

# Psychotherapy

OFFICIAL PUBLICATION OF DIVISION 29 OF  
THE AMERICAN PSYCHOLOGICAL ASSOCIATION

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## PRESIDENT'S COLUMN

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The past few months have been busy and productive ones for the Division of Psychotherapy, as we continue to work toward advancing clinical practice and creating opportunities for, and connections between, our members. In lieu of the traditional President's Column, I would like to take this opportunity to congratulate some of our student members on their success in the field, and dedicate this space to highlighting their scholarship. Below you will find the Abstracts for the Division 29 Student Paper Award Winners. Please join me in congratulating our next generation of psychotherapy practitioners, researchers, and scholars.

### Donald K. Freedheim Student Development Award

**Title:** *Erotic Feelings Toward the Therapist: A Relational Perspective*

**Author:** Jenny H. Lotterman

**Institution:** Teachers College, Columbia University



**Abstract.** This paper focuses on the relational treatment of a male patient presenting with sexual and erotic feelings toward the therapist. The use of relational psychotherapy allowed us to collaborate in viewing our therapeutic relationship as a microcosm of other relationships throughout the patient's life. In this way, the patient came to understand his fears of being close to women, his discomfort with his sexuality, and how these feelings impacted his ongoing romantic and sexual experiences. Use of the therapist's reactions to the pa-

tient, including conscious and unconscious feelings and behaviors, aided in the conceptualization of this case. Working under a relational model was especially helpful when ruptures occurred, allowing the patient and therapist to address these moments and move toward repair. The patient was successful in making use of his sexual feelings to understand his feelings and behaviors across contexts.

### The Diversity Award

**Title:** *From a Linear Match Equation to the Intersubjective Sphere: Negotiating Identities of the Sexual Kind*

**Author:** Jackson J. Taylor

**Institution:** Derner Institute, Adelphi University



**Abstract.** This paper considers the literature on cultural matching in psychotherapy with a focus on sexual orientation matching. The occurrence of explicit (i.e., conscious) and implicit (i.e., unconscious) dynamics in this realm are discussed with regard to the existence of sexual orientation microaggressions. This discussion is extended in the context of negotiating sexual identity in the therapeutic relationship. Issues of transference and countertransference are explored in tandem with Kleinian concepts of projection, projective identification, and developmental positions. The concept of intersubjectivity is borrowed from the contemporary relational psychoanalysis literature to understand better these important treatment considerations. Finally, a case is presented to illustrate the complexity of negotiating sexual identity in the clinical situation.

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### The Mathilda B. Canter Education and Training Award

**Title:** *Intercorrelations Between Individual Personality Factors and Anxiety*

**First Author:** Ashlee J. Warnecke

**Additional Authors:** Caitlyn A. Baum, Jennifer R. Peer, Anthony J. Goreczny

**Institution:** Chatham University



**Abstract.** Previous research has shown five characteristics correlate highly with anxiety and with each other; these are self-efficacy, locus of control (LOC), subjective happiness, life satisfaction, and optimism (Mills, Pajares, & Herron, 2006; Park, Beehr, Han, & Grebner, 2012), but most studies have examined these factors in business professionals or undergraduate students. The present study focused on graduate students. Participants included 113 graduate students from three graduate programs who completed measures examining depression, anxiety, stress, and the five aforementioned factors. Results showed expected correlations between anxiety and other measures. Additionally, subjective happiness and life satisfaction were the only two variables correlated with all of the other variables. Results of stepwise regression analyses showed that optimism, self-efficacy, depression, and life satisfaction accounted for 64% of the variance in subjective happiness. For the life satisfaction variable, the same variables (substituting subjective happiness as a predictor for life satisfaction) accounted for 57% of the variance, but LOC also made a significant independent contribution to this 57%. Lastly, we found psychology students reported more depression and stress and less satisfaction with life, less optimism, less subjective happiness, and more internal locus of control than either occupational therapy or physical therapy.

### The Jeffrey E. Barnett Psychotherapy Research Paper Award

**Title:** *In the Mood? Therapist Affect and Psychotherapy Process*

**First Author:** Harold Chui

**Additional Authors:** Clara E. Hill, Jonathan Mohr, Charles J. Gelso

**Institution:** University of Maryland



**Abstract.** Therapist effects have been increasingly recognized as an important contributor of psychotherapy process and outcome. Most therapist factors studied

so far, however, have been trait factors. Little is known about state factors. Given the emotional nature of psychotherapy, therapist affective states seem relevant. In particular, what predict therapist affect change, and how is therapist affect related to psychotherapy process and outcome? Data from 1,172 sessions of 15 therapists and 51 clients were collected at a psychodynamically-oriented psychotherapy clinic. Therapists and clients rated pre-session affect and post-session affect, as well as post-session session quality. Data were analyzed using multilevel modeling. Therapist increase in positive and negative affect from pre- to post-session was directly related to client pre-session positive and negative affect, respectively, and to client increase in positive and negative affect from pre- to post-session, respectively. After controlling for therapist pre- to post-session change in affect, higher therapist pre-session positive affect was associated with better client-rated session quality, whereas higher therapist pre-session negative affect was associated with poorer client-rated session quality. Thus, therapist affect played a role in therapist functioning and contributed to psychotherapy process and outcome. Dyadic regulation of affect appeared to be a promising mechanism of change that warrants further investigation.

# CONGRATULATIONS TO THE DIVISION 29 STUDENT PAPER AWARD WINNERS!

## THE DONALD K. FREEDHEIM STUDENT DEVELOPMENT AWARD

Jenny H. Lotterman, Teachers College, Columbia University  
*Erotic Feelings Toward the Therapist: A Relational Perspective*

## THE JEFFREY E. BARNETT PSYCHOTHERAPY RESEARCH PAPER AWARD

Harold Chui, Department of Psychology, University of Maryland  
*In the Mood? Therapist Affect and Psychotherapy Process*

## MATHILDA B. CANTER EDUCATION AND TRAINING AWARD

Ashlee J. Warnecke, Chatham University  
*Intercorrelations Between Individual Personality Factors and Anxiety*

## DIVERSITY STUDENT PAPER AWARD

Jackson J. Taylor, M.A., Derner Institute, Adelphi University  
*From a Linear Match Equation to the Intersubjective Sphere:  
Negotiating Identities of the Sexual Kind*

*Please join us as we honor our award winners at  
the Division 29 Awards Ceremony,  
Friday August 8<sup>th</sup>*

*Marriott Marquis Washington DC Hotel, Mint Room at 5:00 pm.  
The awards ceremony will be followed by the Social Hour,  
where you are cordially invited to join us  
for refreshments and fellowship.*



## EDITORS' COLUMN

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This issue of *Psychotherapy Bulletin* is so packed with content that your Editors have space for only a quick word—but that word is EXCITING. With a plethora of student pieces, career development tips and trends, practice-focused articles on therapist happiness and mindful ethical decision-making, timely training and intern information, Student Awards, Division 29 APA Convention programming, plus our regular columns, book reviews and SO MUCH MORE... we hope you will

agree that there is something for everyone between these pages.

Remember to visit the Division 29 website (<http://www.divisionofpsychotherapy.org>) for the latest news, information, and Member resources, and contact us if you have any questions, suggestions, or submissions for the Bulletin (the next deadline is August 1, 2014).

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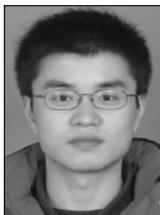
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## Cognitive Errors of Commission and Omission Among Novice Group Counseling Trainees About Group Situations

Xu Li, MEd

Dennis M. Kivlighan, Jr., PhD

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In the realm of group counselor training and development, an emerging area of research has addressed how novices differ from experts in their organization of domain knowledge.



Existing research has investigated experts and novices' knowledge structure about group members (Kivlighan, Markin, Stahl, & Salahuddin, 2007; Kivlighan & Quigley,

1991) and group leader interventions (Kivlighan & Kivlighan, 2009, 2010). Researchers found in general that group counseling trainees possess "lay theories" about these domains that are different from experts' at the beginning of training, yet their organization of such knowledge gradually converge with experts' during the training process, an outcome associated with their improved effectiveness.

To obtain a more nuanced look at the specific aspects in which novices' knowledge structures diverge from experts' about group leader intervention, Kivlighan and Tibbits (2012) compared the knowledge maps of trainees to the average knowledge map of experts to identify common cognitive errors of novice counselors. They proposed two types of errors: *errors of commission*, which denotes relationships (links) between concepts that are present in

trainees' knowledge structures but absent in experts' knowledge structures; and *errors of omission*, which denotes relationships (links) between concepts that are absent in trainees' knowledge structures but present in experts'. This study seems to be the first attempt to specify the divergences between the cognitive maps of experts and novices, which could help educators understand typical misconceptions of their trainees and develop specific goals and foci for training.

These studies show that it is both theoretically and practically meaningful to compare the knowledge structure between novices and experts to facilitate understanding of group counselor training and development. The present study is thus designed to investigate how the novice group counselors' knowledge maps diverge from experts' about *group situations*, which has been a "missing piece" in existing literature.

Donigian and Hulse-Killacky (1999) maintained that group therapists need a systematic and orderly mental organization of group situations to enhance the predictability and facilitate effective management of these occurrences. One objective of group counseling training, therefore, is to help novices understand the latent connections and potential common interventions among a myriad of group situations. When trainees start to view the variety of group situations not as isolated and unique occurrences but as a series of interrelated "clusters"

*continued on page 7*

or “patterns” organized by underlying connections, they will gradually develop intervention strategies to address each type of situation, and will likely become more efficacious.

In this context, the present study attempts to attend to the “missing piece” of group situations and examine how group counseling trainees’ knowledge structure about group situations diverge from those of experts. In particular, we sought to identify novice’s cognitive errors of commission and omission. Similar to Kivlighan and Tibbits (2012), this study uses the Pathfinder Network Analysis (PNA, Schvaneveldt, 1990) to generate a knowledge map for each individual trainee and an expert knowledge map based on the aggregated responses of three expert group therapists. This method has been extensively used in generating and comparing knowledge maps in a variety of areas (Schvaneveldt, 1990), and specifically in a number of group counseling research studies (Kivlighan & Kivlighan, 2009, 2010; Kivlighan & Tibbits, 2012).

## Method

### Participants

*Expert group therapists.* Three distinguished and experienced group therapists were recruited to participate in this study. They were Caucasian males between 61 and 68 years with more than 25 years of experience in leading counseling or therapy groups. They are also fellow members of highly reputable professional associations, and are editors or authors of professional journals and books. They identified themselves as interpersonally oriented.

*Group counseling trainees.* Twenty-eight doctoral-level graduate students taking the group practicum course participated in this study as group counseling trainees. The 9 men and 19 women were an average of 24.3 years old ( $SD = 2.7$ ). They reported few, if any, prior experiences in leading counseling groups.

### Measures

**The revised Group Therapy Questionnaire (GTQ).** The GTQ (Wile et al., 1970; revised by Wile, 1972) is composed of 21 descriptions of realistic situations that typically occur in counseling groups. Participants are required to read each description and indicate from a list of 19 potential responses one or several interventions they would consider doing in this situation.

### Procedure

The three experts completed the GTQ independently. The trainees individually completed the GTQ between their first and second class session. Participants were instructed to select all responses they might consider for each group situation.

### Analysis and Results

Similar to Kivlighan and Tibbits (2012), we used PNA program to generate an individual network map for each counseling trainee and an average network map for the three experts based on their responses to GTQ. After the map generation, each novice trainee’s knowledge map was compared to the referent expert map to identify their *individual errors* of commission and omission. Descriptive statistics of this comparison are tabulated in Table 1. To explore the gen-

*continued on page 8*

Table 1: Descriptive Statistics of Number of Commission Errors, Omission Errors, and Correct Links for the Overall Sample and Two Subgroups

	Overall		G1 (N=23)		G2 (N=5)		U
	M	SD	M	SD	M	SD	
NComm	31.36	7.67	28.78	5.62	43.20	3.19	1.50**
NOMis	17.14	2.19	17.13	2.28	17.20	1.92	55.50

Note. G1 = Subgroup 1, G2 = Subgroup 2. NComm = Number of commission errors; NOMis = Number of omission errors; U is the non-parametric Mann-Whitney test statistics. \*\* $p < .01$ .

eral *common errors* of commission and omission, we adopted the threshold used in Kivlighan and Tibbitts (2012). If a link is absent in the expert map but present in more than 75% of the novice maps, this link in the novice maps is regarded as a *common error of commission*; if a link is present in the expert map but absent in more than 75% of the novice maps, this missing link in the novice maps is regarded as a *common error of omission*.

Results of the above analysis indicated no common error of commission but 17 common errors of omission (Table 2). A closer examination of these errors of omission

reveals that the 17 omission errors centered on four clusters of group situations. Cluster-1 contained Monopolizer, Starting Group, Chairman, and Grumpy Group. Cluster-2 contained Quiet Member, Threat to Quit, Marital Problem, Polite Group, and Group Attack. Cluster-3 contained Threat to Quit, Quiet Member, Return of Absent Member, and Sexualized Meeting. Cluster-4 contained Grumpy Group, Group Silence, Monopolizer, and Side Conversation.

Further examination of the specific interventions used by trainees indicated great variability with no consistent pat-

Table 2: Seventeen Errors of Omission by Group Counseling Trainees

Omitted Links between Situations	% of Trainees Incorrect
1.Starting Group & 9.Monopolizer	89.30%
2.Personal Questions & 3.Chairman	89.30%
3.Chairman & 9.Monopolizer	89.30%
3.Chairman & 20.Fight	89.30%
5.Attack Leader & 8.Late Arrival	89.30%
5.Attack Leader & 12.Marital Problem	78.60%
6.Group Silence & 15.Grumpy Group	85.70%
7.Distressed Woman & 19.Side Conversation	89.30%
9.Monopolizer & 15.Grumpy Group	82.10%
10.Quiet Member & 11.Threat to Quit	89.30%
10.Quiet Member & 12.Marital Problem	78.60%
10.Quiet Member & 16.Polite Group	85.70%
10.Quiet Member & 17.Group Attack	82.10%
11.Threat to Quit & 13.Return Absent Member	85.70%
11.Threat to Quit & 21.Sexualized Meeting	82.10%
15.Grumpy Group & 19.Side Conversation	82.10%
18.Member Drunk & 20.Fight	82.10%

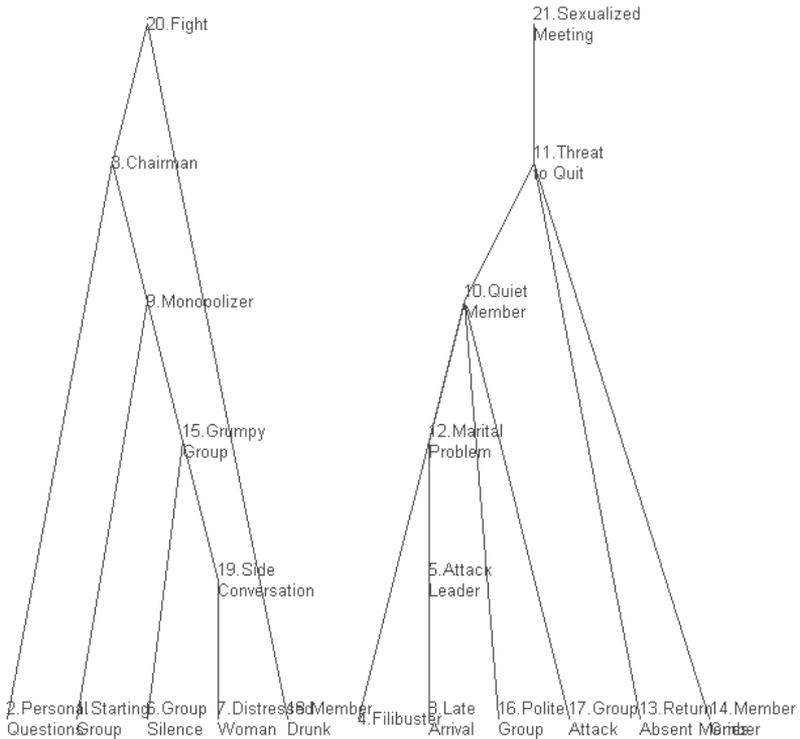
tern. To investigate the possibility of having subgroups, we further analyzed the links in the knowledge maps of the 28 trainees using the Ward method in hierarchical cluster analysis.

Using the agglomeration coefficients (Hair, Black, Babin, & Anderson, 2009), a 2-cluster final solution was found. The first cluster (G1) included 23 trainees, and the second cluster (G2) included the remaining 5 trainees. Non-parametric Mann-Whitney U test indicated that participants in G2 made significantly more commission errors ( $U = 1.50, p < .01$ ) than G1.

We also compared the average knowledge maps of experts (Figure 1) and the two subgroups of trainees (Figure 2), and revealed that those three maps all had two big branches. Examining the endorsement of interventions for each branch of situations, we found that experts tended to use more supportive and emotion-oriented interventions (leader experience and reassurance/approval) in the first branch of situations, and more dynamic-related and insight-oriented interventions (psychodynamic

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**Figure 1**



Average expert knowledge map (tree format) of the 21 group situations.

interpretation, group dynamic interpretation, and group dynamic question) in second branch of situations. Trainees in subgroup G1 tended to use more explorative interventions (group dynamic question, clarification/confrontation/question) in first branch of situations, and more directive interventions (structure, group directed) in second branch of situations. However, the trainees in subgroup G2 did not display any clear pattern of differential interventions of the two clusters of group situations.

## Discussion

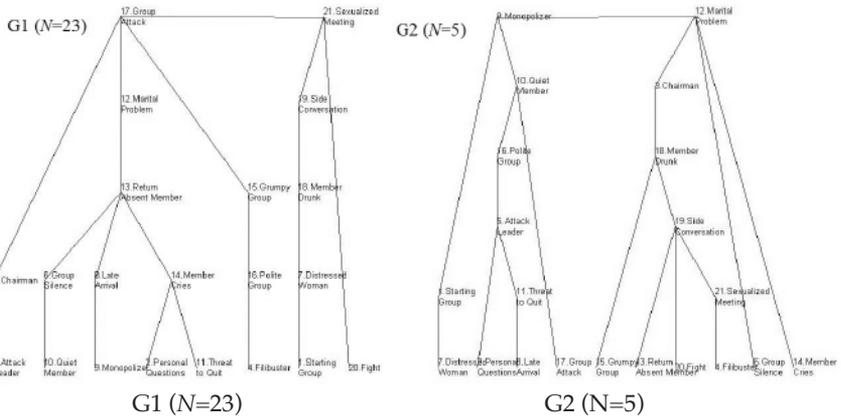
### *Common Cognitive Errors of Group Counseling Trainees about Group Situations*

The first primary finding of this study is that, compared to the 21 correct links identified by the experts, novice trainees

showed no common error of commission, but 17 common errors (85%) of omission. This indicates that novice group trainees who have had minimal training in group counseling have difficulty grasping implicit similarities and have yet to organize and integrate them effectively around potential interventions. This finding is consistent with cognitive psychologists' general findings that novice trainees are less capable of perceiving implicit relationships between concepts and understanding meaningful patterns of domain knowledge (Glaser & Chi, 1988). Also, it supports the argument that novice group counseling trainees need specific guidance for a more in-depth understanding

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**Figure 2**



The average knowledge maps (tree format) of the two subgroups of trainees.

and effective management of various typical group situations (Donigian & Hulse-Killacky, 1999).

The identified omission results in this study might help understand the implicit patterns of group situations trainees generally fail to grasp. Examining descriptions in GTQ (Wile, 1972) in the Cluster-1 situations in which common omission errors occurred, there seems to be a demand from the group to the leader for some structure or guidance (e.g., deal with monopolizer, lead group at the beginning). In Cluster-2 situations, the group is active but impotent in achieving certain group goals (e.g., getting the silent member to talk, convincing the leaving member to stay in the group). In Cluster-3 situations, there is a “problem member” (e.g., silent member, seductive member) who is influencing the general group dynamics. In Cluster-4 situations, the groups are displaying avoidance by acting out, remaining silent, allowing one member to do all the talking, or splitting into subgroups (Yalom & Leszcz, 2005).

Experts approach these clusters of group situations with quite consistent interven-

tions: They uniformly endorse remaining silent, disclosing leader’s feelings, and giving interpretations about group atmosphere. In spite of the variability between these four clusters of challenging group situations, experts seem to regard these three interventions as nonspecific situation-general techniques that can be applied quite broadly. Novice trainees generally do not have such an understanding, given the variability of their responses to these situations; thus, this result suggests that novice trainees may benefit from putting the three situation-general interventions into their repertoire of skills as potential responses to varying group situations.

In addition to the three situation-general interventions, experts also consistently have certain particular responses to the specificity of each cluster of group situations. To address the demand from group for structure in cluster 1 situations, experts consistently consider sharing their own experiences to provide a vicarious model for the group members, which novices feel hesitant to do (Teyber, 2006). To address problems in group dynamics (cluster 2 and 3), ex-

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perts choose to use interpretations at both the group or the individual level, which novices find challenging in doing (Hill, 2014). To address group avoidance in various forms (cluster 4), experts endorse providing reassurance and approval. Overall, novice trainees may find it useful to consider the aforementioned intervention strategies experts use in organizing and responding to varying group situations.

### *Two Subgroups of Trainees*

This study found that a minority of trainees in Subgroup G2 display quite different knowledge structures from the other trainees. They not only fail to perceive the correct relationships between group situations, but also tend to have a number of incorrect relationships in their knowledge structures. In cognitive psychology, the “Theory Theory” (Gopnik & Meltzoff, 1997) posits that people hold their own naive intuitive theories about the world from infancy, and that an individual’s cognitive development can be partly conceptualized as a theory revision process, which includes both establishing correct connections and removing incorrect misconceptions (Kuhn, 2002). From this perspective, this study has suggested that there might be two patterns of learning based on group counseling trainees’ initial knowledge structure: In one pattern trainees need to establish and learn a number of correct relationships between group situations; in another pattern trainees need to both learn those correct relationships and unlearn a number of incorrect relationships.

From the average knowledge structures of experts and two subgroups of trainees, experts differentiate these two branches in a way consistent with Luborsky (1984)’s supportive-expressive conceptualization of psychody-

amic interventions. Unlike experts who approach the two branches of incidents differently from the perspective of the *group process* (whether the group needs support or insight), the first group of trainees tend to respond to the two branches of incidents from the perspective of themselves, i.e., the *group leader* (whether the leader should facilitate exploration by asking questions or give direction by providing structure). This is consistent with the observation of Teyber (2006), who pointed out that novice counselors are inclined to focus on themselves (“what should I do now”) and have difficulty being fully present with the client (“what the client feels and needs”) and attending carefully to the therapeutic process (“what’s been happening here-and-now”). For the second subgroup, no clear pattern of response to the two branches could be identified. This may be because of the additional commission errors made by the second group, which further confused the knowledge structure as a whole. It seems that they represent the subgroup of trainees whose intuitive understanding of group counseling is less differentiated, more inaccurate, and more poorly organized.

In sum, though the relative small sample size might have limited the interpretation of results in this study, it provided a specific account of how experts’ and novice trainees’ knowledge structures about group situations differ, and could potentially inform educators on how to better address the specific misconceptions and assist trainees experiencing greater difficulty in minimizing errors in group situations.

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## EDUCATION AND TRAINING

### Subjective Well-being Among Internship Applicants

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Internship match is a topic of pressing national interest to the training community (Keilin, Baker, McCutcheon, & Peranson, 2007). As such, over the last 18 months the Division's Training and Education Committee developed a series of six articles on this topic. The first article examined how internship is a scare resource that can create a myriad of problems for students, and summarizes recommended actions to address this issue (Fo & Rodolfa, 2013). The second article focused on one of those recommended actions, the development of internship consortia, providing a real-life example (Kestenbaum, Jackson, & Fuentes, 2013). The third installment offered a first-hand account of two doctoral students' preparation, collaboration, self-care, and self-awareness to foster well-being throughout the application process (Melling & Abrams, 2013). The fourth article described the developmental problems that can occur during the transition from graduate student to intern to early career psychologist (Mackaronis & Thorgusen, 2013). The most recent article reported on a national dataset that examined differences in applicant variables such as clinical hours, publications, and personality in regard to students who were successfully matched to different internship set-

tings (Callahan, Swift, Hogan, et al., 2014). Within this final article of the series, we shine the spotlight on the people at the heart of the imbalance issue: the unmatched trainees.

There are a small number of published qualitative and personal accounts of the distress associated with not matching for internship (e.g., Veed et al. 2009; Draper & Lopez, 1997). These accounts suggest that unmatched applicants run the gamut of emotional reactions. Initially, unmatched applicants may experience shock or bewilderment (Draper & Lopez, 1997; Veed et al., 2009). Given that internship applicants are deemed "internship-ready" by their training directors and mentors, and likely felt prepared to apply (Madson, Aten, & Leach,

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2007), it follows that unmatched applicants would feel stunned by the news and uncertain about the reasons for not matching. Applicants also commonly describe feeling demoralized and devastated (Lopez, Draper, & Reynolds, 2001; Madson, Hasan, Williams-Nickelson, Kettman, & Sands Van Sickle, 2007), questioning their qualifications and perhaps asking themselves larger questions about whether they belong in their chosen profession (Veed et al., 2009). This shaken self-confidence may be accompanied by feelings of shame (Lopez et al., 2001) and the desire to isolate (Veed et al., 2009) rather than sharing with others that they were not matched.

The purpose of this study was to further elucidate, empirically and by independent investigators, the phenomenological experience of applicants as they learn of their match outcome. Based on the personal accounts found in the literature, we hypothesized that subjective well-being would decline among applicants notified they were not matched for internship, but increase among applicants notified they had matched to an internship. We also expected that applicants entering the match for a second (or more) time would anticipate their match notification evidencing less subjective well-being than those entering the match for the first time.

## Method

The dataset for this investigation was constructed via combining data gathered in two earlier studies of the internship match (Callahan, Collins, & Klonoff, 2010; Callahan, Hogan, Klonoff, & Collins, 2014). Due to space constraints, the methodologies employed in those studies are not detailed herein, though interested readers may consult the original sources for more information. The analyses presented within this study drew from previously unanalyzed subjective well-being data captured in

those earlier studies.

The four-item measure, Subjective Well-being (SWB), was administered both before and after match notification. Subjective well-being can be thought of as a person's global self-evaluation, which often includes the degree to which a person experiences positive and negative affect in response to life events (Diener & Ryan, 2009). Items characterize applicants' current level of subjective distress, energy level, emotional functioning, and satisfaction with life. Applicants respond to each item using a 5-point Likert scale (0-4), with a total possible score of 0-16, where a higher score indicates greater subjective well-being. The four items in this measure were originally derived from a two-item measure of subjective well-being used by Howard, Leuger, Maling, and Martynovich (1993), who indicated that the two-item scale was correlated with the General Well-Being Scale ( $r = .79$ ; Dupuy, 1977) and the disability scale in the Medical Outcomes Study ( $r = -.65$ ; Stewart, Hays, & Ware, 1988). The four-item version has also demonstrated utility in assessing subjective well-being (Callahan, Swift, & Hynan, 2006; Swift, Callahan, Heath, Herbert, & Levine, 2010), with previous reports indicating internal reliability of .71 and a test-retest reliability of .63. In the current sample, internal consistency was adequate within both the pre-match ( $\alpha = .52$ ) and post-match ( $\alpha = .61$ ) data.

## Results

Applicants' subjective well-being (SWB) prior to match notification was not significantly correlated with eventual match outcome. Similarly, contrary to our hypothesis, participants who were applying to the match a subsequent time did not report significantly less SWB than first time match applicants. Also, no significant group differences

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in scores on the SWB measures were found among 2010 versus 2011 unmatched applicants.

Consistent with our prediction, applicants who did not match reported significantly less SWB ( $M = 10.96$ ,  $SD = 2.91$ ) than those who secured an internship ( $M = 13.67$ ,  $SD = 2.42$ ,  $t[436] = -7.02$ ,  $p < .001$ ).<sup>1</sup> This effect was large ( $d = 1.01$ ) and is illustrated in Figure 1. Among unmatched students, results confirmed the hypothesis of a significant decrease in

SWB from before match notification ( $M = 12.93$ ,  $SD = 2.66$ ) to after notification ( $M = 10.91$ ,  $SD = 3.12$ ) in unmatched students ( $t[42] = 3.77$ ,  $p < .001$ ;  $d = 0.60$ ).

Although applicants who did match experienced a statistically significant increase in SWB from before match notification ( $M = 13.39$ ,  $SD = 2.25$ ) to after notification ( $M = 13.67$ ,  $SD = 2.39$ ), the effect size is quite small and unlikely to be functionally meaningful ( $t[386] = -2.56$ ,  $p = .01$ ;  $d = 0.12$ ).

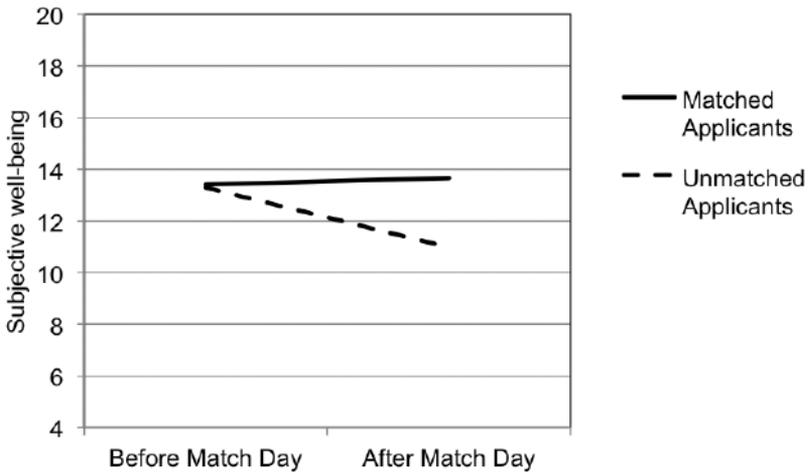


Figure 1. Change in subjective well-being following Match Day.

## Discussion

The findings here demonstrate that going unmatched<sup>2</sup> has a significant, negative impact on applicants' subjective well-being. Personal anecdotes in the existing literature support this finding, but this is the first empirical documentation of an aggregate effect. The observed effect size, 1.01, is large and concerning. In other words, the difference between matched and unmatched applicants in terms of their subjective well-being is a full standard deviation.

We hope that these findings encourage increased attention to the impact of the

match imbalance on students—especially for those who go unmatched. Without question, continued efforts at alleviating the imbalance problem are necessary. Our findings highlight the importance of moving forward in a timely manner.

Notably, APPIC has made significant efforts to alleviate some distress associated with the process itself. Prior to 2011, students applying for internship who did not match to an internship site on Match Day then had the option of entering into the APPIC Clearinghouse to

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attempt to secure an internship. Unfortunately, the Clearinghouse was a chaotic experience for both applicants and internship sites. In 2011, APPIC introduced a second match process, Phase II, which was, in part, geared towards reducing distress of initially unmatched applicants by providing a follow-up match with clear procedures and timelines. In contrast to the forerunning Clearinghouse, Phase II represents an accelerated process nearly identical to the initial match (now called Phase I). Although the conceptualization of Phase II was expected by APPIC (2011) to be “more ... humane” than the Clearinghouse process, to date no empirical, independent investigation has been conducted of whether the distress of unmatched applicants has decreased with implementation of a second match phase. The current study provides a snapshot comparison of the two processes, contrasting applicant distress among those unmatched applicants facing the Clearinghouse in 2010, to those unmatched applicants in 2011 facing the inaugural offering of Phase II. Within this sample, no significant group differences in scores on the SWB measures were found. Although the data indicate that the experience of not attaining an internship match was no less distressing with the advent of the Phase II match process than it was with the Clearinghouse, it is important to consider that this is merely a snapshot of one aspect of the transition. Our survey of applicants did not assess other important variables for which Phase II is likely to demonstrate superiority over the forerunning Clearinghouse experience (i.e., perception of fairness in the application, amount of time allotted, organization and efficiency, and ease of application).

Finally, although this study provides important information to start an empirical

line of inquiry, future research to obtain a more nuanced understanding of applicants’ phenomenological experiences following going unmatched seems merited. A better understanding of these reactions may help those who provide support to students who go unmatched. From a training perspective, it seems possible that unmatched students who continue clinical work in practica or other positions while experiencing demoralization and lowered confidence may find clinical work more emotionally challenging, and may doubt their own competencies. Whether such reactions negatively impact the clinical outcomes of those being treated by the impacted trainee clinician is worth considering. The impact of not matching, both on an emotional and practical level, may residually affect future career decisions. Knowing more about these types of proximal and distal outcomes may help further assist unmatched applicants so that the impact on their career is minimized. Future research that examines the career trajectory of unmatched applicants, drawing from the full population available since the inception of the match, could be very useful in understanding the workforce pipeline.

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

<sup>1</sup> Prior to this analysis, a Levene’s test was conducted and found to be non-significant, ensuring homogeneity of variance among the groups of matched ( $n = 404$ ) and unmatched applicants ( $n = 49$ ; 3 students reported they withdrew from the match prior to Match Day).

<sup>2</sup> In the 2014 match, 20% of applicants who submitted rankings went unmatched.

## Musings from the Psychotherapy Office: Hardwiring Therapist Happiness

Barbara L. Vivino, PhD and Barbara J. Thompson, PhD



Rick Hanson's recent book, *Hardwiring Happiness* (2013), provides a wonderful resource for understanding human beings' tendency to focus on the negative and ignore or minimize the positive. As therapists, we are often challenged to be cheerleaders for the latter—reminding clients of their accomplishments and successes, encouraging

them to reframe how they are thinking, sitting with and modeling compassion in the hopes that they can internalize this experience so that it will somehow transform their limiting perspectives.

In *Hardwiring Happiness*, Hanson (2013) suggests that the human brain has a negativity bias. For survival purposes, the brain evolved to learn quickly from bad experiences but not so much from the good ones. This evolutionary negativity bias is wired into the brain. According to Hanson, this negativity bias is an ancient survival mechanism that was helpful in the past but no longer serves us and is instead the root of much depression, anxiety, and general unhappiness.

With this apparent genetic predisposition for negativity, it can seem daunting at times to help clients make a shift in thinking and experiencing. For those suffering from anxiety, the constant attention to potential negative events has become a way of life and a coping strategy that feels too threatening to lose.

For those mired in the depths of depression, the energy required to notice and savor even the simplest sign of beauty seems impossible to muster. Hanson's (2013) recommendations for overriding the brain's default program suggest that we can build a brain that can balance out and even limit this negativity—and in so doing, allow contentment and a sense of well being to become the new normal. Yet helping a client who is entrenched in pain and suffering embrace this possibility can seem overwhelming and sometimes impossible.

I worked with a client I will call Judy.<sup>1</sup> Now in her early 60s, Judy had been suffering from a Major Depressive Disorder most of her adult life. It seemed as if she had tried every type of medication, therapy, and even electroconvulsive therapy. When she came to see me, she was still so depressed that she had many days in which she could not even get out of bed. She was too depressed to work and was living on social security disability and a small spousal support payment from her divorce. Her expenses were greater than her income and she had exhausted her savings. Multiple friends and family members had suggested she sell her unused piano or take in a boarder, which would enable her to stay in her small house. Judy always countered these suggestions with a reason why this wouldn't work (e.g., the piano needed repair; she couldn't tolerate potential noise from a boarder), therefore resigning herself to a hopeless situation.

As a therapist, it is difficult to sit with a client like Judy. It can elicit hopelessness

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or annoyance or even anger. Some therapists feel pulled to help a client like Judy who seems to be so helpless. Judy told me about a previous therapist who had actually helped her grocery shop! Other therapists will give up on clients like this and refer them to the next therapist or another treatment modality. It is easy to get pulled into a tug of war with clients like this—trying to get them to change while they resist. It is also easy for therapists working with such a client to feel like they have not done enough or that they are somehow inadequate. It becomes more and more difficult to find anything positive to savor in such a therapeutic relationship, let alone help the client be open to finding the positive in his or her life.

Managing our countertransference response is tricky, but quite important. How do we work with our own negativity bias in order to see the good in our client and to stay hopeful when working with a difficult client? In essence, how do we resist the pull toward seeing the world as the client does and also resist pathologizing the client to protect ourselves? Our countertransference reaction can be informative and help us to understand how other people may respond to these clients or how the clients' negativity may keep them isolated, possibly perpetuating beliefs that other people do not care for them or that they are alone in the world. Yet can we be of assistance to clients when we have negative or complicated feelings and thoughts about them ourselves?

In my own experience the people who had the greatest influence on me were people who saw me as more than my problems: teachers who saw the potential in me or therapists who believed in me. How do we as therapists see beyond the presenting symptoms of clients, see them as greater than their issues and help them reach their poten-

tial? How do we work with our own “negativity bias” so that we can maintain hope for our difficult clients and assist them?

New research has indicated that the person of the therapist is an essential factor in successful psychotherapy (Norcross, 2002). It seems that it may not be so much what we do in therapy but it is instead who we are. It seems that the presence or state of mind of the therapist influences the psychotherapy process. Yet how can we maintain a state of mind that has positive benefits with clients as depressed as Judy? Most therapists go to therapy themselves and many therapists seem to have a regular practice of meditation, presence, or mindfulness. Rick Hanson's work, focusing on the positive and building new neural pathways, seems like it may hold additional promise for therapists who deal with difficult clients.

In the first part of his method, Hanson (2013) suggests a process of having a positive experience, enriching it and absorbing it so that it becomes firmly encoded in our brains. Taking the few extra seconds to savor those experiences will generally help therapists approach work with their clients from a more positive place. In the second phase of his method, Hanson suggests a process that seems particularly useful when working with difficult clients. He encourages a practice of visualizing a positive experience and spending time feeling it and experiencing it inside us. When we have a strong connection with the positive experience, it can then be linked with a negative experience. This pairing of a positive experience with a negative can rewire the brain towards the positive according to Hanson. Or, as Hanson suggests with a quote from neuroscience, “neurons that fire together wire together” (p. 10). This does not occur

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quickly, but rather through a gradual accumulation of these positive experiences—drip by drip.

So, if we used this approach with a client like Judy, we might spend some time outside the therapy office visualizing and having a felt sense of a positive experience, such as an experience of compassion or competence. When we felt fully aligned with this experience we could then introduce a thought of Judy's depressive comments or a moment in therapy that was negative. By pairing the positive experience with the negative one, we could theoretically rewire our therapist brain to have a positive bias toward Judy and with our clients in general.

The attitude of the therapist is important in the therapy process yet it is sometimes difficult to maintain a constructive attitude, particularly when working with difficult clients. Hanson's approach may provide a method for shifting our attitudes from negative to positive. By utilizing a practical method for hardwiring therapist happiness, we may be able to sustain work with difficult clients and improve the quality of psychotherapy.

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

<sup>1</sup> All identifying information has been disguised to protect client confidentiality.



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## CONGRATULATIONS TO THE DIVISION 29 AWARD WINNERS!

Please join us as we honor our award winners at the Division 29 Awards Ceremony, Friday August 8th, Marriott Marquis Washington DC Hotel, Mint Room at 5:00 pm. The awards ceremony will be followed by the Social Hour, where you are cordially invited to join us for refreshments and fellowship.



### **Distinguished Psychologist of the Year – Lorna Smith Benjamin, Ph.D.**

Lorna Smith Benjamin, Ph.D., ABPP, FDHC received her undergraduate degree from Oberlin College, and her Ph.D. in psychology in 1960 from the University of Wisconsin- Madison, specializing in learning theory, psychophysiology and mathematical statistics. Her dissertation was with Harry Harlow and principles based on attachment and primatology have framed her research and practice. Her clinical internship and postdoctoral training were in the Department of Psychiatry at the University of Wisconsin, Madison. There, she progressed from postdoctoral fellow to full professor, and taught psychotherapy to psychiatry residents and psychology interns until she left in 1988 to come to the University of Utah Department of Psychology. In 2012, she retired from her positions as Professor of Psychology, Adjunct Professor of Psychiatry, and Founder of the Interpersonal Reconstructive Therapy (IRT) Clinic at the University of Utah Neuropsychiatric Institute (UNI). Presently she has a small private practice, serves as a consultant at UNI, and gives workshops on psychotherapy with difficult cases.

Her methodological contributions include: a few statistics papers; Structural Analysis of Social Behavior (SASB), a model for assessing interpersonal and intrapsychic interactions in terms of “primitive basic” dimensions using self- ratings or observer codings; and Interpersonal Reconstructive Therapy (IRT), an integrative personality- based approach to treatment of complex cases. Recently, she has proposed a version of Natural Biology that is useful in explaining mechanisms of psychopathology in a way that clearly guides clinicians in activating mechanisms of change during psychotherapy with cases that have been nonresponsive. An advisor to the workgroup on personality disorders for the DSM-IV, a consulting editor to two journals (Psychiatry; and Journal of Personality Disorders), her books include: (1996/2003). Interpersonal diagnosis and treatment of personality disorders (Guilford Press). Interpersonal Reconstructive Therapy (Guilford Press) and IRT for Anger, Anxiety and Depression: It is about broken hearts, not broken brains (under review, American Psychological Association).

Her honors include Distinguished Research Career Award from the International Society for Psychotherapy Research; Honorary degree (FDHC) from University of Umea, Sweden; Bruno Klopfer award for outstanding, long-term professional contribution to the field of personality assessment and a Festschrift about her work sponsored by the University of Utah Department of Psychology.



## Distinguished Contributions to Teaching and Mentoring – Mark Hilsenroth, Ph.D.

**Mark Hilsenroth, Ph.D., ABAP** graduated from the University of Tennessee’s Clinical Psychology Ph.D. program in 1996 and completed his Clinical Internship at The Cambridge Hospital/Harvard Medical School. He is currently a Professor of Psychology at the Derner Institute of Advanced Psychological Studies at Adelphi University. At Adelphi, Dr. Hilsenroth is the Primary Investigator of the Adelphi University Psychotherapy Project and devotes his energy to teaching, one-to-one mentoring in psychotherapy supervision and research, as well as his own clinical practice. His research interests are primarily focused on applied clinical issues, with over 150 peer-reviewed journal publications in the areas of psychological assessment & psychotherapy. He is currently the Editor of the American Psychological Association Division 29 journal *Psychotherapy*, and has served on the editorial boards of *Psychotherapy Research*, *Journal of Personality Assessment*, and the *Journal of the American Psychoanalytic Association*. Dr. Hilsenroth has won Early Career awards from several organizations, including the American Psychological Association Division of Psychotherapy (29), Society for Psychotherapy Research, Society for Personality Assessment, and the American Psychoanalytic Association. In 2007 he was also honored with the campus wide Adelphi University Excellence in Faculty Scholarship and Creative Work Award.



## APF /Division 29 Early Career Award – Zac Imel, Ph.D.

Zac E. Imel is an Assistant Professor with the Counseling Psychology Program in the Department of Educational Psychology at the University of Utah and an Adjunct Assistant Professor in the Department of Psychiatry. He received his Ph.D. in 2009 from the University of Wisconsin – Madison and was a post-doctoral fellow with the Mental Illness Research, Education, and Clinical Center (MIRECC) at the VA Puget Sound (Seattle Division) and the University of Washington. He is currently an Associate Editor of *Psychotherapy* and co-author of the second edition of “The Great Psychotherapy Debate” with Bruce Wampold scheduled to be published in 2015. His interests include the intersection of psychotherapy process, basic psychological science, health services, and technology. Specific programs of research include methods for identifying and understanding the behaviors of effective (and less effective) therapists, the utilization of mental health services, emerging computational techniques for modeling psychotherapy process, and meta-analysis of treatment outcome studies.



# ETHICS IN PSYCHOTHERAPY

## Ethics and Mindfulness

Ron Schwenkler, MA, LPC

University of Denver—Graduate School of Professional Psychology



Much of life is spent in motion—physical, mental/emotional, relational, and especially neural motion. Our conscious and non-conscious brain continually scans and interprets this motion, allowing us to focus our attention on other needs and desires, rather than having to pay attention to each motion as it occurs. In the absence of this scanning, psychological problems such as anxiety and hyper-aroused sensory disorders may occur (van der Kolk, McFarlane, & Weisæth, 1996).

There are certain life experiences that alert a person to pay closer attention to the daily motion of life. These alerts come in a many forms, ranging from fear and safety to pleasure and beauty; with seemingly infinite variations between. Of all the “movement” that catches our attention, however, one particular variant likely has the greatest impact on our lives: decision making.

As humans, and unlike any other biological creature on the planet, the decisions we make define who we are. In *Man’s Search for Meaning* (1984), Victor Frankl argues that people must create meaning, even under the most dire of human conditions; this is an example of the power of decisions. Ethical decision making is perhaps most connected with a human being’s highest intellectual abilities. An ethical decision may be thought of as an event that strives to resolve the tension between a highest good and other temptations or desires. This article will examine the process of

mindful decision making through the lens of a Reynolds’s (2006) model of ethical decision making.

### The Reynolds (2006) Model

Reynolds (2006) outlines an ethical decision making model from a management perspective, using neurocognition research to help business managers. Reynolds applies the Jones (1991) tradition, defining an ethical decision as “a decision that is acceptable to a larger community based on its adherence to moral standards of behavior” (Reynolds 2006, p. 273). Such a definition provides a framework through which to explore simple to complex issues, as well as providing room for cultural and legal topics.

Reynolds agrees with Jones (1991) that many of the cited models use a four-stage approach. An example of such a four-stage model was developed by James Rest (1979, 1986), who suggests that an ethical decision begins with an awareness of an ethical issue, followed by an ethical judgment, then by the establishment of an intention to act ethically, with the result being to act with ethical behavior. Although this model is helpful, it raises questions in terms of how one becomes aware that an ethical dilemma is present, the role that bias and intuition may play in terms of judgment, and that intention to act in an ethical way may not lead to actual ethical behavior. Reynolds’ model, on the other hand, adds intuition and persona/cultural beliefs (prototypes) to the deliberate process stated by Rest, as well as adding different classifications of an ethical decision.

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Other writers in the psychology field have also worked to expand the traditional four-stage model. Holcomb (2006), reviewing Bush, Connell, and Denney's (2006) "Ethical Practice in Forensic Psychology: A Systematic Model for Decision Making," notes that the authors include the traditional steps of ethical decision making: Identify the problem, develop possible solutions to the problem, consider the potential consequences of various solutions, choose and implement a course of action, and assess the outcome and implement changes as needed. However, the authors include the additional crucial steps of considering the significance of the context and setting; identifying and using ethical and legal resources; and considering personal beliefs and values.

We can see how the first part of Bush, Connell and Denny's model (2006) has remnants of Rest's model (1979, 1986) and they rightly add to it by including more details concerning the true complexity of an ethical decision. However, both models are limited to *what* should be done in the face of an ethical decision; neither discusses *how* it is done. Even with additional safeguards, the specific neuro-mechanism of an ethical decision is still not understood. I suggest that understanding *how* can help us know more about *what* needs to happen in an ethical context.

Reynolds (2006) uses a dual-processing model to describe ethical decision making. His model differs from others by his incorporation of the role, relationship, and continual redefining of the conscious (C) and the nonconscious (X) systems. The X-system of the model mostly pertains to what many scholars refer to as automatic processing, analysis of the environment, intuition, or implicit learning. Neurologically, the X-system is hugely complex, but researchers believe the lateral temporal cortex, amygdala, and basal ganglia and associated neuro-circuits are

mostly responsible for automated social cognition (Lieberman et al., 2002).

The C-system, or the higher-order conscious reasoning system, is even more complex than the X-system. Mostly talked about as the frontal cortex, the specific areas we are most concerned with in regards to social cognition are the anterior cingulate, prefrontal cortex, hippocampus and associated neuro-circuits (Lieberman et al., 2002).

The X-system holds all things known and organized. As we come in contact with the ongoing motion of life, the X-system is constantly scanning to make sure all is in place. In short, it is responsible for reflexive pattern matching. This vast organization helps keep the cognitive load off the C-system, hence allowing the C-system to engage in the higher cognitive functions such as present moment decision making. The X-system also holds our prototypes, constructs similar in meaning to schemas, belief systems, scripts, and implicit memories (Reynolds 2006).

The C-system is able to analyze rules and provide regulation to the X-system by feeding it additional information to aide in prototype refinement. This refinement allows for further load to be taken off the C-system. There is evidence that the anterior cingulate, which seems to be connected to both the C and X-system, acts as alarm system, allowing the X-system to alert the C-system when something is out of prototypical order. The C-system will then take on the cognitive load in attempts to problem solve. Although Reynolds does not discuss this, if the threat is bad enough, C-system becomes deregulated, with a deeper part of the X-system taking control by engaging the flight or fight mechanism (Scaer, 2007)

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When it comes to ethical decision making, the C-system has two primary modes of engagement: Reflexive and Concession. Reflexive judgment comes from a C/X-system prototype match up. In order for an ethical decision to be a reflexive act, it has to be supported by a lot of experience and proper intuition. The C/X-system prototype match occurs because the prototype matches with the present context, so the ethical decision is reflexive in that little conscious deliberation is needed because of the felt sense of familiarity of the context. The Concession manner of ethical decision making is engaged when there is C/X-system prototype mismatch. The C-system will then engage active judgment in order to analyze, learn, apply rules, reason the rules through, take in outside resources to further reason the rules through, and finally make a judgment and act with ethical intent and behavior. "This level of active judgment is the focal event of ethical philosophy" (Reynolds, 2006, p. 741).

### **Mindfulness**

Taylor et al. (2011) use Bishop's definition of Mindfulness as "a kind of nonelaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the intentional field is acknowledged and accepted as it is" (p. 1524). They compared experienced mindfulness practitioners (those with 1000 to 3000 hours of mindfulness experience) with novice mindfulness practitioners (those with no prior experience, who were instructed in mindfulness for the purposes of the study) using neuro-imaging in effort to discover what happens in the brain during a mindfulness practice when emotional and non-emotional pictures are shown. The significant findings of the study were that "mindfulness attenuated emotional intensity perceived from all valence categories of pictures across the entire sample of participants, whereas functional brain imaging data

indicated that this attenuation was achieved via distinct neural mechanisms for each group" (Taylor et al, 2011, p. 1530). Findings included a deactivation of the medial prefrontal cortex and posterior cingulate cortex in experienced practitioners, with no influence on brain activity in those areas associated with emotional reactivity. Findings for the novice group included a down-regulation of the left amygdala. Taylor et al. stated these findings "indicate that mindfulness constitutes an efficient strategy to promote emotional stability" (2011, p. 1531).

Baijal and Srinivansan (2010) found in their study concerning oscillatory activation that theta oscillations are created during deep meditation in the frontal regions of the brain. It is thought that theta oscillations are involved with working memory operation and attention processing. This research confirms that something is happening to the brain during the practice of mindfulness. The question then becomes, how can mindfulness help us make better ethical decisions?

### **The Reynolds Model and Mindfulness**

In studying Reynolds work (2006), I began to wonder if there were any utility in moving in between a reflexive and active judgment, as well as moving in between the X and C-systems. Clearly the C-system is hugely complex and there is a neurologic difference between reflexive and active judgments. How does one then move in between the X and C-systems, and what could be the use of moving between a reflexive judgment ethical decisions to an active judgment ethical decisions? In the practice psychotherapy, I believe that the difference lies in between making a firm decision (reflexive) and using the context (active) to discover nuances about the dynamics of 1) why the context was

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created in the first place; 2) what we can learn from making the ethical decision; and 3) what we can help another learn from making the ethical decision. Furthermore, even if a Reflexive judgment is made, it is important to activate the Active process in order to further explicate and learn from ethical experiences. The following short example will illustrate the importance of moving between the systems:

A psychotherapist is in session with a client. They have been in a professional relationship for over a year. During a recent session, the client professes his love to the therapist and asks if a romantic relationship is possible.

The X-system becomes alerted that this context is not matching with current prototypes. However, other parts of the non-conscious X-system linked to emotional centers are also activated by the power/pleasure/fear of the idea of a romantic experience with the client. The therapist quickly recognizes the inappropriateness of those thoughts, activating the C-system to make the correct reflexive ethical decision and informs the client that a romantic relationship is not possible. The client has a bit of a surprised look due to the quick, abrupt nature of the response. This surprised look again activates the X-system in the therapist. The C-system is alerted, more fear becomes activated in the therapist upon realizing that the feelings of the client may have been hurt by the therapist's thoughtless response.

The therapist takes a couple of moments, centers and breathes (mindfulness). The mind becomes quieter and the more full context of the client's history comes to the forefront of the therapist's mind. The

reflexive response moves to an active process of deliberating on why these romantic feelings in the client are happening. The ethical decision stands, but the therapist begins to realize that for many, intimate relationships are directly correlated with physical, sexual relationships. The therapist is prompted to discuss the context with the client, with hopes of prompting further insight on the client's view of intimate relationships, which may result in an expanded view of intimacy in general.

Mindfulness has been used throughout the ages as an exercise to create internal cohesion through a disciplined practice of being in the present moment. Ethical decisions are those contexts that demand us to contemplate the best action for us and other sentient beings. An ethical decision requires us to be aware of our prototypes concerning power, pleasure/fear and experience/inexperience. If we are not aware of these prototypes, chances are emotion will find its way into the ethical context, and poor judgments will be made.

Evidence shows that mindfulness can help a person down-regulate emotional centers of the brain (limbic system) as well as deactivating regions associated with self-referential thought process (MPFC and PCC) (Taylor et al., 2011). The consequences of these neuro-activities can create a sense of neutral ground from which to work. I believe this neutral ground can help us navigate between the X and C-system as well as between Reflexive and Active ethical judgments.

### **Conclusion**

Ethical decision making models presuppose that the ethical decision is being

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made successfully. Reynolds' model (2006) uses neuroscience and gives a way to conceptualize "how" ethical decisions are made from a neurocognitive perspective. Other models, such as Rest (1979, 1986) and Bush et al. (2006) can be superimposed on Reynolds' model to give more "what" to the process. Using a mindfulness practice will encourage a neural neutrality as a platform

to work from, and return to, in times of C/X-system mismatching and reflexive/active judgments. Returning to a mindful neutral space can allow for further certainty when making ethical judgments. Furthermore, a mindful practice will allow for regulation of the X-system, if prototype mismatches occur, hence setting the stage for more effective C-system processing.



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## EARLY CAREER

### Never Turn Down the Opportunity to Give a Talk

*Kevin S. McCarthy, PhD*

*Assistant Professor, Chestnut Hill College*

*Research Associate and Psychologist, University of Pennsylvania*



Two years after graduation from my doctoral program, a friend invited me to give a grand rounds presentation at a major university. Despite the fact that I was guaranteed a sympathetic audience and a topic I knew (it was whatever I wanted to speak on), I found myself reluctant to respond and even going to some length to avoid my friend. Generally being self-aware, this behavior puzzled me as much it constrained me. The avoidance was not worry about public speaking – that type of anxiety had long expired with my role as an instructor and professor. I teach research methods and statistics, so I would go as far to say that bored looks and blank faces actually excite the challenge of engagement within me. Moreover, even if it were social anxiety, my role as a psychotherapist gave me several effective treatments for that. When I thought about the opportunity to talk about my own thoughts and observations, it seemed as though those topics that interested me in psychotherapy suddenly could never appeal to others, those research skills I sharpened in graduate school became dull and astigmatic, and those in my imagined audience were motivated to skewer me on my ignorance and roast me over the coals of their knowledge and experience. When the grand rounds schedule was announced and my spot was left “To Be Determined,” my indecision came to the attention of one of the fac-

ulty at the university. He electronically pulled me aside and gave me perhaps one of the most helpful pieces of advice I have received: “Never turn down the opportunity to give a talk.” While I (and he) may be psychodynamic in orientation, we both appreciate the utility of behavioral interventions, and his suggestion propelled me up in front of that audience a few weeks later. But I imagine that there are many other early career psychologists (ECPs) who experience the same inhibition when it comes time to demonstrate what we know and think in a talk. What might drive this reticence, and why might the advice I received be so advantageous for us as a population of ECPs?

Often as psychologists we tend to be underwhelmed by our own thinking, findings, and accomplishments. It is part of our training as scientists and scholars to approach everything with skepticism and to value novelty in opinions and ideas. Our newest doctors are the most likely to endorse this mindset, fresh from imprinting in graduate school and with less experience either to disconfirm these maxims or to employ them more flexibly. In terms of skepticism, graduate school makes us aware that any epistemology or investigation always has limitations and things to criticize, and sometimes we fear that lens of scrutiny will turn on us. We were taught confidence intervals, not confidence. In terms of originality, we come to believe knowledge is ever expanding, demanding

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constant novelty and innovation. Paradoxically, science at the same time requires tedious and meticulous replication, although this tenet is somehow second class to originality. If we follow a tradition or a paradigm, we are made to feel less smart for it, even if we came to agree with that way of thinking through a sophisticated decision process. Finally, ECPs are still accustomed to the role of student as opposed to one who produces and professes knowledge. We expect examination and evaluation and are not surprised when we are told our work is not good enough to stand alone and be independent. Speaking on our own opinion is then understandably anxiety-producing, made worse by the better psychological training we received! When we hear equally intelligent and experienced professionals from other fields speak, we are impressed by the way they seem unencumbered by the same inhibitions we ECPs have about expressing opinions. Training in other fields often treats knowledge much more as a tool than a process, which may account for some of the differences in our confidence as ECPs.

Scientific training might be one of the reasons for our inhibition to present, an anxiety which the advice to never turn down a talk might lessen through exposure. However, at the same time our doctoral education is our greatest asset. A doctorate in hand combined with anxiety about what you know is the sign of a good psychologist. Socrates, perhaps the earliest career psychologist, was thought to have said, "the only true wisdom is in knowing you know nothing." Our worry over the knowledge and observations we have to present is actually the questioning and discernment that a degree in psychology offers. It means that the observations and work you have to offer most likely come from a place of good judgment and, as such,

will be appreciated for their soundness. We should all be so fortunate to have that worry before a presentation!

Not turning down the opportunity to talk is the chance to think deeply about an observation, phenomenon, or connection between phenomena that we have noticed. Thinking is hard to do but easy to avoid, even for psychologists who have extensive training in empirical investigation and who employ these methods every day to help patients. Preparing a talk forces us to clarify our thoughts in order to transmit them to others. We first need to re-earth our own assumptions in thinking about a topic because we are aware our audience may not hold the same starting beliefs. Presenting then is an exercise in mentalization, bringing audience members with you to a conclusion in a progressive, stepwise fashion. Often our assumptions are now forgotten, so automatic and embedded through experience, that when we uncover them we see that our intervening experiences have reaffirmed them (eliciting a sense of pride in how much we have learned in our training), or have disconfirmed them, which becomes an interesting catalyst for a talk in and of itself. In moving from our starting assumptions, we can use the research skills we acquired in doctoral training to sift through the literature, contextualize and contrast our observation with what is known, and direct our thinking to areas that a critical reading shows need examination. The literature search then builds a meaning structure for the origin, nature, and significance of the observation or investigation about which we will be speaking. Often when we are in the midst of our research or clinical work as ECPs, busy as we are, we miss the opportunity to reflect on why what we do is valuable and worthwhile. This benign neglect of our own

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importance also is a contributor to the anxiety we experience in being asked to speak about our work, and in taking the advice to explain our efforts to an audience we are compelled to be made aware of why we do those important things we do.

Presentation is a great opportunity to conquer this anxiety over self-worth as a psychologist, as it is a more forgiving medium to deliver your thoughts compared to others like writing. I often prefer to present my work to help me with the daunting task of organizing my thoughts before I begin writing. Speaking is more interactive, is less exacting, and is often time-limited, whereas writing is in isolation of your reader, is fixed and precise, and is (depending on your degree of perfectionism) interminable. Being in front of an audience, you receive immediate feedback on how well you have conveyed a point or how clear your own thinking might be. In this way, you often receive a second chance to explain yourself and can modify your way of understanding your topic in dialogue with the audience. Writing, on the other hand, demands an order of precision not required in a talk because you will not be present with your reader to eradicate confusion. In relation to the time-limited nature of speaking, when your talk is advertised to a general audience it is assigned a clear start and end. You know by when you must finish your preparations and you know any anxiety in the process will at some point will terminate, making the worry more controllable. Writing is not always subject to the same time constraints. Unless you are beholden to others, you may pour over drafts or run over deadlines because the process has less of an artificial end—if you were in any way like me, imagine your dissertation process!

We ECPs should not feel so anxious in front of an audience because our recent

doctorate indicates an intimacy with the most recent developments in psychology. Senior career psychologists, allied professionals, and laypersons in the audience may have more and varied experience, but ECPs are more likely to be connected to the current literature at least by virtue of their more recent training, if not by their personal recognition. Presenting then a review of a topical area or a personal take on an exciting study conducted by others can be an acceptable outlet to present, as it is likely to be bringing something new to the audience that they have not had occasion to pursue. The recency of training for an ECP often equalizes presenter and audience together as life-long learners, and everyone is one's own professor in that classroom. As a presenter and giver of observations, the ECP is a stimulus to which others respond. In my observation this is often the case—I rarely get through the material I prepared because the discussion often leads in intriguing new directions.

Speaking is an opportunity we should take up as ECPs because it is a service to our profession. Being an ECP comes with involvement in academic groups and professional and scientific societies, like Division 29. These organizations often rely on volunteer speakers to achieve their programmatic missions to promote education and outreach, attract new members, and foster relationships among their members. In following the advice to never turn down a talk, you are likely to earn the gratitude of the person organizing the event at which you are presenting. Not surprisingly, it is difficult to find psychologists who will take time out of their busy schedules to prepare and deliver a professional talk. Similarly, members of these organizations who will attend your talk understand the volunteer nature of most

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presentations, and based on the psychology of attribution this fact should be anxiety-reducing for you. Attendees come to expect variability in quality of these talks, which primes the self-handicapping phenomenon from social psychology: If you excel in your talk, the audience will esteem you higher; if you perform less well, the listeners are unlikely to fault you. Awareness of the volunteer nature of these talks also promotes the realization among audience members that they too were in the pool to be selected to speak and it could have been them up there. Knowing how difficult it is to prepare a talk, they are more likely to experience empathy for you. Finally, you and your audience both recognize the sampling method for selection to speak is not a random process – the mere fact you were selected to talk means you have already been singled out as special in some way.

Lastly, accepting the opportunity to speak as an ECP has its direct rewards. Upon completion, your presentation can make you feel accomplished in your thoughts and what your doctoral train-

ing allowed you to create. You will receive gratitude for your effort and your outreach, often impacting the thinking of those to whom you have finished speaking. Your presentation can also turn into a formal paper, and the feedback from the audience can help “workshop” the project into an improved version. Importantly, giving a talk can create and foster relationships. Speaking engagements are a type of professional networking. You might receive referrals for a psychological area in which you have now marked yourself as expert or you might find collaborators and like-minded others to continue your work and thinking in the topic presented. Lastly, speaking can lead to other invitations to give another talk. Knowing the possible origins of some of our presentation anxiety as ECPs and some of the benefits of overcoming this anxiety by speaking, hopefully we all can take the advice to “never turn down an opportunity to talk.”

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



## The Arc of the Moral Universe

Armand R. Cerbone, PhD, ABPP  
Chicago, IL



*The arc of the moral universe is long, but it bends toward justice.* So said Martin Luther King Jr. (1968).

As I write this, on April 29, 2014, the sports world gave us proof of this. When the National Basketball League banned Donald Sterling for life from the NBA family and pressed for his removal as owner of the Los Angeles Clippers (Branch, 2014), it said racism will not be tolerated and those who discriminate within its authority will be held accountable. Instead of allowing an owner to demean and marginalize the players who contribute to his wealth, the NBA set a forceful example for justice, fairness, and equality.

The APA, too, has a long and proud tradition of opposing discrimination. And it is the mission of the Domain for Public Policy and Social Justice to join in that tradition.

What this brings to mind for us is the importance of our APA core values. Division 29 is a division committed to these core values.

It also brings to mind what is often at the root of the kind of discrimination the NBA players have experienced. And that is the power and blindness of privilege. That privilege is power is well understood. Its blindness is not well recognized, except by those without privilege.

Like Sterling, most of us do not see or

understand our own privilege. To the contrary, we tend to see only the ways in which we are not privileged. That's why it is so important for us to listen to, to really hear, the complaints of those who do not enjoy whatever privilege we enjoy.

Let me explain by example. I have been blind to the privilege of my White face and male gender. Only by listening carefully to those who are not White or male (unfortunately, often after I have blindly caused pain) have I begun to understand the impact of my privilege on them.

There is yet another, equally important truth to this. Everyone reading this, just by virtue of being a member of Division 29 and APA, is privileged, no matter in what ways we may not be privileged.

Let me explain by example again. Even though I am gay, I enjoy the privilege of being White, male, educated, able-bodied, and employed. As gay, I may have less power and am vulnerable as a minority to the majority that is heterosexual. But as an able-bodied, White male, etc., I have power. Lots of it. Particularly in the eyes of those who do not.

If we focus *only* on the way(s) in which we are marginalized, we run the risk of missing personal power that can be used to leverage our rights against discrimination in whatever form it takes.

Moreover, it is incumbent upon each of us to use whatever privilege we enjoy to labor to extend that privilege to those who do not have it. Together, as privi-

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leged and unprivileged, we are far more effective in opposing discrimination.

Admittedly, it is hard and often costly, as history has shown. Yet, every once in a while, as we saw today in L. A. and the NBA, the years of civil rights struggle and strife yield an action that not

only opposes prejudice but sets the bar right where it needs to be: with equality for all, at all times, in all places. No exception.

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



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# DIVISION OF PSYCHOTHERAPY

## APA 2014 Convention Program • Washington, DC

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### THURSDAY, AUGUST 7, 2014

**Symposium:** *Continuing Relevance of Person Centered Therapy  
New Insights, New Directions*

8:00 AM–9:50 AM • Convention Center, Room 154A

*Chair:* Arthur Bohart, PhD

*Participant/1stAuthor:* Mick Cooper, DPhil  
Barbara L. Vivino, PhD  
Arthur Bohart, PhD

*Discussant:* Dale Larson, PhD

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**Symposium:** *A Comparison of Psychotherapy Approaches With One Client*

10:00 AM–11:50 AM • Convention Center, Room 303

*Chair:* Raymond DiGiuseppe, PhD, DSc

*Participant/1stAuthor:* Kristene A. Doyle, PhD, DSc  
Arthur Freeman, EdD

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**Symposium:** *Treating Childhood Abuse and Sexual Disorders –  
Research Findings and Clinical Implications*

12:00 PM–1:50 PM • Convention Center, Room 207B

*Cochairs:* Steven N. Gold, PhD

Veronica Francia Juanes Vaquero, MS  
*Participant/1stAuthor:* Veronica Francia Juanes Vaquero, MS  
Virginia Burk, MS  
Landon Michaels, MS

*Discussant:* Steven N. Gold, PhD

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**Symposium:** *Naturalistic Study of Psychotherapy Supervision Outcome –  
Two Emerging Research Programs*

2:00 PM–2:50 PM • Convention Center, Room 149A

*Chair:* Clifton E. Watkins, Jr., PhD

*Participant/1stAuthor:* Jennifer L. Callahan, PhD  
Tony G. Rousmaniere, PsyD

*Discussant:* Clara E. Hill, PhD



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**Symposium:** *Do Pretraining Helper Characteristics Predict Success in Learning Helping Skills?*

3:00 PM–3:50 PM • Convention Center, Room 144C

*Cochairs:* Clara E. Hill, PhD

Timothy M. Anderson, PhD

*Participant/1stAuthor:* Andres Peres Rojas, BA

Saryn Cranston, MS

Allison Petrarca, MS

Kathryn Kline

**FRIDAY, AUGUST 8, 2014**

**Symposium:** *Self Concealment - Clinical and Health Related Consequences and Mechanisms of Action*

9:00 AM–10:50 AM • Convention Center, Room 143B

*Chair:* Dale Larson, PhD

*Participant/1stAuthor:* Akihiko Masuda, PhD

Barry A. Farber, PhD

Dale Larson, PhD

Ahmet Uysal, PhD

Anita E. Kelly, PhD

**Symposium:** *Information About the Client, Just Not From the Client*

10:00 AM–10:50 AM • Convention Center, Room 209A

*Chair:* Randolph B. Pipes, PhD

*Participant/1stAuthor:* Caroline Burke, PhD

Amanda Miles, MA

Randolph B. Pipes, PhD

**Symposium:** *Large Scale Psychotherapy Data Collected via Smartphones and Tablets*

11:00 AM–11:50 AM • Convention Center, Room 152B

*Chair:* Mark R. McMinn, PhD

*Participant/1stAuthor:* Laura A. Geczy Haskins, MS

Jacob Lowen, BS

Larry Jasper, MA

Jens Uhder, MS

**Poster Session:** *Psychotherapy and Supervision Processes and Outcomes*

4:00 PM–4:50 PM • Convention Center, Halls D and E

*Participant/1stAuthor:* P. Scott Richards, PhD, MA

Priscilla N. Zoma, MA

Rose A. Dunn, MS

Patrick Roebke, MA

Larimar Fuentes, MS

Ha Yan An, MA

Troy P. Rieck, MA

Carlos A. Taloyo, PhD, MA

Gregory J. Petronzi, MA

Robert J. Reese, PhD

Julia Probert, BA

Rose A. Dunn, MS

Giancarlo Collacciani, Jr., MA

Yi Ying Lin, MS

Clifton E. Watkins, Jr., PhD

Larry E. Beutler, PhD

Kevin M. Kieffer, PhD

Julie Maheux, BA

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Jonathan R. Cohn	Frances K. Braun, PsyD
Dana R. Connor, MS	Joshua K. Swift, PhD
Lindsey R. Hogan, MS	Brent A. Luebcke, MS
Tanya L. Kindel, MA	Catherine J. Brack, PhD
Alan Asbridge, MS	Ashley E. Mlotek, MA
Alexandra M. Minieri, EdS, MS	Joseph R. Drake, PhD

### **Business Meeting and Awards Ceremony**

5:00 PM–5:50 PM • Marriott Marquis Washington DC Hotel, Mint Room

*Chair:* Raymond DiGiuseppe, PhD, DSc

## **SATURDAY, AUGUST 9, 2014**

### **Committee Meeting – Editorial Board (invitation only)**

8:00 AM–8:50 AM • Marriott Marquis Washington DC Hotel,  
Judiciary Square Room

### **Symposium:** *Therapist Stories of Inspiration, Passion, and Renewal*

9:00 AM–9:50 AM • Convention Center, Room 103B

*Chair:* Michael F. Hoyt, PhD

*Participant/1st Author:* Laura S. Brown, PhD  
Judith Mazza, PhD

Lillian Comas Diaz, PhD

### **Symposium:** *APA's Resolution Recognizing Psychotherapy*

*Effectiveness – Using Science in the Public Interest*

10:00 AM–10:50 AM • Convention Center, Room 155

*Chair:* Raymond DiGiuseppe, PhD, DSc

*Participant/1st Author:* Linda F. Campbell, PhD  
Melba J.T. Vasquez, PhD

Bruce E. Wampold, PhD

*Discussant:* John C. Norcross, PhD

### **Presidential Address**

11:00 AM–11:50 AM • Convention Center, Room 158

*Chair:* Jacques P. Barber, PhD

*Participant/1st Author:* Raymond DiGiuseppe, PhD, DSc

### **Symposium:** *No Easy Answers – The Ethics of Practicing Social Justice in Psychotherapy*

12:00 PM–1:50 PM • Convention Center, Room 155

*Chair:* Rosemary Adam Terem, PhD

*Participant/1st Author:* Miguel E. Gallardo, PsyD  
Usha Tummala Narra, PhD

Beverly A. Greene, PhD

*Discussant:* Pamela A. Hays, PhD

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**SUNDAY, AUGUST 10, 2014**

**Symposium:** *Psychotherapy Revealed – A Glimpse of  
Eminent Psychotherapists in Session*

8:00 AM–9:50 AM • Convention Center, Room 151B

Chair: Jeffrey J. Magnavita, PhD

Participant/1st Author: Laura S. Brown, PhD  
Thomas Sexton, PhD

John C. Norcross, PhD  
Jeffrey J. Magnavita, PhD

Discussant: Nadine J. Kaslow, PhD

**Symposium:** *BEA Guidelines for Supervision of Health  
Service Psychologists: Who, What, and How*

8:00 AM–9:50 AM • Convention Center, Room 303

Chair: Carol A. Falender, PhD

Participant/1st Author: Carol A. Falender, PhD

Discussants: Elizabeth A. Klonoff, PhD  
Beth Doll, PhD

Jeffrey M. Baker, PhD

**Symposium:** *Supervising Complex Trauma Cases: Fostering  
Professional and Personal Resilience*

10:00 AM–10:50 AM • Convention Center, Room 143B

Cochairs: Steven N. Gold, PhD

Joan M. Cook, PhD

Participant/1st Author: Kelly R. Araujo, PsyD  
Amy E. Ellis, MA, MS

Bryan T. Reuther, PsyD

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**Symposium:** *REBT in the 21st Century: Measurement,  
Intervention, Training, and Outcome*

11:00 AM–11:50 AM • Convention Center, Room 303

Chair: Mark D. Terjesen, PhD

Participant/1st Author: Mark D. Terjesen, PhD

Rachel Camhi, PsyD  
Raymond DiGiuseppe, PhD, DSc  
Kristene A. Doyle, PhD, DSc

**Symposium:** *Developments in Supervision and Training:  
Recent Research and Innovative Applications*

12:00 PM–1:50 PM • Convention Center East, Salon D

Chair: Jeffrey E. Barnett, PsyD

Participant/1st Author: Rodney K. Goodyear, PhD  
Angelita Yu, PhD

Nicholas Ladany, PhD  
Tony G. Rousmaniere, PsyD

Discussant: Jeffrey E. Barnett, PsyD



### Students and Early Career Psychologists (ECPs) Doing Psychotherapy Research: Advice and Opportunities Available Through the Division of Psychotherapy

Susan S. Woodhouse, PhD  
Lehigh University



I began my three-year term as the new Science and Scholarship Domain Representative for the Division of Psychotherapy on January 1, 2014. One of my key goals in this capacity is to support students and Early Career Psychologists (ECPs) who are interested in psychotherapy research. Students and ECPs often wonder how to build a successful research career, what it is like to do research and have a job in academia, whether it is helpful to belong to professional organizations (like the Division of Psychotherapy) and—especially if their own mentors did not have federal research funding—whether it is possible to get research money to fund psychotherapy research. I would like to lay out here some ways in which students and ECPs can build their careers as researchers and make good use of their membership in the Division of Psychotherapy to help them along the way.

#### Students: Exploring a Career in Research and Being Mentored

Gelso's (2006) theory on the research training environment suggests that graduate students often begin training in professional psychology programs feeling some ambivalence about research: interested, but unsure about their own ability to do research. Getting involved in research is the best way for graduate students to clarify their interests, begin to chart their specific career direction, de-

velop their research skills, and gain self-efficacy. Nevertheless, students often feel intimidated by the idea of beginning research in graduate school or worry that it will be a lonely enterprise. Doing research, however, can be a lot of fun and a rewarding social experience.

A wonderful way to begin getting research experience is to join one (or more) research teams. An obvious place to begin would be to find out about the research being done by the faculty in your program. Sometimes more advanced students are doing projects that would be interesting to you, and those can be wonderful opportunities. There may be other researchers doing work that is closely tied to your interests elsewhere in your department or university. For example, when I was in graduate school I had the opportunity do research with my advisor (Dr. Charlie Gelso) in counseling psychology, but also with another well-known attachment researcher (Dr. Jude Cassidy) in developmental psychology. I ended up working for several years as a research assistant in this lab outside my program. That experience taught me about the practical skills it takes to run a federally funded project—and later led to a research postdoc that allowed me to merge my interests in psychotherapy and developmental research to study the process of psychotherapy in parenting interventions.

*Funding Student Research on Psychotherapy.* Students who are interested in

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psychotherapy research often wonder whether it is possible to obtain funding for this kind of research or whether it is possible to do psychotherapy research without any funding. The answer to both questions is yes. First of all, there are many ways to do psychotherapy research without much funding at all. If your institution has a research clinic or a research-active counseling center, you may not need any funding at all. When I designed my first psychotherapy study involving psychotherapists and clients in the community, the only money I needed was postage for mailing questionnaires to participants and providing return postage. These days the main cost for such a questionnaire-based study might be the cost of online data collection (if your university does not already have a license or subscription for such services).

If you do need funding for your research, questions to ask might be whether your college or department offers any funding that would be helpful in doing your project? Does your topic area fit funding available to students through the Division of Psychotherapy or any other division of APA? For example, the Division of Psychotherapy established the Diversity Research Grant for pre-doctoral candidates to foster the promotion of diversity within Division 29 and within the profession of psychotherapy. This annual award provides for 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.

There may even be federal funding available for your dissertation, particularly if your advisor has federal funding already and can serve as your pre-doctoral sponsor. For example, NIH has funding available for students. The key to obtaining such funding (besides hav-

ing a great idea) is having a really good mentor with federal funding who can work closely with you. You can get more information about the Ruth L. Kirschstein NRSA Individual Fellowship Funding Opportunities at [http://grants.nih.gov/training/f\\_files\\_nrsa.htm](http://grants.nih.gov/training/f_files_nrsa.htm), including information about podcasts offered by NIH on grantwriting for new investigators, writing a fellowship application, and graduate students considering a research postdoc experience.

Another idea that can save students money and make psychotherapy research possible is to integrate other students, both graduate and undergraduate, into your research team. Asking other graduate students to join you in your project makes the work more interesting and fun, if you have good colleagues with whom to work. When I was a graduate student, I also included undergraduate students on my research team (for example, doing coding or data collection tasks), and their work helped make the projects possible.

*Building a research community and finding mentoring.* Some students fear that getting involved in research will lead to a lonely life of solitary work in the ivory tower. For better or for worse (if you happen to really like solitary work), in real life research tends to be a social experience that involves dealing with many different people. In my current research, I work closely with other faculty, research staff, and students—but also speak regularly with community agency staff, community leaders, and the public. Much of my own current research, which focuses on addressing mental health care disparities, is based in the community. So I meet every two months with a community advisory board to make sure that my research activities are a fit for community needs, that findings are disseminated to the community in a

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timely manner, and to build and maintain positive relationships with the community. My experience of research is that it is *quite* relational.

One of the things I loved about my graduate school experience was that my advisor had all his students meet regularly as a group to discuss our research, at whatever stage it was. We would all take turns presenting our research ideas to one another and providing feedback to one another. This experience was wonderful preparation for participating in research feedback groups later on, when I got my first academic position.

Going to conferences is an obvious place to begin to build a research community. Sometimes students wait to go to conferences until they have something to present—but it is a good idea to just start going from the beginning, even if at first you are just listening and learning. It is a great way to get oriented to your field and begin to meet people. The Society for Psychotherapy Research (SPR) is a natural for students interested in psychotherapy research because it is typically such a welcoming, inviting, and student-friendly conference. Going to APA is another natural conference to attend for students interested in psychotherapy research. One benefit of APA is that there are many student-oriented events that help to build community and relationships between researchers.

Students who attend APA should be sure not to miss the Lunch with the Masters event that is held each year by the Division of Psychotherapy. This event is a great way to make connections with senior people in the field because you get to enjoy a (free) lunch sitting at a table with a senior person in the field of psychotherapy. It is a wonderful opportunity for informal conversation and mentoring. Senior people also donate books that are raffled off during the Lunch.

There are also many sessions held at APA that provide important information for students about how to navigate career-related issues—including research. For example, this year a student named Christy Denckla and I will be co-chairing a session entitled *Research in Graduate School—Why and How Should I Get Involved?* This session will have a number of speakers who will have information relevant to for students interested in research on psychotherapy and how to effectively get involved in research (Thursday 8/7/2014 1:00 - 2:50 pm in Convention Center Room 204C).

*Students: Building Your CV through Presenting, Writing, and Awards.* For students considering including research in their future careers, a key goal (besides having fun asking questions about things that really matter to you) will ultimately be to build your CV through presenting, writing, and awards. Posters are a great way to begin presenting because they allow you to get practice talking about your research with other people who are also interested in your topic. The key to successful presentation of papers is to practice, practice, practice. You will want to make sure that you practice and get feedback from a group of people who are willing to give you constructive feedback and help you make sure you use the time allotted to you (and no more!) wisely.

Writing is an issue with which many students struggle on some level (e.g., procrastination), but a solid writing practice is absolutely essential for success in research. Not only is it important to build habits that will lead to tenure in the future, it is also important, after all, to be able to share the knowledge you build with other people by publishing your research findings. One book that I recommend to all my graduate students is Boice's (1990) *Professors as Writers*. I

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urge my students not to be intimidated by the title referring to professors—the time to read this book and start using it is in graduate school. This book, which has an empirical basis, by the way, offers some excellent ideas and exercises to help students learn how to write regularly and well.

Awards are another way to build your CV—and at the same time can sometimes help to reimburse you for some of the expenses you may have laid out to do your student research. The Division of Psychotherapy has a number of student paper awards that students should be aware of and apply for. Most of these have application due dates of April 1 each year, so now would be a good time to start thinking about what you might like to submit next year. The Donald K. Freedheim Student Development Paper Award is for the best paper on psychotherapy research, theory, or practice. The Mathilda B. Canter Education and Training Paper Award is for the best student paper on education, supervision, or training of psychotherapists. The Student Diversity Paper Award is for the best paper on issues of diversity in psychotherapy. Finally, the Jeffrey E. Barnett Psychotherapy Research Paper Award is for the best paper that addresses psychotherapist factors that may impact treatment effectiveness or outcome. Check out abstracts from this year's winning papers in this issue of the *Bulletin*, and visit the Division of Psychotherapy website for more information on all of these award opportunities for students.

### **Mentoring for Early Career Psychologists (ECPs) Doing Psychotherapy Research**

Many of the same issues that apply to students also apply to ECPs who do psychotherapy research, but at new level. ECPs in a research postdoc or in their first academic position are working

on building a sustainable and meaningful research program, building a research community, getting funding for their research, managing research teams, and building their CVs through presentations, publications, and awards. In addition, ECPs are also seeking out meaningful ways to gain experience in national service. Membership in the Division of Psychotherapy can be helpful with all of these goals, and the Division is eager to provide helpful support to ECPs.

*Mentoring for ECPs.* One new program the Division of Psychotherapy offers is an Early Career Psychologists Mentoring Program. This is a free, one-year mentoring program that provides mentoring for ECPs (i.e., those with a doctoral degree who are within 10 years of having completed the Ph.D. or Psy.D.). Mentoring is given by two senior, experienced mentors to a group of up to 3 or 4 mentees who have shared professional interests. Mentoring groups meet via videoconferencing with the two mentors for an hour every two months, for a total of six meetings over the course of the year. One of the mentoring groups focuses on psychotherapy research. The research mentors provide mentoring about a variety of ECP concerns related to research. For example, mentees may want to talk about setting a research program, developing successful grant applications, engaging diverse communities in psychotherapy research, or the tenure process. Information about applying for the ECP mentoring program is available on the Division website (<http://www.divisionofpsychotherapy.org/>).

If you are an ECP who would like in-depth mentoring about securing funding for your psychotherapy research, it may be helpful to talk with funding agencies. The National Institutes of

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Health (NIH), for example, holds an annual NIH Regional Seminar. When I was an ECP I requested funding from my institution to attend this seminar, as well as to visit a number of funding agencies in Washington, DC. Being able to talk with program officers at different funding agencies helped me figure out which agencies would be most interested in funding the work that I do, and led to my ultimately being able to secure a \$2.4 million NICHD grant that is focused on identifying the most important targets for parent-infant intervention to improve psychotherapy interventions for low-income parents. Once I identified NIH as the most relevant funding agency for my work, I attended the NIH Regional Seminar in order to learn about the grant application process and the kinds of funding available. I learned so much from that weekend (and you can learn more about the NIH Regional Seminar NIH Regional Seminar happening in June 2014 at <http://grants.nih.gov/grants/regionalseminars/2014/in dex.html>). This seminar demystifies that application and grant review process and provides information about particular areas of interest to the funding agency. It also teaches you the skills you need to stay on top of upcoming grant opportunities in the future.

When I was an ECP, I found it tremendously helpful to become a part of an interdisciplinary behavioral science research group at my university. This group included both senior and junior researchers and met every other week to discuss a particular research idea. Each time we met one of us would present on a project we were working on (at whatever phase), and the group would provide feedback. The idea was to provide critique and support that would help each of us move forward in doing good science and getting the funding we needed. I think this group was the most helpful thing I could have done as an

ECP. Other than individual mentoring from your personal mentors who love you, there is nothing more useful than getting frank feedback and advice from a group of colleagues. One valuable piece of advice I got from this group is the key importance of gathering pilot data when you would like to get funding. The advice I would give is to use start-up funds or other internal funds you can compete for through your institution to do pilot work. I tried to set up my pilot work so that there would be some way to publish from the pilot data, even though the pilot samples were small.

The Division of Psychotherapy also has grants for which ECPs can compete (with application due dates of April 1 each year). These grants could be useful to ECPs establishing a research agenda or collecting pilot data. Three Charles J. Gelso Psychotherapy Research Grants are offered annually to doctoral-level researchers, with two of three grants reserved for ECPs. Each Gelso grant provides \$5,000 toward the advancement of research on psychotherapy process and/or psychotherapy outcome. The Norine Johnson Psychotherapy Research Grant provides \$10,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes (including type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes). Although this grant opportunity is not set aside for ECPs, to qualify one must only have a successful track record of publication. Thus, there should be ECPs who would qualify for such a grant, particularly later on in the ECP timeline. More information about these grant opportunities is available on the Division of Psy-

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chotherapy website (<http://www.divisionofpsychotherapy.org/>) and in the *Bulletin*.

In terms of building the ECP CV, the Division of Psychotherapy can also be helpful with opportunities for awards and national-level service/leadership. Check the Division website for information about the APF/Division 29 Early Career Award. The Early Career award recognizes ECP members of the Division of Psychotherapy who have demonstrated outstanding promise in the field of psychotherapy (in psychotherapy theory, practice, research, or training), and provides for a \$2,500 monetary award as well.

One aspect of the tenure process that I was not aware of in my early ECP years was that my institution expected me to get national-level leadership experience as a part of demonstrating service to the field as a whole. I knew that it was important for tenure to publish, teach, provide service at my institution (at the program, departmental, college, and university levels), and get experience on editorial boards. I was not aware, however, that it was also important for me to become involved in national-level leadership until I got that feedback from the

Dean in one of my early reviews. The Division of Psychotherapy has been a wonderful place for me to get that national leadership experience. I started out as the Chair of the Research Committee, later became the ECP Domain Representative, and most recently was elected as the Science and Scholarship Domain Representative. I think many people, both students and ECPs, do not realize that there are many opportunities to get involved in the Division and the profession of psychotherapy and psychotherapy research. For example, one can become involved as a committee member or committee chair. These experiences can be beneficial for tenure as a part of a balanced portfolio of research, teaching, and service. I have found the Division of Psychotherapy to be a wonderful place to develop professional relationships and receive mentoring, and I would be happy to talk with ECPs (or students) who are interested in finding out more about how getting involved in the Division of Psychotherapy might be a useful way of building your CV.

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



## NOTICE TO READERS

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

### Cognitive Behavioral Therapy (CBT) for Rural Women With Chronic Pain: Implications for a Group Setting

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Chronic pain is a debilitating symptom that may or may not have an organic cause. In rural communities, chronic pain may be more difficult to treat due to patients' limited access to care, lower socioeconomic status (SES), and geographic isolation (Thorn et al., 2011). Psychosocial approaches are viable options for treatment, including Cognitive Behavioral Therapy (CBT) and relaxation training designed specifically for those living in these areas. In chronic pain treatment, CBT focuses on cognitive restructuring in order to decrease catastrophic thinking, maladaptive pain coping, and beliefs of self-control in managing pain (Turner et al., 2007), and research suggests that techniques such as progressive muscle relaxation and biofeedback assist in reducing pain (Jenson, 2011). To understand the use of CBT in this context, however, it is necessary to first understand the subjective experience of chronic pain, as well as how it is managed clinically.

*The Experience of Chronic Pain.* Conditions related to chronic pain vary in clinical manifestation depending on the extent of the pain as well as duration. Initially, chronic pain such as fibromyalgia was viewed with skepticism, as there is no apparent organic cause and biomedical interventions are not seen as efficacious. In the case of chronic back pain, identifying the extent of the pain is difficult to define. Acute low back pain is identified as 0 to 7 days of pain;

low sub-acute pain is identified as 7 days to 3 months; and chronic back pain is viewed as more than 3 months (Frank, 1993). This low back pain may be seen associated with anatomical trauma or no trauma whatsoever. In both cases, it can be displayed by shooting pain accompanied with tingling, numbness, or burning. Furthermore, 70-85% of individuals will experience back pain some time in their life (Frymoyer, 1988), and is the second leading cause for physician visits (Hart et al., 1995). Persistent pain is viewed as *chronic* if endures beyond anatomical healing; this varies according to the initial injury or origin of the pain (for example, back pain identified beyond 6 months post-healing would be considered chronic; for post-herpetic neuralgia, beyond 3 months) (Apkarian, Baliki & Geha, 2009).

*Treatment of Chronic Pain.* After diagnosis is verified, patients with chronic pain tend to be referred to pain management specialists, often pain centers where a multidimensional approach is initiated. This could include pharmacological, medical, and analgesic approaches that in most cases fail to alleviate pain symptoms or improve outcomes such as reduction of pain, physical range of function restoration, and symptom relief maintenance (Apkarian, Baliki & Geha, 2009). Given the limitations of existing physiological treatments for chronic pain, psychosocial approaches may hold promise for more effective intervention, as they address the underlying cognitive processes of those affected by long-term experiences of pain, such as catastrophizing, fear, depression,

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disability, and symptom severity (Apkarian, Baliki & Geha, 2009).

*CBT and Chronic Pain.* Cognitive restructuring is a component of CBT. Unrealistic thought processes that follow pain or the fear of future pain can lead to a maladaptive coping response (e.g., catastrophic thinking), which are found to be linked with higher levels of pain (Jenson, 2010). Cognitive restructuring involves teaching the patient helpful and reassuring thoughts to accompany the negative thoughts, as well as teaching the patient distraction and strategies to combat irrational thoughts. Some studies have interpreted activation in the right prefrontal cortex as correlated with a patient's beliefs about his or her control of the identified pain, as well as the analgesic response (Jenson, 2010).

Another component of Cognitive Behavioral therapy is adaptive cognitive coping in response to initial pain. Healthy cognitive coping includes ignoring pain and developing positive counter beliefs to negative thought processes (Jenson, 2010). Behavioral interventions include coping with pain by engaging in healthy behaviors, such as goal setting with hobbies, socializing, or involvement with events not related to pain. Engaging in positive interactions contributes to more relief of pain through better psychological function versus engaging in pain behaviors that increase the subjective experience of pain (Jensen, 2011). Treatment effects include such factors as rumination, self-efficacy, and control (Turner et al., 2007).

*Women and Chronic Pain.* There has been a growing amount of research in sex differences of pain experiences. It appears that women experience pain more than men, possibly due to various factors including hormonal differences, early life exposure to pain, pain coping, and stereotypical gender roles in pain ex-

pression (Bartley & Fillingim, 2013); this heterogeneity complicates the research and clinical practice in this arena. Also, women report higher rates of chronic pain related diagnoses such as fibromyalgia, Irritable Bowel Syndrome, temporomandibular disorders, chronic tension headaches, and interstitial cystitis (Fillingim et al., 2009). Interestingly, even though research supports a higher report of pain-related issues, no studies have reached a consensus on whether women experience pain at a lower threshold. Some experimental studies have not been able to replicate pain sensitivity, while others have suggested there is a greater pain sensitivity response in woman (Fillingim et al., 2009). Regarding studies on pain coping skills, women differ from men on a psychosocial level. For example, men tend to utilize distraction and problem solving techniques whereas as women use a large range of coping skills such as social support, positive statements, and attentional focus (Bartley & Fillingim, 2013). Women also report higher rates of skepticism and feeling blamed or belittled when revealing chronic pain symptoms to healthcare providers; this gender difference may help identify the various experiences of pain, specifically from a woman's perspective (Werner & Malterud, 2003).

*Rural Health, Diverse Populations, and Chronic Pain.* The needs of residents of rural areas in reference to chronic pain are unique. Due to comparatively limited access to care, low socioeconomic status (SES), and low literacy levels, barriers to treatment are structurally different in small towns in comparison to larger metropolitan areas (Thorn et al., 2011). As chronic pain is a major healthcare issue, being geographically isolated also complicates the issue and contributes to a higher risk for poor pain outcomes (All, Fried, & Wallace, 2000). The need to iden-

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tify lower cost and more effective therapeutic interventions (e.g., CBT, relaxation training) become even more pressing in these communities. A group setting, specifically with CBT would satisfy that need in rural areas. Little to no cost is associated with maintaining and facilitating a group oriented with CBT. Under the supervision of psychologists, CBT training can be manualized and constructed in such a way that technicians with little experiences may be capable to serve the community. Furthermore, specialized training or expertise (e.g. a licensed psychologist) is not always granted for this line of treatment. Many support groups similar to this framework are housed within local facilities, such as hospitals, community areas and churches; thus, expanding the opportunities to the rural population.

*Implications for CBT in Group Settings.* Cost effective treatments are ideal in rural areas due to geographic limitations and access to care challenges. Offering group treatment for women with chronic pain may improve access to services and offer a more cohesive experience for patients. The following proposed group format follows the stages of CBT according to Corey (2000). Detailed descriptions will be provided for each stage, as well as information for the possible future utilization and creation of a group for women dealing with chronic pain in a rural location.

### **Corey's stages in Cognitive Behavioral Therapy**

Out of the wide variety of interventions employed by CBT, this group would focus primarily on three components: (1) cognitive restructuring; (2) behavioral/coping training; and (3) relaxation training. Although other concepts would come into play (modeling, pain management, social support, etc.) (Corey, 2000), these three elements would be emphasized throughout the progression of the group. Intervention techniques would

include worksheets, homework (e.g., thought processes, journaling of pain, daily relaxation practice), and relaxation training for five minutes upon closing of the group. Common worksheets include the ABC's worksheet, in which A is identified by activating event, B is Behavioral outcome and C is consequence of the behavior. This assists individuals in the process of evaluating cognitive processes involved with specific events and evaluating outcomes of irrational thinking patterns.

*Initial Stage.* According to Corey (2000), the initial stage would consist of an educational component on such topics as collaborative empiricism and the uniqueness of this intervention. Over the span of approximately two to three groups, the patients should be able to define CBT and the intent of its use. Because the group would be action-focused, patients should also be willing to collaborate with the group as a whole and utilize homework assignments to the best of their ability outside the group.

*Storming/Norming (transition).* This stage consists of the leader(s) assisting the group to focus on conflict resolution instead of conflict management. Through examination of group dynamics, conflicts and power struggles can be brought to the group to resolve or explore. A major portion of this interaction in CBT involves modeling by group leader(s); the interactions group leader(s) have with group members and/or each other can teach new conflict management skills. It would be vital to initiate relaxation training (e.g., progressive muscle relaxation, hypnosis, guided visualization) at the end of each session in order to inhibit any anaphylactic response (e.g., pain flare up) because of this conflict. These interactions of examining the conflict and resolving or norming it build a stronger supportive group based on a kind of kinship (what

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Corey terms “moving beyond the security of cohesiveness”; pg. 100, Corey). This collaboration and cooperation facilitates cohesion of the group. Ultimately, it is hoped that, through identification of shared experiences of pain and challenging thought processes, a sense of closeness and opportunities for self-disclosure would arise among chronic pain group members.

*Working stage.* The working stage incorporates many of the additional interventional techniques from CBT, including modeling, behavioral rehearsal, reinforcement, cognitive restructuring, homework assignments, and problem solving (Corey, 2000). Modeling would remain consistent from the group leader(s) to ensure patients within the group are able to see representative and rational behavior. Structurally, a session could consist of a “check in” referencing a relevant topic, such as pain symptoms and coping strategies utilized over the last week; the group could then progress to a problem-solving exercise with effective feedback. Throughout and across sessions, cognitive restructuring could be utilized. If cognitive distortions arise during any part of the session, a group leader or fellow group member could bring it to everyone’s attention and assist in finding alternative ways to challenge the thinking. For example, if a group member discusses going through the steps of problem solving but states she “could not deal with the pain” in response to the situation, her peers can help her identify this unhealthy thinking. For example, some members might say in response that she *is* able to cope and has done well for herself, thereby supporting the member and helping her challenge her thinking. She can then utilize that feedback to challenge the identified problematic thinking process the following week, as an outside of group homework assignment.

*Mourning stage (termination).* The termi-

nation stage would be designated as one or both of the final two sessions, indicated clearly in the informed consent form regarding group. These sessions would focus on receiving feedback from the group, a process shown to be beneficial in the termination stage of CBT-oriented group therapy (Corey, 2000). Learning how to respond to pain symptoms with new tools is fundamental to group members receiving continued benefit from their CBT training. During this process, members would also be guided by the group leader(s) to identify potential challenges and setbacks. Effective feedback, support, and identification of individual post-group goals would be used to assist in decreasing subjective experience of pain and resolving interpersonal conflict

### **Summary and Limitations**

Although the challenges facing this population are daunting, utilizing a gender-focused, multidimensional Cognitive Behavioral Therapy and relaxation training approach may assist women in rural settings coping with chronic pain. Limitations to this format would include the potential difficulty some group members may have investing time in outside activities (e.g., such as homework around practicing healthy thinking skills or challenging negative pain responses); in those cases, group members are unlikely to benefit from this form of treatment. In addition, the rigidity of an overly-structured program might take attention away from the underlying meaning of the group member’s behavior (Corey, 2000). Despite these potential concerns, Cognitive Behavioral Therapy and relaxation training may be an attractive, gender-responsive, and cost-effective option for chronic pain treatment in women, especially in a rural geographic location.

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

### Swing Dancing Along the Spectrum: A Proposed Unique Adjunctive Treatment Approach for Individuals With Autism Spectrum Disorder

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Autism Spectrum Disorder (ASD) is a class of developmental disorders typically diagnosed during childhood. Per the current *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, ASD is characterized by social deficits and repetitive behavioral patterns, which cause clinically significant impairment, and are not better explained by intellectual disability (American Psychiatric Association, 2013). In adulthood, these deficits are associated with employment difficulties and notable lack of involvement in social activities (DeRosier et al., 2011; Gutstein & Whitney, 2002). This paper proposes swing dancing as an adjunct treatment option for high functioning adults with ASD, or those who would qualify for ASD, Level 1 in the *DSM-5*; it also includes a proposed schedule for this adjunctive treatment. Level 1 is the least severe of three ASD categories and is defined as describing individuals who require support or those who may have the ability to engage in communication, but struggle with initiating and maintaining social interaction. Swing dance is a category of social, partner dance initially set to swing style jazz music. This category most notably includes Lindy Hop, Charleston, Jitterbug and Balboa. Swing dance is an activity, which grants social structure, is typically surrounded by an accepting social culture, and helps individuals to further their physical awareness and adeptness.

This concept was born organically out of a college swing dance class at Oberlin College. I first took and later taught the class, and was moved by the level of social acceptance present in swing dance culture. Observations by students included that they knew what to expect from this social interaction, which made it more manageable; being socially awkward seemed to matter less in swing dance class; all that mattered was the dancing; the movements were so thoroughly discussed that they were easier to manage and control; and the chance of social rejection was so low that they experienced little social anxiety.

There is currently no standard care for ASD (Warren, et al., 2011); however, many clinicians advise intensive Applied Behavior Analysis (ABA) (National Research Council, 2001). ABA is an empirically supported intervention and is grounded in basic behavioral principles, including positive reinforcement, extinction, stimulus control, and generalization (National Research Council, 2001). Although ABA is considered one of the most effective treatments, it has only a modest evidence base and there is still considerable uncertainty about for whom ABA is most likely to be effective (Reichow et al., 2012). Given these realities, individuals with ASD must often use adjunctive treatments that focus on specific impairments (Granpeesheh, Tarbox & Dixon, 2009).

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Current treatment for autistic individuals often includes a focus on structured social exposure to help participants experience some relief from their social anxiety through practice (DeRosier et al., 2011). Minne and Semrud-Clikeman (2011) noted that individuals with autism thrive when placed in social situations during which they receive regular feedback and guidance about their social interactions. This treatment is correlated with participants forming stronger emotional connections with peers and parents, as well as greater self-confidence. Barnhill et al. (2002) found social skill improvement when participants were provided scripts to follow in social situations. This proposed adjunctive treatment approach provides participants with a carefully structured, accepting environment within which to practice social interaction. This proposed class is designed to teach skills that would be easily applied outside of the class. It is hoped that this proposed class would provide an opportunity for participants to form lasting friendships and a new social activity.

Swing dancing, true to the 1920s culture in which it began, is extremely rule-bound (Usner, 2001). In swing classes, structure is provided through specific social coaching, demonstration of upcoming content at the start of each session, consistent timing and order of classes, and direct and specific instruction of physical activities and social interactions. It is hypothesized that this rigid structure will align well with the rigid thought patterns typically observed in ASD individuals, and will provide social comfort by establishing clear expectations and boundaries for participants. This structure is found throughout swing dance culture, providing consistency for participants who choose to continue to participate in the swing dance community after the end of the class. Swing dance culture also includes

specific sets of social rules that reduce the chance of social rejection and make social expectations clear. These scripts are fairly uniform throughout United States swing dance culture. It is hypothesized that these established social scripts, coupled with the assurance that participants will not be rejected when they ask others to dance, will help ease the experience of social anxiety often experienced by individuals with ASD (DeRosier et al., 2011). Swing dancing exists in a culture of acceptance, a culture in which it is okay to be different. As Paul Parish noted, when discussing the 1930s swing culture, “there were no prejudices at all; dancers could weigh 300 pounds, be white, or have only one leg—it didn’t matter ... if they could dance” (Parish, 1999, p. 52).

Dance Movement Therapy (DMT) has been found to be an effective treatment for individuals with many diagnoses, including autism (Ritter & Graff Low, 1996). DMT is defined as using movement as an avenue to further emotional and physical individual integration (Ritter & Graff Low, 1996). DMT provides participants with an active, multisensory environment. This proposal for swing dance best fits under the category of DMT, though most DMT is not partner dance. DMT is correlated with an individual sense of security, improvement in body schema and nonverbal expression, and with an increased sense of connectedness (Behrends et al., 2012).

Studies support the importance of aerobic exercise for individuals with autism and recognize that exercise must be “intensive” in order to be therapeutic (Szot, 1997). Aerobic exercise is correlated with a decrease of problematic behaviors in autistic participants, including a reduction in stereotypic, repetitive behaviors (Szot, 1997; Elliot et al., 1994). Swing dance is an athletic, vigorous form of

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exercise. A great deal of practice is also involved in this proposed class in order to account for the increased level of clumsiness found in individuals with ASD (Green et al., 2002).

McGarry and Russo (2011) note that mirroring opportunities provide participants the chance to increase emotional understanding and empathy. DMT provides prescribed mirroring experiences in choreographed dance, in lead/follow partnered dances, and with the mirroring of emotional themes in music. McGarry and Russo (2011) also found a correlation between movement synchrony and ratings of empathy, meaning that the experience of dance is correlated with a greater feeling of empathy. These researchers draw a parallel to other forms of therapy that focus on the practice of mimicry, including mimicry in more typical individual and group talk psychotherapies, and note the general improvement in social behaviors by autistic participants.

This proposed class is similar to the author's previously employed college syllabus, with certain changes made in order to better serve ASD participants. It is a ten-session class that includes instruction for East Coast, Lindy Hop, and Charleston. (The proposed schedule can be seen in Table 1: Proposed Adjunctive Treatment Schedule, available in the online version of the Bulletin at <http://www.divisionofpsychotherapy.org/publications/psychotherapy-bulletin/>).

Like a typical swing dance class, this class could be taught by swing dance teachers without psychological training. However, it would be beneficial for the teachers to familiarize themselves with the DSM-5 ASD, Level 1 diagnosis (American Psychiatric Association, 2013), in order to better assess which participants will be a good fit for the group and in order to better understand participants'

needs. The format of the class does not require teachers to engage in specific psychological interventions or counseling—but it does require patience, understanding, and a particular educational approach which may be novel to some instructors, and may require practice to master. Dance instructors without previous psychological training would benefit from autism awareness and may even benefit from specific training in facilitating a class with individuals with high functioning ASD. The swing class would benefit from a variety of teaching methods, including modeling, one-on-one instruction, and a great deal of repetition and practice. Corbett et al. demonstrated the efficacy of modeling as a teaching method for individuals with ASD (Corbett et al., 2011). In addition to modeling swing dance movements, it will be important for instructors to also model social scripts and open communication about potential social and physical discomfort. A high level of repetition and practice is suggested for this class. Partnered dancing requires a physical understanding of both self and other, meaning moves are typically difficult to master. In the college setting, this class was able to accommodate up to 50 participants at a time. However, due to the increased physical difficulties (Green et al., 2002) and social anxiety (DeRosier et al., 2011) that high functioning ASD participants may experience, it is proposed that this class include a lower number of participants (10 to 20), allowing for five to ten rotating couples.

Individuals with high functioning ASD have a tendency to have specific, narrow, and specialized interests (American Psychiatric Association, 2013), so swing dancing may not be a good fit for all those who qualify for the class. Swing dancing is also a highly social activity and may be particularly daunting for those with higher levels of social anxiety.

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In addition, swing dancing requires a great deal of physical touching, which may be off-putting for some ASD individuals who may be particularly sensitive to physical touch. Some of this discomfort may be alleviated if group instructors are able to engage participants in meaningful conversation surrounding their concerns and help participants to progress slowly in conjunction with their comfort level. However, some individuals may still determine that this adjunctive treatment is not a good fit for them.

Empirical research is required to properly assess this proposal. Questions include, but are not limited to, the following: Would gains achieved in a swing dance setting be generalizable to other social and physical activities? How long would the gains achieved be maintained? Would participants continue to utilize swing dancing and swing dance social skills and continue in community activities? It is vital for this proposal to be properly researched in order to determine efficacy. It is my hope that this theoretical proposal can serve as a backbone or introduction to future research in using swing dancing as a new form of DMT for the high functioning ASD population.

In conclusion, swing dancing is proposed as an adjunctive therapy to help young adults on the Autistic Spectrum Disorder (ASD) to improve their social and kinesthetic abilities. Dance Movement Therapy (DMT) has been shown to be an effective treatment to help participants decrease social anxiety, and increase physical awareness and comfort. Swing dancing is a partner dance that serves to expand upon DMT's effectiveness by providing increased opportunities for participants to practice mirroring in a safe, structured social environment with step-by-step physical instruction. This proposed class would be generalizable and would introduce participants to a social activity that they can be involved in within the community. New treatment options are necessary, as most treatment for individuals with high functioning ASD is aimed at children and adolescents, leaving few options for adults. It is important that research follow up on this proposal to empirically test the efficacy of swing dancing as an adjunctive therapy for young adults with ASD.

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



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## STUDENT FEATURE

### Career Considerations for Clinical Psychology Psy.D. Students

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#### Introduction

A large number of clinical psychology doctoral students graduate each year, half of whom are from Doctorate of Psychology (Psy.D.) programs (American Psychological Association, 2010). Statistics compiled by the Association of Psychology Postdoctoral and Internship Centers (APPIC, 2011), demonstrate that Psy.D. students represent 45% of all students in the yearly national internship match (APPIC, 2011). Unfortunately, these students tend to have higher student loan debt than their counterparts, Doctorate of Philosophy (Ph.D.) students. Psy.D. students' average debt is \$123,787, compared to an average of \$53,160 for Ph.D. students (APPIC, 2011). A 2009 American Psychological Association (APA) salary survey reported an average salary for licensed doctoral level clinical psychologists (based on 1,750 valid responses) of \$87,015 (Finno, Michalski, Hart, Wicherski, & Kohout, 2010). In hopes of reducing Psy.D. student debt and building satisfying careers, this paper aims to in-

form Psy.D. students of their employment opportunities and provide loan repayment considerations.

#### Employment Settings

Work opportunities for Psy.D. graduates include psychotherapy, assessment, supervision, consultation, administration, teaching, and research. These activities take place in governmental organizations, the armed forces, community mental health centers, correctional facilities, educational settings, academia, college counseling centers, medical settings, corporate organizations, and independent practice. These settings have various hiring requirements, offer differing compensation packages, and ranging of levels of autonomy and flexibility, which will be reviewed and condensed below. Table 1 summarizes career options for Psy.D. graduates.

*Veteran Affairs.* In 2012, the Department of Veterans Affairs (VA) announced a plan to hire 1,600 additional mental health professionals, making it the  
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largest employer of psychologists in the United States (Dao, 2012). Despite this fact, getting hired is actually quite difficult. The positions are competitive, with several dozen applicants for each available position, which is largely due to the VA's benefits, competitive pay, and job security. Psychologists with the VA are generally hired at an initial pay grade of GS-11 (early career staff psychologist), with promotion potential to a GS-15 (Director, Center of Excellence). Compensation for these positions ranges from approximately \$57,000 to \$150,000 annually plus a comprehensive benefits package (medical, dental, retirement). These positions require the applicant to have completed both an APA accredited doctoral program and an APA accredited internship. In most cases a current, unrestricted state license is recommended, but often this requirement can be waived for a maximum of two years from the date of hire. Interested applicants can view VA jobs at [www.vacareers.va.gov](http://www.vacareers.va.gov) or [www.usajobs.gov](http://www.usajobs.gov). It should be noted that the VA has part time positions and offers up to ten veteran preference points (if qualified) for military veterans.

*Armed Forces.* Another employment opportunity for Psy.D. graduates, especially those interested in working with military personnel, is within each branch of the armed forces. There are three primary ways for individuals to obtain these positions: as government contractors, via a military scholarship, or by joining the military post-degree as a psychologist. For those individuals who are hired as contract psychologists, these positions are paid according to the government GS pay scale (similar grade to the VA). These positions vary widely in scope of practice, from performing direct client care in mental health clinics to advising policy makers or providing psychological expertise to specialty units (Special Forces, training schools,

survival, escape and evasion conditioning etc.). In terms of entering the armed forces through scholarship, each branch of the military also offers full scholarships for students pursuing graduate degrees in psychology. These scholarships typically require that the individual complete the application process with a military recruiter. If the applicant is successful, the student can receive up to two years of full tuition, plus books and fees. They will also receive a monthly stipend of approximately \$2,000. Upon graduation they will be commissioned as an officer and be required to serve at least one year for each year they were on scholarship. Another option is to join the military as a psychologist after a doctorate degree and licensure have been obtained. Similar to those receiving the military scholarship, these individuals are commissioned as officers and are eligible to receive loan repayment. The Army Loan Repayment Program offers up to \$65,000 in loan repayment for psychologists (Clark, 2012). More information on all of these programs can be obtained by visiting [www.usajobs.gov](http://www.usajobs.gov) to find out about current openings or a local military recruiter to with whom to discuss the health professions scholarship program.

*Department of Corrections.* Correctional facilities offer another unique employment setting for Psy.D. graduates. In correctional settings psychologists balance the needs of incarcerated individuals while ensuring the safety of the community and the correctional facility (Boothby & Clements, 2000). Licensure is required for these government positions. These positions generally offer full benefits, including relatively generous vacation packages, and salaries ranging from \$69,000 to \$80,000 (Todd, 2008).

*Community Mental Health.* Community mental health centers are another em-  
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ployment setting for Psy.D. graduates. In these settings, psychologists tend to work with severe and persistent mental illness, as well with primarily low-income, Medicaid, and uninsured individuals. In 2008, over 17 million people utilized mental health services at community mental health centers across the United States (Wells, 2010). For interested applicants, having a license is generally preferred for positions, which range from part-time to full-time. The positions generally offer comprehensive benefits with salaries ranging from \$63,000 to \$80,000 (Finno et al., 2010).

*Educational Settings.* Other settings that allows Psy.D. graduates the opportunity to participate in a variety of activities are elementary, middle, and high schools. In these placements, a large component of the psychologist's work entails psychoeducational assessment. It is estimated there are approximately 42,060 jobs in these settings for psychologists (Todd, 2008).

*Academia.* For Psy.D. students considering working in academia after graduation, starting as an adjunct professor can be a great way to get a "foot in the door." As an adjunct professor, a psychologist may have the opportunity to teach undergraduate and graduate level courses. Responsibilities of an adjunct professor typically include creating a syllabus, preparing and delivering lectures, and leading classroom discussions. Grading and evaluating students' assignment and holding office hours are additional job requirements. Compensation for adjunct positions varies by type of institution and program, but typically ranges from \$3,000 to \$4,500 per course at the graduate level (Wicherski, Hamp, Christidis, & Stamm, 2014). While traditional benefits are not typically available for adjuncts, most programs offer certain privileges, such as access to the Employee Assistance Program, entry to the

library, reduced memberships at the gym, and discounts at the bookstore as well as other school-affiliated events. Working as an adjunct professor can provide recent graduates with flexibility and opportunities for building connections with other well-established professionals in the field. In addition to adjunct positions, Psy.D. graduates should consider pursuing clinical and tenure-track positions at psychology professional schools and in Psychology Departments at universities. These positions may prefer teaching experience or prior work as a teaching assistant, but it is not always a requirement. Developing an area of expertise and/or showing that you have published in a specialty area can create opportunities for teaching positions.

*University Counseling Centers.* Psy.D. graduates can work in one of approximately 677 university counseling centers across the nation that serve undergraduate and graduate students, as well as staff and other members of the college community (Mack, 2004). At university counseling centers there are often opportunities for early-career psychologists who are license-eligible. Salaries range from \$54,000 to \$78,000 (Finno et al., 2010), with comprehensive benefits packages. Many university counseling centers offer flexible paid and unpaid vacation, due to the varying seasonal demands of the counseling center.

*Medical Settings.* Psy.D. psychologists can work in a variety of medical settings. Health care settings allow a psychologist to work in many capacities, such as a behavioral health consultant, psychotherapist, assessor, crisis interventionist, and rehabilitation specialist. Psychologists work in inpatient and outpatient settings. Employment in medical settings typically requires licensure and a degree from an accredited doctoral

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program and internship. Often medical settings have a preference for several years of experience. Salaries can range from \$60,000 to \$120,000, depending on the setting and position (Finno et al, 2010).

*Organizational Settings.* Another area of employment for Psy.D. graduates in industrial-organizational (I/O) psychology. This type of work entails collaborating with organizations to improve productivity, retention, team cohesion, and anti-discrimination practices in businesses, with salaries ranging from \$55,000 to \$200,000. In a down economy, psychologists who can help companies make sound selections and human resource decisions, boost employee engagement, and help people improve work performance are in high demand (Novotney, 2011). A degree or relevant training in I/O psychology is preferred (Todd, 2008).

*Consultation.* Consultation is another area career option for Psy.D. graduates. Block (2000) defines a consultant as “a person in a position to have some influence over an individual, group or organization but who has no direct power to make changes or implement programs.” Being a clinical psychology consultant involves applying clinical or research skills in a variety of settings. It also requires flexibility and creativity. A survey of current consultation psychology jobs advertised on Indeed.com, for example, lists a variety of clinical psychology consultation jobs in areas of business administration, management, forensics, behavioral health, organizational development, and research, with a salary range of \$30,000 and \$110,000.

*Independent Practice.* Independent practice is often chosen by Psy.D. psychologists who seek to specialize in psychotherapy and/or assessment. Approximately half of all psychologists who deliver mental health services work

primarily in private practice (DeAngelis, 2011). Private practice has many benefits such as autonomy, financial gain, and flexibility in terms of time and schedule (DeAngelis, 2011; Bureau of Labor Statistics, 2013). In a difficult economy, starting a private practice after graduate school can be challenging due to lack of business training, community connections, and clientele (DeAngelis, 2011). Those who lack business experience can benefit from consultation from experts in accounting, taxes, and mental health law, and with practitioners in established private practices. The Practice Institute (<http://thepracticeinstitute.com/>) is one such organization that offers free monthly webinar, phone consultation, articles, and a home study course for individuals starting a private practice. Another resource is The American Psychological Association’s Division of Private Practice (<http://www.division42.org/>), which offers consultation, resources and opportunities for networking.

### **Other Strategies and Considerations**

There are a number of helpful strategies to assist young professionals in beginning their private practice careers. Psychologists starting out in independent practice may benefit from developing a niche, paying attention to social, geographical, and political trends. Psychologists are encouraged to develop a plan that includes a mission and values statement. Prior to starting a private practice, it is imperative to that psychologists understand the potential income factors and to create a budget. A useful tool to start to calculate these figures is available at <http://thriveworks.com/blog/private-practice-profit-calculator-how-much-can-you-make/>. It is important to note, however, that this tool does not calculate the amount of taxes one is required to pay. Clinicians in private practice can pay up to 35% of their income in

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taxes; this figure varies by individual, state, and by available deductions (Internal Revenue Service, 2013). Additionally, independent practitioners must note that administrative activities, such as charting, consultation, and referrals, will be unpaid.

*Postdoctoral Fellowship.* Postdoctoral clinical, counseling, and research fellowship positions have become popular and increasingly important in obtaining licensure and employment). Obtaining a postdoctoral position is beneficial in many ways (Smith-Bailey, 2004). These positions offer advanced training in a specialty area, clinical hours for licensure, pay equivalent to starting salaries for other entry level clinical psychology positions, and student loan deferment. Positions usually range in duration from one to two years and have salaries ranging from \$20,000 to \$40,000 (APA, 2013; Kirshstein, 2012). Finding a postdoctoral fellowship position can prove challenging. One challenge is that there is no unified application or notification process. This requires interested applicants be willing to use several different methods to learn about potential positions (Kuo, 2012). To help remedy the issue, the APA has a postdoctoral fellowship listserv to which students can subscribe that allows them to receive emails regarding available postdoctoral positions all over the country (Kuo, 2012). As well, the APA offers a database of postdoctoral positions. The limited availability of positions has made obtaining a postdoctoral fellowship challenging and highly competitive. Obtaining a position may entail travel costs, which may prove difficult for an internship student. While acquiring a postdoctoral position may require time, research and financial cost, there are many demonstrated benefits.

*Loan Repayment.* Given the state of the economy and competition for employ-

ment positions, it has become increasingly important that Psy.D. graduates remain abreast of career options. Although the development of a niche has previously been the most viable route in securing a position, it no longer guarantees the ability to acquire gainful employment. Unfortunately, this dilemma is further compounded by Psy.D. students' increasing educational loan debt. Because entering the field of psychology may not be paired with a large paycheck, a number of repayment options have been developed to encourage graduates to continue to work with vulnerable and at-risk populations. According to the Federal Student Aid website, some of the available loan repayment options include pay-as-you-earn, income-based, and public service forgiveness (<http://studentaid.ed.gov/repay-loans>). The repayment options can allow graduates to pay up to a percentage of their income towards their loans, which offers considerable financial relief. It is important to note that anecdotal reports indicate some graduates have had problems with getting their loans repaid. For example, graduates often realize, after consolidating their loans, that they are no longer eligible for certain repayment programs. Therefore, graduates should contact their loan originator or servicer before beginning to pay on their loans, to confirm the type of loans they possess, repayment options and the conditions associated with that particular loan.

### **Recommendations**

A workforce analysis for the field psychology is strongly encouraged. While there is a considerable amount of unmet mental health need in the U.S., there also seems to be a lack of funding and positions. With substantial changes to health care in the foreseeable future, including the Affordable Care Act, increased clar-

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ity about funding sources and where clinical psychologists are needed is necessary. In addition, it is important that students be aware of existing loan repayment programs. It is strongly recommended that academic programs review information regarding student loan debt and repayment programs during the admissions process, so that students can be fully informed before matriculating.

**Summary**

Overall, Psy.D. graduates should be encouraged about their career prospects. A 2009 survey of graduates from the Graduate School of Professional Psychology at the University of Denver revealed that, despite increasing student debt, graduates were highly satisfied with their careers (Burgamy et al., 2009).

As noted here, a wide variety of career options are available to Psy.D. graduates. According to Kuther (as cited in Novotney, 2011), the level of success a graduate achieves can be dependent on thinking about the skills he or she has developed and how they might best be put to use in forging careers in both traditional and in new settings. While earning a clinical psychology degree can be costly, the clinical psychologist tends to be equipped with skills that can be focused on specialty or diverse areas, providing many opportunities for financially successful, meaningful, and rewarding careers.

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## Leaving on a Jet Plane

Pat DeLeon, Ph.D.

Former APA President



This Spring's Practice Directorate State Leadership Conference (SLC) was appropriately titled, "Creating Roadmaps for Practice." Last year Executive Director

Katherine Nordal reminded those attending that: "The clock is ticking towards full implementation of the law [President Obama's Patient Protection and Affordable Care Act (ACA)] and January 1, 2014, is coming quickly. But January 1<sup>st</sup> is really just a mile maker in this marathon we call health care reform. We're facing uncharted territory with health care reform, and there's no universal roadmap to guide us. What many of our practitioners increasingly will need to promote: the value and quality they can contribute to emerging models of care. I believe that if we are not valued as a health profession, it will detract from our value in other practice arenas as well. So regardless of how we feel about the current state of our health care system, psychology must take its seat at the table and contribute to the solutions needed to fix our ailing system." SLC continues to be, in my judgment, one of the highlights of APA's year. The leaders of our profession from around the country get a first-hand glimpse of the policy/political forces that are impacting their daily professional lives. Perhaps most importantly, our next generation of colleagues is actively encouraged to become involved in shaping the future of *their* profession.

The 500+ colleagues in attendance this year—including President Nadine Kaslow and President-elect Barry

Anton—heard an inspiring vision from Katherine: "The way the [ACA] is unfolding reminds us that no single advocacy strategy for psychology can address the diverse legislative, regulatory, and marketplace environments we see from one state to another. The landscape continues to take shape. Speaking of landscapes, you know as well as I that the professional terrain for psychologists—and other health care providers—has been somewhat rocky in recent years. Disruption and demands on practitioners have raised anxiety levels. Meanwhile, our country still doesn't pay nearly enough attention to mental health and substance use treatment. We've carved out this treatment from medical care and made people jump through hoops to get the psychological services they need. Mental health care is chronically underfunded. About 20% of our population experiences a mental health disorder in any given year, compared to a lifetime incidence of 6% for adults with cancer. Health care reform implementation is a work in progress. And there are hopeful signs, especially related to the goal of increasing the ranks of Americans with health insurance coverage. Keep in mind that all enrollees in the new health insurance exchange plans benefit from federal requirements for mental health parity. As we confront serious problems and the uncertainty of a health care system in flux, psychology continues to demonstrate that we're poised to face those challenges.

"Many psychologists know that we scored a major win regarding Medicare

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payment in 2014. In essence, we reversed the downward payment trajectory for psychological services. The 2014 Medicare fee schedule marked the first time since 2007 that the payment pool allocated for Medicare psychological services increased. The 8% jump meant that psychologists gained the second highest increase in payment allocation among all Medicare provider groups for 2014. A combination of professional, marketplace, legislative and regulatory developments encourages more collaborative, multidisciplinary practice models. The demand for evidence-based practices and the use of quality measures related to process and outcome, including behavioral health measures, will grow. And the increasing use of technology for electronic health record keeping and telepsychology service delivery will continue to evolve.

“Many of our members seem attuned to this evolution. In a survey last fall, we asked what specific changes members were likely to make in their practice over the next three to five years. Nearly half of respondents indicated they will increase their use of technology for professional purposes. And one-third of all respondents said they ‘will further diversify practice activities and skills.’ That was particularly true for our early-career respondents. Again, there is no single optimal path forward for practitioners. We need lean, mean advocacy machines to protect our seat at the table and move psychology forward as the health care marketplace evolves. Psychology is a learned profession filled with smart, creative people. We achieve good results when psychologists get energized and commit themselves to making positive things happen. These experiences fill me with optimism as I look down the road toward our practice future. Let’s all continue putting to good use our collective energy and enthusiasm for the profession we love. Our pa-

tients, our profession and our future are depending on leaders like you!”

### **A Special Vision for the U.S. Army:**

This April, the Senate Appropriations Committee invited the three military Surgeons General to testify on their budget priorities for the coming fiscal year. Interestingly, the DoD announcement regarding the hearing highlighted the critical role their mental health and psychological providers play in the achievement of the services’ underlying mission. The U.S. Navy Surgeon General noted: “Psychological Health is an important component of overall force health protection. We recognize that prolonged operational stress can have potentially debilitating consequences.” This institutional appreciation of the value of mental health care represents a fundamental change in the historical DoD posture and, as the nation steadily implements the ACA with its emphasis upon encouraging comprehensive and holistic systems of care, speaks well for the potential future of all behavioral and mental health disciplines.

The U.S. Army Surgeon General Patricia Horoho consistently reminds her colleagues that the Army health care system only sees its beneficiaries 100 hours a year. And, that what the Soldiers and their Family Members do during the rest of the time has a significant impact upon their overall health status. “Since 1775, America’s medical personnel have stood shoulder to shoulder with our fighting troops, received them at home when they returned, and been ready when called upon to put their lives on the line. While the wounds of war have been ours to mend and heal during a period of persistent conflict, our extraordinarily talented medical force also cared for the non-combat injuries and illnesses of our Soldiers and their Families. It is an honor to serve as the commander of this

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outstanding healthcare organization, caring honorably and compassionately for our 3.9 million beneficiaries ....

“Our medical teams have achieved the highest combat survival rates in history. Multiple improvements in battlefield medical care ... have contributed to the all-time high survivability rate of 91% during Operations Enduring Freedom and Operations Iraqi Freedom despite more severe and complex wounds. Moreover, our unwavering support of wounded, ill, or injured Soldiers has allowed necessary healing and recovery, and enabled a 47% return to duty rate for the Force. This translates to a cost-avoidance to recruiting and training of \$2.2 billion. We also have considered the long-term impacts of war, recognizing that not all combat injuries are visible. The rapid coordination of traumatic brain injury screening and clinical practice guidelines allowed for our in-theater concussive care centers to provide a 98% Return-to-Duty rate. In addition, by embedding capabilities such as behavioral health and physical therapy with deployed units, we provide early intervention and treatment, keeping the Soldier with the unit and decreasing the requirements to evacuate Soldiers from theater. Through a combination of efforts, suicides in Active Duty Soldier ranks fell from 165 to 126 in 2013 .... To maintain a ready and deployable Force, our Nation’s Total Army requires a comprehensive System for Health designed to maximize the fighting strength, prevent disease and injury, build resiliency, and promote healthy behaviors .... Our readiness platforms include ... programs and initiatives designed to improve healthy behaviors, such as the Performance Triad of healthy sleep, activity, and nutrition, increase the health and resilience of our Soldiers to better prepare them for challenges unseen.”

Lt. General Horoho pointed out that

since September 11, 2001, more than 1.5 million Soldiers have deployed and many have deployed multiple times. Our nation has never endured two simultaneous conflicts for this length of time. The Army is charged with being prepared to face tomorrow’s challenges. As Katherine emphasized, there will be an increased reliance upon evidence-based guidelines and the Army is a good example. “Wartime medical lessons learned have led to over 36 evidence-based, battlefield-relevant Clinical Practice Guidelines that have decreased combat morbidity and mortality .... While research in civilian medicine can take 16 years to integrate findings into clinical practice, through collaboration with organizations such as the Defense Centers of Excellence and the Defense and Veterans Brain Injury Center, we are able to more rapidly translate research findings into the latest guidelines, products, and technologies. Improved data sharing between agency, academic, and industry researchers accelerate progress and reduce redundant efforts without compromising privacy. This rapid coordination is what led to a 98% RTD [return-to-duty] rate in theater for those Service Members treated at our Coordinated Care Centers in Afghanistan. In August 2013, the White House released the National Research Action Plan (NRAP) mandating interagency collaboration to better coordinate and accelerate TBI and psychological health (including suicide) research. MRMC [Army Medical Research and Materiel Command] is working closely with other federal agencies such as National Institutes of Health (NIH), National Institute of Neurological Disorders and Stroke (NINDS), National Institute on Disabilities and Rehabilitation Research (NIDRR) and the Department of Veterans Affairs (VA) to execute the President’s National Research Action Plan.”

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“A key element of our Warrior Ethos is that we never leave a Soldier behind on the battlefield. This commitment extends beyond the battlefield to the unwavering commitment of Army Medicine .... As an Army, as a military, and as a Nation, we have a global influence on medicine and health .... Women have been a part of America’s military efforts since the Revolutionary War. As their roles continue to evolve, Army Medicine recognizes the unique health concerns of women in the military. Females make up 15.8% of the Force today—including Active Duty and RC [reserve components]—and the percentage of women continues to grow, up from about 4% from 20 years ago .... The Army is the first military service to focus specifically on women’s health issues, particularly related to deployed environments.

“We are aggressively moving from a healthcare system—a system that primarily focused on injuries and illness—to a System for Health that now incorporates and balances health, prevention and wellness as a part of the primary focus for readiness. Through early identification of injury and illness, surveillance, education, and standardization of best practices, we are building and sustaining health and resiliency. This also moves our health activities outside of the brick and mortar facility, brings it outside of the doctor’s office visit, and into the lifespan where more than 99% of time is spent and decisions are made each day that truly impact health. We are investing on research focused on prevention .... We recruit Soldiers, but re-enlist Families .... We have an enduring obligation to the men and women in uniform, to their Families who serve with them, and to the retired personnel and Families who have served in the past.... The Army Medicine Team is proudly Serving to Heal, and Honored to Serve.”

**Telehealth/Telepsychology:** One of the most intriguing workshops at SLC was chaired by Deborah Baker—“Developing a Roadmap for Telepsychological Practice.” Already 21 states have affirmatively addressed the issue of insurance reimbursement for Telehealth services, with an additional 19 state legislatures currently considering legislation. The underlying issue of licensure mobility/portability is complex. For example, does the locus of the patient or provider or both provide the legal authority for licensure board jurisdiction? Thoughtful views from the APA Insurance Trust (Jana Martin) and the Association of State and Provincial Psychology Licensing Boards (ASPPB) (Fred Millan) were shared—all clearly seeking ways to ensure that psychology will be responsive to the dramatically evolving health care environment. Will, for example, a special licensure category be established for providing Telepsychology care? It was refreshing to hear how proactive the joint APA-ASPPB-Insurance Trust taskforce, co-chaired by Fred and Linda Campbell, has been during its deliberations. Steve DeMers pointed out that ABPPB has received a special grant from the Health Resources and Services Administration (HRSA) to address the underlying issues. In her testimony, Surgeon General Horoho noted that the Army currently offers care via Telehealth in multiple medical disciplines across 18 time zones and in over 30 countries and territories. In fiscal year 2013 the Army provided over 34,000 real-time patient encounters and consultations between providers in garrison and over 2,300 additional encounters in operational environments. While the Army provides care via Telehealth in 28 specialties, Tele-Behavioral Health accounts for 85% of the total volume in garrison and 57% in operational environments, with over 2,000 portable clinics

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ical video-conferencing systems having been deployed to support Behavioral Health providers across the globe. The April *APA Monitor* reported that 44% of veterans returning from Iraq and Afghanistan come home to rural ZIP codes. The shortage of health care providers of all specialties in rural America has been well documented. Telehealth/Telepsychology is increasingly becoming a viable response to this critical national need.

**The Substance Abuse and Mental Health Services Administration (SAMHSA):** In submitting her Fiscal Year 2015 budget justification, the Administrator of SAMHSA echoed many of the themes raised by Katherine at SLC. “Our nation stands at a critical crossroad. Recent tragic events and the Administration’s call to action on the mental health and well-being of our citizens have spurred critical public health investments. At the same time, our health care system is preparing for the influx of individuals now eligible and enrolling for coverage. The Mental Health Parity and Addiction Equity Act, along with the Affordable Care Act, also requires coverage for mental or substance use disorders to provide the same level of benefits as is provided for general medical/surgical treatment. Yet, millions of Americans do not receive the help they need. It is time for our country to address these issues, and SAMHSA must lead the way .... Behavioral health problems contribute to early death, disability, lost productivity, and high health care costs. But if we intervene early, we can save lives and lower these costs. Despite the existence of effective treatments, it typically takes more than six years for people to receive treatment after the onset of a mental illness or substance use disorder. The FY 2015 Budget Request includes funding to help teachers and other individuals who interact

with youth recognize early signs of mental illness, and to improve referrals and access to mental health services for young people ages 16 to 25.” The budget emphasizes SAMHSA’s responsibility to help the nation act on the knowledge that behavioral health is essential for health; prevention works; treatment is effective; and people recover from mental and substance use disorders.

Two of SAMHSA’s proposed Strategic Initiatives are Health Care and Health Systems Integration and Health Information Technology. The first Strategic Initiative focuses on health care and integration across systems, including systems of particular importance for persons with behavioral health needs such as community health promotion, health care delivery, specialty behavioral health care, and community living needs. Integration efforts will seek to increase access to appropriate high quality prevention, treatment, recovery, and wellness services and supports; reduce disparities between the availability of services for mental illness (including serious mental illness) and substance use disorders compared with the availability of services for other medical conditions; and support coordinated care and services across systems. The Health Information Technology Strategic Initiative will ensure that the behavioral health system—including states, community providers, patients, peers, and prevention specialists—fully participate with the general healthcare delivery system in the adoption of Health IT, including interoperable electronic health records (EHRs), and the use of other electronic training, assessment, treatment, monitoring, and recovery support tools, to ensure high-quality integrated health care, appropriate specialty care, improved patient/consumer engagement, and effective prevention and wellness strategies.

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**A Critical Agenda—The Elderly:** As Katherine pointed out at SLC, psychology is one of the “learned professions.” As such, we have a societal responsibility to provide proactive leadership. Former Hawaii Psychological Association (HPA) President Terri Needels: “Thanks for the letter about long-term care. I am increasingly concerned about the way that Medicare does not address the needs of patients with Alzheimer’s or dementia if they are not incontinent. I am seeing more and more caretakers who are utterly exhausted and beside themselves trying to care for a family member with Alzheimer’s at home. Their family members are wandering around during the day, getting lost, falling, and are at risk for exploitation and harm while the caretakers are at work. The caretakers are reporting that they can’t get their loved ones into nursing homes unless they are incontinent. Does this sound correct? I am not an expert on the admission rules but am really concerned and appalled that the system (if this is really true) would only allow admission into a high level of care if someone has a physical, rather than psychological, difficulty. Medicare must cover memory care or we are going to be facing a huge social crisis in the near future. Who is taking responsibility for changing this? I would certainly be willing to work on supporting proposals for the necessary changes in coverage. I have clients who would be willing to testify and I imagine there are many other providers treating clients with similar situations. Seems to me that I worked on this a long time ago.” If psychology will not act on behalf of our patients and their families—who should we reasonably expect will?

**Wisdom From The Past:** This Spring I had the opportunity of returning to Purdue University where I obtained my psychology degree. A fellow graduate, Angela McBride, was present and we were able to reflect upon our personal journeys. She is a “living legend” within the nursing profession, having retired as Dean of the Indiana University-Purdue University (IUPUI) School of Nursing, which is the largest in the nation (if not in the world). Visiting with my major professor, Clifford Swensen, was a definite highlight: “Having been involved in politics, and for a long time in university politics, there are some things I have observed. 1.) Any change hurts somebody. Who is being hurt and how can you ameliorate that? 2.) The status quo has a lot of vested interests. Where are they and how can you alleviate their concerns? 3.) Any change brings about unanticipated, undesirable side effects. How can you anticipate them as much as possible, but more important have in place means of coping with and ameliorating them? 4.) Opponents are not evil enemies. They are people who have a vested interest somewhere and have a different point of view. 5.) In any fight, the objective and overall purpose often gets lost, and the goal is simply to win the fight. The longer I observe, the more I am convinced that a lot of conflict is based on the last item.” Is it any wonder that at the federal level, and we expect with the implementation of the ACA, change often takes significantly longer than initially expected? All my bags are packed, I’m ready to go.

Aloha.



## BOOK REVIEW

### **Book Review of *Caribbean Healing Traditions: Implications for Health and Mental Health*. Edited by Patsy Sutherland, Roy Moodley, and Barry Chevannes. New York: Routledge, 2013, 280 pp. ISBN 9780415842334.**

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In the opening forward of this edited book, Dr. Suman Fernando notes that healing traditions have been an important part of all human societies “from time immemorial—they may well be a *sine qua non* of the very existence of human beings as social beings” (p. xv). The main goal of this book is to take the reader on a journey through the many healing traditions found in the Caribbean and the rich history surrounding these traditions. Our voyage takes us from Haiti and the rituals of *Vodou* (Chapter 6) to the practice of *Santería* in Cuba (Chapter 8) to *Revival*, an indigenous religion practiced in Jamaica (Chapter 10) as well as many others. The emphasis is always on expanding our awareness of these healing traditions from historical, theoretical, and empirical perspectives. The editors note that the Caribbean constitutes one of the world’s largest mobile societies, with a growing number of Caribbean individuals living outside of the Caribbean. Therefore, this book targets health and mental health professionals who may encounter these healing traditions in their work with clients in the United States and elsewhere.

The book is divided into four parts and 19 chapters, with all chapters aimed at promoting knowledge and understanding of Caribbean healing systems and communicating an urgency to integrate these healing traditions into psychology and other health professions. Part I be-

gins with a thorough description of the history, philosophy, and development of Caribbean healing traditions. In Chapter 1, Patsy Sutherland does an excellent job of anchoring the reader by first providing a definition of healing traditions as “the practices and knowledge that existed before the beginnings of modern medicine that are used to promote, maintain, and restore health and well-being” (p. 15). These practices are based on the idea that numerous ancestral spirit entities, gods, and deities animate the world and that these spirits frequently intervene in everyday life. It then becomes the responsibility of treatment providers to be aware of how belief in these spirits might influence the lives of their clients in both positive and negative ways.

Sutherland expertly reviews for the reader how colonialism, slavery, indenturedship, and the plantation economy shaped and reshaped healing traditions in the Caribbean over time. Most notably, she argues that traditional healing practices exist and continue to exist to meet the healthcare demands of the Caribbean people when modern medicine is unavailable. During colonial times, Shamans and other healers were often able to reach people who lacked access to or were distrustful of the medical practices advocated by their colonial masters. These healers became invaluable in meeting the healthcare needs of their people.

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In Chapter 2, by Wendy Crawford-Daniel and Jicinta Alexis, the focus shifts to the importance of the biopsychosocial model, which stresses the biological, psychological, and social components of health and illness, in treatment with Caribbean clients. The authors note that when Caribbean individuals meet with Western healthcare providers, they often do not mention their use of healing practices. This lack of communication impacts treatment and fosters a sense of secrecy that impairs the working alliance between practitioner and client. Providers must ask about healing beliefs in an open and nonjudgmental manner.

Part II is truly the gem of this collection. This section focuses on specific traditional healing practices and types of healers found in the Caribbean, such as *Obeah* (Chapter 5), *Vodou* (Chapter 6), *Sango* (Chapter 7), *Santería* (Chapter 8), *Espiritismo* (Chapter 9), *Revival* (Chapter 10), and *Spiritual Baptists* (Chapter 11). Each of these chapters immerses the reader in the rich history as well as the unique practices offered by each healing tradition. As a reader unfamiliar with many of these healing traditions, I was struck by the similarities across the different practices. Most notably, all chapters emphasize solidarity and belongingness as important components of the healing traditions. This sense of community allows Caribbean individuals to remain connected to ancestors and family members, even in the context of migration. These traditions offer solace in the face of upheaval, discomfort, or loss. To challenge these traditions is to challenge the client's connection to significant others, thus risking premature termination by the client. Ghislène Méance in Chapter 6 notes that many psychotherapy interventions stress individuality and independence, which runs counter to the values of the more collectivistic traditions found in the Caribbean. She encourages practition-

ers to be aware of this distinction in their work with Caribbean clients.

Interestingly, many chapters also note that healing traditions are intrinsically empowering, fostering a sense of agency in their followers despite the historical disenfranchisement through slavery and indentureship experienced by many in the Caribbean. In fact, Sutherland notes in her chapter that all healing traditions are symbolic of the need for control and survival during life on the plantation. In this way, healing traditions transcend everyday experiences to heal the wounds associated with absence and loss.

If there is one limitation of this section, it is the redundancy between the histories presented in each chapter and the historical overview provided in Part I of the book. It was often repetitive to read through similar historical backgrounds from chapter to chapter; especially given that Part I was so informative. However, as a clinical supervisor in a university training clinic, I appreciate that each chapter in this section can stand alone so that I may select specific chapters to recommend to my trainees when they are working with clients with a particular Caribbean belief system.

In Parts III and IV, several models of integration between Caribbean healing practices and Western practices are described. Part III focuses on how Caribbean belief systems have become blended over time with other organized religions, such as Christianity (Chapter 12) and Islam (Chapter 15), while Part IV concludes with a series of chapters reviewing empirical literature on the integration of Caribbean healing systems and conventional health and mental health systems. For example, Anahí Viladrich in Chapter 18 reviewed research on the emergence of botánicas in New

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York City. Botánicas are ethnic-religious stores that provide a physical and social space for informal faith-healing networks (e.g., *Santería*). Viladrich argues that botánicas are one possible avenue for practitioners to learn more about Caribbean healing traditions and encourages practitioners working with Caribbean clients to visit one of these cultural stores as part of their training.

It was in these last two sections of the book that I found myself wanting more guidance on how to best integrate healing practices with conventional psychotherapy approaches. Throughout the book, all authors make a strong case for using a biopsychosocial model to conceptualize Caribbean clients and for practitioners to be aware of and understand the importance of healing practices. It was in this last section that I was hoping for more specific practice guidelines. This would be especially informative for my clinical supervision of trainees. Our university clinic serves a

predominately Afro-Caribbean student population and many of our clients use healing traditions in their everyday life. It is not uncommon for our clients to reference “spirits” or other supernatural forces while in treatment. While we stress cultural competence throughout our training program, our students often struggle with how to truly integrate their understanding of traditional cultural practices with the theory and techniques they are learning in class. I found myself wanting at least one additional chapter focusing exclusively on the practicalities and challenges of integrating Caribbean belief systems with conventional psychotherapy approaches. However, this is a minor limitation in what is otherwise a well-organized and informative book. Overall, this book should pique the curiosity of any practitioner working with Caribbean clients and inspire them to continue their educational journey through the Caribbean to inform their practice.



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## BOOK REVIEW

### Book Review of *Psychotherapy Integration* by George Stricker. Washington, DC: American Psychological Association, 2010, 150 pp. ISBN 978-1-4338-0719-0.

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The Psychotherapy Integration Movement has always been predicated on a desire to stretch beyond the confining mold of a particular psychotherapy orientation. Some of us wished to expand well beyond the theoretical and practical limitations of a single school of psychotherapy. Most of us, however, have chosen to preserve the core theoretical constructs of our home orientation, and incorporate illuminating ideas and effective practices from other psychotherapy orientations. In the 30 short years since the inception of the Society for the Exploration of Psychotherapy Integration (SEPI), the psychotherapy integration movement has achieved at least one of its major goals—the desegregation of psychotherapy orientations. Or, as I like to say in more melodramatic moments, we have crushed *therapeutic apartheid*. In the past, for a therapist or researcher associated with one psychotherapy orientation to speak positively about the theoretical constructs and clinical strategies and techniques of another orientation often led to serious negative professional consequences. Today, however, graduate students as well as many current practitioners and researchers take it as commonplace to explore, study, borrow, or investigate ideas and practices from orientations other than the one to which they give fealty, and to assimilate them into their current ways of thinking, practicing and conducting research.

The field of psychotherapy integration has been kaleidoscopic in its production of various pathways to psychotherapy integration. These pathways include theoretical integration, technical eclecticism, and common factors. But a closer look suggests that each of the 24-plus models of integration thus far developed is based in a home theory of psychotherapy. Thus assimilative integration, originally defined by Messer (1992), represents the current mainstream approach to psychotherapy integration (Wolfe, 2001).

Thus it is timely for the Theories of Psychotherapy Series to publish a book on psychotherapy integration written by Dr. George Stricker, who is not only one of the founders of SEPI, but also one of the two developers of Assimilative Psychodynamic Integration (Stricker & Gold, 2005), the main theory of psychotherapy integration presented in this book. This slim volume contains an excellent if concise review of the history of the psychotherapy integration movement, presents a clear and current updating of the theory and process of Assimilative Psychodynamic Integration, a brief review of research evidence for the efficacy of various integrative therapy approaches and a review of several recent publications addressing future developments in the field. The book manages to touch most of the important milestones within the field of psychotherapy integration without having the allotted space to consider any in great detail.

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Stricker writes in a clear prose style, which makes it easy for the reader to absorb and process the information within. The chapter on Therapy Process is helpful in expanding the limited coverage of representative models of the several pathways to integration. In this chapter, there is a significant amount of case material to illustrate specific models of theoretical integration, common factors, technical eclecticism, and assimilative integration. But while this case material fleshes out to some degree the limited presentation of the core theoretical ideas of each approach, I would have liked a broader consideration of the theory in each case. These are tasty hors d'oeuvres, but they leave us hungry for dinner. The few deficiencies that attend this book are primarily due, I suspect, to the space requirements associated with the Series. It is impossible to effectively capture in one volume the amazing degree of fecundity and creativity produced by all those who have explored the possibility of integrating the best ideas, strategies, and practices of the single school psychotherapies.

In my view there is one major deficiency

in this book, and that is the absence of the integrative perspective that might be called holistic unification. This is an effort by a few SEPI-ites to work toward a unified conceptual framework in psychotherapy. This is an extension of the theoretical integration pathway to psychotherapy integration. This approach attempts to unify all of the relevant variables in clinical science that influence the process and outcome of psychotherapy. This is admittedly a minority point of view in SEPI, as well as a gargantuan undertaking, but one that should have a voice. Emanating from this perspective is a new journal, *Journal of Unified Psychotherapy and Clinical Science* and a recent book (Magnavita & Anchin, 2013). Despite my minor quibbles, this is an excellent introduction to the field of psychotherapy integration. It should whet the appetite of any psychotherapy practitioner, theorist, or researcher who is interested and willing to assimilate this groundbreaking development within the more general field of psychotherapy.

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



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