Psychotherapy

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BULLETIN

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Division of Psychotherapy ■ 2013 Governance Structure

ELECTED BOARD MEMBERS

President
William B. Stiles, Ph.D.
P.O. Box 27
Glendale Springs, NC 28629
Phone: 336-877-8890
Email: stileswb@miamioh.edu

President-elect
Raymond DiGiuseppe, Ph.D.
Psychology Department
St. John's University
8000 Utopia Pkwy.
Jamaica, NY 11439
Ofc : 718-990-1855
Email: digiuser@stjohns.edu

Secretary
Barry Farber, Ph.D., 2012-2014
Dept of Counslg & Clinical Psychology
Columbia University Teachers College
525 W 120th St
New York, NY 10027
Ofc: 212-678-3125 / Fax: 212-678-8235
Email: farber@tc.columbia.edu

Treasurer
Jeffrey Zimmerman, Ph.D., ABPP 2013-2015
391 Highland Ave.
Cheshire, CT 06410
Phone: 203-271-1990
333 Westchester Ave., Suite E-102
White Plains, NY 10604
Ofc: 914-595-4040
Email: drz@jzphd.com

Past President
Marvin Goldfried, Ph.D.
Psychology
SUNY Stony Brook
Stony Brook, NY 11794-2500
Ofc: 631-632-7823 / Fax: 212-988-4495
Email: marvin.goldfried@stonybrook.edu

Domain Representatives

Public Interest and Social Justice
Armand Cerbone, Ph.D., 2012-2014
3625 N Paulina St
Chicago, IL 60613
Ofc: 773-755-0833 / Fax: 773-755-0834
Office Phone 2: 312 608 7674
Email: arcerbone@aol.com

Psychotherapy Practice
Barbara Thompson, Ph.D., 2013-2015
3355 St. Johns Lane, Suite F.
Ellicott City, MD 21042
Ofc: 443-629-3761
Email: drbarb@comcast.net

Education and Training
Jesse J. Owen, Ph.D. 2013-2015
ECPY Dept
College of Education and Human Dev.
University of Louisville
Louisville, KY 40217
Ofc: 502-852-0632
Email: jesse.owen@louisville.edu

Membership
Annie Judge, Ph.D. 2013-2015
2440 M St., NW, Suite 411
Washington, DC 20037
Ofc: 202-905-7721 / Fax: 202-887-8999
Email: Anniejudge@aol.com

Early Career
Susan S. Woodhouse, Ph.D. 2011-2013
Counseling Psychology
Department of Education and Human Services Lehigh University
111 Research Drive
Bethlehem, PA 18015
Phone: 610-758-3269 Fax: 610-758-3227
Email: woodhouse@lehigh.edu

Science and Scholarship
Norm Abeles, Ph.D., ABPP, 2011-2013
Dept of Psychology
Michigan State University
110C Psych Bldg
East Lansing, MI 48824
Ofc: 517-337-0853 / Fax: 517-333-0542
Email: abeles@msu.edu

Diversity
Caryn Rodgers, Ph.D. 2011-2013
Prevention Intervention Research Center
Albert Einstein College of Medicine
1300 Morris Park Ave., VE 6B19
Bronx, NY 10461
Ofc: 718-862-1727 / Fax: 718-862-1753
Email: caryn_rodgers@yahoo.com

Diversity
Beverly Greene, Ph.D. 2013-2015
Psychology, St. Johns University
8000 Utopia Pkwy.
Jamaica, NY 11439
Ofc:718-638-6451
Email: bgreene203@aol.com

APA Council Representatives
John Norcross, Ph.D., 2011-2013
Dept of Psychology
University of Scranton
Scranton, PA 18510-4596
Ofc: 570-941-7638 / Fax: 570-941-7899
Email: norcross@scranton.edu

Linda Campbell, Ph.D., 2011-2013
Dept of Counseling & Human Development
University of Georgia
402 Aderhold Hall
Athens, GA 30602
Ofc: 706-542-8508 / Fax: 770-594-9441
Email: lcampbel@uga.edu

Student Development Chair
Margaret R. Tobias, M.S., 2013-2014
1102 Battery Avenue
Baltimore, MD 21230
Telephone: 973-615-4399
Email: mrtobias@loyola.edu

STANDING COMMITTEES

Continuing Education
Chair: Tammi Vacha-Haase, Ph.D.
Dept of Psychology, Clark Bldg .
Colorado State University
Fort Collins, CO 80523
Ofc: 970-491-5729 / Fax: 970-491-1032
Email: Tammi.Vacha-Haase@ColoState.EDU

Diversity
Amit Shahane, Ph.D.
Emory University School of Medicine
Dept. of Psychiatry and Behavioral Sciences
341 Ponce De Leon Ave.
Atlanta GA, 30308
Ofc: 404-616-6760
Email: aashaha@emory.edu

Early Career Psychologists
Chair: Rayna D. Markin, PhD
Department of Education and Counseling
302 Saint Augustine Center
800 Lancaster Ave
Villanova, PA 19075
Email: rayna.markin@villanova.edu
Ofc: 610-519-3078

Education & Training
Chair: Jairo Fuertes, Ph.D.
Derner Inst. of Advanced Psychological Studies
Adelphi University Hy Weinberg Center Rm 319
158 Cambridge Ave.
Garden City, NY 11530
Ofc: 516-877-4829
Email: jfuertes@adelphi.edu

Fellows
Chair: Tammi Vacha-Haase, Ph.D.

Finance
Steve Sobelman, Ph.D.
2901 Boston Street, #410
Baltimore, MD 21224-4889
Ofc: 410-583-1221 Fax: 410-675-3451
Email: steve@cantoncove.com

Membership
Chair: Jean Birbilis, Ph.D.
University of St. Thomas
1000 LaSalle Ave., MOH 217
Minneapolis, Minnesota 55403
Ofc: 651-962-4654 fax: 651-962-4651
Email: jmbirbilis@stthomas.edu

Nominations and Elections
Chair: Raymond DiGiuseppe, Ph.D.

Professional Awards
Chair: Marvin Goldfried, Ph.D.

Program
Chair: Rodney Goodyear, Ph.D.
Email: rod_goodyear@redlands.edu

Psychotherapy Practice
Chair: Barbara Vivino, Ph.D.
921 The Alameda #109
Berkeley, CA 94707
Ofc: 510-303-6650
Email: bvivino@aol.com

Psychotherapy Research
Chair: Cheri Marmarosh, Ph.D.
Professional Psychology Suite 103
The George Washington University
1922 F Street
Washington, D.C.
Email: cmarmarosh@gmail.com

Social Justice
Chair: Rosemary Adam-Terem, Ph.D.
1833 Kalakaua Avenue, Suite 800
Honolulu, HI 96815
Ofc: 808-955-7372 / Fax: 808-981-9282
Cell: 808-292-4793
Email: drrozi@yahoo.com

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Published by the
DIVISION OF PSYCHOTHERAPY
American Psychological Association

6557 E. Riverdale
Mesa, AZ 85215
602-363-9211
e-mail: assnmgmt1@cox.net

EDITOR
Lavita Nadkarni, Ph.D.
lnadkarn@du.edu

ASSOCIATE EDITOR
Lynett Henderson Metzger, Psy.D.
lhenders@du.edu

CONTRIBUTING EDITORS

Diversity
Beverly Greene, Ph.D. and
Caryn Rodgers, Ph.D.

Education and Training
Jesse J. Owen, Ph.D. and
Jairo Fuertes, Ph.D.

Ethics in Psychotherapy
Jennifer A.E. Cornish, Ph.D.

Psychotherapy Practice
Barbara Thompson, Ph.D. and
Barbara Vivino, Ph.D.

Psychotherapy Research, Science and Scholarship
Norman Abeles, Ph.D., and Cheri Marmarosh, Ph.D.

Perspectives on Psychotherapy Integration
George Stricker, Ph.D.

Public Policy and Social Justice
Armand Cerbone, Ph.D., and
Rosemary Adam-Terem, Ph.D.

Washington Scene
Patrick DeLeon, Ph.D.

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Susan Woodhouse, Ph.D. and
Rayna Markin, Ph.D.

Student Features
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Central Office Administrator
Tracey Martin

Website
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PRESIDENT'S COLUMN

More on Closing the Gap between Research and Practice

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

Scholarly and professional organizations such as the Division of Psychotherapy exist for communication and advocacy. As I begin my year as President, I'm happy to report that Division 29 is continuing its history of achievement in both of these domains.

Communication

During 2013 we will celebrate the 50th year of publication of our journal, *Psychotherapy*, the jewel in Division 29's crown. Under the leadership of Editor Mark Hilsenroth, the journal will publish several special features to commemorate this golden anniversary. The first issue of 2013 will be a special issue entitled *Psychotherapy Outcome: A Return to the Beginning*. It will begin with a reprint of the journal's very first article, written by Hans Strupp, "The Outcome Problem in Psychotherapy Revisited" (1963, vol. 1, pp. 1-13) followed by reprints of a reply by Hans Eysenck (1964, vol. 1, pp. 97-100) and a short rejoinder by Strupp (1964, vol. 1, p. 101; note that volume 1 extended over 1963-1964). This exchange recapitulated the development of the debate about the effectiveness of psychotherapy in the decade following Eysenck's (1952) controversial critique. In the special issue, this reprinted exchange will be followed by articles by authors now active in psychotherapy process and outcome research, who will address progress on these issues over the intervening 50 years and offer suggestions for how the field can move forward. Later in this Golden Anniversary volume of *Psychotherapy* will be special issues on *Psychotherapy Training and Professional Development* and on *Clinical Process*. And there will be other special features.

As you know—or can see by reading further if you are reading this column in the *Bulletin* (it also appears on the web site)—*Psychotherapy Bulletin* is an official newsletter that is more than a newsletter—filled with substantive articles and commentary of interest to psychotherapy theorists, researchers, practitioners, and trainers as well as Division news. Thanks to persistent efforts by Libby Williams, who was Division 29 president in 2011, Internet Editor Ian Goncher and our web site team, and members who have lent us back issues to scan, we are building an electronic archive back issues of *Psychotherapy Bulletin* and other Division documents. The archive will make this accumulated information electronically available to all. To see the issues available now, go to http://www.divisionofpsychotherapy.org/publications/psychotherapy-bulletin/.

If you haven't done so already, I strongly recommend exploring the new Division 29 website, recently revamped by webmaster Ian Goncher with help especially from Steve Sobelman and Jeff Barnett. As you know or can see by further clicking if you are reading this column on the web site (it also appears in *Psychotherapy Bulletin*), there are many new resources, and the old ones are more accessible. Go to http://www.divisionofpsycho-

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therapy.org/.

As I write, Rod Goodyear, Program Chair, is constructing Division 29's program at the 2013 APA Convention, to be held July 31 through August 4 in Honolulu. More details will emerge soon. This is Division 29's annual chance to meet face to face. I hope to see you at the panels and poster sessions as well as at the Division's annual awards ceremony and social hour, which will include a celebration of the journal's golden anniversary.

Advocacy

A signal event in 2012 was APA's Resolution on the Recognition of Psychotherapy Effectiveness: http://www.apa.org/news/press/releases/2012/08/resolution-psychotherapy.aspx. Division 29's APA Council Representatives, Linda Campbell and John Norcross, along with other prominent Division members, including Nadine Kaslow and Melba Vasquez, played very significant roles in ensuring the integrity of the resolution and shepherding it through the APA legislative process.

We are proud that long-time member Nadine Kaslow, who was President of Division 29 in 2009, has has now been elected president of the whole APA for 2014. She joins a long and distinguished list of Division 29 members, officers, and presidents who have been elected to the APA Presidency.

Finally, we are putting our money where our aspirations are: In 2013, Division 29 will offer over $25,000 in awards and grants to advance research, practice, scholarship, and diversity in psychotherapy. As a member of the Division, you are eligible to apply. Calls for grant proposals appeared in the December issue of *Psychotherapy Bulletin,* and descriptions are available on the Division website: http://www.divisionofpsychotherapy.org/members/awards/.

The *Psychotherapy Bulletin* is Going Green:

Click on
www.divisionofpsychotherapy.org/members/gogreen/

EDITORS' COLUMN

Lavita Nadkarni, Ph.D.
Lynett Henderson Metzger, Psy.D., J.D.
University of Denver – Graduate School of Professional Psychology

We are again pleased to present you with papers that you should find informative and helpful in this first issue of the *Psychotherapy Bulletin* for 2013. We are thankful to have our previous talented team of contributing editors, domain representatives, division administrator Tracey Martin, and Editorial Assistant Jessica Del Rosario, and welcome our new contributors. We continue under the able leadership of Jeffrey Barnett and the Publication Board. The 2013 Contributing editors and Domain representatives are as follows: Caryn Rogers and Beverly Greene (Diversity), Susan Woodhouse and Rayna Markin (Early Career), Jesse Owen and Jairo Fuertes (Education & Training), Jennifer Erickson Cornish (Ethics), Annie Judge and Jean Birbilis (Membership), Barbara Thompson and Barbara Vivino (Psychotherapy Practice), Norman Abeles and Cheri Marmarosh (Psychotherapy Research, Science, and Scholarship), George Stricker (Psychotherapy Integration), Armand Cerbone and Rosemary Adam-Terem (Public Interest and Social Justice), Margaret Tobias (Student Features) and Patrick DeLeon (Washington Scene).

In this issue, we welcome William Stiles' first column as Division 29 President. There is an engaging article written by Andrés E. Pérez Rojas, Avantika Bathia, and Charles J. Gelso, which furthers the research on language switching within psychotherapy. Barry Wolfe has provided an insightful article on integrative psychotherapy. As many of us have just finished the selection process for graduate students and interns, we are privileged to have several articles which reflect the current status of education and training in psychology. You will find Melody Fo and Emil Rodolfo's article on internship training and Jesse Metzger and Barry Farber's article on doctoral training incredibly helpful. As always we are pleased to have student voices represented in the *Bulletin*—the three articles contained in this issue are found in the Ethics, Diversity, and Student sections. Pat DeLeon is back with his insights in the Washington Scene. Finally, we present a pro bono services initiative and survey from the Social Justice and Public Policy domain.

As usual, please contact us with your ideas, suggestions, criticisms, and comments. Your contributions are always welcome. All members are encouraged to submit work that you believe would provide interesting, scholarly, timely and useful information to the membership.

Lavita Nadkarni
(303-871-3877, Lnadkarn@du.edu) and
Lynett Henderson Metzger
(303-871-4684, lhenders@du.edu)

PSYCHOTHERAPY INTEGRATION

When My Integrative Treatment Fails

Barry E. Wolfe, Ph.D.
Rockville, MD

A key motivation that led me to look beyond my original "single school" psychotherapy orientation was the experience of failure (Wolfe, 1992). Trained originally as a Rogerian person-centered therapist, I attempted to treat specific phobias with this single school approach. Later, I discovered that cognitive-behavior therapy (CBT), although typically helpful was rarely ever a durable or comprehensive treatment for anxiety disorders. When the number of failures reached a tipping point, I was beset by a crisis of faith that eventuated in a commitment to an integrative perspective in psychotherapy (Wolfe, 2001). Since absorbing that initial insight on the limitations of any single orientation, I have labored to develop an integrative treatment model for anxiety disorders, one that would effectively treat both the symptoms and the underlying determinants of any anxiety disorder (Wolfe, 2005). Now two decades later, I have to report the astonishing outcome that my integrative psychotherapy is not 100% effective. In this brief report, I would like to share some of the reasons why my treatment fails and to describe some actual cases of failure.

Failure is a topic that has been rarely addressed in the psychotherapy literature (Lampropoulos, 2011). As a field, psychotherapy has been reluctant to publicize its defects. At least part of the field's inhibition may be due to the complexity of the construct of failure. As Lampropoulos (2011) points out, "Failure may include dropout, or premature/unilateral termination, nonresponse (no change), partial change, slow change, deterioration/negative effects, and relapse (failure to maintain gains)" (p. 1093).

But times they are a changing. In 2011, two different journals published a special issue on failures in psychotherapy. *Cognitive and Behavioral Practice* (Dimidjian & Hollon, 2011) focused on failures in evidence-based cognitive-behavioral therapy for specific disorders, while the *Journal of Clinical Psychology: In Session* (Lampropoulos, 2011) concentrated on presenting clinical material from a number of different therapeutic perspectives demonstrating both general and orientation-specific reasons for therapeutic failure.

Reasons for Therapeutic Failure

In the broadest sense, therapeutic failures, however defined, are due to patient/client factors, therapist-factors, and treatment and relationship-related factors. Across three major psychotherapy orientations (i.e., Psychodynamic, Cognitive-behavioral, and Experiential therapy), client/patient factors include:

- Severity of psychopathology
- Chronicity
- Symptom Comorbidity
- Personality characteristics
- Lack of motivation
- Trauma History
- Difficulty processing emotions
- Cognitive, behavioral and emotional avoidance
- Perfectionism

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- Severely negative self-concept
- Shame
- Problems of impulse control
- Lack of psychological mindedness
- An externalizing orientation (i.e., always blames others)
- Patients with unrealistic goals for therapy
- Patient-treatment mismatches
- Patient readiness and/or ambivalence about change
- Coexisting medical conditions or psychosocial stressors

Therapist-related factors include:

- Poor or inaccurate case formulation
- Therapist negative attitudes and behaviors, particularly therapist hostility
- Therapist inability to communicate interest, caring, competence and confidence
- Therapist failure to manage counter-transferential reactions to patients
- Therapist lack of flexibility in the conduct of their specific therapeutic approach
- Therapist difficulty in repairing alliance ruptures.
- Therapist's failure to establish a central therapeutic focus

Treatment and Relationship-Related factors include:

- Therapy duration
- Therapy frequency
- Difficulty of homework assignments or practice exercises
- Patient-treatment mismatches
- Sequencing of intervention components
- Poor therapy alliance
- Unresolved alliance ruptures

(Gold & Stricker, 2011; Hopko, Magidson, & Lejuez, 2011; Watson, 2011).

Failures in My Integrative Psychotherapy

One of the promissory notes of the psychotherapy integration movement has been that integrative approaches to psychotherapy would exceed the benefits produced by single school psychotherapies. The development of my integrative psychotherapy, which has been described in two earlier *Psychotherapy Bulletin* articles (Wolfe, 2011; 2006a), was based on the assumption that it eventually would become a more comprehensive and durable treatment for anxiety disorders than the mainstream cognitive-behavior therapy. It is a therapy that attempts to interlace ideas and procedures from cognitive-behavior, psychodynamic and experiential forms of psychotherapy. It begins with a symptom-focused CBT therapy and with the patient's interest and informed consent moves to a depth-oriented focus on the underlying painful self-perspectives that generate severe anxiety. Clinically, it has been found to be effective with specific phobias, panic disorder (with and without agoraphobia), social anxiety disorder, generalized anxiety disorder and obsessive-compulsive disorder (Wolfe, 2005). However, as yet, there have been no empirical studies conducted on this treatment.

When my treatment fails, it is usually because of one or more of the above-listed client-therapist-relationship factors. However, I have been able to isolate five recurring reasons for failure of my integrative therapy: (a) poorly managed counter-transference responses; (b) the undetected alliance rupture (c) patient does not buy therapist's rationale for treatment; (d) the tenacity of a patient's shame-based self-beliefs; and (e) the depth work seems too difficult and painful because of patients fear of their emotions.

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The therapist's poorly managed counter-transference

The most frequent reason for my therapy failures is a poorly managed counter-transference response to my patient. I once treated a stockbroker who was referred to me after a 20-day stay in a hospital for a severe depressive episode. I tried to maintain a position of empathic attunement with him, but the more he talked, the more difficulty I had in stomaching what he had to say. He had one goal in life, which was to make as much money as possible. He did not seem to care how he did it. He sold mortgages and was clear about his contempt for the buyer of his mortgages. He was very candid regarding the many stratagems he employed to manipulate and entice the unwary into purchasing his products. I felt myself tighten up whenever he would gleefully recount how he had snookered some poor sucker into buying a mortgage. Although I did not initiate the break, after 10 sessions, the patient concluded that additional sessions were likely to be unproductive. I knew I hadn't and probably couldn't give him the best psychotherapy of which I was capable.

Undetected alliance ruptures

A second major reason for therapeutic failures is the undetected alliance rupture. I once treated a psychology graduate student whose sister had recently and unexpectedly died. She was having a severe grief reaction. During our fifth session, I had invited her to engage in some empty chair work with her sister, which she gently refused. After that session, I never heard from her again, nor did she ever respond to my phone calls and letter inviting her to share with me her reasons for her abrupt therapy termination. I suspect that I had moved too quickly into a very painful and tender area of her emotional life, but I do not really know.

Patient does not buy therapist's rationale for treatment

Much earlier in my career, I saw a nurse who was suffering from frequent panic attacks and clearly would meet criteria for panic disorder. She was taking Xanax, but discovered that she was pregnant. She was very fearful of possible teratogenic effects of Xanax on the fetus, but did not know of any other effective treatments for panic. Realizing that she was medically trained, I carefully and tactfully outlined the psychosocial model of panic, which contrasted sharply with the biomedical model. When I had concluded my psychoeducational mini-lecture, her eyes were ablaze with astonishment and anger. "I've never heard of *that*," she said, referring to the psychosocial model. "That sounds like quackery to me," she added, and then proceeded to storm her away out of the office. This patient clearly did not buy the rationale for my treatment.

The tenacity of the patient's shame-based beliefs

Several patients that I have treated have suffered terribly from an all-encompassing sense of shame. One young woman in her early 20s began therapy by describing what sounded like some fairly routine obsessions and compulsions. She clearly met criteria for obsessive-compulsive disorder (OCD). Her major fear was that she was going to hurt or possibly kill a member of her family. She began to hide any sharp implements she could find. I was optimistic that exposure plus response prevention would at least be an effective symptom focused treatment. But what we jointly discovered was that her sense of agency had been so damaged by the shame she felt about her entire person (i.e., physical and psychological self) that she was unable to perform any homework assignment that I would give her. We were able to do some exposure work in session, but whatever apparent gains

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appeared would not last. Later her obsessions included the fear that she would spontaneously utter the N word, which would increase her sense of shame. Once again, we attempted in-session exposure work by having her say the N word over and over. But this produced minimal reductions in her obsessional fear. I tried everything I knew to work around the difficulties she had with the behavioral treatment, but nothing worked. Nonetheless she highly valued our sessions together. I was her only source of empathy. I reduced my efforts to empathic attunement and saw her for over two years. No progress was made on her obsessions or compulsions, but she was able to develop enough of a sense of agency that resulted in her obtaining two very different jobs. She excelled at both. When treatment was terminated, she was still suffering miserable from her OCD, but was able to function independently from her family. This was not a total failure, but I was very discouraged by my inability to help her ameliorate her OCD.

The depth-oriented work seems too difficult and painful

In my experience, I have had many patients benefit from the symptom-focused CBT treatment and then consciously decide that the depth oriented was either too difficult or too painful. They terminated therapy grateful for the reduction in their anxiety symptoms but clear that there was more work to be done on the underlying determinants of their anxiety disorder. A case in point was a man in his 60s suffering from obsessive-compulsive disorder. In preparation for a visit from his two year old granddaughter, he would spend five to six hours on his hands and knees meticulously examining every square inch of his house for little objects that he feared his granddaughter would place in her mouth and perhaps eventually swallow. For three months, we engaged in an Exposure Plus Response Prevention protocol that reduced his preparation from six hours to less than an hour. He initially agreed to engage in the third stage of my treatment, the depth-oriented phase that begins with a focusing technique designed to elicit the underlying painful perspective on self (i.e., self-wound) (Wolfe, 2006b). A memory quickly surfaced of his doing harm to an enemy soldier in an earlier war, which left him totally disgusted with himself. After this initial contact with his self-wound, he decided that the depth-oriented work was too difficult and painful for him to continue. Clearly, he received benefit from the symptom-focused phase of our work so that from my perspective this was a partial success and partial failure.

Conclusion

All therapies fail, even integrative approaches. For the most part, they fail for the same reasons that single school approaches fail. There may be differences in the relative frequencies of specific reasons for failure associated with specific approaches to psychotherapy. For example, many of my patients do well with the symptom-focused phase of treatment but have difficulty overcoming their fear of painful emotions. At the same time, I have found clinically that a comprehensive and durable treatment of an anxiety disorder usually involves a corrective emotional experience. However, to experience the latter, a patient must be able to grapple with the former, that is, their painful emotions associated with very negative self-beliefs. Some patients are not ready or able to confront and experience the pain and power of their negative emotions. This is, in fact, one of the most painful lessons that I have learned from my own therapeutic failures.

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

Does Language Matter? On Switching Languages in Psychotherapy

Andrés E. Pérez Rojas, M.S., Avantika Bathia, M.A., and Charles J. Gelso, Ph.D.
Department of Psychology, University of Maryland, College Park

Introduction

As the United States becomes increasingly diverse, it is also becoming increasingly bilingual. According to the 2011 American Community Survey from the U.S. Census Bureau, close to 21% of Americans speak another language in addition to English at home, a figure that has steadily risen in the last three decades. Bilingualism in the U.S. is also very diverse: Over half of the bilingual population speaks Spanish, with the rest speaking French, Chinese, and many other languages. Given these trends, it seems important to understand how language might influence the therapeutic process with bilingual people. The purpose of this study was to examine the role of bilingualism and cultural identity in shaping bilingual clients' perceptions of bilingual psychotherapists.

One variable that has garnered attention in the bilingual psychotherapy literature is language switching. Alternating between languages in conversation is normal and widespread among bilingual people (Heredia & Altarriba, 2002). Some authors have argued that encouraging bilingual clients to switch languages at strategic points in therapy may foster trust, genuineness, and uninhibited expression of affect in the therapeutic relationship (Margos & Urcuyo, 1979; Pitta, Marcos, and Alptert, 1978). More recently, Santiago-Rivera and Altarriba (2002) theorized that language switching could bolster the therapeutic bond and help clients express themselves in whichever language is most meaningful. They also posited that language switching could be seen as a culturally sensitive intervention that promotes greater understanding between the bilingual client and therapist.

The literature on language switching in psychotherapy, however, has relied almost exclusively on case studies (e.g., Pitta et al., 1978). Indeed, there exist only a handful of empirical studies on the effects of switching languages in therapy, and the data offer mixed support of its effectiveness. A recent qualitative study found that Spanish-English bilingual therapists viewed switching from English to Spanish as an effective way to build an alliance with their bilingual Latino clients (Santiago-Rivera, Altarriba, Poll, Gonzales-Miller, & Cragun, 2009). In turn, experimental analogue studies suggest that bilingual Latinos perceive therapists who switch from English to Spanish in therapy as being no more credible or multiculturally competent than English-monolingual therapists (Ramos-Sanchez, Atkinson, and Fraga, 1999; Ramos-Sanchez, 2009).

Several limitations of this literature are worth noting. Although Santiago-Rivera et al. (2009) provided valuable informa-

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tion about bilingual therapists' views on using language switching in therapy, it is unclear to what extent it actually helps form the alliance, given that only therapists' views were assessed. With regard to analogue studies, it is possible that the way in which therapists in these studies switched from English to Spanish was ineffectual. For instance, the therapists repeatedly spoke Spanish with clients who spoke to them only in English, and there was no indication in either study that such switching from English to Spanish was clinically warranted (e.g., to help clients articulate a thought). Thus, the theorized effects of language switching may have been nullified.

In light of these limitations, we sought to improve the manipulation employed in prior research by conducting an audio-analogue design study wherein a bilingual Latina therapist invited a bilingual Latina client to switch to Spanish when the client struggled to express herself in English. We were guided by theory and case descriptions (e.g., Rosensky & Gomez, 1983) that suggest that inviting bilingual clients to switch languages when they have difficulty expressing material may further the therapeutic work. We hypothesized that *an invitation to switch languages would have a positive effect on important psychotherapy process variables (i.e., therapist credibility, multicultural competence, therapeutic bond, and willingness to see a therapist)*.

We also wanted to see whether the invitation to switch languages would interact with cultural identity, which consists of ethnic and national identity (Berry, Phinney, Sam, & Vedder, 2006), to affect the dependent variables. There is evidence to suggest that how bilingual people evaluate others who switch between their languages during conversation may depend partly on their group identity (Tong, Hong, Lee, & Chiu, 1999). We hypothesized that the effect of the invitation to switch languages would be moderated by cultural identity. Specifically, we expected that *for participants high in ethnic identity, the invitation to switch languages would be positively related to all dependent variables, but for those low in ethnic identity the invitation would have no effect*. We also expected that *for participants high in American identity, the invitation to switch would have a negative effect on all dependent variables, but for those low in American identity the invitation would have no effect*.

Participants and Procedure

Participants were 63 (12 men, 51 women) Latino university students at a large mid-Atlantic university. Participants' ages ranged from 17 to 35 years with a mean of 19.97 years (SD = 2.87), and their generation status ranged from first to fifth generation, with the majority (63.5%) being second generation in the United States. With regard to language, 42 (66.7%) participants reported that Spanish was their native language; 18 (28.6%) said English was their native language; and three (4.8%) indicated they acquired both simultaneously. Based on self-reported estimates of English and Spanish usage, and self-reported ratings of proficiency in reading and writing, speaking fluency, and listening ability, participants could be regarded as fluent in both languages, but their more proficient and current dominant language was English.

We drafted and recorded two scripts of a session between a bilingual Latina therapist and client. Two sets of actresses played the therapist and client to minimize actress effects; otherwise both sets of recordings were identical, except for the manipulation of the independent variable. In the session, the client explored her feelings about a romantic breakup, and as she delved into deeper material, she struggled to articulate her-

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self. The therapist responded by either encouraging the client to continue exploring by switching from English to Spanish (*invitation to switch condition*) or to continue trying without inviting the client to switch (*no invitation to switch condition*). Doctoral students in counseling and clinical psychology programs rated the believability of each actress and that of the script in depicting a therapy session. On the basis of their responses, we determined that the recordings were believable and could be used as stimulus in the study.

About a week prior to the experiment, participants completed demographics and cultural identity measures. For the experiment, participants were asked to read background information on both client and therapist before listening to the recording. Participants were then randomly assigned either to the *invitation to switch* or the *no invitation to switch* condition. Afterward, they were asked to imagine what it would be like to work with the therapist to solve an emotionally painful personal problem, and to rate her credibility, multicultural competence, the alliance they would anticipate having with her, and their willingness to work with the therapist. They also completed a measure of socially desirable responding, and a manipulation check.

Measures

Participants' perceptions of therapist credibility were assessed with the Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983). This 12-item instrument assesses perceptions of therapist expertness, attractiveness, and trustworthiness, using a list of adjectives rated on a scale ranging from 1 (*not very descriptive*) to 7 (*very descriptive*). For this study, the internal consistency coefficient alpha of the total CRF-S was .92.

The Cross-Cultural Counseling Inventory-Revised (CCCI–R; LaFromboise, Coleman, & Hernandez, 1991) was used to assess perceptions of therapist multicultural competence. The CCCI-R has 20 items that are rated on a 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strong agree*). We chose a subset of six CCCI-R items for this study. The internal consistency alpha of the 6-item CCCI-R was .78.

We measured participants' anticipated alliance to the therapist with a modified version of the 12-item Bond subscale of the Working Alliance Inventory (WAI-B; Horvath & Greenberg, 1989). We recast the WAI-B's items in the future tense to assess the bond participants would anticipate with the therapist if they worked with her. The internal consistency coefficient alpha of the modified WAI-B was .84. We also asked participants to respond to a single-item question that assessed their willingness to work with the therapist in personal therapy.

To assess participants' identification with the larger American society as well as their ethnic culture, we used the American Identity Questionnaire (AIQ; Phinney & Devich-Navarro, 1997) and the commitment subscale of the Multigroup Ethnic Identity Measure-Revised (MEIM-R-C; Phinney & Ong, 2007). Both measures are composed of three items that are rated on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). For this study, the internal consistency coefficient alphas of both measures were .84.

Participants also completed the Balanced Inventory of Desirable Responding-6 (BIDR-6; Paulhus, 1991), which assesses two forms of socially desirable responding: Self-Deceptive Enhancement (SDE), which refers to the individuals' unconscious tendency to exaggerate their positive qualities, and

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Impression Management (IM), the conscious tendency to exaggerate positive qualities and appear normatively appropriate. The internal consistency coefficient alphas were .78 (SDE) and .80 (IM).

Results

Means, standard deviations, and intercorrelations of all continuous independent and dependent variables are shown in Table 1. Impression management significantly correlated with multicultural competence and the anticipated bond, and self-deceptive enhancement significantly correlated with willingness to see the therapist. Thus we included them as covariates in analyses involving those dependent variables.

We found no significant actress effects on participants' responses to the dependent measures, and no differences between participants assigned to conditions with respect to demographic variables. We also did not find differences on participants' responses to the dependent measures based on demographics. We did find, however, that women were significantly more willing to see the therapist than men. Given that there were too few men in our sample to explore this finding further, we simply added gender as a covariate when analyzing willingness to see the therapist.

Preliminary analyses also showed that the manipulation was successful. We asked participants to respond to a true-or-false question of whether the therapist asked the client to speak Spanish in the session. Every participant in the invitation to switch condition responded *True* to this question, and every participant in the other condition responded *False*.

The hypothesis that the invitation to switch languages would have a positive effect on all dependent variables was not supported. Univariate analyses revealed no significant main effects (p-values ranged from .15 to .66) of condition on any of the dependent variables. These results are summarized in Table 2. Hierarchical regression analyses showed that our interaction hypothesis was also unsupported. We found no significant interactions between experimental condition and participants' ethnic and American identities.

Discussion

Our results indicated that the therapist who invited the client to switch to Spanish was seen as no more effective than the therapist who did not invite the client to switch languages. These results reinforce previous findings that switch-

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Table 1.

Means, Standard Deviations, and Intercorrelations Among All Continuous Variables

Variable	*M*	*SD*	1	2	3	4	5	6	7
1. Credibility	5.43	1.06							
2. Multicultural Competence	4.80	0.74	0.54**						
3. Anticipated Bond	5.39	0.84	0.71**	0.57**					
4. Willingness to See Therapist	3.63	1.02	0.45**	0.29*	0.51**				
5. Ethnic Identity	4.51	0.66	0.08	0.11	0.20	0.24			
6. American Identity	4.08	0.97	-0.05	0.05	-0.16	-0.27*	-0.09		
7. Impression Management	6.56	3.92	0.14	0.34**	0.36**	0.31	0.06	-0.10	
8. Self-Deceptive Enhancement	5.56	3.59	-0.08	0.12	0.09	-0.36**	-0.01	0.05	0.34**

Note. Credibility = Counselor Rating Form – Short; Multicultural Competence = Cross-Cultural Counseling Inventory – Revised; Anticipated Bond = Working Alliance Inventory – Bond subscale; Willingness to See Therapist = Willingness Item; Ethnic Identity = Multigroup Ethnic Identity Measure-Revised Commitment subscale; American Identity = American Identity Questionnaire; Impression Management = Impression Management subscale of the Balanced Inventory of Desirable Responding-6; Self-Deceptive Enhancement = Self-Deceptive Enhancement subscale of the Balanced Inventory of Desirable Responding-6.

Table 2.

Means, Standard Deviations, and 95% Confidence Intervals of Therapist Credibility, Multicultural Competence, Anticipated Bond, and Willigness to Work with the Therapist as a Function of Experimental Condition

Dependent Variable	Experimental Condition					
	Invitation to Switch to Spanish			No Invitation to Switch to Spanish		
	M (SD)	95% CI	*n*	*M (SD)*	95% CI	*n*
Credibility	5.37 (1.02)	4.99, 5.74	33	5.49 (1.11)	5.10, 5.89	30
Multicultural	4.91 (0.77)	4.68, 5.17	33	4.67 (0.71)	4.41, 4.92	30
Anticipated Bond	5.31 (0.86)	5.04, 5.59	33	5.48 (0.84)	5.17, 5.75	30
Willingness	3.67 (0.85)	3.33, 4.04	33	3.60 (1.19)	3.25, 3.96	30

Note. Credibility = Counselor Rating Form – Short; Multicultural = Cross-Cultural Counseling Inventory – Revised; Anticipated Bond = Working Alliance Inventory – Bond subscale; Willingness = Willingness Item. Values for Multicultural and Anticipated Bond reflect an Analysis of Covariance (ANCOVA) in which impression management was the covariate. Values for Willingness reflect an ANCOVA in which self-deceptive enhancement and gender were covariates.

ing languages does not affect important process variables such as credibility and multicultural competence (Ramos-Sanchez et al., 1999; Ramos-Sanchez, 2009). The present study extends these findings to the working alliance and a willingness to work with a therapist. In short, it seems that bilingual Latino/as who are thoroughly immersed in English and American culture do not find an invitation to switch languages as a more or less effective intervention. Our findings also suggest that cultural identity may not affect how bilingual clients perceive therapists who invite clients to switch languages.

We acknowledge that there are important limitations to the present study. First, there are limits to the external validity of our findings given the inherent limitation of the analogue design. That is, reactions by actual bilingual clients to being invited to switch languages by actual bilingual therapists may be quite different from reactions to a simulated therapist. Future researchers should test our findings using other methods, such as a quasi-experimental design, with actual client-therapist pairs. Second, the client and therapist depicted here were Latina, whereas the bilingual population is quite heterogeneous. In fact, research in this area has focused on bilingual Latino/as, so it would be fruitful to extend the scope of this work to include people of different linguistic and ethnic backgrounds. Finally, our sample size was small, which may have limited the power to detect desired effects. Future researchers may try to replicate our findings using a larger sample.

Notwithstanding these limitations, the present results and those of similar prior studies challenge the prevailing view that language switching is an effective therapeutic intervention. Indeed, we do not think there is enough compelling evidence to suggest that language switching has the kind of effect on the therapeutic process that many theorists over the past several decades have posited. The evidence even suggests that language switching is, in fact, ineffectual with clients who are proficiently bilingual.

What to make of these contrasts? We think that the extant evidence taken as a whole suggests that language switching *in itself* is not an effective therapeutic intervention. It may be, for instance, that language switching is effective when the therapeutic alliance is strong, whereas it may have a negative or no effect at all when the alliance is weaker. This possible moderation hypothesis could explain why analogue studies have not found the positive effects of language switching described in case studies (e.g., Pitta et al., 1978) or that therapists endorsed in the Santiago-Rivera et al. (2009) study. Thus, the role that language switching plays in psychotherapy

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with bilingual clients may be more complex than has been theorized so far, and may be dependent upon factors that have not been considered yet. In this way, perhaps the most fundamental question to address going forward is for whom, under what conditions, and to what extent is it effective to switch languages in therapy?

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

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The Internship as a Scarce Resource: What Will Students and Our Profession Do?

Melody Joy Fo, M.A., University of California, Davis
Emil Rodolfa, Ph.D., California School of Professional Psychology-Alliant International University

The Impact of Internship as a Scarce Resource

Last year, 4435 desperate souls ran an epic race knowing not all of their companions would cross the finish line. After months of tabulating hours, drafting cover letters and essays, soliciting reference writers, and crisscrossing the nation for interviews, 53% of doctoral psychology applicants learned they matched to an APA or CPA accredited internship, 18% to a non-accredited internship, and 29% withdrew or did not match to a position (APPIC, 2012). For psychology doctoral students, the internship year is heralded as the capstone of training, the crowning achievement of one's graduate career, and the culmination of the journey as a trainee. Yet, each year, an increasing number of first time applicants are joined by applicants who did not match in previous years creating a bottleneck that worsens with each passing year (Keilin, Baker, McCutcheon, & Peranson, 2007; APPIC, 2013). It's clear that despite being a requirement for graduation and an essential aspect of training, the internship experience is becoming an increasingly scarce resource for an increasing number of students. This reality affects students long before they actually enter the match, throughout the grueling process of the match, and continues to haunt some students long after the match is over.

Students enter the match for the first time typically during the fourth year of graduate study, yet its impact on the four years prior cannot be underestimated. First year students quickly learn the internship year is a requirement for graduation and the fear of not matching can lead students to pursue the "hours game" at the cost of other opportunities. The belief that accumulating high numbers of direct clinical service hours increases one's chances of successfully matching with an internship program results in less time devoted to pursuits such as research, teaching, and program development. This pursuit may also lead to sacrificing quality for quantity. All too often students may select practicum training experiences based on the opportunity to accumulate clinical hours rather than the chance to pursue individual areas of interest or quality learning experiences. This has a cumulative detrimental effect when students reach the end of their training experience with a high degree of uncertainty about their treatment population of interest and what works well for them in the therapy office.

The internship imbalance additionally results in many students going to great lengths in an effort to maintain a competitive advantage. To meet minimum requirements, most students complete 20 hour per week practicum placements while enrolled in full-time coursework. As students advance in their training, some take on additional hours of

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practicum training in addition to possible research, teaching, or paid-employment responsibilities. For many students, this investment of time and energy results in postponement of relationships, marriage, and childbearing. In 2010, the median years to completion of a doctoral degree in a health service subfield of psychology was 5 years for a Psy.D and 6 years for a Ph.D. (Mulvey, 2011), with recent graduates reporting a mean age of 35 (Kohout et al., 2008). With the stark reality that 29% of students did not match in 2012 and the outlook appearing increasingly grim each year, the effect of this crisis on the sacrifices students feel pressured to make are all too real.

The match process itself is a test of endurance for many. Students are expected to commit to paper the professional, theoretical, multicultural, research, and personal identity they have masterfully developed over the past four years. Amidst the flurry of activity aimed in part at increasing one's odds at securing the scare internship resource, many students suddenly realize they've lost sight of the big picture. Aren't we here after all to learn about psychology, how to effect change in our clients, and who we are as psychologists? Yet, as students sit down to answer the big question of "who am I," some realize that in an effort to thwart the possibility of not matching, training opportunities were selected less with the goal of learning in mind and more with the goal of acquiring an internship. This stress and anxiety experienced by most students is compounded by the costs involved in the match process. In 2011, the average applicant spent $1,812 on application submissions, match registration fees, travel, and other costs associated with the match process (APPIC, 2011). Combined with the potentially disheartening possibility of not matching, for many students, the scarcity of internship positions results in a match process characterized by fear, anxiety, and stress.

In the hours, days, and weeks after match, students are thrown into a whirlwind of emotions, decisions, and realities many of which have enormous implications for their future. Those who successfully match may be required to move themselves and possibly family members across the country. Those who do not match during the first phase, may make decisions related to applying to more sites, withdrawing from the match, applying to non-accredited sites, or attending sites outside of the APPIC system. All of these choices have potential implications for students' futures related to licensure, mobility, employment, and eligibility for loan repayment (Madson et al., 2007). Those who remain unmatched or who prefer an APA accredited or APPIC member site will likely chose to enter the match again in the following year. Not matching can potentially undermine a students' self-confidence and impact financial obligations. A survey compiled by the APA Center for Workforce Studies (2009) paints a bleak picture of the debt the average student accumulates, as 78.1% of recent Ph.D. and Psy.D. students in health service provider subfields of psychology reported debt related to graduate education while 21.9% reported no debt. Of those students reporting debt, a mean of $88,610 was reported and ranged from no debt at all to $150,000. As a result of the internship imbalance, students appear to be paying increasingly high costs for graduate education that impact their future career trajectory, personal lives, and financial obligations.

Recently, a more subtle effect of the internship crisis has been the conflict surrounding efforts to better understand

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the issue and propose solutions. When viewed from a supply and demand perspective, some point to larger academic programs as playing a role in the introduction of more students to the applicant pool than the shared community resource can manage (Baker, McCutcheon, & Keilin, 2007; Madson et al., 2007). Others point out that students from more clinically oriented programs have a lower probability of success in the match process and subsequently may be unequally contributing to the decline in match rates (Parent & Williamson, 2010). In seeking responsibility for the scarcity of internship positions, a climate of blame has developed. This climate affects students who are already overburdened with the pressure of securing an internship, such that students from these identified programs may believe they are less likely to succeed in the match. For this reason, such students may settle for non-vetted internships, sites that do not align with their training goals, or sites that offer little or no monetary compensation. When students sacrifice the quality of their training, it creates a potential risk to those who receive our services and ultimately undermines the reputation of our profession (McCutcheon, 2011). Even the failure to acquire adequate compensation as an intern hurts not only students but also the reputation of their programs and the profession of psychology as a whole as it undercuts the fundamental worth of the valuable work we perform. Doling out blame as we deal with the internship imbalance ultimately works to undermine the value of our profession at a time when we need to unite if others are to take our profession more seriously.

The issue of declining internship match rates is not a concern limited to doctoral psychology students. Besides the experience of distress the imbalance creates for students as they navigate the match process, it has created a ripple effect that affects faculty and academic programs as well as the reputation of our profession.

So What's a Good Profession To Do?

Hatcher (2011) highlighted that the psychology internship imbalance has created binds for students and problems for the quality of education and the profession as a whole. Drawing on the literature of the management of scarce but renewable common pool resources, Hatcher provided specific suggestions to understand this problem and to resolve it. He encouraged doctoral programs and their academic associations to work together to develop a governance structure to manage the essential resource, the psychology internship position.

Clearly psychology internship positions are a scare resource. Only 80% of internship positions in the APPIC Match are APA Accredited while the majority of the remaining 20% are APPIC member programs (APPIC, 2012). Some other internship programs have developed and are members of local rather than national associations (Schaffer et. al, 2011). In addition, some academic programs have developed captive internships (Cornish, Smith-Acuna, Nadkarni, 2005) that may or may not participate in the APPIC Match. But unfortunately, these positions cannot handle the current number of students applying for internship, as almost 30% of students applying for internship in 2012 did not match. Hatcher (2011) called for increasing collaboration between the academic program associations in order to manage the demand for internships, but little has changed since his call to action except the number of students who did not match increased.

As described earlier in this paper, students are paying a significant price

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due to a training process that may or may not lead to an internship position and the ability to take the next step to reach a student's career goal. Clearly the comments presented earlier in this paper provide a first hand account of the painful road that all doctoral students are on. APA has required that programs provide basic information about the match rates to potential students. But applicants to doctoral programs rarely know anything about the need to examine program match rates. Undergraduate psychology advisors need to do a better job informing doctoral program applicants about the difficulties and pitfalls in the educational process leading to becoming a psychologist. If this is done and students are adequately informed about these issues, the number of students seeking a doctoral degree in psychology may experience a significant reduction.

Once accepted into a doctoral program, faculty should help students understand that the "hours game" described above may have limited utility. Students are spending significant effort to accrue hours of supervised experience at the practicum level at the cost of other aspects of their program. Rodolfa, et al. (1999) and Ginkel, Davis, and Michael (2010) replicating the Rodolfa, et al. study found that although hours were important, many aspects of the internship application process were important to internship training directors. Although this issue has been discussed by the APPIC Match Coordinator (Keilin, Baker, McCutcheon, & Peranson, 2007), students may gravitate to accruing hours because it is something they can do to feel an enhanced sense of control over a process where they have limited control.

Rodolfa, et al. (2009) highlighted numerous suggestions to resolve the match imbalance. They encouraged APA to follow-through and do a workforce analysis. Although APA has taken steps to develop the foundation for a workforce analysis (Rozensky, et al., 2007), APA has not completed this task. Our nation is struggling with conflicts and problems that call for resources to help resolve them and support our citizens. Peterson and Rodolfa (2000) described the need for more not fewer psychologists, while Robiner and Crew (2000) emphasized that the need for psychology practitioners has plateaued. Without a workforce analysis, we will not know the real answer.

What is clear, however, is that the number of psychologists should not be driven by the bottleneck at internship. The profession of psychology must come to a consensus on the nature of this problem and take significant steps to relieve the bottleneck.

The American Psychological Association should be commended for developing $3,000,000 in grants to reduce the imbalance by creating up to 530 new internships (Dingfelder, 2012). Surprisingly, however, the number of grant dollars awarded has been significantly less than what APA offered resulting in approximately 75 internship positions. Does that mean there are not sufficient programs interested in developing accredited internships?

Our nation needs the mental health assistance offered by psychologists and should better support the education of those psychology trainees who will provide this service in the future. The profession of psychology also needs to better support the students upon whose shoulders our profession rests. Students should experience a sequence of training that is not clouded by unnecessary anxiety due to the bottleneck at internship. This sequence of training to become a

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psychologist should be challenging, engaging and supportive to help students learn the competencies of the profession. It should not be divisive or unnecessarily anxiety provoking.

For at least 16 years the internship imbalance has existed and grown. The profession has highlighted the courageous conversations (Grus, McCutcheon, & Berry, 2011) it has had discussing what to do about the imbalance, but the imbalance continues to grow. It is truly time for the academic associations to take strong action to eliminate the internship bottleneck and create a new and healthy training environment for students seeking to enter the profession of psychology who will be trained to provide service to a public in need.

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

NOTICE TO READERS

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

Clinical Psychology Ph.D. Program Admissions: Implications of the Mentor-Model Approach

Jesse A. Metzger, Ph.D., McGill University, Montréal, Canada
Barry A. Farber, Ph.D., Teachers College, Columbia University

The values and processes of admissions committees in clinical psychology Ph.D. programs have a direct impact on not only the selection of clinical psychologists, but also, by extension, on the nature of their training, on those who ultimately use their services (e.g., clients), and on the shape and quality of the field at large. Research has affirmed the importance to these admissions committees of applicant research interests, experience, and productivity; match between applicant and program; and an epistemic orientation to scientific inquiry (Keith-Spiegel, Tabachnick, & Spiegel, 1994; Keith-Spiegel & Wiederman, 2000).

The high valuation of applicant research skills is often tied to programs' use of a "mentor-model" approach to graduate education and admissions. In this model, graduate students and mentors form extended relationships centering primarily on research and scholarly activities (Ponce, Williams, & Allen, 2005). Most clinical psychology programs combine elements of mentoring by individual faculty with training on a more general programmatic level. Typically, though, the stronger the emphasis on research in a given program—and the more research-oriented the faculty—the more prominent the role of individual mentoring in a student's training (Clark, Harden, & Johnson, 2000; Fauber, 2006), as faculty are invested in working with students who believe in their research, work in their labs, and publish.

Benefits of positive mentoring relationships include student development of professional skills, enhancement of confidence and professional identity, scholarly productivity, enhanced networking, dissertation success, and satisfaction with one's doctoral program (Clark et al., 2000; Johnson, Koch, Fallow, & Huwe, 2000). However, some see the mentor model as primarily serving the needs of individual faculty members of programs rather than the students for whom it was ostensibly designed. Karon (1995), for example, suggested that the mentor model leads to a restriction of originality and intellectual risk-taking in the realm of student research. Moreover, in at least some cases, there is a marked discrepancy between what applicants to clinical programs are primarily selected for (specialized research skills) and what they primarily end up doing (clinical work) (Craighead & Craighead, 2006; Gelso, 20006).

How does the model impact the admissions process? First, applicants are now more often encouraged or explicitly asked to specify the faculty member(s) with whom they would most like to work; they come to expect that their application materials will be viewed by these faculty members and thus aim to appeal to their interests. Second, the evaluation process becomes one by which the applicant's match with a par-

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ticular faculty member's research is emphasized over his or her fit with the program's general goals or clinical ability. A third implication is that faculty may feel pressure to admit only those applicants whom they view as "low risk/high-probability contributors to the successful operation of their labs" (Fauber, p. 231), as opposed to applicants whose interests and talents may be more diverse, let alone clinical in nature.

This study explored both the extent of the role of the mentor model in clinical Ph.D. programs and the direction of its impact on a variety of program domains, including student and faculty scholarly productivity, programmatic morale, and the overall quality of the student body.

Method

Participants

Participants (N = 50) were Directors of Clinical Training (DCTs) of APA-accredited clinical psychology Ph.D. programs in the U.S. and Canada whose programs were listed on the APA "Accredited Programs in Clinical Psychology" website (APA, 2009, May 21). The response rate was 29.2%, with 50 out of 171 DCTs recruited completing the survey. Of those responding, 56% were male, 42% were female, and one participant did not report his or her gender. Mean age was 50.08 years (SD = 7.87; range = 34 to 69); mean number of years as DCT was 5.52 (SD = 5.75; range = 1 to 28).

As rated by DCTs, programs tended to be somewhat more research-oriented than clinically-oriented (M = 5.09, SD = 1.14; where 1 = extremely clinically oriented, 4 = equal emphasis, and 7 = extremely research oriented), to place significant emphasis on evidence-based treatments (EBTs) in their clinical training (M = 5.39, SD = 1.02), and to emphasize a cognitive-behavioral (CBT) orientation (M = 5.49, SD = 5.49). Other orientations were considerably less emphasized, including psychodynamic, M = 2.55, SD = 1.41. The majority of programs endorsed a scientist-practitioner training model (70.5%, n = 31), followed by a clinical-scientist training model (27.3%, n = 12).

Measure and Procedure

A questionnaire was designed specifically for this study. Program characteristics of clinical-research emphasis, degree of program emphasis on EBTs, and program theoretical orientation were assessed using 7-point Likert scales. The extent to which DCTs believe their programs utilized a mentor-model approach to admissions was also assessed via 7-point Likert scale (1 = not at all, 7 = exclusively).

Data collection took place over a two-month period in the Spring of 2009. All 171 DCTs were emailed a letter of invitation to participate in "a research study on the clinical psychology Ph.D. program admissions process," an informed consent form, and a link to access the online survey. A second, "reminder" email was sent one month after the initial email.

Results

The DCTs in this sample tended to somewhat-to-strongly agree with the statement, "the emphasis in clinical psychology Ph.D. program admissions has shifted toward a mentor-model approach in recent years (toward 'matching' admitted applicants with particular faculty members)" (M = 5.48, SD = 1.27, where 1 = very strongly disagree, 4 = no opinion/not sure, and 7 = very strongly agree). On average, their programs tended to utilize a mentor-model approach "most of the time" (M = 5.82, SD = 1.17, where 1 = not at all, 4 = no opinion/not sure, and 7 = exclusively). The

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extent to which DCTs agreed that admissions has shifted toward greater use of the mentor-model was moderately associated with program CBT emphasis (r = .40, n = 43, $p < .01$) and EBTs in the training of students (r = .36, n = 44, $p < .05$).

To what degree do DCTs whose programs utilize a mentor-model approach to admissions at all—all but one in this study—believe this approach has had a positive or negative impact on 20 program domains? As Table 1 indicates, only two item means fell below the "no impact" mid-point, indicating a "somewhat negative impact": applicant honesty about research interests (M = 3.63, SD = 1.30) and admission of applicants whose research interests are broad/varied (M = 3.68, SD = 1.23). However, the proportion of negative responses data—endorsement of rating points 1, 2, or 3 on the scale—indicates that considerable percentages of DCTs also believe that the mentor-model has led to a decrease in the admission of clinically talented applicants (nearly 25%), the degree of originality of student research projects (22%), the diversity of the student body (19.5%), and faculty cohesion (19.5%). By contrast, no DCT indicated any degree of negative impact of the mentor model on faculty scholarly productivity.

Discussion

The results of this study indicate that the mentor-model approach is at the very

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Table 1

Mean Ratings of Domain-Specific Impact of Mentor-Model Approach

Domains	*M*	*SD*	*n*	Proportion of Negative Response
Student scholarly productivity	5.98	1.11	41	2.4%
Faculty scholarly productivity	5.88	.95	41	0.0%
Overall quality of student research	5.83	1.14	41	2.4%
Faculty morale	5.78	1.24	41	7.3%
Student morale	5.51	1.05	41	7.3%
Average number of years to student program completion	5.39	1.28	41	7.3%
Overall quality of the student body	5.39	1.34	41	9.8%
Overall quality of student writing	5.29	1.29	41	7.3%
Student involvement in professional organizations	5.15	1.17	41	2.4%
The field of clinical psychology in general	4.88	1.20	40	12.5%
Programmatic cohesion/sense of community	4.88	1.35	41	14.6%
Overall quality of student clinical work	4.83	1.28	41	7.3%
Faculty cohesion	4.71	1.42	41	19.5%
Curriculum	4.60	.98	40	2.4%
Degree of originality of student research projects	4.54	1.25	41	22.0%
Diversity of the student body	4.32	1.23	40	19.5%
Maintenance/achievement of desired gender ratio	4.22	.76	41	2.4%
Admission of clinically talented applicants	4.10	1.16	41	24.4%
Admission of applicants whose research interests are broad/varied	3.68	1.23	41	56.1%
Applicant honesty about his/her research interests	3.63	1.30	41	56.1%

Note. "Negative responses" = 1, 2, or 3 on 7-point Likert scale.

heart of most clinical psychology Ph.D. program admissions. The data point to many perceived benefits of the mentor-model approach, yet also suggest some troubling trends.

The DCTs in this study reported that this model has a positive effect on most domains of their programs. The finding of its perceived positive impact on students—in particular, on student scholarly productivity, quality of student research and writing, student morale, years to student program completion, quality of the student body, student involvement in professional organizations—is consistent with research by Clark et al. (2000) and Johnson et al. (2000), whose clinical psychology graduate student participants reported similar benefits. It is noteworthy that most of these domains, while beneficial to students themselves, also benefit programs' standings with respect to APA accreditation standards. The model's perceived positive impact on faculty domains—faculty scholarly productivity and morale—suggests that faculty are motivated to admit students who will contribute to the success of their research labs, and that their productivity goes hand-in-hand with high morale.

Thus, the model appears to carry clear benefits for students, faculty, and programs in general. At the same time, according to DCTs, the mentor-model approach has a negative impact on the admission of applicants whose research interests are varied, as well as on applicant honesty about research interests. Although some applicants who initially "modify" their interests to secure a match with a mentor may later find great satisfaction in this research, there is something unsettling about this pattern. Indeed, to the extent that the mentor-model rewards dishonest reporting by some applicants, the question arises as to whether this constitutes a violation of the APA's (2002) Ethics code. According to Principle C: Integrity: "Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or *intentional misrepresentation of fact*" (emphasis added). While these applicants are not yet psychologists, it seems troubling that practically the first step in their training process may de facto steer them toward behavior that falls short of professional standards of integrity.

There are several limitations of this study. The first is the relatively low response rate (29.2%). Although this rate falls within the range seen in similar studies (e.g., Landrum, Jeglum, & Cashin, 1994), a higher rate would increase confidence in the generalizability of these findings. In a related vein, it is important to reiterate that this research focused on Ph.D. programs only, and that the admissions practices of Psy.D. programs, growing in popularity, are unlikely to reflect these same patterns.

The Ph.D. in clinical psychology is somewhat of an anomaly; it is defined by mastery of both research and clinical skills, and it functions as both a research and a professional degree. In fact, though, the majority of clinical psychology Ph.D. graduates do not pursue academic careers, nor conduct research after graduation. Only 25% of 1995 doctorate recipients from university-based clinical psychology programs were employed in academic settings; by contrast, 48% were in health care delivery settings (Belar, 2006). The field of clinical psychology—specifically Ph.D. programs—may need to address the question of whether an admissions system that prioritizes the research match between applicants and a specific faculty member (and has many benefits) is truly justifi-

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able, given both its potential for ethical murkiness and the multiple real-world (i.e., clinical) responsibilities graduates are likely to have.

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If we don't know where we're going, we won't know when we got there: A response to Greenberg on where is psychology and psychotherapy going

George Steinfeld, Ph.D
Center for Brief Psychotherapy, Trumbull, Ct

In a recent article, Greenberg (2012) asks where is psychology and psychotherapy going? He mentions a number of concerns including, the importance of the therapeutic relationship, that he feels it is going digital, and argues the pros and cons of this direction for our field.

Well, responding to Greenberg's request to continue this discussion, after almost 50 years of doing this thing called therapy, I don't know where it's going. I don't even know where I am going, since "you never know" (Ram Dass). I am aware of where it was when I started, in the 1960's, where it's moving now (digitally and otherwise), and where I would like it to go. This article starts where I would like it to go and the reasons I feel this way. I will address some of the issues mentioned, but will add some things I hope to see in our field before I die. I write this in the interests of our future clients who are suffering and will continue to suffer, and what I believe we can do to minimize, even eliminate the suffering, even though we may not eliminate the pain of living and loss.

The first issue that Greenberg addresses is the controversy as to the usefulness of treatment manuals. I'm not educated on this issue, have never used manuals, so I leave it to the researchers to investigate this mess. Since the evidence strongly suggests that the therapeutic relationship or alliance (the bond) formed between the clinician and patient lies at the heart of psychotherapies that produce positive benefits I would like to address this issue and here is why.

What exactly is the treatment relationship? What exactly is involved in the treatment relationship? What exactly does it do to facilitate positive results? What kind of treatment relationship establishes this bond that supposed to facilitate treatment change? I even have questions regarding what exactly is facilitated, that is, what kind of change is facilitated by the treatment relationship.

My experience tells me that listening in a non-judgemental manner, ala Carl Rogers, an aspect of a therapeutic alliance, to the clients' concerns is useful. I was in therapy from 1961-1964. My therapist, well trained and motivated to help through listening, helped me unburden my pain. He was a good man, psychodynamically trained, in the Sullivanian tradition, as many NY analysts were in those days. He had little to offer in terms of direction, and perhaps said 3 or 4 things during that period, except for "our time is up; I'll see you next Tuesday." Nevertheless, it was helpful since I knew nothing else and expected nothing else. Subsequently, my experience also tells me that listening with compassion, though helpful, is not enough and can, in fact, be destructive to the change process. Many clients, who have been in therapy with other practitioners, have

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told me they terminated therapy because the therapist just listened. They frequently say they don't even remember the therapist's name and what they got from the experience. Some have said that listening without feedback made things worse for them. It was this realization that led me to change my approach in the late 1960s. Listening and understanding was not enough to help patients, as much as I wanted it to be. Up until the late 1960s, we listened, with an occasional "interpretation (ours, not the patient's, which we then offered as the "Truth," hoping the patient would buy in and this would lead to change). Our interpretations never helped my patients, but it did fool me into thinking, along with my supervisors, that we were trying. But I've learned that "trying is lying." We either are helping, not helping or harming our clients. Trying, a client told me is "bullshit." In those days, we had little to offer patients. If the patient didn't accept our interpretation, for example, and did not change, he was called "resistant," one of the craziest things we did to patients. I discovered that therapists are as resistant to change as clients are. Many reasons, not discussed here, but can be read in a recent unpublished paper (Steinfeld, 2012). Starting in the late 1960s, with relaxation and behavior therapy we could help people change their behavior, if this is what they wanted. In the 1970s, cognitive theory and practice emerged as did briefer therapies which helped people change their thoughts and feelings and behavior. Previously, the idea of change was not even discussed, let alone the concept of" Cure," heaven forbid. So, back to the treatment alliance. It seems that the therapeutic alliance is based on the experience of the client, what he/she expects and wants in this relationship. Nonjudgmental listening is fine, as I said, especially in early sessions. But, I was trained by Abert Ellis. I loved Al, not because he listened, which he did, but because he could help me become aware of my dysfunctional cognitions while always accepting me as a totally acceptable, though screwed up person. Something he frequently confronted therapists with when he lectured. The group usually laughed, knowing how true it was.

Al would confront my irrational beliefs. Prior to this I did not even realize how dysfunctional they were. I thought my thoughts were reflective of reality, not my "perception" of reality. Al helped his patients change those irrational and dysfunctional concepts and thereby their feelings and subsequently their behavior. So do other cognitive behavioral therapists (Beck and others). Most of my patients like this approach; that's why I've been using the cognitive behavioral model since the early 1970's. Recent research has reported this as useful for many clinical issues, so I hope we continue to improve these cognitive models. I also hope future approaches also move further towards briefer therapies since I believe that effective and efficient therapies give people what they pay for. I consider effectiveness and efficiency to be ethical, as did, Jay Haley (1990), who developed Strategic therapy. Haley was one of my teachers as well. Regarding this issue of interminable psychotherapy, I once asked a noted psychoanalyst when therapy ends, and he said, quite matter-of-factly, that therapy "never ends," clearly a self-serving position. This is in the interest of the therapist and not necessarily the patient .This leads us into being clear regarding contracts we develop with clients and what the exit strategy is. Also, the word "cure" was never mentioned in psychotherapy. To me cure is when the agreed on changes are achieved in line with the contract (Steinfeld, 1980). Of course, contracts are

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always renegotiable. So, where do I hope treatment or psychotherapy is going? Toward briefer treatment (B), more integrative (I), with clear therapeutic goals (S-olution focused), a clear time when therapy ends and is directed by the client (C). I have called this process BISC (Steinfeld, 2012). I also hope this forces us to be more mindful, and in the tradition of Buddhism, to develop compassion and wisdom as part of our ethical treatment as it moves toward a more spiritually oriented, holistic framework with interventions that flow from this.

I will not discuss the digital age issues that Greenberg mentions and how it will affect our future. I'm not familiar with this area of focus. In line with some of the above comments, to reboot psychotherapy treatment, I believe we need to augment traditional approaches with an array of newer intervention models since this can move us forward on this holistic pathway of treatment.

For example recent developments in the field of energy psychology (Feinstein, 2012; Craig, 2000; Callahan, 1982; Lipton, 2010), supported by developments in neuroscience and quantum physics, can facilitate this integration of mind body and spirit. I propose, as others have, that cognitive behavioral therapy as an aspect of the constructive metatheory (Mahoney, 1995) be further developed, where energy interventions are employed to rapidly change negative cognitions and emotions. APA seems to be resistant to allowing energy techniques, like EFT (Emotional freedom techniques, Craig) to be deemed an empirically approved therapy, despite the myriad of positive clinical and research support for these procedures in the treatment of PTSD and related anxiety disorders (Feinstein, 2012). Even our esteemed profession can be resistant to something new which is supported, while promoting psychoanalytic psychotherapy, where empirical support is clearly lacking. Talk about self serving bull@#*%. These newer therapies, combined with mindful-based cognitive behavioral interventions can move us toward a more ethical, client served practice. Based on the neuroscience research (Hanson & Mendius, 2009), mindful based practice (cognitive therapy) suggests that changing thoughts can change the brain, which then continues to further change thoughts and then the emotions that follow, not to mention supporting our immune system, as we open up new behavioral options for the client, in the interest of the goals of the patient. Theoretically, the cognitive model, as supported by clinical research, as many have noted, and newer developments in the neurosciences, propose that the mind changes the structure of the brain, quite fascinating from my point of view.

Meditative and other mindful-based interventions increase our awareness of the interpersonal and intra personal experiences, and more specifically, neuroscience research shows how implicit memory, as well as an explicit memory, affects our cognitive appraisals, which in turn affect our emotions and experience of reality. This allows for more behavioral choice, and ultimately, more responsibility to choose healthful or harmful paths. It also makes possible a spiritual approach to psychotherapy, or at least a way of dealing with spiritual (not religious) issues that arise in therapy. For more on how implicit memory determines our perception of reality through a proposed process of priming see Steinfeld (1967, 2012). Once we are clear about this process, it opens up the possibility that we can integrate psychological and spiritual issues in psychotherapy. In the West, it's "I'll believe

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it when I see it." With a spiritual perspective, it's "I'll see it when I believe it," including our "experience" of God. Would love to discuss this further.

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Ethical Considerations of Trauma-Focused Cognitive Behavioral Therapy

Jessica R. Green
University of Denver Graduate School of Professional Psychology, Masters Program in Forensic Psychology

It is important for every psychologist to be familiar with and adhere to the American Psychological Association (APA) *Ethical Principles of Psychologists and Code of* Conduct (Ethics Code, APA, 2002, amended 2010). In particular, psychologists are guided by five principles in the Ethics Code. The first ethical principle (Principle A) involves safeguarding the welfare of clients (beneficence), and avoiding harm (nonmaleficence). This paper will examine the ethical considerations involved in trauma-focused cognitive behavioral therapy (TF-CBT) with children and adolescents, particularly exploring the client's re-experiencing of the trauma. In other words, how can psychologists approach trauma survivors in psychotherapy in such a way as to avoid re-traumatization, while still addressing the scope and effect of extreme stressors from the traumatic experience?

Trauma-focused cognitive behavioral therapy is a components-based psychotherapy involving trauma-sensitive interventions with family, humanistic, cognitive, and behavioral principles (Lang, Ford, & Fitzgerald, 2010). Cohen, Mannarino, and Deblinger (2006) explain that TF-CBT is a short-term (12 to 16 sessions) intervention for children and adolescents (ages 3 to 17) suffering from posttraumatic stress reactions. It is also an intervention employed in therapy with their caregivers. This intervention technique was designed to address and reduce both behavioral and emotional problems associated with trauma exposure (Cohen et al., 2006). The goal is to build cognitive-behavioral skills and gradually expose the client to the feared trauma triggers and memories (Lang et al., 2010). Cohen et al. (2006) describe this intervention by the acronym PRACTICE: Psychoeducation and Parenting skills, Relaxation, Affective expression and modulation, Cognitive coping and processing, Trauma narrative, In-vivo exposure, Conjoint sessions, and Enhancing future safety and development.

The use of TF-CBT fosters an environment wherein both the child and guardian can build coping skills while processing the trauma and sharing details of the trauma with each other through narratives. The children and guardians participate in "separate but parallel" sessions, but also attend therapy sessions together to reinforce concepts and build positive relationships via communication (Lang et al., 2010).

The efficacy of TF-CBT has been tested and supported in many randomized controlled trials demonstrating that this method of intervention for trauma does indeed decrease symptoms of posttraumatic stress (Cohen & Mannarino, 2008). That said, the potential negative effects of re-experiencing a traumatic event in such a vivid and personal manner could be harmful for children. Newman (2007)

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reported that participants in trauma-focused research experience distress in sharing their traumatic experiences with the investigators. This could also hold true for clients in psychotherapy.

Ariga et al. (2008) demonstrated that being confronted with traumatic news, such as the re-telling of a traumatic event, led to the development of PTSD in 61.9% of the participants. Since TF-CBT involves the affected child sharing his/her experience with his/her guardian and vice versa, each client may be susceptible to the development of posttraumatic stress features in reaction to this sharing of experience. Concurrently, Van der Kolk (2007) noted that exposure to specific emotional or sensory triggers allow the client to feel and act in a similar manner as during the initial trauma (which would seemingly prevent the catharsis intended to be elicited during the TF-CBT process).

In addition to Principle A, Ethics Code standard 3.04 states that a psychologist should take "reasonable steps to avoid harming [his/her] clients/patients… and to minimize harm where it is foreseeable and unavoidable." Particularly for clients who have presented with Posttraumatic Stress Disorder, the most characteristic symptom involves reliving aspects of the trauma in a distressing and vivid way, through flashbacks, nightmares, and other intrusive and sensory mechanisms. The re-experiencing of a traumatic event may in fact be traumatic in itself, so it is useful to consider how to approach a client in trauma-focused therapy while still adhering to the Ethics Code. Unlike treating the trauma with medications, as recommended by the American Psychiatric Association Practice Guidelines (2004), Mayor (2005) recommends utilizing structured psychological treatments that focus on the specific event such as trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing.

Despite the high success rate in lowering symptoms of posttraumatic stress and increasing positive communication and coping skills, there are many risks inherent in trauma-focused psychotherapy that involves recalling experiences of the trauma. In these cases, it is key to separate the traumatic exposure (which is the recall) and the actual traumatic experience, because this could hinder the positive therapeutic effect psychologists seek. Newman (2007, pages 57-59) notes a few ideas to consider when using trauma-focused therapy with a client presenting with distress brought on by addressing a previous trauma:

- Does the distress experienced by the client exceed the level of "harm or discomfort ordinarily encountered in daily life or during the routine physical or psychological examinations?" (Newman, 2007, pg. 57)
- Does the re-experiencing of a traumatic event in therapy cause distress that encompasses existing feelings, or does the experience evoke emotions that were not previously felt?
- At what point could the distress be considered harmful rather than "emotional engagement?"
- Is upset in any way related to regret about engaging in therapy?
- In the context of therapy, what is the benefit or gain from engaging in the recall of traumatic events?
- Are secondary effects of trauma affecting the client (such as medical, financial, and social difficulties), and could those effects influence the therapeutic approach, process, and experience?

The answers to these questions may vary from session to session. As is typical with most therapeutic processes,

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there will be good days, and there will be more difficult days. If the answers to these questions enable the psychologist to think about the therapy in a different way, and maybe choose a different, less risky approach, then Principle A and standard 3.04 of the Ethics Code may still be met. If the psychologist can be psychologically-minded, self-aware and conscientious, and take the time to realize and understand the systems in which he/she is working, then this sort of trauma-focused, and trauma-inducing, therapy can be extremely beneficial for the client.

In order to use TF-CBT effectively and without harming the client, it is necessary to be aware of and recognize possible distressing moments for the client. Though TF-CBT is only meant to be a short-term intervention (Cohen et al., 2006), the clinician should take the necessary time to guide the client through the process slowly and deliberately rather than encouraging the client to immediately prepare the trauma narrative. The clinician should also employ the phase-based PRACTICE method of TF-CBT (Cohen et al., 2006) wherein the client focuses on the initial preparatory components (psychoeducation, parenting skills, relaxation, affective expression, cognitive coping), then use subsequent gradual exposure techniques to process the traumatic event (Lang et al., 2010). As therapy progresses, the child and guardian may learn to utilize these coping skills in addressing their traumatic experience through the personal narrative (Grasso, Joselow, Marquez, & Webb, 2011). Ultimately, the re-experiencing of a trauma may be less distressing if the client utilizes the newly acquired positive coping mechanisms.

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

Social Justice and Public Policy: Initiative on Pro Bono Provision of Services

Rosemary Adam-Terem, Ph.D., Committee Chair

Writing about *pro bono* work on this Martin Luther King Jr. Day, two quotes came to mind. From Mahatma Gandhi: "The best way to find yourself is to lose yourself in the service of others." And from Dr. King: "Life's most persistent and urgent question is, 'What are you doing for others?'" Our committee has taken on the task of examining the work psychotherapists do for no or little money.

The original initiative

During his presidency of Division 29, Jeff Magnavita chose among his four initiatives the goal of establishing "a mechanism for listing nonprofit organizations which we endorse that provide pro bono mental health services" (Magnavita, 2010).

Hoping to highlight those organizations, as well as individuals who are embedded in communities around the world offering their services on a pro-bono basis, the goal was to feature them on our website with easy access links for those of us who are committed to pro-bono work and want to find worthy organizations to which to contribute our services.

Dr. Magnavita noted "there are amazing individuals amongst us who work tirelessly for the benefit of others." As an example, he noted that in 2009, Dr. Barbara Van Dahlen Romberg was selected for the Rosalee G. Weiss Award and Lecture for work as founder and president of the Give an Hour Foundation (www.giveanhour.org). This innovative nonprofit organization recruits psychotherapists willing to volunteer just one hour a month to provide services to military personal returning from Middle East deployment.

As the domain representative for the Public Policy and Social Justice Domain at the time, I was asked to work on a mechanism for reviewing organizations which we might endorse as good stewards for giving back to our communities.

Not so easy

I decided to begin with some fact-finding, and put out a request for information to the STPA's to see what was happening in each state, territory and province. I had no responses. In his 2010 column, Dr. Magnavita had asked members to contact me with suggestions for worthy organizations or individuals we could feature for their community service. I had no responses. Searching the internet for interesting *pro bono* programs proved quite difficult and very piecemeal, though I did find several interesting programs, which will be described in future columns and eventually on the website. It was hard to find enough programs to set criteria for the original initiative. Obviously, we need a different approach.

Perhaps no one is interested in *pro bono* work?

This seemed very unlikely especially given our proclivity as a helping profession to want to work for the benefit of others. We are all aware that our Ethics Code states in Principle B: Fidelity and

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Responsibility: "Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage." So why was this so elusive? Many hypotheses came to mind: people are already doing enough *pro bono* work; they are too busy; they see *pro bono* work in different ways. Some research on the topic might be useful, so with the help of the committee, we created a survey which will soon be accessible on our website, posted to our listserv, or can be copied from the Bulletin and sent in the old-fashioned way.

Please take a few minutes to read the survey here and if you fill it out, please send it to me at drrozi@yahoo.com or by mail to me at 1833 Kalakaua Avenue, Suite 800, Honolulu, HI 96815.

DIVISION 29 PSYCHOTHERAPY
COMMITTEE ON SOCIAL JUSTICE AND PUBLIC POLICY
SURVEY ON *PRO BONO* PROVISION OF SERVICES

We are interested to learn more about psychotherapists' views and practices regarding the provision of *pro bono* services. Please take a few minutes to complete this brief survey. We would be especially grateful for your comments and ideas in the open questions. Thank you.

1. How important do you consider *pro bono* work to be?

Extremely	Very	Fairly	Not very	Not at all
5	4	3	2	1

2. Do you believe that psychologists have an ethical obligation to provide some *pro bono* services? ❍ YES ❍ NO

Demographics

3. Your age: _____

4. Your gender: _____

5. Your profession:
❍ psychologist ❍ psychiatrist ❍ social worker ❍ nurse ❍ counselor
other, please specify: _____

6. Years in practice: _____

7. Type of practice:
❍ Independent/private ❍ Counseling center ❍ Hospital ❍ Clinic
❍ Mental Health Center ❍ Government organization
❍ Other, please specify: _____

8. Location of practice:
❍ Urban ❍ Suburban ❍ Rural
❍ Other, please specify: _____

9. State(s) where you practice, please specify: _____

10. Populations served: ❍ Child and adolescent ❍ Family ❍ Adult
❍ Older adult ❍ Special populations, please specify:
_____

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11. Do you provide *pro bono* services to clients/organizations in your practice?
❍ YES ❍ NO

12. If NO to Question 11, why do you not provide *pro bono* services?
❍ Cannot afford to forego income
❍ Feel that reimbursement rates are so low in some cases, they amount to *pro bono* work
❍ Do not believe in *pro bono* provision of services
❍ Do not know how to get started
❍ Feel that the help I provide is enough
❍ Other, please specify: _____

13. If YES to Question 11, what type of *pro bono* services do you provide?
❍ Psychotherapy
❍ Assessment/testing
❍ Consultation to staff/management
❍ Supervision of trainees/early career psychologists
❍ Mentoring of students/early career psychologists
❍ Other, please specify: _____

14. If YES to Question 11, how many hours per week do you spend in *pro bono* work? ❍ 1-2 ❍ 3-4 ❍ 5-6 ❍ More

15. If YES to Question 11, how many *pro bono* clients/patients do you work with per week? ❍ 1-2 ❍ 3-4 ❍ 5-6 ❍ More

16. If YES to Question 11, what percentage of your average work week do these hours of pro bono work represent? _____

17. If YES to Question 11, do you participate in any organized *pro bono* program?
❍ YES ❍ NO
Please specify any such programs:
_____
_____
_____

18. If YES to Question 11, what are your reasons for proving *pro bono* services?
❍ To give back
❍ Because there is such a need
❍ Because it is the right thing to do
❍ Because it is expected
❍ Other, please specify: _____

19. What do you consider to be the best model for provision of *pro bono* services?
What does the best model mean to you in this context? _____
_____
_____
_____
_____

Religiosity and Psychosis: Clinical and Cultural Consideration

Scott Waltman, MS
Pacific University

Religious background is a socio-cultural variable that is an important part of a person's identity (American Psychological Association, 2002), and yet some friction still exists between psychology and religion (Cummings & Cummings, 2009; Ng, 2007). In considering the impact of religion and spirituality upon an individual, it is important to be mindful of how complex the impact of religion and spirituality can be upon a person's values, perceptions, and experiences. It has been stated that "although we speak of a client's 'religious background,' for many clients religious issues are in the foreground of their lives" (Koltko, 1990, p.132). For some religiosity is more than a preference or affiliation; it is an integral part of their identity. It guides how they view themselves and the world around them. It impacts the decisions they make. For some, their religious affiliation and spiritual practice is who they are.

These factors notwithstanding, many clinicians are uncomfortable addressing issues of religion and spirituality (Huguelet et al., 2011). This may be due to markedly lower rates of theism found in psychologists and psychiatrists than those found in the general population (Pierre, 2001). It has been suggested that American psychology's views have been influenced by "militant atheism" (Cummings & Cummings, 2009, p.315). It has yet to be established that psychology in general devalues religion; however, there is a perception in some of the literature that religion is viewed unfavorably and diminutively by psychologists (Cummings & Cummings, 2009). These possible biases and perceptions of biases serve as barriers to communication and culturally sensitive patient-care.

Clinician Biases

It has been suggested that "clinicians have inherent biases where religious interpretations are required" (Ng, 2007, p.65). A number of prominent figures in the history of mental health possessed and expressed negative views regarding religion (Pierre, 2001). It is the perceptions of some psychologists that these biases persist and serve as a barrier to effective client care (Cummings & Cummings, 2009). The interplay between religion and science can be difficult, as religion tends to be intuitive, abstract, intangible, and conceptual, while science strives to be reductionistic and empirical (Ng, 2007). It has been suggested that friction occurs when psychologists strive to reductionistically view religion as a purely psychological phenomenon (Cummings & Cummings, 2009).

The Journal of Theoretical and Philosophical Psychology recently featured a special issued entitled, "Is there a pervasive implicit bias against theism in psychology?" In that edition Slife and Reber (2009) contend that there is a pervasive bias against theism in psychology. A number of researchers responded to Slife and Reber's claims of atheistic bias.

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Richardson (2009) critiqued their article and agreed with the conclusion that pervasive anti-theistic biases exist in psychology; however, Alcock (2009) refuted these claims of implicit biases and stated the argument was "Christian propaganda" (p.80). There remains some disagreement about the existence or pervasiveness of anti-theistic biases in the field of psychology. Whether these biases actually exist, they certainly are perceived, and as discussed above even the perception of bias can be a barrier to communication and progress.

Religiosity and Psychosis: Differential Diagnosis

It will be important to consider the diagnostic instructions given to clinicians to assess whether anomalous experiences constitute psychosis. As noted by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*):

> Isolated experiences of hearing one's name called or experiences that lack the quality of an external percept (e.g., a humming in one's head) should also not be considered as symptomatic of Schizophrenia or any other Psychotic Disorder. Hallucinations may be a normal part of religious experience in certain cultural contexts. Certain types of auditory hallucinations (i.e., two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behavior) have been considered to be particularly characteristic of Schizophrenia. If these types of hallucinations are present, then only this single symptom is needed to satisfy Criterion A. (American Psychiatric Association, 2000, p. 300)

The *DSM-IV-TR* states that hallucinations may be a normal part of religious experience, and yet there is no means given to determine what constitutes a "normal part of religious experience." Generally clinicians are not trained theologians and they are ill equipped to assess the normalcy of an individual's religious or spiritual experience.

Extant literature provided little guidance on how to differentiate between anomalous experiences, religious experiences, and hallucinations. Prince (1992) pointed out that "highly similar mental and behavioral states may be designated psychiatric disorder in some cultural setting and religious experiences in others" (as cited in Lukeoff, 2005, p.235).

Moreira-Almeida and Cardeña (2011) found that anomalous and psychotic-like experiences are common in the general population. Moreira-Almeida and Cardeña suggest that around 90% of these cases are not associated with psychotic disorders. They pointed out that spiritual experiences often include non-pathological dissociative or psychotic experiences.

Differential diagnosis between religious experience and psychotic experience is difficult as there are no clear guidelines to distinguish between "normative" and "pathological" religious beliefs (Mohr et al., 2010; Pierre, 2001).

The *DSM-IV-TR* defines delusions as "erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. . . . The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear contradictory evidence regarding its veracity" (American Psychiatric Association, 2000, p. 299).

A delusion has been described as a strongly-held, false belief. Yet determin-

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ing if a religious belief is delusional based upon the fallacy of the belief is difficult, as there is no means to objectively observe or test the veracity of the belief. With this in mind, Pierre (2001) offered clinical considerations for differential diagnosis. He stated that determining whether a belief was delusional based upon content was not a useful distinction. He stated that instead it was more relevant to look at the person's relationship with the belief, asserting that delusional patients told their beliefs in a qualitatively different manner than non-delusional patients. Pierre suggested that clinicians focus on the strength of the conviction, preoccupation, and identification associated with the belief. The counsel to focus on the relationship with the belief rather than the content is consistent with the writings of Mohr et al. (2010), who discussed the utility of examining the non-content aspects of a delusion.

Lukoff (2005) suggested that the V-code of Religious or Spiritual Problem (V62.89, American Psychiatric Association, 2000) could be an appropriate diagnostic label for anomalous experiences with religious themes. "Spiritual emergencies warrant the *DSM-IV-TR* diagnosis of religious or spiritual problem, even when psychotic symptoms may be present, including hallucinations and delusions" (p.239).

Recommendations

Based upon the information discussed above, the following recommendations are made to enhance the diagnosis and treatment of individuals with schizophrenia.

Spiritual Assessment

It is essential that clinicians inquire about patients' religious and spiritual practices. Mohr et al. (2010) called for a systematic assessment of spirituality for all patients. Huguelet et al. (2011) presented a method of assessing spirituality and religiosity in outpatients with schizophrenia. They asserted that their method was "well tolerated" (p.81). The topics covered in their spiritual assessment included: religious and spiritual history, effect of the illness on spirituality or religiousness, current spiritual or religious beliefs and practices, subjective importance of religion in general, subjective importance of religion in coping with the illness, and synergy of religion with psychiatric care.

Differentiating between Pathology and Faith

The demarcation between "normative" religious belief and religiously-themed delusions is not clear. It has been suggested that the demarcation between "normative" religious beliefs and psychotic experiences can be ambiguous; consequently, it has been recommended to view this distinction as existing on a continuum (Ng, 2007).

The recommendations of Pierre (2001) and Mohr et al. (2010) are echoed. It is recommended that clinicians who desire to differentiate between religious experience and pathology focus not on the unverifiable content of the belief, but rather on the conviction, preoccupation, and identification with the belief.

Further it is recommended that clinicians strive to have an open mind with regard to the religious and spiritual beliefs of the client. As noted by Koltko (1990),

> the wise therapist does not attempt to excise or change normative religious beliefs and values (i.e., the values and beliefs adopted by a community of believers over several generations). Those beliefs and values have been extant for much

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> longer than the therapist's approach to treatment…The wise therapist uses information about a specific religion as a backdrop. It is most important to know what a client's religion means to the client, as well as what that religion "officially" states…Finally, the wise therapist skillfully uses the power inherent in a client's beliefs to enhance the client's functioning. Religion is orthogonal to pathology (p. 139).

The advice given by Koltko not only applies to working with persons with schizophrenia, but could be pertinent to working within a multitude of settings with varying populations.

Incorporating Spiritual Care Providers into Treatment

It has been pointed out that mental health clinicians are generally ill-equipped to assess spiritual and religious beliefs, yet are expected to assess for the presence of psychopathology (Ng, 2007). Means of improving the current situation may include systematic changes. Mohr et al. (2010) suggested that mental health providers seek the advice of the clergy. Those in some treatment settings may want to consider the possible benefits and drawbacks of including a chaplain or religiously oriented individual on interdisciplinary treatment teams.

Individuals with religiously-themed delusions may be at risk of being alienated from religious communities (Mohr et al., 2010). If religious leaders were more involved with treatment, it is possible they would be able to encourage outreach and fellowship with these vulnerable individuals.

Summary and Conclusions

Psychology and psychiatry have a history of being perceived as devaluing religion. These biases may serve as a barrier to delivering culturally sensitive care to religiously and spiritually oriented patients. Anomalous experiences may be common to the human experience and may not be indicative of psychosis. One area in which the interaction between mental health and religion can be especially difficult is the intersection of religiosity and psychosis. Little instruction is given in the *DSM-IV-TR* to determine if an individual's religious belief is normative or delusional. Making this determination based upon the content of the belief may not be useful; instead, it is recommended that these decisions be based upon the person's relationship with the belief. It is important to investigate the conviction, preoccupation, and identification with the belief to best assist with accurate identification of pathology versus a continuum of normative religious expression.

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

STUDENT SECTION

Instilling in Trainees the Essence of Being a Psychotherapist—Supervisor and Student Perspective

Jeffrey E. Barnett, Psy.D., ABPP, Loyola University Maryland
Margaret R. Tobias, M.S., Loyola University Maryland

I have provided psychotherapy education and training in the classroom setting and in clinical supervision for almost 30 years. Over this time, several patterns and themes have emerged concerning student and supervisee training needs, common perspectives they express, and ways that I have been able to play a small but hopefully important role in the development of their professional identities—particularly in regard to what it means to be a psychotherapist and how they may develop the needed competencies to be ethical and effective psychotherapists throughout their careers.

Key issues include: (1) the need for an understanding of, and focus on, the centrality of the psychotherapy relationship, coupled with an understanding of how this unique relationship contributes to assisting clients in achieving their treatment goals; (2) how the process of clinical supervision is essential to the professional growth and development of the trainee as well as in providing their clients with the most effective clinical services possible, including ways in which supervisees and their supervisors may play an active role in helping to ensure an optimal supervision process and experience; and (3) how integrating a focus on ethics into all aspects of clinical supervision and psychotherapy practice is essential for providing effective psychotherapy to clients. The role of each of these aspects of training is highlighted in my view of what it means to be a psychotherapist, and each plays a unique role in professional identity development.

Less is More: A Focus on the Relationship

As educators and clinical supervisors, it is important that we remember what it was like to be a trainee, new to the process of learning to become a psychotherapist. It is a daunting experience and the feeling of responsibility for a client's wellbeing can be overwhelming. Often, trainees feel a strong need to "be of help" to their clients, something that typically involves providing them with observable benefits in a timely manner. There may be a strong need to feel that they have provided their clients with "something of value" or that they have tangibly "made a difference for the client."

It is often comforting for trainees to be able to teach a new skill, to implement a technique, give advice, or assign a home work activity, feeling that they have *done something* of value for their client. Too often, this "doing" is motivated by feelings of insecurity as a new psychotherapist, a belief that he or she must provide quick symptom relief or some other tangible benefit each session (or perhaps the client might not return!), and a lack of understanding of the value and importance of the relationship in psychotherapy.

Gluhoski (1994) wrote poignantly about common misconceptions of cognitive

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therapy that are consistent with the views of many trainees and may apply to other forms of psychotherapy as well. These include a focus on the use of technique for immediate symptom reduction and the belief that a focus on the relationship is unnecessary to the treatment process, among others. Yet, the literature is replete with evidence of the importance of the therapeutic alliance and the role of the relationship over time for achieving meaningful growth and positive outcomes in psychotherapy (e.g. Ackerman & Hilsenroth, 2003; Norcross, 2002; Wampold, 2007).

It is essential that we educate students about this literature and assist them to see the value of the development of the treatment relationship with their clients, helping them to understand how this plays a larger role in treatment than merely focusing on behavior change. Despite countless studies that focus on a wide range of techniques that may be integrated into psychotherapy to assist clients, the more we learn, the more we see the importance of the psychotherapy relationship, the treatment alliance, and the use of common factors championed by Carl Rogers as essential for meaningful and lasting psychotherapeutic change (e.g., Kahn, 1986; Rogers, 1992).

It is vital that we provide students and supervisees with the encouragement and support needed for them to take their time with clients, convey genuine and deep caring for their clients, and assisting their clients in tell their stories. In our culture of desire for quick fixes and the pursuit of pleasure (McWilliams, 2005) we must inculcate in psychotherapists-in-training a commitment to taking the time, and making the emotional commitment, to taking this arduous journey with their psychotherapy clients. Rather than asking: "What technique or intervention can I use to help reduce these symptoms?", it is hoped that psychotherapists-in-training will ask: "How can I create a relationship in which my client can feel safe enough to be him or herself with me and freely engage in the psychotherapy process to work toward his or her long term goals?" By helping to create therapeutic relationships with clients, trainees are then able to connect with clients in a meaningful way that forms the basis for the hard work they will do in psychotherapy—work that can lead to the growth and change they desire, helping clients over time to *get* better, not just quickly helping them to *feel* better (Ellis, 1996).

Clinical Supervision: When Taking Risks Isn't Risky at All

Ongoing clinical supervision is integral to the development of psychotherapists-in-training. It is, as Goodyear (2007) describes, the "signature pedagogy" of the professional training of psychotherapists. Thus, how the supervision process is carried out is of paramount importance for the development of the clinical competence of trainees as well as the development of their professional identities as psychotherapists.

While the supervisory relationship is intended to be a supportive and encouraging relationship, by necessity it is evaluative in nature as well. Supervisors have the potentially contradictory roles of training and nurturing supervisees while simultaneously serving as gatekeepers of the profession (Johnson, Elman, Forrest, Robiner, & Schaffer, 2008). Knowing this, supervisees may find themselves sharing what they think their supervisors want to hear, reporting on their successes but not their failures, and not pushing themselves outside their comfort zones out of fear of making mistakes and being evaluated negatively. In these situations supervisees may be hindered in the development of their professional competence, an unfortunate situation for supervisees and

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their current and future clients alike.

It is hoped that supervisors will also focus on relationship in clinical supervision; not just the relationship between supervisees and their clients, but also the relationship between themselves and their supervisees. By creating what Winnicott (1965) termed a safe holding environment, supervisees can feel the safety and security needed to take chances and push themselves to try new ways of interacting with their clients. Supervisors may help achieve this by informing supervisees from the outset that: "You will not be graded on how well you implement specific techniques or on how much progress your clients make in a certain period of time. Rather, you will be evaluated on how receptive you are to the feedback provided in supervision and by how much you push yourself to learn and grow as a psychotherapist." Further, supervisors might say: "I don't want you to tell me all the things you are doing well. That won't be helpful to you or to your clients. Instead, I want you to tell me about what you tried that didn't work as you hoped. Then, together we can explore what happened and why, with both of us learning from this together."

It is hoped that supervisors can promote a collaborative working relationship between themselves and their supervisees, working together toward their shared goals of supervisees' professional growth and the welfare of the supervisees' clients. Not only does this model a collaborative relationship that supervisees will hopefully emulate with their clients, it will also serve to foster an environment in which risks can be taken so that growth can occur.

A Focus on Ethics

The training of nascent psychotherapists involves the development of a wide range of skills. Some are relational and some are more focused on psychotherapeutic technique. A psychotherapist may possess high levels of clinical competence, including knowledge and skills in psychotherapy. Yet, failure to anticipate, to understand, and to adequately address ethics issues and dilemmas in clinical practice will likely result in jeopardizing the treatment relationship and process, and prove to be highly problematic for psychotherapist and client alike. Educators, trainers, and clinical supervisors must integrate training in ethical practice into psychotherapy education, training, and clinical supervision.

Educators and supervisors should see themselves as ethics role models. The training environment provides numerous ongoing opportunities to model ethical practice to include respecting confidentiality, maintaining appropriate boundaries, practicing within (and only within) one's areas of competence, and openly discussing one's approach to addressing ethical dilemmas that are experienced. Additionally, training in ethics can be integrated into all classroom and supervision experiences.

Graduate students by and large are an intelligent and literate group. They therefore will do very well at reading and familiarizing themselves with the Code of Ethics of their profession. It is the application of the Code of Ethics to the myriad dilemmas they will face, however, that will prove most vexing. An initial challenge faced by psychotherapists-in-training is to navigate the boundary between their personal values and beliefs and the principles and standards of the Code of Ethics. Psychotherapy clients will not be well served by psychotherapists who either follow their own values and beliefs or who rigidly adhere to the standards of the Code of Ethics regardless of the situation or circumstances. As Handlesman, Gottlieb, and Knapp (2005) explain, the

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goal for each psychotherapist-in-training is to come to integrate their personal values with the values and standards of the profession as articulated in the Code of Ethics. Assisting trainees in accomplishing this will help them to develop a more nuanced and thoughtful approach to ethical practice.

In addition to modeling ethical conduct, clinical supervisors can raise ethics issues within classroom and supervision environments and then promote open discussion of these issues and how to most appropriately respond to them. The use of an ethical decision making model should be encouraged, and a process that leads to the best possible course of action under the circumstances should be sought. Rather than asking: "What is the right thing to do in this situation?" or "What is the right answer to this question or dilemma?", students should be encouraged to engage in a deliberative process that seeks to maximize benefits to the client while minimizing risks of harm or exploitation. When faced with an ethical dilemma, students should be encouraged to ask questions such as: "What are my motivations here and am I thinking of my client's best interests?", "What are my obligations to my client and to others and will taking this intended course of action be consistent with them?", "Will this action be likely to be helpful to my client and not result in causing harm?", "What options and alternatives are reasonably available to me and what are their relative risks and benefits?", "Will acting in this manner be consistent with the informed consent agreement, the agreed upon treatment plan, and my client's best interests?", and " Would I be comfortable with my colleagues learning of these actions on my behalf or would I prefer if they be kept secret?"

Trainees must learn that the goal of ethical practice is not to do the "right" thing and the goal of ethical decision making is not to find the one right answer. Rather, the goal is to engage in a thoughtful deliberative process that helps us to make the best possible decision under the present circumstance, with the information available at the time. Further, trainees must learn that ethical dilemmas are an accepted part of the practice of psychotherapy. They are not to be avoided or feared. Instead, they should be planned for, anticipated, discussed, and then addressed utilizing consultation and the application of a decision making process.

It is essential for trainees to understand that being an ethical psychotherapist does not happen by accident and it does not occur in isolation. It results from an active deliberative process that involves the ongoing use of colleagues. Johnson et al. (2012) describe this as creating a competent community; that is, a group of colleagues who speak openly with each other and who support each other in the ongoing pursuit of ethical practice. Each of the actions described above can be modeled by educators and supervisors to encourage the development of the habits consistent with a career-long approach for promoting the ethical practice of psychotherapy.

Conclusion

A vision of three essential elements of being an effective psychotherapist has briefly been shared. This vision includes a focus on the treatment relationship over an emphasis on the application of techniques to achieve symptom reduction or relief, the use of clinical supervision as an incubator in which the supervisee can experiment and grow professionally, and an emphasis on integrating an active approach to ethical decision making and practice in all the psychotherapist does. It is hoped that psychotherapists-in-training and those providing the training will consider these recommendations and utilize them in their pursuit of professional excellence.

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Response to Instilling in Trainees the Essence of Being a Psychotherapist: A Student Perspective

Margaret R. Tobias
Loyola University, Maryland

As I sat down to read Dr. Jeffrey Barnett's writings about some of the key issues and challenges involved in training psychotherapists, all three areas he described fit well with my experiences thus far as a clinical psychology graduate student. His comments about the importance of the therapeutic relationship in the treatment of symptoms, the effective use of the supervisory relationship, and the integration of ethics into our education and work as psychotherapists made perfect sense to me as some of the key issues on which to focus attention in a training environment, although of course there are many other pivotal issues as well. As I read each section of Barnett's paper, my thoughts turned to several personal experiences I have had over the last two and a half years of my clinical training. Sometimes, these experiences fit cleanly with the issues Barnett discussed. Other times, Barnett's writings drew my attention to areas where my experience has differed slightly from his recommendations and led me to reflect on personal changes and improvements I can make in my training.

After engaging in some of these initial reflections on my own experiences in training, I decided to take a step back from Barnett's list of important issues, and come up with a list of my own, attempting to define a few of what I currently feel are some of the most relevant elements of psychotherapist training as a trainee. I was interested in discovering whether my own thoughts on these issues as a trainee would differ in any great way from the thoughts of a seasoned professional so actively involved in training new clinicians. A few key phrases arose in my mind during this process of reflection. These included "trial by fire," the role of ethics in early training, and the importance of self-challenge. What I realized as I thought further about these phrases is that they fell much more closely in line with the issues Barnett had discussed than I expected.

Trial by Fire

Trial by fire. This is a phrase that has repeated in my mind since I began my graduate studies at Loyola University Maryland in 2010. It is a word that I have consistently felt describes several aspects of my clinical training, although the meaning behind the phrase has evolved as I have advanced through my graduate program. The phrase "trial by fire" sounds daunting, and that is initially how I felt about our clinical work at Loyola. During the first week of our program, we began our practicum placement at the Loyola Clinical Centers in Baltimore. Although many of us had little to no hands-on experience working with clients, we were immediately expected to conduct in-depth intake interviews with real clients who had real problems and needed real help. Trial by fire. I myself had come straight from my undergraduate studies, where the closest thing to clinical experience had been an introductory psychopathology class. Trial by fire. Despite my reservations and insecurities, something possessed me to volunteer myself to conduct the first intake interview. During week one. With hardly any graduate training through coursework or supervision under my belt. And with my new supervisor and several classmates watching behind the one-way mirror. Trial by fire. And so my clinical training began, and several "trial by fire" experiences followed. Our second year began with the

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expectation that we immediately start seeing psychotherapy clients at the Loyola Clinical Centers. Granted, we had a year of training and practice with intake interviews under our belts, but being in the room with a client we were supposed to directly help? Without a supervisor in the room with us in case we did something wrong? Trial by fire. What I have realized over the course of training, however, is that, while our anxious reactions told us, "You're not ready for this. You're going to make a mistake. You have no idea how to help this person," the faculty and supervisory staff knew we were ready to be "in the room" with clients. They knew we were capable of relating to them, demonstrating warmth, reflecting on their feelings. They knew that even though we felt that we were largely unprepared, we were already capable of providing a key piece of what our clients needed: a therapeutic relationship. I also learned over those first two years that I was becoming both less anxious, and, more importantly to me, more comfortable with feeling anxious. I grew accustomed to the "trial by fire" feeling and grew to appreciate how beneficial it had been to me. Despite the initial anxiety that trainees inevitably feel, the faculty and supervisors in my program held in high regard the benefit of providing trainees immediately with experience being "in the room" with clients and building healing relationships with them. And it paid off.

As I reflected on these experiences, I realized that they fit closely with Barnett's discussion of the focus on the therapeutic relationship being more important than an overreliance on the use of technique in treatment. As a great deal of research strongly suggests that the therapeutic alliance is a consistent predictor of treatment success (see Martin, Garske, & Davis, 2000 for a review), I feel that the most effective training of psychotherapists should begin with this sort of "trial by fire" experience of learning to build this kind of relationship before much technique is taught. Although we learned many elements of technique and theory during our initial year at Loyola, we were first exposed to the basic relationship with clients. I believe this was hugely beneficial to me and my classmates in demonstrating how the therapeutic relationship lays the foundation for the treatment of symptoms and the later use of technique. Especially considering what Barnett described as the tendency for new trainees to rely heavily on the use of technique-driven treatment strategies, like skill-building and homework assignments, in an effort to produce immediate and tangible improvement in treatment, I feel it is beneficial to preempt those tendencies in trainees by placing early focus on the relationship itself and delaying the teaching of specific techniques. Although "trial by fire" might be a bit of an extreme phrase and maybe one more likely to be used by an anxious trainee than a clinical supervisor or faculty member, I do feel that there are tangible benefits to "throwing trainees in" to clinical experience with a focus on relationship building.

The Role of Ethics During and After the "Trial by Fire"

In line with Barnett's argument, one element that must be specifically taught and monitored during the "trial by fire" period of early clinical experience is ethical decision making. Barnett brought up the excellent point that understanding and effectively utilizing knowledge of ethics is not based simply on a memorization of the Code of Ethics. Instead, it must be a continual active learning process in which trainees and professionals develop an ability to consider many elements in an ethical decision-making process. These elements include the Code of Ethics, personal value sys-

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tems, the well-being and best interests of our clients, and consultation with other professionals.

While I have expressed what I feel are some great benefits to an immediate relationship-based start to clinical experience, I do feel that at least a brief introduction to ethical guidelines is essential before trainees begin working directly with clients. After this point, and as further clinical experience begins to include the integration of techniques and more independent work, an increasingly in-depth education in ethics is of primary importance. As Barnett described, I agree that the understanding of and competence in ethics truly develops as a trainee gains experience in engaging in discussions with peers, supervisors, and other professionals to sort out the many elements that are essential to a carefully made ethical decision. In my experience over the past two and a half years, I have read the Code of Ethics and taken a course in ethics to increase my understanding of ethical issues, but nothing has been more educational than those instances in which I have come across ethical dilemmas with my own clinical work. Through personal contemplation, discussion during supervision, and consultation with my peers, I have engaged in decision-making processes that affect my work and my clients' well being. These experiences, with the foundation of knowledge I have about the Code of Ethics itself, have helped me work toward solidifying my working knowledge of the ethical decision-making process.

The Importance of Challenge and Self-Challenge as a Trainee

As I continued to reflect on what I have come to feel are essential elements of a successful psychotherapy training experience, the concept of being challenged and, more importantly, challenging myself, was a particularly salient one for me. Through several different experiences over the last two and a half years, I have come to gain an increasing understanding of how strong the correlation seems to be between being able to challenge yourself to self-reflect in an honest way and an increase in skill and success as a psychotherapist.

The link between my thoughts and Barnett's points are especially clear here. He discusses the ease with which supervisees can fall into a comfortable yet often unproductive pattern of reporting what they feel their supervisor wants to hear and sharing their successes rather than their failures. The danger here is that a great deal more is learned from examining mistakes, failures, and insecurities than from doting on successes and skills that have already been acquired. Ronnestad and Skovhold (1993) refer to this type of stagnation in supervision as "pseudo-development" (p. 398). Reflecting on my own experiences with supervision as I have advanced through my program, I have gradually come to be aware that I have tended to fall into this pattern, much as so many other trainees do. With this awareness, my hope is that I can continue to develop in my ability to challenge myself to examine my limitations and grow from them.

One example of this increase in awareness for me has been the realization during the early semesters of my training that there are supervisors who focus on the "tough stuff" and those who do not. I have tended to think of the "tough stuff" as including things like my anxieties and insecurities in working with clients, clinical cases in which I feel unsure about how to proceed with treatment, techniques I have tried out in sessions that have not worked as I hoped, and my personal reactions to no-

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shows, cancellations, and drop-out cases. I have found that the supervision sessions in which I am pushed to talk about the "tough stuff" make me particularly anxious, yet are those from which I feel I am benefitting the most, as these areas leave more room for improvement. It is from those supervision sessions that I leave with a great deal more knowledge about myself and about providing effective psychotherapy. The supervisors who have tended to simply require a weekly update and provide more objective help with deciding upon diagnoses and creating treatment plans make me feel much more at ease and are of course helpful in my training, yet provide less valuable opportunities for growth. This has demonstrated to me the importance of being challenged by supervisors, as Barnett has alluded to.

As time passed during my early training, different experiences also demonstrated to me the importance of learning to challenge *yourself*, rather than relying on others to do the challenging for you. The value of being able to challenge yourself, in regard to your skills, limitations, well being, anxieties, insecurities, and gaps in knowledge, lasts long after training ends. Without supervision later on, those who have become comfortable with self-challenge seem likely to be much more effective clinicians as they are able to continue with lifelong growth as psychotherapists.

I came to understand this value of self-challenge as the observations received from my various supervisors have evolved and changed over the semesters. Being observed by a supervisor through the two-way mirror during first-year intake interviews was nerve-wracking. Knowing that my second-year psychotherapy sessions were being recorded for later viewing by my supervisor was uncomfortable. My awareness this year that my psychoeducational evaluations are being observed is stressful. The day this year that my psychotherapy sessions stopped being observed in any way initially provided me with a great sense of relief. This meant my supervisor would no longer watch my tapes or make notes from live observation of my limitations or things I tried that did not work. I feel sure that many clinical trainees would share these sentiments. What has been a priceless lesson for me, though, is my realization when this observation ended that I was suddenly much more responsible for my own clinical learning. Supervision sessions felt particularly good for a while, given that I was reporting what was going well with my clients and what my plans were for moving forward with them. This much I was comfortable with, at first. After a while, however, I became aware that, in keeping my supervision sessions so "safe," I was cheating myself out of advancing my clinical skills. My positive reports were, in effect, leading to a notable lack of training and learning experiences from my supervisor. All we were talking about were techniques and skills I already knew about or felt perfectly comfortable with. I suddenly gained a new appreciation for those supervisory tools of observation.

I have learned that despite the anxiety that being observed might create, having someone else see and bring up your limitations for discussion makes clinical growth much more possible. Without that, the onus rests on you as the supervisee or psychotherapist to create the challenge yourself. The difficulty with self-challenge is that it goes against the foundation of what we as students know, as individuals who have gone through many years of education. We have been trained since kindergarten to prove to others what we know, what skills we

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have acquired, and what we have accomplished. All of this helps us to earn good grades and the respect of our teachers. Interestingly, the opposite often seems to be true in clinical training. Yes, we are evaluated throughout training and must continue to prove ourselves in this way for certain tasks, but a key in clinical training is learning and growing from our mistakes and weaknesses. It seems that, contrary to what we are accustomed to, we need to learn to be vulnerable and grow accustomed instead to recognizing and acknowledging our limitations in order to gain the most from our education. Thus, one of my own primary goals in the remainder of training and in my future practice is to strive to increase my comfort with and ability to challenge myself to reflect more on the "tough stuff." I would encourage anyone in training or professional practice to do the same: to honestly examine your ability to challenge yourself and strengthen it as much as possible.

Conclusion

Reflecting on what I believe are key elements to an effective psychotherapy training experience has been a rewarding experience for me. I truly feel that the "trial by fire" experiences I have had, particularly in the earliest semesters of my training, have helped me understand the value of the therapeutic relationship as the foundation of effective psychotherapy. I also reflected on the value of an early introduction to key ethical guidelines during this "trial by fire" period, followed by an in-depth education about the more lengthy and ever-so-important decision-making process regarding ethical dilemmas in clinical practice. Finally, my reflections on the importance in being challenged by supervisors and, more importantly, learning to challenge one's self throughout training and a career in clinical work, have helped me see just how essential a focus on the "tough stuff" can be to effective psychotherapy.

It has also been interesting to discover the similarities and connections between my own reflections as a student and Barnett's reflections as a seasoned professional who has dedicated much of his career to the training of psychotherapists. While our perspectives turned out to overlap a great deal, we are both aware that there are many other pivotal elements to what creates a successful training experience and an effective psychotherapist. I am also sure that many other students and professionals might feel differently about what items top that list of key elements to training. Dr. Barnett and I would be delighted to hear from anyone interested in sharing their thoughts on this matter. We encourage you to voice your opinions through the new blog in the student section of the Division 29 website (www.divisionofpsychotherapy.org/students) and look forward to hearing from you!

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

WASHINGTON SCENE

What is Past is Prologue

Pat DeLeon, Ph.D.
Former APA President

Looking Back—A View of the Future? Nearly a decade and a half ago, the President's Committee on Advisors on Science and Technology submitted the report of their Panel on Educational Technology, titled "On the Use of Technology to Strengthen K-12 Education in the United States." "In an era of increasing international economic competition, the quality of America's elementary and secondary schools could determine whether our children hold highly compensated, high-skill jobs that add significant value within the integrated global economy of the twenty-first century or compete with workers in developing countries for the provision of commodity products and low-value-added services at wage rates comparable to those received by third world laborers. Moreover, it is widely believed that workers in the next century will require not just a larger set of facts or a larger repertoire of specific skills, but the capacity to readily acquire new knowledge, to solve new problems, and to employ creativity and critical thinking in the design of new approaches to existing problems …. During a period in which technology has fundamentally transformed America's offices, factories, and retail establishments, however, its impact within our nation's classrooms has generally been quite modest."

Psychologist John Bransford served on that Panel which made several high-level strategic recommendations that are clearly relevant today, both for education and for health care reform. 1.) Focus on learning with technology, not about technology. Although both are worthy of attention, it is important to distinguish between technology as a subject area and the use of technology to facilitate learning about any subject area. 2.) Emphasize content and pedagogy, and not just hardware. Particular attention should be given to the potential role of technology in achieving the goals of educational reform efforts through the use of new pedagogic methods focusing on the development of higher-order reasoning and problem-solving skills. 3.) Give special attention to professional development. The substantial investment in infrastructure that is necessary will be largely wasted if teachers (and today's clinicians) are not provided with the preparation and support they will need to effectively integrate information technologies into their teaching (and clinical practice). At that time, only about 15 percent of the typical educational technology budget was devoted to professional development, a figure which the Panel felt should at least be doubled. Ongoing mentoring, consultative support, and the allocation of time are absolutely necessary. 4.) Engage in realistic budgeting. While voluntarism and corporate equipment donations may be of both direct and indirect benefit under certain circumstances, White House policy should be based on a realistic assessment of the relatively limited direct economic contribution such efforts can be expected to make overall. Educational technology is an unusually high-

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return investment (in both economic and social terms) in America's future. 5.) Ensure equitable, universal access. Access to knowledge-building and communication tools based on computing and networking technologies should be made available to all of our nation's students, regardless of socioeconomic status, race, ethnicity, gender, or geographical factors, and special attention should be given to the use of technology by students with special needs. The rate of home computer ownership diverges widely for students of different racial and ethnic groups and socioeconomic status. 6. Initiate a major program of experimental research. A large-scale program of rigorous, systematic research on education in general and educational technology in particular will ultimately prove necessary to ensure both the efficacy and cost-effectiveness of technology use within our nation's schools. Funding levels for educational research have been alarmingly low.

Health policy observers of the systematic implementation of President Obama's landmark Patient Protection and Affordable Care Act (ACA) are acutely aware of its investment in, and emphasis upon, the inherent potentially revolutionary contributions of the advances occurring in communications and computer technology; i.e., electronic health records, evidence-based protocols, tele-health, comparative clinical effectiveness research, as well as virtual realities. And, we would suggest, similar evolutionary obstacles, such as getting too far ahead of practitioners must be expected. Change is always unsettling.

The Panel urged that in order to ensure high standards of scientific excellence, intellectual integrity, and independence from political influence, a critical education-oriented research program should be planned and overseen by a distinguished independent board of outside experts appointed by the President, and should encompass (a) basic research in various learning-related disciplines and on various educationally relevant technologies; (b) early-stage research aimed at developing new forms of educational software, content, and technology-enabled pedagogy; and (c) rigorous, well-controlled, peer-reviewed, large-scale empirical studies designed to determine which educational approaches are in fact most effective in practice. Such a program could well prove critical to the economic security of future generations of Americans and should thus be assigned a high priority in spite of current (1997/2013) budgetary pressures. Within the ACA, the newly authorized Patient-Centered Outcomes Research Institute (PCORI) might well serve a similar function.

The Panel further noted that if computers are destined to play an increasingly important role in education over the next 20 years, it is natural to ask what roles will be played by human beings (i.e., the Human Element). Although it seems clear that the expanded use of technology in education will have significant implications for teachers, students, parents, and community members, there is reason to believe that interpersonal interactions among all these groups will be at least as important to the educational process of 2017 as they are in 1997. Indeed, the changing nature of these interactions is probably as central to the promise of new educational technologies as the hardware, software, and curricular elements. The Panel also appreciated that there was a growing consensus that technology should be applied in such a way as to foster broader community-wide involvement in the educational process. It was further thought that the linking of schools with research universities,

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public libraries, and private companies could make valuable educational resources available to both students and teachers while simultaneously building awareness within each community of the needs of its local schools. "Real-world" projects initiated by outside organizations often generate considerable enthusiasm among students and frequently prove unusually effective from an educational perspective. Some educators at that time were even discussing the possibility of instituting "tele-apprenticeship" or "tele-mentoring" programs involving brief, but relatively frequent interactions between students and other community members that would be impractical in the absence of networking technologies due to travel time considerations.

Not surprisingly the Panel found, and we would seriously wonder if the comparable data is any different today, that the most significant disparities in socioeconomic status access to technology is not found in the schools, but in the homes of the students. As of June 1995, computers were present in only 14% of all households headed by adults who had completed no more than a high-school education, and in which annual household income was less than $30,000; the comparable figure for households headed by college-educated adults having a combined income of more than $50,000 per year was more than five times greater, at 73%. Similarly, on average girls and boys differed only slightly in their use of computers at school and at home. On a personal note, at the Uniformed Services University of the Health Sciences (USUHS) graduate school of nursing, it is impressive how graduate students today are able to effectively utilize technology to integrate relevant You Tube (which was created in February, 2005) videos routinely into their classroom presentations.

Integrated Healthcare—New Training Models? Fundamental to the President's ACA vision is providing patient-centered, integrated primary health care for all Americans in which the various disciplines will work collaboratively, rather than competitively. Over the past several decades, visionary health psychologist Cynthia Belar, now Executive Director of the APA Education Directorate, has been urging psychology to appreciate the magnitude of change that is approaching. "There is nothing new about interprofessional education (IPE), team based care, or integrated care. What is new is the national recognition of its importance for 'Crossing the Quality Chasm' (Institute of Medicine (IOM)) and the increasing calls for such by leaders in medical education. Indeed the "Interprofessional Competencies for Collaborative Care" have now been endorsed by a number of health professions, and will go to the Council in February for APA's endorsement. The APA governance groups and the Board of Directors have been uniformly supportive to date.

"Psychologists in health settings have often provided team based care, but training for such has usually begun at the internship or postdoctoral levels. With the focus on interprofessional competencies there are increased demands for interprofessional education in the earliest stages of training, where students can learn with and from each other and before stereotypes get rigidified. The IOM Global Forum on Innovations in Health Professions Education, of which APA is a sponsor, has made this the primary topic for its first two forums. It is being clearly acknowledged that those not trained to work together will not know how to work together after they graduate.

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"Early involvement in IPE provides a challenge for doctoral programs housed in colleges of arts and sciences or universities without other health professions students, but not one impossible to meet. In fact the Graduate Psychology Education program of HRSA, of which APA was the architect, has since its inception required the training of psychologists with at least two other health professions for receipt of grand funds. To my knowledge, other than the Burdick Rural Interdisciplinary training program which unfortunately has not been funded for a number of years, such requirements are not part of other Title VII, Title VIII, or Medicare GME programs, but one wonders why not.

"We have said before how federally qualified health centers (FQHCs) and departments of internal medicine, pediatrics, and family practice can provide invaluable experiences in training for team-based primary care, which is seen as the foundation for the reformed health care system. In my opinion, programs that want to prepare health service providers should run, not walk, to these settings and work to establish collaborative opportunities for training. Psychology has articulated the competencies needed in the healthcare environment, including the special needs of primary care. Even the Patient-Centered Primary Care Collaborative (an advocacy group of employers, providers, payors, and consumers) recognizes the need for new models of training that require not only team-based skills but a population-based perspective. (I am currently the co-chair with a family practitioner of the Education and Training Task Force.) Psychology has some superb programs that provide relevant training, but we need more."

Health Insurance Exchanges: In 2014, the ACA will ensure that health insurance exchanges will be available in every state with all plans providing the same package of essential health benefits, although they will vary by four different levels of "actuarial value" (percentage of costs that a plan pays on average). The individual States can decide whether they will set up their own exchanges, or rely upon the federal government. At the last APA State Leadership conference, Practice Directorate Executive Director Katherine Nordal strongly urged the attendees to get personally involved at the state level. "We're facing uncharted territory with proposed new models of care. Change is inevitable…. We're going to have to address health insurance exchanges. These are exchanges that provide health plans for individuals and small businesses that will be set up at the state level." The State of Hawaii was the first in the nation to declare its intent to establish a state-certified exchange. Governor Neil Abercrombie: "The successful establishment of the Hawaii Health Connector is part of our New Day Plan in transforming healthcare in Hawaii."

Coral Andrews is executive director of the Hawaii Health Connector whose aim is to provide an online marketplace that is of Hawaii-for-Hawaii, effectively taking into account the state's unique culture and its Prepaid Health Care Act, an employer health mandate in effect since 1974 and incorporated into the ACA. "We are socializing our vision to the Board and stakeholders-at-large, focused on a community investment model. Our brand/logo will be built on the host culture's teachings and values. We are working on it. If we remain grounded in what we value and the Native Hawaiian cultural ideals, then it will act as a guidepost as we seek to navigate these new blended public-private models.

"Our proposed sustainability plan

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would draw like-minded community leaders together around the opportunity to improve the overall health and well-being of the population. We don't just want to teach consumers how to come to an exchange to buy. We want to focus on the longer term opportunity of social change. If we can, in that consumer encounter, provide the education and critical thinking tools to them, then we have a greater opportunity of effecting change overall. If we truly believe in the core values of our host culture, then that should be the basis by which we develop our plan. Internationally, these ideas of social transformation have been applied to impoverished societies. The true intent of the ACA is what we're focused on; not just building an IT system.

"We have recruited a development officer from the Hawaii Community Foundation to assist us with strategy and sustainability. We believe that there are philanthropists and like-minded organizations in Hawaii who will join us in gaining momentum around the idea of a community investment model. There are also very cool theories and analyses that have emerged from the Stanford Social Innovation Center and a non-profit called Code for America. Applying some of these ideas in this market could be interesting. When all is said and done, we want to be able to look back and know that we have invested time in something that improves the health and well-being of our population and supports a more prosperous Hawaii. The end opportunity is a stimulated economy via indirect efforts."

The NMSU/SIAP Interdisciplinary RxP Program: "The New Mexico State University/Southwest Institute for the Advancement of Psychotherapy Interdisciplinary Master's Degree Program in Clinical Psychopharmacology stands out from other APA "designated training programs" (i.e., meets the APA model curriculum) in many important ways. We are the only program located in a state with prescriptive authority so we frequently have program alumni and working prescribing psychologists attend our classes for continuing education, enriching class discussion with perspectives from the prescriptive practice world. We are the only program that offers live in-person instruction throughout the course, fostering more student interaction with our instructors as well as strong collegial relationships among students during breaks, lunches, and before and after class.

"The centerpiece of our program is the nine class integrated Advanced Pathophysiology and Physical Health Assessment module where students are instructed by family practice physicians using a systems-problem based learning approach. The first day of the weekend is a lecture followed by a day of hands-on assessment skills practice in a real world family practice clinic setting. The curriculum for this module, though challenging, uses the same texts and instruction methods as the New Mexico State University Nurse Practitioner graduate program, giving our program added clinical rigor. New this iteration, we have added a section on clinical primary care psychology to each class, helping equip psychologists for work in primary care or other medical settings, with and without a prescription pad. Another unique experience is our neuroanatomy/brain dissection lab taught by a prescribing neuropsychologist. If you have never had the opportunity to see exactly what a choroid plexus looks like in person, you should consider our program. We are also the only program directed by a practicing prescribing/medical psychologist (myself), who became the first prescribing psychologist working at the New Mexico

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Behavioral Health Institute (the State Psychiatric Hospital) in 2008.

"In 2012, our program established an ongoing part-time residency program for psychologists to do the required physician supervised practicum hours in a primary care clinic setting serving families in southern New Mexico in a partnership with La Clinica de Familia, a Federally Qualified Health Center (FQHC). Two psychologists are presently doing their practicum hours there and several more are currently being credentialed and plan to begin in 2013. Another exciting new option is shadowing a prescribing psychologist the day before or the day after the class weekend. Students sign up to accompany a working prescriber at his/her practice setting on the Friday or Monday around the class weekend, combining the practical and academic in one trip to New Mexico. Our website for further information is http://education.nmsu.edu/cep/siap [Christina Vento]."

The Commonwealth Fund's 2012 Annual Report: This year was a dramatic one for health care reform and, for several months around the Supreme Court's decision on the constitutionality of the Affordable Care Act (ACA), a time in which an unusually large number of Americans were closely following federal health policy. As we learned last summer, the Supreme Court ultimately upheld the law, enabling vital health care delivery and health insurance reforms to continue and an estimated 30 million Americans to gain health insurance coverage by the end of the decade. The United States is finally on the path to join all other major industrialized countries in ensuring near-universal health insurance coverage. This accomplishment in one that U.S. presidents have struggled to achieve over the past hundred years. Thanks to the health reform law, we as a nation will no longer have a health care system that allows so many Americans to suffer from treatable diseases because they cannot afford health care – or to lose their savings to pay for treatment.

In many ways, the ACA has been the fruition of work that The Commonwealth Fund and others have conducted over the past 20 years. The law's principles were articulated a decade ago. Today, a number of these principles and recommendations are beginning to realize their promise. There has already been substantial progress in the first two years of ACA's implementation. After 12 years of increases in the uninsured, the number of people without coverage dropped by 1.3 million in 2011. Nearly all states have taken legislative or regulatory steps to implement the law's early insurance market reforms and coverage of preventive care services without cost-sharing. We may be witnessing new models of health care delivery, improved quality and safety, health information technology, and preventive care. Aloha.

Book Review of Peebles, M.J. (2012). *Beginnings: The art and science of planning psychotherapy*. 2nd ed. New York: Routledge.

Michael Karson, Ph.D., J.D., A.B.P.P. (Clinical)
University of Denver-Graduate School of Professional Psychology

Peebles's book is a tour de force not because it tells you or reminds you how to start a psychotherapy, which it does, but because it explains why the beginning is so important. With clear prose that reveals her clinical wisdom, she emphasizes the importance of developing a working alliance. Too often these days, the alliance stands for unrelenting niceness and rapport, which can lead to a social relationship that, far from setting the stage for taking off masks, reminds clients of other social relationships where masks are required. But Peebles keeps her footing and explains why the alliance has to be around doing the work of therapy. She discusses the development of treatment goals, a case formulation, and a focus for work in collaboration with the patient, and she shows beyond any doubt how this leads to a formulation that is unique to the particular patient (and therefore engrossing), and how its collaborative roots sustain the alliance through the inevitable trials of change.

A large portion of the book is devoted to a categorization of concerns that is nothing short of brilliant. She divides psychotherapy foci into deficit, trauma, character pathology, and conflict, an easily recognizable set of concepts that she selected because each implies a different approach. She provides theoretical foundations and treatment implications for each.

Peebles is a psychoanalyst who also sees families and does hypnosis. She goes out of her way to welcome readers of other theoretical orientations by largely avoiding psychoanalytic jargon and by explaining herself in plain English. This parallels and models her insistence on including patients in her thinking, and she's very good at it.

The book is aimed at beginners, but the clinical wisdom is so pervasive that anyone can enjoy it. I've been asking trainees since I read it what their case formulation and focus are, and it has been an immediate boon as we discover that they are often not on the same page as their patients about what they are doing together. *Beginnings* is full of ideas about what therapy is, and these are fleshed out in ways that remind the reader of therapy at its best. For example, she starts with an extended discussion of slowing things down in therapy and taking time to understand psychologically important moments and interactions. Anyone can drift without supervision or consultation, and Peebles is the best kind of consultant; she reminds you of who you are when you are at your best (a leitmotif of the book is doing this for patients). As a practitioner for almost 40 years, I was delighted to find what felt like an old friend and colleague, someone who sees the world as I do, but with more clarity.

AMERICAN PSYCHOLOGICAL ASSOCIATION DIVISION OF PSYCHOTHERAPY (DIVISION 29)

Diversity Research Grant for Pre-Doctoral Candidates

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

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

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

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

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

Caryn Rodgers, Ph.D.
(caryn.rodgers@einstein.yu.edu) &

Beverly Greene, Ph.D.
(bgreene203@aol.com)

by midnight, April 1, 2013. Incomplete or late application packets will not be considered.

The application must include:

- A 1-2 page cover letter describing how the applicant's work embodies the Division's interest in promoting diversity in the profession of psychotherapy and how the funding will be used to support the applicant's dissertation work;
- A 1-page document outlining a detailed budget;
- A 5-10 page research proposal (alternatively, a Dissertation Proposal may be submitted, regardless of length);
- 1 letter of recommendation from the applicant's current direct supervisor or advisor; and
- 1 letter from the applicant's dissertation advisor or director of clinical training certifying that the applicant is currently in the process of completing research for the dissertation.

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Once a complete application has been received (on or before the deadline), selections will be made using the following criteria:

- Consistency with the Diversity Research Grant's stated purposes;
- Clarity of the written proposal;
- Scientific quality and feasibility of the proposed research project;
- Budgetary needs for data collection and completion and presentation of the project;
- Potential for new and valuable contributions to the field of psychotherapy; and
- Potential for final publication or likelihood of furthering successful research in topic area.

Additional Information

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

The *Psychotherapy Bulletin* is Going Green:

Click on

www.divisionofpsychotherapy.org/members/gogreen/

NOTICE TO READERS

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

Rodney Goodyear, Ph.D.

I am honored to be a candidate on this Presidential slate. I have been a Division member for more than three decades and many of my heroes and heroines in the field have been prominent members of the Division. As well, I have enjoyed my opportunities to serve the Division in several roles (currently as Program Chair).

My work has focused primarily on teaching and supervising psychotherapy. This is evident in my scholarship (e.g., Bernard and Goodyear is arguably the best known and most widely used supervision book worldwide) which also has extended to psychotherapy processes. I have had the opportunity to serve as an editorial board member of several psychotherapy journals (e.g., *Psychotherapy Research*).

Supervision and training also has been the center of my professional work. For example, I directed USC's APA accredited counseling psychology program for 20 years, have served on both APA's Continuing Education Committee and the Commission on Accreditation, and currently am a member of APA's supervision guidelines task group. I have received the Council of Counseling Psychology Training Programs *Award for Lifetime Contributions to Education and Training. in Counseling Psychology.*

Whoever is Division President will need to maintain a focus on both internal and external focus. Internally, we must continue to address the attrition that all APA divisions are encountering (e.g., more than 60% of APA members now belong to no division), with a consequent greying of our membership (the Division's mean age now stands at 63, per John Norcross's latest survey).

Psychotherapy is the single most frequent activity of both clinical and counseling psychologists, an advantage for our Division which is developing initiatives to (a) draw in new members and then (b) retain them by providing benefits that members perceive as sufficiently valuable to stay. These important efforts must continue—and as we do, we also need to find ways to increase our perceived relevance to psychologists of color, who currently comprise only a small portion of our membership.

Externally, we have an important responsibility to promote effective psychotherapy practice. Certainly our journal, *Psychotherapy*, does this with its impact that extends well beyond the Division. But through leadership and advocacy, our Division has shaped—and should continue to do so—opinion and practice. The Resolution on the Effectiveness of Psychotherapy is one important recent example of an initiative in which our leadership played a role and which we should continue to promote.

My Fulbright Distinguished Lecturer appointment last year at Yonsei University heightened my interest in psychotherapy practice worldwide. I would like our Division to be more deliberate in the attention it gives to members and affiliates in other countries and to the work they do.

I would bring to this position administrative skills developed as both program and Division Chair at USC and then an Associate Dean. But any President also will have the important advantage of being a member of the strong leadership team that Division 29's talented Executive Board provides. It would be my privilege to work with them and for the Division in the role of President. ■

Steven A. Sobelman, Ph.D.

Thank you for the opportunity to serve Division 29. I would be honored to be your President. I am currently serving as the Division's Finance Committee Chair. Last year, I completed my second three-year term as the Division's Treasurer and was pleased to report that even during the economic downturn, the Division is in very good financial shape. As Treasurer, I have worked with six Division Presidents and served on the Executive Council. I believe that I have a good sense for where the Division has been and what challenges we face in a rapidly changing environment. In my multiple roles I have served as CE Chair, chair of the technology committee, and as a member on the Finance Committee. You will see that my past experiences and commitment to the Division have provided me with a strong foundation to lead us through rapid changes in health care reform, practice, science, and technology.

My professional life has dealt with two worlds—psychology and corporate America. Psychologists have not always been able to operate within the corporate environment because we often lack the skills or knowledge necessary for running organizations effectively. I will try to bring a strong history of organizational experience and entrepreneurial leadership to the role of President.

I have spent many years teaching, practicing, and advocating for psychology where I have enjoyed various leadership positions. I served as President, APA Division 49 and also served as President of the Maryland Psychological Association. I currently serve as the Chair, Maryland Board of Examiners of Psychologists. I also maintain a private psychotherapy practice and was a fulltime faculty member and director of graduate programs in psychology at Loyola University (Maryland). I was founder and clinical director of a large private mental health facility in the Baltimore Metropolitan area. I have a breath of experience in both the public and private sector from which I can draw as your President.

Before we sold our company last year, I was the CEO of a mid-sized, IT company specializing in Electronic Medical Records. I've had significant experience with investor relations and venture capital exploration and have learned fiscal responsibility. This experience has been invaluable to me in the role as the Division 29 Treasurer.

As your President, I will continue to bring a vigilant and progressive approach to maintaining a strong Divisional presence within APA and the professional community. I propose the following initiatives: (1) create a more streamlined and fiscally responsible organizational structure; (2) provide fiscal responsibility to the membership; (3) explore approaches for increasing non-dues revenue, e.g., online CE workshops; (4) increase member and student scholarships and awards; (5) explore incentives for value added services to the membership; and (6) reach out to the membership to find ways to make your dues worthwhile.

I strongly believe that if you want to get something done, you give it to a busy person with a track record of effective leadership. I am willing to be that busy person with a track record of achieving results and effective leadership. Thank you for your consideration and I welcome and appreciate your vote. ■

CANDIDATE STATEMENTS
Representative to APA Council

Jean Carter, Ph.D.

Division 29 elects APA Council representatives who demonstrate leadership in the Division and APA and who are committed scientist-practitioners. I promise to serve you well and continue the tradition.

Leadership in Division 29
Member-at-large and president. As president, led the reorganization that created domain representatives, broadening and deepening our focus. Energized the committees and actively encouraged diversity throughout the Division. Stabilized the Division financially. Member and Chair of the Publication Board, returning to the Pub Board in 2012.

Leadership in APA
I know APA! I served previously in Council and as a member of the APA Board of Directors. I served as member and chair of two APA Committees (CAPP and CODAPAR) and member and Vice Chair of the APA Finance Committee, as well as on numerous task forces.

Commitment to Science and Practice
As a full time independent practitioner in Washington, DC, for over 30 years, I know the rewards and challenges intimately. I deeply value the central core of science in psychology, and have served as an ad-hoc reviewer and on editorial boards of several journals, including *Psychotherapy*. I have just completed 6 years as an associate editor of *Professional Psychology: Research and Practice*. I was honored to serve on the APA Task Force on Evidence Based Practice in Psychology, where we developed the APA policy statement on EBPP.

Me, Personally
I strive for consensus building and collaboration based on shared goals and values, while also understanding and recognizing differences. I take the trust placed in me seriously, and work tirelessly at things I am committed to. I remember that decisions made on behalf of APA affect individuals, and that impact must not be minimized. I laugh easily, like people a lot, and care passionately about psychology! ■

Jennifer Erickson Cornish, Ph.D., ABPP

It is a tremendous honor to be nominated by our Division of Psychotherapy for a Council of Representatives seat. The chance to represent psychotherapy issues during this challenging time for psychology and for APA would be an immense privilege.

I am currently associate professor and director of clinical training and internship consortium at the University of Denver Graduate School of Professional Psychology. I previously served on the Council of Representatives for the Colorado Psychological Association and during that time co-founded and was the first chair of the Education and Training Caucus. For Division 29, I had the pleasure to be editor of *the Psychotherapy Bulletin* where I continue as contributing editor for Ethics in Psychotherapy. I have been particularly pleased to encourage students to publish in the *Bulletin* and thus become more involved in our Division.

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Other national service includes the APA Ethics Committee, secretary of Division 17, and the APPIC Board.

Current issues facing Council include the Good Governance Project (and our need to ensure that the voice of psychotherapy continues to be heard in whatever new governance configuration is established); the continued relationships between practice, science, education, and the public interest; advocating for funding for psychotherapy and for psychotherapy education and training; and promoting psychotherapy (by psychologists) within the Affordable Health Care for America Act and within integrated and interprofessional models of healthcare. When I was previously on Council, I shared the agenda overview prior to meetings and asked for input, and then following meetings sent out notes with more request for input. If elected, I would endeavor to continue such open communication. I am asking for your vote, and hope that I have the opportunity to serve our Division well on the Council of Representatives. ■

John C. Norcross, Ph.D.

I am honored to be nominated for another term as your APA Council Representative for the Division of Psychotherapy. Division 29 is my natural professional home in that my daily responsibilities entail teaching, supervising, practicing, and researching psychotherapy as a university professor and as an independent practitioner.

My service to the Division traverses a variety of activities and a number of years. I have served as President, Council Representative, chair of the Education & Training Committee, and chair of our Publications Committee. I have edited several special issues of *Psychotherapy*, contributed regularly to our *Psychotherapy Bulletin*, and conducted comprehensive studies of the Division 29 membership. In addition, with Drs. Don Freedheim and Gary VandenBos, I codeveloped the APA Psychotherapy Videotape Series and coedited the second edition of *History of Psychotherapy*.

Recent books include *Psychotherapy Relationships That Work, Psychologists' Desk Reference* (with Gerry Koocher and Beverly Greene), *Self-Care that Works* (with Linda Campbell and others), *Handbook of Psychotherapy Integration* (with Marv Goldfried), and *Systems of Psychotherapy: A Transtheoretical Analysis* (with Jim Prochaska), now in its eight edition. I also edited the *Journal of Clinical Psychology: In Session* for 10 years. All of this is to say that my primary commitment is to advance psychology and psychotherapy.

Succinctly stated, my priorities as your Council Representative will be to: maintain the quality and integrity of psychotherapy in the face of health care industrialization; enhance the integration of practice and research in psychotherapy; advocate for the centrality of psychological treatment in daily life; and expand services for the Division 29 membership. Perhaps most importantly, I will strive for an open mind, a responsive ear, and an active stance toward the interests of the membership.

I welcome your continued support and collaboration. ■

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Abe Wolf, Ph.D.

I am honored to be nominated as Council Representative for the Division of Psychotherapy. I am deeply committed to building bridges between psychotherapy practitioners and researchers and will work to give our field a strong voice in a body that represents the entire field of psychology.

I have practiced, taught, and researched psychotherapy. After 30 years of practicing and teaching psychotherapy at a major metropolitan county hospital, I am now in full time private practice. I know the challenges of delivering services to the needy and how private practitioners are challenged by decreasing compensation from insurance companies. As a Professor of Psychology at the Case Western Reserve University School of Medicine with over 50 published articles in psychotherapy and health psychology, I am aware of the challenges of translating research into practice.

I have served on the board of the Division of Psychotherapy for 15 years. I was president of the division in 2006. My service also included terms as Secretary, Chair of the Student Development Committee, Publication Board member, Member-at-Large, Mid-Winter Convention coordinator, and editorial consultant to the journal Psychotherapy. In 1996, I was honored by the Division with the Jack Krasner Early Career Award. As founding Internet editor of our Division, I understand the importance of this medium and how we can to use it to further the mission of our organization.

This year I coedited Transforming negative reactions to clients: From frustration to compassion. I have also remained active with the Society of Clinical Psychology and the Division of Psychotherapy in a collaborative initiative to provide practicing therapists with a way of disseminating their clinical experiences in using empirically supported treatments to the research community.

The field of psychotherapy needs strong representation. I will strive to provide that representation on the APA Council. ■

CANDIDATE STATEMENTS
Diversity Domain Representative

Jean Birbilis, Ph.D., L.P., B.C.B.

Division 29 is inclusive. Contributing to this inclusiveness as the Diversity Domain Representative would be an honor. I previously served as Education and Training Committee Chair and currently serve as Membership Committee Chair and a member of the Diversity Committee. The opportunity to create joint initiatives to achieve goals of multiple committees is an exciting prospect. For example, the Membership and Early Career Psychologist Committees worked together to create a proposal for initiating mentorship through Division 29; this will also create a venue for cultivating future leaders of Division 29 from diverse backgrounds. What an excellent example of the Division motto, "Be connected"!

The Diversity Committee has created awards and resources that pertain to diversity and psychotherapy. The Committee can also engage the Division in reflection regarding what diversity means and how it can be addressed most fully by the Division. As a professor in a Psy.D. program that addresses competency in diversity in the most inclusive manner possible and a practitioner myself, I offer three examples of emerging, diverse populations who need the attention of psychotherapists. (1) The military has a unique culture, and veterans often face challenges during reintegration. How can Division 29 encourage attention to military culture as an aspect of diversity in psychotherapy research and practice? (2) As approximately 30 million previously uninsured citizens obtain healthcare insurance, how can Division 29 help assure adequate inclusion of psychotherapy in the healthcare system in the future? (3) As baby boomers continue to age, how can Division 29 assist psychotherapists in addressing the needs of the elderly?

Finally, I would like to see Division 29 actively pursue members from diverse training backgrounds. Less than 10% of current Division 29 members have Psy.D.s, yet more students are graduating from Psy.D. programs, which focus on training practitioner scholars, than from Ph.D. programs each year. ■

Jairo N. Fuertes, Ph.D., ABPP, LMHC

Dear Colleagues I have been nominated for the position of Domain Representative for Diversity within Division 29. I appreciate the nomination and agreed to run for the position. I have conducted research in the area of diversity for many years now, in areas that pertain to therapist multicultural competence, acculturation stress, and Universal-Diverse Orientation. I believe with sincere interest in addressing the importance of diversity in the field of psychotherapy, given the rapidly changing demographics in the country, the evidence which points to disparities in outcome against ethnic and racial diverse clients and patients, and the unfortunate reality of bias and oppression that negatively effect the well-being, advancement, and mental

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health of many minority, immigrant, and historically oppressed groups in the United States. I do have some experience in advocating for diversity. For example, I currently serve as Chair of the Diversity Committee within the Derner Institute of Advanced Psychological Studies at Adelphi University. I also have experience within Division 29, where I currently serve (and in December 2013 will end) a three-year run as Chair of the Education and Training Committee. If elected as Domain representative for Diversity, I will work with my colleagues in D29 to advocate for diversity-related needs and opportunities, including promoting the importance of multicultural competence for psychotherapists, promoting research to diminish and eliminate outcome disparities in mental health care, and greater awareness and inclusion of diversity related factors in all aspects of Division 29 governance. Thank you. Gracias! ■

NOTICE TO READERS

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

CANDIDATE STATEMENTS
Early Career Psychologist Domain Representative

Rayna Markin, Ph.D.

I am honored to be nominated to run for Early Career Domain Representative. I received my doctorate in Counseling Psychology in '07 from the University of Maryland, College Park, and I am an assistant professor at Villanova University. I am currently serving in Division 29 as the Chair of the Research Committee. There are a number of reasons I would like to serve as the Early Career Domain Representative. First, as someone who identifies as both a psychotherapist and a psychotherapy researcher, I welcome the opportunity to represent other ECPs who also identify as clinicians and/or researchers. I want to provide a way for the next generation of psychotherapists and psychotherapy researchers to have a voice in Division 29, facilitate involvement of early career psychologists in Division activities, and help early career psychologists tap into the support that is available through Division 29. As someone who studies the psychotherapy relationship, I feel it is essential to build bridges and establish connections between ECPs themselves, but also between experienced members of the Division and ECPs. For example, during my time as Chair of the Research Committee, I planned the Luncheon with the Masters series and helped to develop a Mentorship program for the Division. As an ECP myself, I understand the unique challenges that ECPs face, but also their unique strengths that can add to the Division. Whether advocating to support a new investigator's research, or a clinician starting a practice, or an instructor teaching a psychotherapy course for the first time, I would be honored to represent other ECPs with diverse backgrounds and experiences. ■

Amit Shahane, Ph.D.

I am honored to be a nominee for Division 29's Early Career Domain Representative. As an early career, licensed psychologist practicing in Atlanta, GA, I have a strong commitment to organizational service and involvement in developing innovations within the field of psychology.

Currently, I am a full time Assistant Professor in Emory University School of Medicine's Department of Psychiatry and Behavioral Sciences. As a faculty member, I am involved in psychotherapy training and supervision of practicum students, interns, medical students, and psychiatry residents. In addition, I participate in various committees ensuring professional and collaborative relationships across university and hospital settings.

Within Division 29, I enjoy serving as the current committee chair for the Diversity Domain. As committee chair, I have worked to build collaborative relationships with other Division 29 domains, and advance the values and mission of the Diversity Domain. I hope

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to further build my relationship with Division 29 and expand my role as the Early Career Domain Representative.

In addition to my service in Division 29, I have been fortunate to participate in multiple APA divisions and other professional psychology organizations that further the needs of early career psychologists. Currently, I serve on Early Career Professionals (ECP) Council (Div. 38), and have provided an early career voice within ASPPB's (Association of State and Provincial Psychology Boards) standard setting study. Through these experiences, I have had the good fortune to gain leadership, organizational, and communication skills that I hope will enrich my work as the Early Career Domain Representative.

If elected, I would work to further enhance awareness of early career issues across all Division 29 domains, as well as advocate for early career perspectives in all APA and Division 29 initiatives. Thank you for your consideration and I would greatly appreciate the opportunity to serve as the Early Career Domain Representative. ■

CANDIDATE STATEMENTS
Science and Scholarship Domain Representative

Bernard S. Gorman, Ph.D.

Bernard Gorman received his Ph.D. (1971) in Personality and Social Psychology from the City University of New York, and completed postdoctoral studies in psychotherapy at the Institute for Rational Emotive Therapy. He has written numerous articles and presented many convention papers in the areas of personality assessment, multivariate analysis, and relationships between cognition and affect. He co-authored the textbook, **Developmental Psychology** (Van Nostrand, 1980) with Theron Alexander and Paul Roodin, and co-edited the research monograph, **The Personal Experience of Time** (Plenum, 1977) with Alden Wessman. He is the author of several instructional computer packages published by Random House and McGraw-Hill. His book, **Design and Analysis of Single Case Research**, with Ronald Franklin and David Allison, focuses on the intensive study of individuals over time.

Gorman is SUNY Distinguished Teaching Professor of Psychology and State University of New York Faculty Exchange Scholar at Nassau Community College/SUNY, where he teaches courses in general psychology, abnormal psychology, child and adult development. He holds an adjunct professorship in Hofstra University's Graduate Psychology and Gerontology Programs, where he teaches courses in gerontology, multivariate statistical analysis, qualitative analysis, computer applications in psychology, and psychometrics. He received the State University of New York Chancellor's Award for Excellence in College Teaching. For more than 15 years, he combined his interests in measurement research, clinical issues, and teaching as a psychologist in the New York State Office of Mental Health. He served as vice-president of the Metropolitan New York Chapter of the American Statistical Association from 1993-1998. He is a Senior Research Scientist in the Department of Psychiatry at Beth Israel Medical Center, New York, where here is part of a research team investigating the efficacy of psychotherapy. He is a Fellow of Division 1 of the American Psychological Association. He served as a member of the National Science Foundation Research Coordination Network on DNA microarray technology, where he developed multivariate statistical analysis methods for studying gene expression.

He is on the Editorial Boards of the journals: *Psychotherapy: Research and Practice; The Journal of Psychotherapy Research; Psychology and Marketing, and Psychodynamic Psychiatry, the Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry.* He also conducts site visits as a member of the American Psychological Association's Commission on Accreditation. ■

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Susan S. Woodhouse, Ph.D.

I am honored to be nominated to run for Science and Scholarship Domain Representative. Division 29 has been a key intellectual home for me within APA. I would enthusiastically spearhead research-related initiatives for Division 29. I am a psychotherapy researcher, including research on psychotherapy process, the psychotherapy relationship, and research on preventive interventions for families with young children. I am the PI on a $2.9 million NIH-funded study that focuses on basic science questions relevant to psychotherapy with diverse, low-income, underserved families with young children (and includes an applied component). I am involved in a number of additional research projects and NIH grant applications that focus on psychotherapy and prevention work with diverse, low-income, underserved families. I strongly believe that that the work we do on the psychotherapy relationship, process, outcomes, client strengths, and culturally appropriate psychotherapy is important; and that the science of psychotherapy is relevant to the public good. I would like to be a part of supporting psychotherapy research and the dissemination of psychotherapy research findings. In my own community-based psychotherapy research, I have had to think hard about how to build trust with community stakeholders, engage the community in the research, and bring the results of the research back to the community. I believe those skills translate well to serving as the Science and Scholarship Domain Representative.

I received my doctorate in Counseling Psychology in 2003 from the University of Maryland, College Park, and I am an Associate Professor at Lehigh University. I am currently in my final year of a 3-year term as the Division 29 Early Career Domain Representative. Prior to that, I served for two years as the Chair of the Research Committee in Division 29. These experiences have prepared me well to serve the Division as the Science and Scholarship Domain Representative. ■

AMERICAN PSYCHOLOGICAL FOUNDATION

PSYCHOLOGY PHILANTHROPY

REQUEST FOR PROPOSALS
Visionary Grants
And
The Drs. Rosalee G. and Raymond A. Weiss Research and Program Innovation Grants

About the American Psychological Foundation (APF)

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

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

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

About the Grants

The Visionary Grants and Drs. Raymond A. and Rosalee G. Weiss Program and Innovation Grant support innovative research, education, and intervention efforts that advance psychological knowledge and application in

- Understanding and fostering mental-physical health connections
- Reducing stigma and prejudice
- Understanding and preventing all forms of violence
- Addressing long-term psychological needs in the aftermath of disaster

Preference will be given to early career psychologists (seven years or less postdoctoral), and pilot projects that, if successful, would be strong candidates for support from major federal and foundation funding agencies, and "demonstration projects" that promise to generalize broadly to similar settings in other geographical areas and/or to other settings.

Amount

Visionary Grants range from $5,000-20,000
Drs. Raymond A. and Rosalee G. Weiss Program and Innovation Grant: up to $2,500

Applicants may apply for one or both grants.

American Psychological Foundation
750 First Street, NE • Washington, DC 20002
P: (202) 336-5843 • F: (202) 336-5812 • Foundation@apa.org • www.apa.org/apf

APF does not allow institutional indirect costs or overhead costs. Applicants may use grant monies for direct administrative costs of their proposed project.

Eligibility Requirements

Applicants must:

- Be affiliated with 501(c)(3) nonprofit organizations. APF will NOT consider the following requests for grants to support:
  - political or lobbying purposes
  - entertainment or fundraising expenses
  - anyone the Internal Revenue Service would regard as a disqualified group or individual
  - localized direct service
  - conference/workshop expenses
- Have demonstrated competence and capacity to execute the proposed work

IRB approval must be received from host institution before funding can be awarded if human participants are involved

Evaluation Criteria

Proposals will be evaluated on:

- Conformance with stated program goals and requirements
- Innovative and potential impact qualities (*introduction of proven interventions in a similar setting , minor extensions of established theory, or work that has little chance of replication or use beyond the proposed setting do not qualify as innovative or impactful*)
- Quality, viability, and promise of proposed work
- Criticality of proposed funding for proposed work (*mere contributions to larger funded efforts, or "add-ons" that could/should be carried out under that funding are discouraged*)
- Competence and capability of project leaders

Proposal Requirements

Please include the following sections in your proposal (no more than 7 pages; 1 inch margins, no smaller than 11 point font):

- Goals and Objectives. Describe the primary purpose and specific goals of the project or program, including the issues/challenges that it will address, and an explanation of which APF priority(ies) the work falls within.
- Workplan and Timeline. Describe the action plan and schedule by which the project or program as a whole is to be carried out. When appropriate, indicate where in that time frame the APF funding will be applied.
- Program Evaluation/Outcomes Measures. Describe, using appropriate quantitative and qualitative measures, how the results of the effort will be evaluated and reported. If a

time-limited project, indicate how success or impact will be determined; if a continuing program, indicate both "milestone indicators" and annualized plans for the future; if a current ongoing program, also provide any current evaluation data.

- **Personnel.** Please list the project personnel and their specific functions. Please attach the CVs of all major personnel.
- **Budget.** Please indicate the amount of funding requested from APF and justify it on the basis of the specific role this contribution will play toward attaining the project's or program's goals ("seed money" justification is acceptable). In cases where major funding from other sources has been received or is anticipated, please include the following: total budget; amount in hand and committed; and amount from other sources. Justify the specific need for APF's contribution.
- Please attach your organization's IRS determination letter.

Submission Process and Deadline

Submit a completed application as a single PDF document online at http://forms.apa.org/apf/grants/ by **May 1, 2013**.

Please be advised that APF does not provide feedback to applicants on their proposals.

Please contact Parie Kadir, Program Officer, at pkadir@apa.org with questions.

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

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Central Office, 6557 E. Riverdale Street, Mesa, AZ 85215
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American Psychological Association
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Mesa, AZ 85215

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