Yasmin Cole-Lewis as a Student Representative. Lastly, Viviana Padilla-Martinez, Ph.D., Postdoctoral Fellow at the Edith Nourse Rogers Memorial Veterans Hospital, is joining the executive board as Membership Chair.

With respect to updates and news, Drs. Buchanan (Past President), Chiang (Secretary), and Teran (President) will be facilitating a workshop titled, "Responding to Microaggressions in Therapy, the Workplace and the College Classroom" at the 2016 APA Convention in Denver, CO. Additionally, Alfiee Breland-Noble, Ph.D. (2014 President) was recently awarded Fellow Status in Division 12. Congratulations, Dr. Breland-Noble! 🎉

Section VII: Emergencies and Crises

Section VII's President is stepping down and into the role of Section Representative. Danny Zamir will be assuming the role of President and Marc Hillbrand is President-Elect. The Chapter continues to focus on providing quality programming at APA and continued advocacy in the areas of risk assessment. This year's Annual Convention programming will focus on training risk assessment. The Section has additionally submitted a detailed comment to the APA Accreditation Commission concerning the need for psychologists to be trained in the evaluation and management of behavioral emergencies; that is, suicide risk and violence risk. We have been told that there will be a response to our comment by the CoA and we are awaiting that response. The Section also continues to focus on growing membership in early career psychologists and highlighting their research with our research award. 🎉

Section VIII: Association of Psychologists in Academic Health Centers

Submitted by Sharon Berry, PhD, ABPP

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 organization.

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. The APAHC Research Committee, lead by Gerald Leventhal, PhD, conducted an online survey in collaboration with APA Center For Workforce Studies to address questions

related to integrated care and interdisciplinary teams in various clinical work 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.

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.

Under the leadership of the APAHC Diversity and Disparities Task Force Chair, Dr. Alfiee M. Breland-Noble, the Task Force contributed to the 2015 APAHC conference by nominating Drs. David Satcher and Arlene Noriega as keynote speakers. Dr. Satcher's talk was very well received by all attendees and focused on the topic of integrated care as a mechanism for health equity. Dr. Noriega's timely talk focused on issues relevant for the mental health needs of LGBTQ populations. The TF also supported special outreach to the local HBCU (Historically Black Colleges and Universities) in the area to encourage their participation

in the conference including Drs. Satcher and Noriega's primary academic home, Morehouse School of Medicine. The TF is also planning to incorporate cultural relevance in evidence based and other forms of care through a planned special issue of the section's flagship journal Clinical Psychology in Medical Settings.

Members continue to benefit from valued APAHC publications, including the Grand Rounds newsletter, and our flagship journal: Journal of Clinical Psychology in Medical Settings. A recent newsletter featuring the creative talents of Editor Cesar Gonzalez, PhD, ABPP, focused on Rural Health. The March 2016 Journal will highlight articles based on presentations at the 2015 APAHC Conference: Academic Health Centers in the Era of Interprofessionalism: Multifaceted Contributions to Psychology.

APAHC welcomes new members, including student members, and board members reflect the diversity of those in academic health settings, including early career and student representatives. 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



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.div12.org/mentorship](http://www.div12.org/mentorship) to become a mentor today.

Congratulations to our 2016 Award Winners!

Award for Distinguished Scientific Contributions to Clinical Psychology presented to **Leslie C. Morey, Ph.D.** for distinguished theoretical or empirical contributions to Clinical Psychology throughout their careers.

Florence Halpern Award for Distinguished Professional Contributions to Clinical Psychology presented to **J. Gayle Beck, Ph.D.** for distinguished advances in psychology leading to the understanding or amelioration of important practical problems and outstanding contributions to the general profession of clinical psychology.

Stanley Sue Award for Distinguished Contributions to Diversity in Clinical Psychology presented to **Nolan Zane, Ph.D.** for 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 presented to **Gregory L. Stuart, Ph.D.** for excellence in mentoring clinical psychology graduate students, interns, postdoctoral fellows and junior faculty.

David Shakow Early Career Award for Contributions to Clinical Psychology presented to **Thomas M. Olino, Ph.D.** 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.

Theodore Blau Early Career Award for Distinguished Professional Contributions to Clinical Psychology presented to **Brian Hall, Ph.D.** and **Cara L. Lewis, Ph.D.** for professional accomplishment 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.

The American Psychological Foundation Theodore Millon Award presented to **Joshua Miller, Ph.D.** for outstanding mid-career advances in the science of personality psychology including the areas of personology, personality theory, personality disorders, and personality measurement. This award is given jointly by The American Psychological Foundation and the Society of Clinical Psychology.

Samuel M. Turner Early Career Award for Distinguished Contributions to Diversity in Clinical Psychology presented to **Lauren Mizock, Ph.D.** for 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.

Distinguished Student Research in Clinical Psychology Award presented to **Hannah Williamson** for exemplary theoretical or empirical contributions to research in clinical psychology.

Distinguished Student Practice in Clinical Psychology Award presented to **Halina Dour** for outstanding clinical practice contributions to the profession.

Distinguished Student Service in Clinical Psychology Award presented to **Chardée Galán** for outstanding service contributions to the profession and community.

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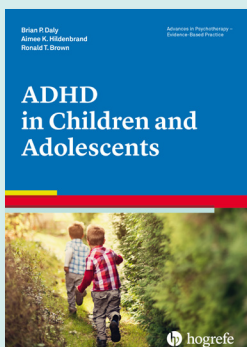
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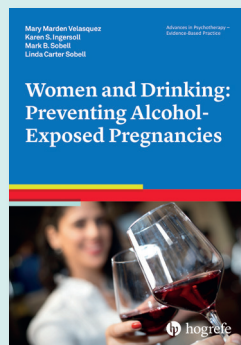


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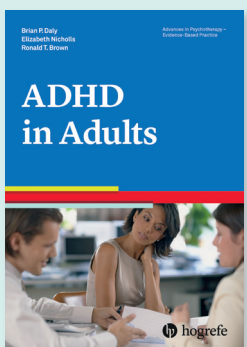
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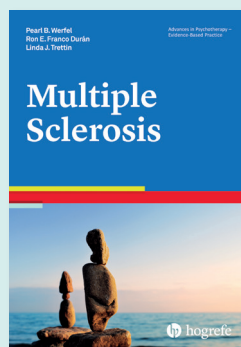


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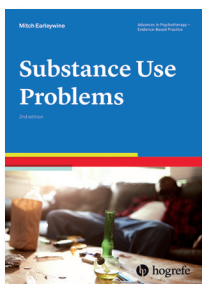
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