I graduated from the University of Wisconsin-Milwaukee in 2003 and subsequently completed post-doctoral training at Yale University School of Medicine. I took my first faculty appointment in the fall of 2004 at Oklahoma State University and subsequently (2007) joined the faculty at the University of North Texas where I am affiliated with the doctoral program in clinical psychology. Trained in the Boulder model, I highly value the integration of science and practice and strive to integrate these elements into all aspects of my work. As I emerged into an independent investigator, my research began to center on two themes: (1) improving services in the training clinic setting and (2) understanding distress and resiliency following exposure to trauma. The common ground between these two areas is that both include disproportionately high representation of financially disadvantaged individuals. Training clinics, in part because of the use of sliding fee schedules, are a major referral source for the disadvantaged. Similarly, traumatic experiences are common among financially disadvantaged individuals (Perkonigg, Kessler, Storz, & Wittchen, 2000). Below I will detail the objectives in each of these areas with illustrative contributions that my lab and I have accomplished.

**Long-Term Objective 1: Improve Psychological Services in the Training Clinic Setting**

Training clinics serve at least two important responsibilities: they serve an important training role with future providers and they also serve an important role in providing care to disadvantaged persons seeking low-cost services. Thus, my research spans both of these responsibilities. My first short-term objective was to identify if any barriers to improvement of services exist. Unfortunately, my lab has found that the rate of attrition can be very high, at 77% in two different training clinics (Callahan, Aubuchon-Endsley, Borja, & Swift, 2009; Swift, Callahan & Levine, 2009). A very large meta-analysis has recently confirmed that high attrition is uniquely associated with this type of clinic (Swift & Greenberg, 2012).

Thus, my second short-term objective was to understand contributors to attrition (Swift & Callahan, 2010). In seeking to understand attrition, we (Swift & Callahan, 2008) found that individuals expect a recovery rate (line A in figure) that is significantly higher than recovery rates evidenced in typical outpatient settings (lines B and C) or training clinics (line D). In addition, we found that the effect of patients’ pretreatment role expectations on premature termination was moderated by pretreatment effectiveness expectancies among training clinic patients (Callahan, Aubuchon-Endsley, Borja, & Swift, 2009). Across studies, the findings suggest that when expectations are not met, patients become dissatisfied and terminate treatment. Thus, my lab has worked to identify methods and develop measures for prospectively identifying individuals at risk of attrition through measurement of pretreatment expectancies (Aubuchon-Endsley & Callahan, 2009; Aubuchon-Endsley & Callahan, in press).

My third short-term objective was to thwart attrition in training clinics. Building off of the findings from my lab’s expectancies research, we randomly assigned clients to either an active control condition or to a pretreatment communication intervention (PCI) that targets patient expectancies. Patients assigned to PCI were three and a half times more likely (RR = 3.55) to complete treatment compared to patients in the active control condition. Fully 77% of the PCI patients were retained through the full course of treatment, while only 31% of the active control group completed treatment (Swift & Callahan, 2011). These findings were used to support a grant proposal earlier this year to the Patient-Centered Outcomes Research Institute (PCORI) for a multi-site phase II randomized clinical trial of PCI. This proposal was scored and invited for revision; resubmission is currently planned for the February 2014 cycle.

My lab’s work towards achieving the first long-term objective has brought up additional questions for investigation. As a result, we have made contributions examining (1) methods for classifying patient termination status (Swift, Callahan, & Levine, 2009); (2) convergence between trainee clinicians’ judgments and patients’ judgments (Farnsworth & Callahan, 2013; Swift & Callahan, 2009); (3) the role of client preferences in the treatment decision-making process (Swift & Callahan, 2009; Swift & Callahan, 2011; Swift, Callahan, Ivanovic, & Kominia, 2013; Swift, Callahan, & Vollmer, 2011; Tompkins, Swift, & Callahan, 2013); (4) the role and amount of variance in patient outcomes that is accounted for by supervisors of trainee clinicians (Adcock, Callahan, Aubuchon-Endsley, & Connor, 2012; Callahan, Almstrom, Borja, Swift, & Heath, 2009; Wrape, Callahan, Ruggero, & Watkins, in press); (5) processes of clinically significant deterioration (Swift, Callahan, Heath, Herbert, & Levine, 2011; Swift, Callahan, Herbert, & Heath, 2012) and symptom onset.
Long-term Objective 1: Translation and Implementation of the PPQ

Unfortunately, impoverished individuals are disproportionately exposed to traumatizing stressors and subsequently experience less resiliency. Although I study diverse stressors, I am most known for my work in the understudied area of high-risk pregnancy and infant mortality. My work on a novel measure of distress in this unique population has been translated into at least 5 languages. My first short-term objective was to establish an ongoing partnership to further this line of research. Developing this relationship and initiating research in my geographic region is extremely important in light of neighboring Dallas and Tarrant counties (which encompass the Dallas/Ft. Worth metroplex) consistently demonstrating elevated infant mortality rates. We have recently completed translation (to Spanish) and back-translation on an exhaustive battery of study measures and plan to initiate participant recruitment during spring 2014.

My second short-term objective was to increase dissemination of this line of research to a broader audience. To that end, my lab published a paper in the Journal of Perinatal and Neonatal Nursing to (1) identify traumatization risk and protective factors, (2) explain the range of possible mental health sequealae, and (3) describe the use of the PPQ for identification of distress in mothers as well as for outcome tracking when coupled with treatment (Callahan & Borja, 2008). In addition, we were invited by a Japanese journal to submit a paper on the topic of infant mortality (Callahan, & Dittloff, 2008).

My third short-term objective was to integrate the seemingly disparate psychological outcomes that have been reported following trauma exposure (i.e., resiliency, anger, anxiety) and elucidate pathways to recovery. First, we sought to examine different operationalizations of the appealing, but vague, construct of resiliency (Borja & Callahan, 2008). Second, we examined the relationships among personality variables, social support, and psychological outcomes to trauma (Borja, Callahan, & Rambo, 2009). Third, we sought to operationalize a comprehensive theoretical model, the Trauma Outcome Process Assessment (TOPA), and test it empirically with structural equation modeling (SEM) (Borja & Callahan, 2009; Callahan, Borja, Herbert, Maxwell, & Ruggero, in press). We have also examined trauma outcomes within specific populations, including World Trade Center first responders (Ruggero, Kotov, Callahan, Kilmer, Luft, & Bromet, 2013) and war-exposed children (Gerber, Hogan, Maxwell, Callahan, Ruggero, & Sundberg, in press). The data gathered from the accomplished international project on war-exposed children was recently used to support a grant proposal to Psychology Beyond Borders (under review) for a larger study focused on mental health outcomes among former child soldiers in Uganda.

Other Scholarship Contributions

I teach the doctoral sequence in clinical assessment and strongly believe that it is imperative that I attend to (1) illustrating the scientist-practitioner model to students enrolled in my courses, and (2) maintaining my own expertise in this area. Thus, some of my work has been primarily for this purpose (e.g., Almstrom, Wisdom, & Callahan, 2008; Hawkins et al., 2008; Heath & Callahan, 2013; Rambo, Callahan, Hogan, Hullman, & Wrape, in press; Rodriguez, Ruggero, Callahan, Kilmer, Boals, & Banks (2013); Wisdom, Callahan, Grice, Connor, & Nichols, 2012; Wisdom, Callahan, & Hawkins, 2011; Wisdom, Callahan, & Shaw, 2010).

Summary

In summary, I have amassed 67 publications (57 peer reviewed) at this time, with multiple additional manuscripts currently in press. In addition, I have received six grants to extend my work into the future. Both my students and I have been recognized for the high quality work we have accomplished together via competitive honors and fellowships. I am actively training the next generation of investigators researching mental health disparities and during the time of my LRP award I have directed ten masters theses and eight dissertations (additionally, three thesis and three dissertation projects are currently in data collection). Notably, students from my lab have gone on to prestigious internship positions [Medical University of South Carolina (trauma track), University of North Carolina, SUNY Upstate Medical Center, and Yale University School of Medicine] and early career jobs (program administrator with NIH, tenure-track university faculty).