

# Psychotherapy

OFFICIAL PUBLICATION OF THE SOCIETY  
FOR THE ADVANCEMENT OF PSYCHOTHERAPY  
OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

[www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)

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# Society for the Advancement of Psychotherapy ■ 2017 Governance Structure

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**PSYCHOTHERAPY BULLETIN**

Published by the  
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THE ADVANCEMENT  
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**PSYCHOTHERAPY BULLETIN**

Official Publication of the Society for the Advancement of  
Psychotherapy of the American Psychological Association



**2017 Volume 52, Number 2**

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### SAP Updates and Upcoming Events

*Jeffrey Zimmerman, PhD, ABPP*



#### Thoughts and Insights From Asia

Professor Jiang from Oriental Insight invited a delegation from SAP leadership (Drs. Chang-

ming Duan, Armand Cerbone, Rod Goodyear, and me) to present at Oriental Insight's conference entitled "Supervision and Ethics: The conference of professionalization of psychological counseling and therapy" this April in Wuhan, China. Dr. Carol Falender was also on the program. I had the distinct honor and privilege of giving a keynote entitled, "Bringing Harmony to Families: Ethically building professional competencies to reduce conflict."

On my way to China I started thinking how we certainly have our share of conflict in our own profession, personal lives and institutions of government and culture. As a mediator and collaborative divorce mental health professional, and as someone who does a lot of work with couples, I am frequently helping my clients have "difficult conversations." However, it does not stop there.

#### Difficult Dialogues

On the SAP website, you can find an article by Pauline Venieris, MA, MMFT (<http://societyforpsychotherapy.org/difficult-dialogues-internship/>). She spoke to difficult dialogues she has had in her training. I was touched to see how open she was. I started to think of some of the difficult dialogues I have had during my term as President-Elect and this year as your SAP President. I want to share with you a few observations which may seem like "old hat," but to me need

repeating as I am struck by how "old hat" often is not integrated into our patterns of communication and interaction.

Many Chinese people pride themselves on respect and honor. I think these concepts are important to keep in mind and then act on. In difficult dialogues this is crucial. Too often I witness ridicule and disregard of the other's view, rather than truly seeking to understand the other's perspective. Devaluing the other's perspective and taking adversarial positions do little to further dialogue. Rather it tends to polarize and create an "us versus them" mentality. It promotes what can seem like the arrogance of one's own view at the expense and disregard of the other's view. Imagine instead if you and the other person truly demonstrated and experienced respect in the midst of the discussion about your differences. Might that favorably impact the process? Might that favorably impact the outcome?

While debate can be important, usually debate is fraught with a devaluing of the other's perspective, rather than an honest attempt to truly understand their perspective; to really "get it." Debate is about determining whether "A" or "B" should prevail. However, once each person understands the other, they can work towards solving for "A" and "B" where both views are honored.

I must say how pleased I was when many of our colleagues discussed the APA "Boys Don't Cry" video with me. Many of us had strong, but differing re-

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actions. The discussions about the piece, culture, race, gender and privilege that I had with different members were some of the most honest and respectful. Our Society is blessed to have members who will take the time to engage in this way. As psychotherapists, we should set the standard for healthy discussions both in and out of the psychotherapy session.

### **Oriental Insight**

Arriving in China at 8 pm (23 hours after leaving home) Lauren and I were met at the airport by a graduate student (Lily) and Dr. Jiang's administrative assistant (Finny). We did not have to search for them, they found us. From that moment on we realized that Chinese hospitality is something to behold. Throughout our stay, every concern and need was effectively attended to. The conference ran flawlessly. But more importantly, our Chinese hosts touched our hearts. There were times of closeness, openness, tears, and sharing. In such a short time, we had connected deeply with one another.

During our stay, Changming and I met with Professor Jiang to speak about ideas for continuing to build the relationship between OI and SAP. Changming will be discussing these ideas with the International Committee and then presenting them to the EC and Board as needed. It is quite possible SAP will have an opportunity to help impact training and practice standards in China—very exciting!

### **World Congress of Psychotherapy (WCP)**

In July, our international activities will continue, as SAP has 5 symposia which will be presented at WCP. There are more than 20 presentations included in the symposia. We hope to build our international relationships while focusing on my presidential initiative related to bringing mental health services to the underserved. I hope you can join us. If

you do, stay tuned for information about a social hour we are in the midst of setting up.

### **Convention 2017**

We will carry the theme of my Presidential Initiatives into Convention 2017. We have a diverse program that also spans issues around training and supervision, repairing therapeutic ruptures, various treatment strategies, and helping build our resilience as clinicians. We have 2 poster sessions you can attend. Dr. Gary Howell has done an amazing job as program chair. Thank you, Gary. And thank you to all our presenters and those of you who will be attending. Please be sure to come to our business and awards meeting and social hour which will be held on Friday in the Marriott Marquis. I hope to see you at convention. Please come up and say "Hello" and of course let me know if you have even an inkling of interest in getting more involved in SAP.

### **This Issue of the *Bulletin***

This will be the last print issue of the *Bulletin*. This was a difficult decision for the Board, which is committed to continue to bring you the *Bulletin* and all it has to offer, but will allow us to provide content in a cost-effective and environmentally-friendly way online. So, please stay on the lookout for the electronic version. If you do not get the electronic copy please check your spam and trash files and then reach out to Dr. Lynett Henderson Metzger (Editor, lynett.hendersonmetzger@du.edu) to let her know.

### **Results From Governance Election**

Finally, please join me in congratulating the winners of this year's election for positions in the Society's governance. They are:

**President-Elect:** Nancy L. Murdock, PhD

**Secretary:** Rebecca M. Ametrano, PhD

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**Domain Representative–International Affairs:** Frederick T. L. Leong, PhD

Please also join me in thanking all the candidates for being willing to volunteer their service to the Society.

**Domain Representative–Public Interest and Social Justice:**  
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Wishing you all a safe and healthy Summer 2017. —Jeff



## NOTICE TO READERS

**References for articles appearing in this issue can be found on the Society's website under "Publications," the "Bulletin." Please click on the Bulletin issue for which you would like references. Go to the Table of Contents, and find "References." References for all articles in the issue will begin on that page.**



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## EDITORS' COLUMN

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Welcome to the last printed issue of *Psychotherapy Bulletin*! We are delighted to offer you a selection of articles focused on practice, research, education, and training, including three contributions in keeping with our continuing “difficult dialogues” theme. In this issue, authors explore the challenges and rewards



of revealing diagnoses or sharing research with clients, practicing liberation psychotherapy or identifying as a feminist psychotherapist, and attending graduate school in psychology as a first-generation graduate or international student. Our new Contributing Editor for Ethics, Dr. Apryl Alexander, looks at current policy and ethical implications of conversion therapy, and we have a variety of interesting and timely columns, features, and updates (be sure not to miss the Student Award and 2017 APA Convention information). On a much more somber note, in this issue we also remember Dr. Eugene Gendlin, who died on May 1, 2017.

We join SAP President Jeff Zimmerman in welcoming our newly-elected Domain Representatives, and offer our hearty thanks to our outgoing contributors. It was wonderful to see so many SAP members in Denver for the Society for the Exploration of Psychotherapy Integration conference in May (see photo of our own Kevin McCarthy, PhD, receiving the Marvin R. Goldfried New Researcher Award). And for those of



you attending to APA this summer, safe travels and enjoy.

August 1, 2017, is the deadline for our first digital-exclusive Bulletin format (you can find the announcement later in this issue and here: [www.societyforpsychotherapy.org/bulletin-announcement](http://www.societyforpsychotherapy.org/bulletin-announcement)), and we would love to hear from you with a contribution or idea. Submission guidelines can be found online, as can all kind of other wonderful content and information—check us out at: <http://societyforpsychotherapy.org/> (and feel free to email Lynett and Cara directly with articles or feedback).

Thank you for your support of *Psychotherapy Bulletin*. Halfway through its 52nd year, the Bulletin remains a source of news for members, a place for the exchange of thought-provoking ideas, and a forum that welcomes experienced researchers and first-time authors, alike.

We hope you will join us on the next phase of our journey.

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# PSYCHOTHERAPY RESEARCH, SCIENCE, AND SCHOLARSHIP

## Sharing Research Findings: Did We Forget the Patient?

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### Psychotherapists as Scientist Practitioners

Research is important in the scientific field of psychotherapy, where we tend to think of ourselves as “scientist-practitioners” (Overholser, 2012). Although some psychologists are active researchers and clinicians, the importance of consuming research and research productivity as well as the attitudes toward science and research evidence might differ per setting (e.g., academic or private practice; Llewelyn, Hardy, & Aafjes-van Doorn, 2015). Conducting research can be an enjoyable and intellectually stimulating endeavor, especially if the findings leave our personal laptops and research labs, and are read and used by others in the field. Therefore, researchers share their findings with other professionals in peer-reviewed journals, on listservs, as well as in press releases for popular magazines and social media. With a bit of luck, this research evidence then gets used by clinicians, policymakers, insurance companies, and psychology professors who educate our students. Ultimately, we hope our research will enhance the efficacy and effectiveness of the treatments we offer our patients, and help patients reduce their suffering.

Even if we are not active researchers ourselves, as clinicians we are reflective “*scientist-practitioners*” who strive to offer the best evidence-based practice to

our patients (Llewelyn & Aafjes-van Doorn, 2017). Moreover, many clinicians take the role of “curious scientist”; involving patients in their road to recovery as “expert by experience,” increasing agency and eliciting more realistic views by challenging irrational thoughts or Socratic questioning. We often roll our eyes when patients tell us they have been given (incorrect) treatment diagnoses by their friends or when patients have been browsing the internet to find an answer to their multitude of worries. So why do we not help them along and present our patients with the research findings they are looking for to understand themselves better and inform their decisions? In this world of alternative facts, would it not be our responsibility to identify and share the most relevant and robust research evidence with our patients?

### Sharing Research With Patients

*Why we don't.* There might be several reasons why we as scientist-practitioners decide not to share research findings with our patients, either by deliberate choice or for more implicit reasons. First, we might hold ethical objections. For example, some clinicians hold the view that they should be the people who digest research findings and not burden patients with this. They argue that, given our training in searching, reading, digesting, and interpreting relevant research, making decisions about care is our professional responsibility,

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and this should not be expected of the less educated lay patient (e.g., Garcia, 1987; Shalowitz & Miller, 2008). Similarly, others might argue that sharing common research findings with patients does not have therapeutic benefit. For example, the research evidence on the modest effectiveness and efficacy of most psychological treatments, as well as data on patients who deteriorate, or the fact that more experienced and expensive therapists are no more effective than their students (e.g., Tracey, Wampold, Lichtenberg, & Goodyear, 2014), might not be something the clinician wants to share. Indeed, sharing these findings might not make our treatments more effective, especially since research tells us that positive patient expectations, hope, and belief in the therapist and therapeutic methods is crucial for treatment outcome (e.g., Constantino, 2012).

In addition, we may be reluctant to share research with our patients for reasons of which we are less consciously aware. We know, for example, that research is not everyone's cup of tea. Most clinicians joined the profession with an interest in people rather than research, have not actually published their dissertation research, and have had negative experiences with trying to get research projects published (Llewelyn et al., 2015). Moreover, some more clinicians might not be convinced by the quality or relevance of the current psychotherapy "evidence-base" and may see research as an intrusive threat to the intimate therapeutic encounter rather than a tool for treatment improvement; these clinicians may prefer to be guided by their clinical intuition instead (Taubner, Klasen, & Munder, 2016). Also, more practically, in our busy practices time is taken up by urgent clinical issues that need our immediate attention, and research might not be on the top of our agenda (Llewelyn et al., 2015). On a

more personal level, the thought of sharing research findings (either our own or those of our colleagues) might make us feel insecure and vulnerable about our own scientific expertise. We might, for example, find the study results difficult to understand ourselves, and we might not be sure what they mean or how they relate to our individual patients. And even if we do understand the research and want to share it with our patients, we might doubt ourselves (Taubner et al., 2016), be afraid to fall off our pedestal and lose the position of expert, or not know how to go about sharing it in the most therapeutic way.

*Why we should.* Dissemination of research findings with patients may be important for a number of ethical, research, and therapeutic reasons. First, patients in the community deserve access to the knowledge they have made possible through participation or other forms of engagement in a study. And if they have not participated yet, they might be more inclined to do so when they can see how research participation might be used to improve clinical practice. Second, community dissemination creates opportunities to explore the implications of research findings from a local perspective (McDavitt et al., 2016). This means that by sharing the latest research findings with our patients, new evidence-base is more likely to be considered, implemented, and immediately applied—there and then. Third, involving patients in discussions about new findings is particularly crucial for addressing health disparities and may guide future clinically-relevant research, bridging the practice-research gap (Goldfried, 2012).

But sharing research evidence with patients is not only beneficial for the long-term greater good of patients at large; sharing research, including its flaws, contradictions, and limitations might be

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helpful to our immediate patients in treatment, too. First, it seems unethical to expect patients to choose a particular therapy approach, treatment, or therapist when they do not have access to the evidence-base and do not understand the scientific jargon. Arguably, it is therefore therapists' responsibility to share the honest, unbiased research findings, as well as their opinions based on particular patients.

Besides the obvious benefit of the gained knowledge itself, one could argue that the process of sharing research findings might also be therapeutic to our patients. Patients often come to therapy because they want to learn how to change their old ways. Patients have often developed their maladaptive coping mechanisms for a good reason, and letting go of old patterns is hard. Therefore, clinicians with a "curious scientist" approach might provide great examples of curiosity toward new information, openness to trying out new methods, and life-long personal development. This is not to say that we should accept research findings as given truths or that research findings are the only source of evidence in clinical practice. When the research evidence is unclear or we feel uncertain, this might provide the perfect opportunity to role-model how to tolerate not-knowing exact answers, as this uncertainty in life and relationships is exactly why patients come to us.

### **Research-sharing Opportunities**

*Patients who participated in research.* The most obvious situation in which scientist-practitioners may share research findings is when they provide feedback to participants in their research. Providing feedback to participants is usually required by ethical research review committees (Shalowitz & Miller, 2008), and is a nice gesture of appreciation to the people who were kind enough to give their time to participate in our research,

increasing their likelihood of participation in the future. In practice, sharing findings with participants might not be so easy, however. By the time the research is conducted, written up for a dissertation and/or publication—often months or years later—the lack of up-to-date contact details and confidentiality issues (if no explicit permission is given beforehand) might provide practical obstacles. If research is conducted as part of larger scale Practice Research Networks, the process of providing regular feedback to participants might be more streamlined as participants stay involved for a longer period, and might, for example, opt in to receive publication updates.

However, one does not have to wait for research projects to be completed before sharing information with participants. For example, in some qualitative research projects, researchers may return to participants while research is being conducted to ensure that their categories, constructs, explanations, and interpretations "seem right" or "ring true," and to discover if something is missing (Goldblatt, Karnieli-Miller, & Neumann, 2011). This "member-check" process has a twofold intent: from a methodological perspective, to minimize misinterpretations of participants' accounts; from an ethical standpoint, to empower participants, through their active involvement in the study. Regardless of research method, the service user involvement movement that has been implemented across mental health services in the United Kingdom promotes the participation of patients in all parts of the research process, including focus groups to help generate research ideas and patient-led research review meetings in universities and clinics (Kara, 2013).

*Patients at large.* Outside the context of research projects, psychologists can also

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use their teaching, consulting, and presenting skills to share research findings with patients and their families at community services, nonprofits, and informal support groups. Due to our all-round scientific and clinical training, we might be particularly well placed to digest and translate findings from dense research papers into understandable, palatable, and relevant suggestions for clinical practice (Llewelyn et al., 2015). Presenting research evidence to larger groups of (prospective) patients and their families might have a ripple effect in reducing stigma, supporting prevention, and raising the profile of psychological treatment.

*Our own patients.* Many psychology researchers are also clinicians and therefore have the dilemma of how much and what of their research work to share with their patients. In treatment sessions with our own patients, we may choose to share findings from research that we conducted ourselves, recruit our patients for our current research projects, or explain our reasons for proposing an experimental treatment approach. Also, we might want to share our own track record of treatment results. As more clinicians are now measuring progress on a regular basis, we can provide prospective patients with information on our own practice outcome data. A great example of this can be found on the website of clinician-researcher Tony Rousmaniere ([www.drtonyr.com](http://www.drtonyr.com)), where he clearly states his treatment outcomes for patients to judge and interpret.

Besides sharing our own research, we might decide to tell our own patients about research findings from experts in the field. During a therapy session, we may choose to discuss general psychotherapy research findings or refer to books, papers, or presentations, with the aim of giving our interventions increased face validity or helping our pa-

tient decide between different treatment options. Patients might ask for the evidence-base of treatments themselves, or clinicians might choose to initiate these topics at a particular time in treatment. Without any empirical evidence, we cannot know if and how this research sharing might be productive therapeutically. It is likely that its effect is dependent on the therapist, patient, therapeutic relationship, timing, and service context. Research-sharing might, for example, be experienced as unnecessarily patronizing, creating distance and ruptures in the alliance. A reference to a research publication might show how up to date and knowledgeable a therapist is or might serve as proof to the patient that the therapist does not really see the patient as an individual. It is also possible that research-sharing is experienced by patients as a humanizing and normalizing self-disclosure of not-knowing exact answers, a type of “gift giving” of knowledge, a collaborative team effort in finding the best solution, or simply a welcome intellectual distraction from the therapeutic work at hand. And even if patients are helped by knowing general research findings, are patients actually interested in their clinician’s research endeavors? From my own experience as a patient in psychoanalysis, I remember reading a few of my analyst’s journal publications with the desperate hope of getting to know the person behind the therapist. Somehow this seemed within the professional realm and more acceptable than trying to search for him on Facebook or LinkedIn. But what did it tell me? My analyst had other interests? Other areas of expertise that did not involve me and my problems? I am not sure that was what I wanted to know.

### **Considerations Moving Forward**

As scientist practitioners, we should at

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least consider the opportunities and possible benefits of sharing research findings with our patients. Whether we decide to share research evidence in a therapy session might depend on our patients' therapeutic needs. However, regardless of what we deem best for our individual patients at a given point in time in their treatment, this should not deter us from disseminating research findings to research participants and mental health patients more generally. We could, for example, see our patients as experts by experience, and involve them in developing research questions or checking research findings. Also, we could share our understanding of the current evidence-base at patient support groups, give presentations through mental health services, or use our professional website to guide our patients through the world of evidence-based practice. Besides the ethical responsibil-

ity of involving our participant-patients, the potential benefits for future patients, and the direct benefit of the gained knowledge to our patients, the research sharing process itself might provide an additional implicit learning experience that could have important therapeutic value. Future empirical investigations on the effect of sharing research with our patients on treatment outcome is warranted, and might help us understand how, when, and with whom different ways of research sharing might be beneficial. As psychotherapists, we are both a "scientist" and a "practitioner," so sharing research with our patients might not be too far-fetched!

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## PUBLIC INTEREST AND SOCIAL JUSTICE

### Difficult Dialogues: Why I Am a Liberation Psychotherapist

Lillian Comas-Díaz, PhD  
Washington, DC



Developed by the psychologist/priest Ignacio Martín-Baró, liberation psychology examines contexts of oppression to foster critical consciousness, emancipation, and transformative action. In this article I use a liberation tool—*testimonio*—first person narration that expresses psychosocial experiences as a protagonist/witness (Aron, 1992).

For over 35 years I have incorporated liberation psychology into my psychotherapy practice. Although classically trained, I have long resonated with liberation psychology's challenge to mainstream psychotherapy's ahistorical, acontextual and individualistic underpinnings (Comas-Díaz, Lykes, & Alarcon, 1998).

My journey was forged in 1986 when, as a member of a joint American Psychological Association and American Psychiatric Association mission to Chile to investigate mental health abuses, I witnessed liberation psychotherapy in action while meeting with psychologists working with victims of political repression under the Pinochet dictatorship (Bales, 1986).

Liberation psychotherapists *accompany* clients by developing collaborative relations that acknowledge power inequality in relationships, as well as in society

(Comas-Díaz, 2000). They promote *conscientización* (critical consciousness) (Freire, 1970) by teaching clients to critically perceive their circumstances, analyze the causes of their oppression, and discover new paths of action.

Concientización raises critical questions such as *What? Why? How? For whom? Against whom? By whom? In favor of whom? In favor of what? To what end?* (Freire & Macedo, 2000). This aspect of liberation psychology helps clients to understand the mechanisms of oppression, fosters agency, and encourages engagement in personal and collective social justice. Following is an example of a conscientización dialogue (the name and identifying details have been changed):

Joy: I was furious. A White guy jumped in front of me at the pharmacy line.

Lillian: What?

Joy: Yes, I told him that I was next.

Lillian: What happened?

Joy: He ignored me and started to talk to the pharmacist.

Lillian: Why do you think he did that?

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Joy: I guess I'm invisible. Lillian: Any other reason?

Lillian: How come? Joy: Well, the political climate promotes people like him keeping people like me down.

Joy: I'm a working class middle age Black woman. I don't count. Lillian: I am sorry you went through this experience. In addition to being furious, what other options did you have?

Lillian: Who benefits from your invisibility? Joy: Isn't that obvious? He does, because he is an angry White man who gets ahead by ignoring a Black woman. Joy: Talking to the pharmacist? Better yet, calling the manager!

Lillian: How is that for you? In addition to fostering conscientización through dialogue, I use liberation tools such as activism—art with a social justice purpose (Sandoval & Latorre, 2008)—to help clients connect with their cultural strengths, recover their historical memories, and reformulate their identities.

Joy: I don't like it. Lillian: Whom does his behavior hurt? Joy: You did not hear me? It hurts me.

Lillian: I heard you, but bear with me. Who else may be hurt by his behavior? Liberation psychotherapists focus on clients' lived experience to foster an existential examination of their life purposes (Comas-Díaz et al., 1998). As such, they promote holistic wellbeing through the integration of indigenous psychological healing into psychotherapy (Comas-Díaz, 2012).

Joy: Besides me, well, other Black women. Lillian: Who benefits from his behavior? Liberation psychotherapy has been applied to migrant populations (García-Ramírez, de la Mata, Paloma, & Hernandez-Plaza, 2011), LGBT clients (Russell & Bohan, 2007; Singh, 2016), women (Lykes & Moane, 2009), people of color (Bryant-Davis & Comas-Díaz, 2016), and others.

Lillian: That's a funny question. Not me. Mm. His ego? Joy: How do you understand that? In sum, liberation psychotherapy can be applied to anyone since most individuals experience areas of oppression. Finally, you don't need to abandon your

Joy: I've seen it before. He was exercising White male dominance. Lillian: To what end? Joy: To keep me in my place.

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theoretical orientation to practice liberation psychology. Are you ready to become a liberation psychotherapist?

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A graphic featuring a globe, a computer monitor, and a microphone, all set against a dark background. The text 'FOR THE ADVANCEMENT OF PSYCHOLOGY' is written in a circular path around the globe. Below the graphic, the text 'SOCIETY FOR THE ADVANCEMENT OF PSYCHOLOGY & NONL...' is written vertically on the right side, and 'CAN PSYCHOLOGICAL ASSO' is written horizontally at the bottom.

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## STUDENT FEATURE

### What You Don't Know Might Hurt You: Disclosing and Discussing "Difficult" Mental Health Diagnoses

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Clients request, question, or reject information related to their diagnoses at various times, and in a myriad of ways (e.g., "My partner says I have Borderline Personality Disorder, do I?", "My mood is all over the place! Do you think I'm bipolar?", "Maybe it's ADHD?"). At intake, clients seek clarification of the nature of their difficulties, as well as reassurance that their problems are understandable and treatable. Throughout treatment, they may wonder if therapy is working and if the therapist's conceptualization of the problem is lacking or flawed. A proportion of clients will even contest their therapists' opinion and/or propose alternative diagnoses. Such instances of doubt may occur following stressful life events, media exposure, and conversations with others—including other health professionals—and are apt to increase in this era of easy and rapid access to an ever-increasing wealth of information. Despite their normativity, such discussions are often challenging, uncomfortable, and anxiety-provoking encounters for clinicians—especially for those beginning their clinical careers, and in cases of so-called "difficult" diagnoses—i.e., conditions associated with significant

morbidity, stigmatization, and/or poor prognoses (Holland, Holland, Geary, Marchini, & Tross, 1987; Mitchell, 2007). Consequently, many therapists circumvent or entirely avoid such conversations.

These reactions are not uncommon. Let us consider the process of therapist reflection and decision making in the context of a single diagnosis—for purposes of this article, borderline personality disorder (BPD). BPD is a complex mental illness characterized by pervasive instability across several affect-related domains, and is frequently accompanied by impulsive and self-damaging behaviors [e.g., suicidal and non-suicidal self-injury, substance abuse, disordered eating, risky sexual activity, aggression, reckless spending, etc. (American Psychiatric Association, 2013; Skodol et al., 2002)]. Despite its ubiquitous prevalence across clinical settings, as well as the severe degree of distress and functional impairment associated with the disorder, many clinicians struggle to disclose this diagnosis to their patients. Available evidence suggests that mental health professionals are more reluctant to recognize and disclose BPD diagnoses to clients than they are other psychiatric disorders—including schizophrenia (Clafferty, McCabe, & Brown, 2001; Gunderson, 2011; McDonald-Scott, Machizawa, & Satoh, 1992; Paris, 2007). Indeed, a recent study conducted on a sample of U.S. psychiatrists found that

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not only did over half (57%) fail to disclose BPD, but over one-third (37%) also refrained from documenting the diagnosis in patients' charts (Sisti, Segal, Siegel, Johnson, & Gunderson, 2016). This practice appears to be even more prominent among those treating adolescents (e.g., Griffiths, 2011; Koehne, Hamilton, Sands, & Humphreys, 2013; Laurensen, Hutsebaut, Feenstra, Van Busschbach, & Luyten, 2013). Although several empirically-supported treatments (e.g., dialectical behavior, schema-focused, mentalization-based, and transference-focused therapies) have been found effective at relieving BPD symptoms and contributing to lasting improvements in functioning and quality of life (Gunderson, 2011), many clinicians continue to diagnose and treat 1) the co-occurring conditions that frequently manifest among those with BPD (e.g., post-traumatic stress disorder or complex PTSD), or 2) another unrelated psychiatric illness with a similar presentation (e.g., bipolar disorder) that has a better pharmacological prognosis.

### **Why Can These Dialogues Be So Difficult?**

Barriers to diagnostic disclosure are varied, and result from an interaction of several factors. Although some of these concerns may be diagnosis-specific—such as fears of initiating or perpetuating self-harm behaviors among those with BPD (Howe, 2013; Lequesne & Hersh, 2004)—the majority apply to other forms of severe mental illness (e.g., schizophrenia, dementia). The MUM (“keeping Mum about Undesirable Messages”) effect, or propensity to remain silent when posed with the challenge of delivering unfavorable news (Rosen & Tesser, 1970), is one useful framework for understanding why it is so hard for therapists to initiate these conversations with clients. Studies have shown that decision-making regarding diagnostic disclosure among psychologists and social workers is influenced by the MUM

effect (Merker, Hanson, & Postin, 2010; Rumpza, 2015), which attributes such reticence to a combination of concern for the recipient, societal norms, and the communicator (Tesser & Rosen, 1975). In terms of their clients, practitioners may be wary of potential iatrogenic effects, such as self-fulfilling prophecy, demoralization and decline in morale and mental/physical health, patient over-identification with the label, and self-stigmatization (Davidson & Roe, 2007; Garner, 1985). Public stigma about serious mental illness (e.g., Corrigan, 1998) can also be a major deterrent to diagnostic openness. Well-intentioned therapists may rightfully fear that a label will bias the way friends, family, medical professionals, and society view the affected individual (Corrigan, Green, Lundin, Kubiak, & Penn, 2001). Related considerations include how a diagnosis such as BPD may marginalize patients in terms of their access to future mental health care services (Kealy & Ogrodniczuk, 2010).

Finally, there are those who question the validity of the BPD diagnosis. Indeed, the DSM system allows for 256 combinations of symptomatic profiles leading to diagnosis (Biskin & Paris, 2012), meaning that two individuals with BPD may end up overlapping on only one of nine criteria (five are necessary for diagnosis). Although much research supports the existence and utility of diagnosing BPD among adolescents, many clinicians continue adhering to scientifically-antiquated practice guidelines advocating caution in youth personality disorder diagnoses (Chanen, Jovev, McCutcheon, Jackson, & McGorry, 2008; Kaess, Brunner, & Chanen, 2014; Sharp, Ha, Michonski, Venta, & Carbone, 2012; Sharp & Tackett, 2014). Some argue that BPD's multidimensionality may obscure specific treatment targets (Paris, 2009); promisingly, empirical

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investigations exploring clinically-meaningful subtypes—a related concern—are now underway (Johnson, Temes, Scala, & Levy, 2017; Sleuwaegen et al., 2017). Nevertheless, it has been argued that conferring other (less controversial) diagnoses or withholding diagnosis entirely may be more harmful, as it precludes patients and their therapists from accurately prognosticating about expected treatment response (Paris, 2005b). Therapists understand that diagnostic classification systems are ever-evolving products of ongoing empirical research and yet must rely upon current information to help treat patients until more refined constructs are established (for more on the subject of diagnostic validity versus utility, see Kendell & Jablensky, 2003). For these and other reasons, skirting around the issue of BPD with clients, diagnostic hedging and/or partial diagnostic disclosure, and “backstage borderline talk”—in which members on coordinated care teams discuss a clients’ borderline diagnosis amongst themselves without sharing it with the affected individuals—are frequent and unfortunate clinical phenomena (McNab, McCutcheon, & Chanen, 2015).

### **Benefits of Disclosure**

Thus, we argue there can be enormous utility to the diagnostic process if handled properly by a trained and empathic provider. Obtaining the diagnosis provides many clients with a much-needed sense of relief often after years of suffering, and helps explain the multifarious set of symptoms with which they have struggled. Regardless of their condition, clients tend to report significant increases in positive mood associated with feelings of hope and validation following diagnostic feedback provision (Holm-Denoma et al., 2008). In terms of BPD, research has shown that patients benefit after receiving the diagnosis and “often feel as if the clinical picture ‘fi-

nally makes sense’” (Biskin & Paris, 2012). Brief psychoeducation immediately following BPD diagnosis has actually been shown to attenuate core symptoms of the disorder (Zanarini & Frankenburg, 2008), demonstrating its function as a clinical intervention in and of itself. The aspect of substantiating and validating may be particularly important for those with BPD, many of whom have experienced chronic emotional invalidation in central attachment relationships (Linehan, 1993). Probst (2015) has described naming as a form of validation that functioned to “[welcome one] into one’s tribe” (p. 246).

When imparted in a client-centered manner, the act of sharing a BPD diagnosis can strengthen the therapeutic relationship and lead to greater patient engagement and improved outcomes (Biskin & Paris, 2012). Clients are often empowered when they feel they are actively involved in clinical decisions regarding their health and wellbeing (Blackhall, Frank, Murphy, & Michel, 2001). There are benefits to clinicians as well. Knowledge that a client has BPD allows clinicians to account for a co-occurring and heterogeneous set of cognitive, affective, and behavioral symptoms in the same individual (Paris, 2007). Such information helps guide treatment formulation and clinical decision-making. Informed providers who employ/recommend appropriate strategies with their BPD clients are more effective providers, and vice-versa. Diagnostic disclosure, when communicated effectively, can thus have significant bearing on treatment course and outcome.

### **Ethical Considerations:**

#### **The Dialectic of Help Versus Harm**

There are several accompanying ethical considerations that treatment providers must entertain when disclosing psychiatric diagnoses, many of which can be

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tied to the APA principle of beneficence/nonmaleficence, but that also encompass those of fidelity/responsibility, integrity, and respect for people's rights/dignity (American Psychological Association, 2016). For example, some argue that disclosing diagnosis of serious mental illness has the potential to harm patients by instilling stigma, fear, or distress, disrupt treatment, or even prompt suicide (see Pinner, 2000). Clinicians may rationalize aphorisms such as "what you don't know doesn't hurt you" and "ignorance is bliss" as reasons to censor diagnostic information and shield clients from potentially upsetting news about their mental health; however, there is thus far no evidence to support this view (Yeung & Kam, 2008). Indeed, in spite of occasional increases in short-term distress following diagnostic provision, long-term benefits have consistently been documented across serious mental health conditions (Erde, Nadal, & Scholl, 1988; Holm-Denoma et al., 2008; Paris, 2007). In fact, Fallowfield, Jenkins, and Beveridge (2002) have described how deception—whether it manifests via outright avoidance or the use of ambiguous or deliberately misleading language when communicating about diagnoses—can engender misunderstandings and prevent clients from participating in key aspects of their care. Indeed, inadequate disclosure of a BPD diagnosis can lead to confusion about the treatment process, therapeutic targets, and expectations regarding improvement (Biskin & Paris, 2012). Without awareness of their illness and associated prognosis, patients are deprived of autonomy and the ability to consent to a course of treatment. Such a lack of knowledge has implications regarding the manner in which patients make basic decisions related to their health, including planning for crises and making psychiatric advance directives (Clements, Cizman, Forchuk, Pallaveshi, & Rudnick, 2015).

This "right to know" is a fundamental ethical standard that is covered under several sections of the American Psychological Association Code of Conduct [see Informed Consent (Section 3.10), Informed Consent in Assessments (Section 9.03), and Informed Consent to Therapy (Section 10.01) in Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2016)]. Withholding pertinent information about a client's mental health status can also be considered an affront to basic respect (Yeung & Kam, 2008). In consideration of the right to self-determination, we recommend that clinicians at the least inquire about and comply with their clients' preferences regarding knowledge of their diagnosis.

#### **Caveats to Disclosure:**

##### **The Importance of Context**

While the literature indicates that a majority of mental health service users (62%–88%) desire truthfulness regarding diagnosis (Milton & Mullan, 2014), therapists should always weigh the costs and benefits on a case-by-case basis (Marzanski, Jainer, & Avery, 2002). Although limited, extant research indicates that certain groups may prefer varying degrees of disclosure. In particular, culture and age have emerged as potential moderating factors on the relationship between disclosure of medical diagnoses and outcome (Blackhall et al., 2001; Kagawa-Singer & Blackhall, 2001); however, few investigations have been conducted in the area of mental illness specifically. Generally speaking, certain patient populations (e.g., those from collectivistic cultures, with less formal education, of lower SES, at older ages) tend to view disclosure in more negative terms, and may want family members to be more integral parts of managing their care (Blackhall et al., 2001; Kwak & Salmon, 2007). Clinicians must ultimately integrate cultural competence

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into their practices, while simultaneously precluding stereotypes from overshadowing individual client preferences regarding disclosure and truth-telling (Berkman & Ko, 2009).

Timing is another factor to consider, both in terms of how providing a diagnosis will affect the patient and the therapeutic relationship (Fox, Lafortune, Boustani, & Brayne, 2013). Some settings, such as the Dialectical Behaviour Therapy (DBT) Centre of Vancouver, incorporate structured, comprehensive psychodiagnostic assessments and subsequent feedback into the intake process; however, such standards are not the case in all clinics. While early disclosure is generally advocated (Post & Whitehouse, 1995), there are cases in which strengthening the therapeutic relationship prior to such revelation may be beneficial. Examples include cases wherein clients present for treatment of a different and unrelated, yet valid problem (e.g., grief), with issues of imminent risk, and/or with concurrent problems such as extreme paranoia or distrust of the mental health care system. However, waiting too long before sharing a diagnosis may have equally detrimental effects. It can seriously compromise trust if a client hears about a diagnosis from another source, and delayed disclosure may prevent critical early intervention (Chanen et al., 2008; Paris, 2005a; Sharp & Tackett, 2014) and may fail to add clinically significant predictive utility to treatment for concurrent disorders, such as depression (Newton-Howes, Mulder, Ellis, Boden, & Joyce, in press). Unfortunately, there remains a dearth of empirical investigations reporting on this topic, and more research is needed before conclusions regarding the effects of diagnostic disclosure timing can be reached.

### **Practical Considerations for Disclosing Mental Health Diagnoses**

How might we broach this challenging topic with clients? Several protocols for

mental health diagnostic disclosure have been developed (Milton & Mullan, 2014). These include the broader SPIKES technique, adapted from oncology (Cleary, Hunt, Escott, & Walter, 2010; Cleary, Hunt, & Horsfall, 2009; Cleary, Hunt, & Walter, 2010) as well as other, more targeted illness-specific (Levin et al., 2011; Outram et al., 2014) and culturally-sensitive (Hwang, 2008) models. What unites these approaches is their focus on adequate preparation, appropriate and accurate use of assessment tools, face-to-face communication, the incorporation of idiographic variables (especially client perception of the problem), addressing the issue of stigma, sensitive and empathic responding, and continued follow-up (Milton & Mullan, 2014; Milton, Mullan, MacCann, & Hunt, 2017; Pinner, 2000). The importance of devoting adequate time to such discussions is also essential, yet often overlooked in terms of its effects of attenuating negative effects associated with receiving a difficult diagnosis (Gallagher, Arber, Chaplin, & Quirk, 2010). We encourage psychology training programs to implement discussion of such communication points, which are summarized in **Table 1 (top of next page.)**

### **Specific Tips When Imparting a BPD Diagnosis**

Once a clinician has obtained client permission, conducted a valid assessment, and determined the appropriateness of a BPD diagnosis, there are particular steps that can be taken to facilitate effectual disclosure. Professor Alexander Chapman, a psychologist who has extensive research and clinical experience with BPD, suggests that clinicians begin with a statement akin to the following: "Given the collection of symptoms/difficulties you've been experiencing over x period of time, my perception is that you are dealing with something called BPD" (A. L. Chapman, personal communication,

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**Table 1***General Recommendations Pertaining to Diagnostic Disclosure*

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Empirically-informed guidelines for clinicians
<ul style="list-style-type: none"><li>• Consider the use of a formal protocol that integrates assessment and diagnostic provision into treatment.</li><li>• Titrate delivery of diagnostic information at a pace that reflects client needs.</li><li>• Conduct regular, ongoing treatment monitoring and assessment to determine the impact of diagnosis on clients. Remain open to reevaluating, revising, and discussing diagnoses with clients throughout treatment.</li><li>• Provide clients with ongoing psychoeducation and resources about the disorder in ways they can understand, including referrals to specialized services when appropriate.</li><li>• Weigh the pros and cons of disclosure on a case-by-case basis, including consideration of the client's background, social support network, culture/ethnicity, and personal desires.</li><li>• Maintain primacy of the therapeutic relationship, both in terms of having established trust at the time of disclosure and using Rogerian conditions (empathy, genuineness, and positive regard) in the process delivering the news.</li><li>• Address the issue of stigma and the impact this can have on the life of the patient in terms of self, relationships, and health care.</li></ul>

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October 2015). Those with BPD expertise also recommend showing the client a list of diagnostic criteria and asking about the degree to which they identify with any of them (Biskin & Paris, 2012). This step can be linked with psychoeducation about the disorder, including a discussion about the epidemiology and biosocial processes involved in illness generation and maintenance. Depending on client preference, clinicians may use this opportunity to offer book recommendations or links to BPD support resources [e.g., National Education Alliance for Borderline Personality Disorder (NEA-BPD: <http://www.borderlinepersonalitydisorder.com/>); Treatment and Research Advancements for Borderline Personality Disorder (TARA; <http://www.tara4bpd.org/>)]. Clients should be given sufficient time to process this information; the combination of assessment and information delivery may require several sessions. Discussion about the various forms of stigma and their significance for the client will need to be addressed, and may continue throughout treatment. Finally, dialogue pertaining to recent improvements in psychotherapeutic treatment for BPD, psychopharmacological options, and

prognosis will potentially help alleviate some of the anxiety that accompanies diagnosis, and may in fact provide a measure of hope. Indeed, if communicated in a competent and empathic manner, it is thought that diagnostic disclosure may actually strengthen the working alliance and improve treatment compliance (Paccaloni, Pozzan, & Zimmermann, 2004; Shergill, Barker, & Greenberg, 1997; Zanarini & Frankenburg, 2008).

**Summary**

Initiating disclosure of a mental health diagnosis can be challenging and feel like a test of one's clinical skills. Nevertheless, we believe that these conversations are essential to the therapeutic process, and ultimately, in clients' best interests. When conducted in a sensitive, client-centered manner that is linked to clients' stated goals and values, such dialogues can offer much-needed validation, assist in organizing treatment planning, and lead to better outcomes.

**References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website. [www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)**

# Psychoeducational Training, Mental Health Literacy, and Help-Seeking Among African American College Students

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### Background Information

Prevalence of mental disorders among college students is comparable to that of non-students of the same age, and these disorders are increasing in number and severity (Blanco et al., 2008). Among African American college students, the underutilization of mental health services is especially prevalent. Adult African Americans are 10% more likely to report experiencing serious psychological distress than White adults (U.S. Department of Health and Human Services Office of Minority Health,



2017). African Americans are reported to have more chronic mental illnesses, such as psychotic disorders, and higher levels of disability (Rüsch et al., 2009). Yet, an estimated 25% of African Americans in need of professional mental health treatment fail to receive such services, as compared to 13% of Whites (Wells, Klap, Koike, & Sherbourne, 2001). This large treatment gap is greatly impacted by a lack of mental health knowledge (Rüsch et al., 2009). This study explores the effectiveness of psychoeducational training sessions in in-

creasing mental health literacy, as well as the willingness to seek help for mental health issues among African American college students.

*Help-seeking behaviors.* The prevalence of mental illness is the greatest among adolescents and young adults age 16 to 24 years. There is also a strong reluctance to seek professional help among this group (Gulliver, Griffiths, & Christensen, 2010). Cultural factors significantly impact groups that have strong social networks and less access to professional mental health care, such as African Americans. In general, culture biases against health care professionals prevent many African Americans from seeking help due to prior experiences of inadequate treatment, misdiagnoses, and a lack of cultural understanding from mental health providers (Rao, Feinglass, & Corrigan, 2007). Despite the abundance of research supporting the positive outcomes of intervention through mental health services, many African American young adults, including those of college age, will not voluntarily enter treatment, while others will pursue services but will not adhere to the prescribed treatment (Corrigan, 2004).

*Mental health literacy.* Mental health literacy consists of the knowledge, beliefs, and abilities that enable the recognition, management, and prevention of mental health problems (Jorm et al., 1997). Lack

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of knowledge of mental illnesses is of primary concern with regard to help seeking and treatment outcomes, as it may result in difficulty recognizing the risk factors, signs, and symptoms related to specific mental illnesses, as well as the appropriate professional help and pharmacological treatments for these illnesses. Delayed or untreated mental disorders are associated with school and job failure, teenage child-bearing, and early, violent, or unstable marriages (Kessler et al., 1997; Kessler, Foster, Saunders, & Stang, 1995; Kessler, Walters, & Forthofer, 1998). In contrast, possessing such knowledge promotes mental health stigma reduction, increased help-seeking behaviors, early detection, and positive treatment outcomes for mental illness (Robinson, Li, & Li, 2013). The likelihood of help-seeking is greatest among young adults who possess the ability to recognize symptoms of mental illness and have the knowledge and encouragement to seek help.

### **Attenuated Psychosis Syndrome**

Young adulthood is often associated with increased psychosocial stressors which give rise to a critical risk period for severe mental illnesses, such as psychosis. Studies examining lifetime prevalence rates of psychotic symptoms in the general population have consistently shown that a large percentage of people report having experienced psychotic symptoms, without meeting full criteria for a psychotic disorder diagnosis (Hanssen, Bijl, Vollebergh, & Van Os, 2003; Kendler, Gallagher, Abelson, & Kessler, 1996). Before the onset of psychotic disorders such as schizophrenia, there is typically a gradual decline in functioning, accompanied by the onset of subclinical or attenuated psychotic symptoms (APS) (American Psychiatric Association, 2013). Therefore, the APS phase may be the optimal period for preventive intervention due to the de-

velopmental vulnerability of adolescents and young adults. Interventions that provide culturally sensitive strategies to delivering knowledge of mental illness and help-seeking options may have the greatest likelihood of reducing effects of untreated subclinical psychotic symptoms (Adebimpe & Cohen, 1989).

### **Psychoeducational Training Session**

We conducted a study to explore if psychoeducational training sessions were effective in increasing mental health literacy and enhancing help-seeking behavior among African American college students attending a Historically Black university. We trained 177 college students between ages of 18 and 28 (male =52, female=125) who identified as Black or African American. This study, approved by the university Institutional Review Board, was a pre- and post-test design with a training session in between the pre and post-tests (about 75 minutes). Questionnaires and vignettes (pretest and posttest) were used to measure mental health literacy—knowledge of mental illness (psychosis related in particular) and help seeking behaviors, and to screen for APS. The training sessions included a Power Point Presentation introducing the concept of attenuated psychosis syndrome and discussing stigma, help-seeking pathways, and resources on campus and in the community. The presentation was intended to be culturally sensitive and accessible to the college age population, and included African American characters, as well as songs and lyrics depicting subclinical and full-blown psychotic symptoms.

The results of this study show that participants' ability to accurately identify APS symptoms increased by 26% following the psychoeducational training sessions. Additionally, following the psychoeducational training sessions, 52% of

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participants reported a high likelihood of seeking help for mental health issues.

Furthermore, findings of this study show that culturally sensitive psychoeducational training sessions would increase mental health literacy and enhance knowledge of severe mental illness and key symptoms. Research also supports improving mental health literacy as a useful tool in influencing help-seeking behaviors (Wright, McGorry, Harris, Jorm, & Pennell, 2006). Such evidence is similar to the current findings in that participants' positive attitudes toward help seeking increased following the mental health literacy intervention.

Our results also showed that participants screened as having a higher risk for psychosis would have higher help-seeking behavior following the psychoeducational training session. What is more, these participants identified a campus counselor or psychologist as the individual from whom the character should most likely seek help for related symptoms. The accurate identification of appropriate help-seeking options among participants further supports the effectiveness of the psychoeducational training. Researchers have shown that barriers to mental help-seeking may be due to the cultural mistrust held by many African Americans in predominantly White treatment settings (Dzokoto, Hicks, & Miller, 2007). There-

fore, in addition to training treatment providers to be more culturally competent, it is critical to educate African American college populations about severe mental illness symptoms and treatment resources. Such education sessions may shorten the duration of untreated illness, which may improve the outcome of future treatment.

In summary, colleges and universities are optimal settings for improving mental health literacy because of the high-risk age group served at these institutions. Nearly half of American youth attend some form of post-secondary education (National Center for Education Statistics, 2005). Reducing delays between first onset and treatment may improve the prognosis for mental illness among student populations and prevent the adverse social outcomes often associated with mental illness. Results from the current study suggest that enhancing mental health literacy has implications for influencing help-seeking behavior. In order to promote help-seeking behavior among ethnic minority college students, culturally responsive campus-based mental health services should be offered within higher education.

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### Where Do We Fit? Challenges Faced by First-Generation Graduate Students in Professional Psychology

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Considerable literature exists on the value of supporting first-generation college students (FGCS) since Billson and Terry (1982) coined the term, “first-generation college student” to describe students whose parents did not attend college. However, there is limited research on first-generation graduate students (FGGS), especially those in health service psychology programs. Motivated in part by the American Psychological Association’s (APA) commitment to increasing recruitment and retention of diverse doctoral students to serve increasingly diverse patient populations (APA, 2002), and by data indicating FGCS are likely to come from diverse backgrounds (Davis, 2010; National Science Foundation, 2015), it is essential to identify best practices for programs to nurture the success of psychology doctoral students.

First-generation college students are as likely as their non-first-generation peers to aspire to graduate education, yet are less likely to earn graduate degrees (Engle & Tinto, 2008). Applying the Cultural Mismatch Theory (Stephens, Fryberg, Markus, Johnson, & Covarrubias, 2012), this study examines the challenges FGGS face in their pursuit of graduate education by answering the following questions: 1) How do FGGS navigate college into a professional psychology doctoral program; 2) what are their experiences within the doctoral

training program; and 3) what recommendations do these students have for programs to better support first-generation students. Recommendations to improve support and retention are discussed.

#### First-Generation College and Graduate Students

Researchers estimate that 43%-50% of college students can claim first-generation status (Choy, 2001; Nunez & Cuccaro-Alamin, 1998). At the undergraduate level, first-generation students are considered an at-risk population compared to their non-first-generation peers; they report feeling less prepared for college (Reid & Moore, 2008), perceive more barriers to attending college (Gibbons & Borders, 2010), and are at higher risk for attrition (Billson & Terry, 1982; Woosley & Shepler, 2011). FGCS are more likely to identify as a racial minority, come from a lower socioeconomic class, speak a language other than English at home, have concerns about financial aid, and take on full-time work to finance their education (Bui, 2002; Terenzini, Springer, Yaeger, Pascarella, & Nora, 1996; Warburton, Bugarin, & Nunez, 2001). Negative psychological phenomena common to all students, such as imposter syndrome and stereotype threat, seem to affect the performance of FGCS more acutely than their non-first-generation peers (Martinez, Sher, Krull, & Wood, 2009). Furthermore, those with multiple stigmatized aspects of identity (i.e., gender-, race-,

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and income-based threats) experienced significantly greater stereotype threat effects (e.g., decreased academic performance) than those with fewer stigmatized identities (Tine & Gotlieb, 2013), which is salient because FGCS are more likely to hold multiple identities vulnerable to stereotype threat (Davis, 2010).

Existing FGGS research identifies financial barriers (Michalski, Kohout, Wicherski, & Hart, 2011) and limited social capital (Gardner & Holley, 2011) as two culprits that limit access to doctoral training. The APA has shown a commitment to multiculturalism and advocates for diversifying graduate student populations, particularly given the primary entry point to becoming a psychologist is earning a graduate degree (APA, 2002). Since 1987, the Doctor of Psychology degree (PsyD) has steadily outpaced traditional Doctor of Philosophy (PhD) degrees as a viable path to becoming a psychologist. From 2007 to 2008, 53% of clinical doctorates were awarded in PsyD programs (Kohout & Wicherski, 2010). Acceptance rates in PsyD programs are higher than PhD programs (31% and 8%, respectively), but so is the median student debt at graduation (\$120,000 and \$68,000, respectively) (Michalski, Kohout, Wicherski, & Hart, 2011; Kohout & Wicherski, 2009). Identifying other opportunities to support first-generation students becomes paramount to successfully diversifying training programs and the field of health service psychology.

### **Cultural Mismatch Theory**

Performance, and consequently, success, in academic settings is mediated by individual factors and interaction with the environment. For many, college is a cultural experience; for some, it is a cross-cultural experience (Stephens et al., 2012). The Cultural Mismatch Theory states that "individual performance is

contingent on whether people experience a match or a mismatch between their own cultural norms and the norms that are institutionalized in a given setting" (Stephens et al., 2012, p. 1180). The theory claims: 1) American university culture reflects pervasive middle-class norms of independence; 2) the effect of the university culture's focus on independence depends on the students' cultural frameworks; and 3) a cultural match or mismatch affects students' performance by influencing students' perception of the setting and tasks required of them (Stephens et al., 2012, p. 1193).

First-generation students were found to adhere more closely to the interdependent model of self (e.g., be connected to others, respond to the preferences of others) than independent model of self (e.g., follow your passion, chart your own course) found in universities. Interdependent students wanted greater guidance from professors and became frustrated when excessive value was placed on them pursuing their own paths. The more closely a student's model of self is similar or adaptable to the institution's existing framework, the more likely the student is to succeed, and the converse is true for mismatches. Based on these findings, the researchers proposed changes to improve institutional culture to "recognize, appreciate, and accommodate more than one cultural model of how to be a student" (Stephens et al., 2012, p. 1194). Importantly, they believe that expanding the institutional culture to capture interdependent notions would benefit first-generation students without hindering non-first-generation students' performance.

### **Methods**

After IRB approval, six PsyD participants (five women and one man), rang-

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ing in age from 26 to 39 years old, were interviewed to explore their decision to attend college, graduate school, and the current institution. Students were asked how their college and graduate experiences differed, the impact and challenges of their first-generation status, support systems, whether they felt their experience would have differed if they were not first-generation students, and recommendations for the institution. The following races/ethnicities and socioeconomic backgrounds were self-identified in the participants: Caucasian (1), Asian (2), Hispanic/Latina (1), Native American (1), and biracial (1); upper-middle class (1), lower-middle class (2), lower middle working class (1), and working class (2). For seven of the participants' parents, the highest level of education was high school/GED; one parent completed a trade school; and four parents did not complete high school. This study utilized Grounded Theory (Corbin & Strauss, 2015; Glaser & Strauss, 1967) and the Cultural Mismatch Theory (Stephens et al., 2012) for analysis.

## Results

Three conceptual themes emerged. **Different Worlds**—referring to the emotional toll and isolation students felt from their families of origin (“It’s almost like living in two different worlds, and one where they are completely unfamiliar with this side of things. I wish I could tell them and they would just know why it’s so hard.”). Students described feeling disconnected from their families of origin as they pursued specialized, doctoral education. The isolation was exacerbated in a field where clinical work can be emotionally taxing and social support becomes paramount to one’s self-care (“Going into a psychology program, it’s such a personal, educational experience .... we’re talking about really intense, heavy things that we’re dealing

with on a daily basis and when you come home from a long day at work, they don’t really understand.”). **Figuring it Out**—referring to students overcoming challenges and missteps to find resilience. College, while still unfamiliar to first-generation students and their families, was a more common experience amongst one’s peers. Because graduate school was not a normative step after college (“If I wanted to do it, I would have to figure it out on my own.”), students desired more guidance and support as they pursued graduate school. Some learned the hard way after accruing debt from programs that did not move them toward their desired career paths. **Finding Support**—referring to places and people from whom students found support and strength. Graduate school brought mixed experiences with faculty and peers (“My perception of graduate school—it gives me the impression that everyone is so busy and [you] try not to get into other people’s way”). Faculty seemed harder to access and peers seemed to have greater access to valuable resources, further intensifying the challenges already present in a rigorous, demanding environment. These themes shed light on the unique challenges of first-generation students, particularly the impact of mismatches between students’ implicit cultural framework and that of the academic institution.

## Discussion

First-generation students felt confident to pursue doctoral training following positive and successful academic performance in their undergraduate program. Students spoke of challenges from high school to college, while persistence, determination, and willingness to ask for help were critical variables that helped students “figure it out.” These students benefited from a strong match

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between themselves and the college institution. Shared values such as diversity, access to professors, mentoring relationships, smaller settings, and access to important resources (i.e., first-generation student groups) helped them succeed. An adequate cultural match between college institution and cultural values allowed personal ambition and intelligence to flourish.

Students spoke of the distinct emotional distance felt between themselves and their families of origin after enrollment. Attempts to share new experiences with family were met with misunderstanding, invalidation, or outright discouragement, which caused varying degrees of psychological distress. As students gain economic and social capital through their doctoral training, a cultural distance appears to grow between them and their families of origin. This isolation is exacerbated within a graduate program where social, economic, and cultural distance already exists between themselves, their peers, and the institution. FGGS who feel trapped in an ambiguous space—no longer like their families of origin, and not quite like their graduate peers—may be at greater risk of attrition and hardship unless there is a strong match with their graduate program, or they are able to quickly adapt to the norms of the program. The Cultural Mismatch Theory suggests they succeeded because of the goodness of fit between themselves and their undergraduate institution; a similar issue of match with the graduate institution mediates their success or struggles.

Remarkably, students believed it was *not* the program's responsibility to provide support (namely, emotional support) beyond practical aid (i.e., financial aid, academic breaks). Graduate school was perceived as "the last stage before you step out into society," and represented a

test of sorts, as if to see whether the student were truly able to "figure it out," alone. A shared sentiment was that any support for first-generation students should be provided before graduate school, as currently-enrolled students "should know how by now."

The Cultural Mismatch Theory would suggest the pressure to adapt to an independence model may be due to the explicit and implicit messages of the institution. Even more than undergraduate institutions, peers and faculty members in doctoral programs are likely to come from middle- and upper-class backgrounds that highly value cultural models of independence. Thus, when the norms of doctoral institutions reflect the people within it, the potential for a severe mismatch between first-generation students' models of self is more likely, and perhaps creates a starker contrast and greater impact than that which is observed at the undergraduate level. The results suggest that messages of independence and pressure for self-reliance created a sense of isolation from family, from peers, from faculty, as well as psychological distress for the individual. Notably, the impact of cultural mismatch at the graduate level extends beyond academic performance, into the student's psychological well-being and experience of self and others. Students spoke of the emotional toll felt with family members as they enter a different social identity, the sensitive content encountered in clinical psychology (i.e., secondary trauma), and the importance of (and difficulty in achieving) connectedness with social support. The critical question that follows is: Is it the student's responsibility or the institution's responsibility to adapt their cultural norms to "recognize, appreciate, and accommodate more than one cultural model of how to be a student" (Stephens

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et al., 2012, p. 1194)? In agreement with the authors of the Cultural Mismatch Theory, recommendations are provided to encourage institutions to consider small changes that can expand their reach to first-generation students and thereby increase their support for the academic pursuits of all students.

**Recommendations**

Graduate programs committed to investing in first-generation students can implement changes to the existing, normative culture to be more responsive and inclusive of first-generation students' needs. While these students have significant strengths, resilience, and academic ability, they have little guidance from external sources to support or understand their graduate endeavors, which requires more specialized knowledge. The graduate program itself becomes the most critical and primary source of practical support (i.e., financial aid, permission for self-care/time-off), emotional support (i.e., mentoring, normalizing the graduate school experience, encouraging peer relationships), and academic and professional guidance (i.e., advising, career development, understanding and choosing a specialty focus). Programs may benefit from taking into account the following considerations:

- Identifying first-generation students at admission (thus allowing programs to target interventions early).
- Providing additional support with practicum placements and understanding how these early training experiences could impact career trajectories, including internship, post-doctoral training, and so forth.
- Facilitating professional relationships, especially by those sensitive to first-generation issues, through su-

pervision, mentoring, or advising—crucial for professional and personal development to help students incorporate feedback to identify areas of interest and strength for career specialization as well as success in the program.

- Discussing issues related to first-generation students in diversity courses or discussion groups, allowing for the normalization of these students' stories and offering a space for them to verbalize their experiences.
- Offering additional sources of financial aid for first-generation students, which could increase heterogeneity in the student population to potentially include socioeconomic differences, correlated with a variety of other identity statuses and life experiences.
- Providing multicultural training to faculty which includes current literature and research related to first-generation students as an underrepresented group.

These efforts to diminish the negative impact of cultural mismatch for current first-generation doctoral students will not only be helpful for the individuals, but could also improve diversity within training programs and in the practice of health service psychology.

**Editors' Note:** This article was adapted from a doctoral paper completed in May of 2017 (Chair: Jennifer Erickson Cornish, PhD; Committee members: Lavita Nadkarni, PhD, and Kenli Urruty, PhD).

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# ETHICS IN PSYCHOTHERAPY

**Editor's Note:** Meet our new Contributing Editor in Ethics, Dr. Apryl Alexander. Dr. Alexander received a BS in Psychology from Virginia Tech and a MS in Clinical Psychology from Radford University. She received both her MS and PsyD in Clinical Psychology from the Florida Institute of Technology, with specializations in forensic psychology and child/family therapy. Dr. Alexander completed a pre-doctoral internship at Patton State Hospital, a fellowship at Minnesota State Operated Forensic Services, and spent three years at Auburn University before joining the Graduate School of Professional Psychology at the University of Denver. Her current research and clinical work involves the assessment and treatment of adjudicated juveniles, victimization in adolescents and emerging adults, and trauma- and culturally-informed practice.

## Conversion “Therapy”: Current Policy and Ethical Issues

Apryl Alexander, PsyD  
University of Denver



On April 25, 2017, Senate Bill 928 (2017)—Therapeutic Fraud Prevention Act of 2017 was introduced to Congress. The act would “prohibit, as an unfair or deceptive act or practice, commercial sexual orientation conversion therapy, and for other purposes.” Conversion therapy, also known as reparative therapy, is a term for approaches aimed at changing lesbian, gay, and bisexual (LGB) people to a heterosexual orientation (Yarhouse & Burkett, 2002) or at diminishing same-sex behavior and/or attractions. Senate Bill 928 provides a broader definition of conversion therapy (to include gender identity) as:

any practice or treatment by any person that seeks to change another individual’s sexual orientation or gender identity, including efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender, if such person receives monetary compensation in exchange for such practices or treatments.

Additionally, this year several states introduced bills which would prohibit licensed mental health professionals from using conversion therapy with minors. New Mexico became the most recent state to pass such legislation (April 7, 2017) and 17 other states filed bills in this year. To date, several states (California, Illinois, New Jersey, New York, Oregon, Vermont, and the District of Columbia) have passed similar laws banning conversion therapy with minors.

Conversion therapy is based on the belief that an LGB sexual orientation is a mental illness or sinful (Haldeman, 2002). The American Psychiatric Association (APA) removed homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1973—over 40 years ago. Further, in 2000, the American Psychological Association affirmed that “same-sex sexual and romantic attractions, feelings, and behaviors are normal and positive variations of human sexuality regardless of sexual orientation identity” (American Psychological Association, 2009).

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### **Risks Associated With Conversion Therapy**

Despite the acknowledgment that homosexuality is not a mental illness, conversion therapy is still being practiced. Individuals with varying levels of mental health training—psychologists, psychiatrists, social workers, pastoral counselors, religious leaders, and laypersons with no formal training (Yarhouse & Burkett, 2002; Yarhouse, Burkett, & Kreeft, 2002)—engage in conversion therapy. Patients report the following techniques: various talk-based therapies, electric shock, orgasmic reconditioning aversive conditioning, isolation with someone of the opposite sex, exorcism, covert sensitization, marriage, and gender modification therapy (Tozer & McClanahan, 1999). For children and adolescents, conversion therapy attempts to change a child’s behavior, dress, and mannerisms to be more consistent with those stereotypically expected of their assigned sex at birth (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015).

Many professional organizations are in consensus that conversion therapy may be harmful to clients (American Psychiatric Association, 2000; American Psychological Association, 1998; GLMA, 2013; National Association of Social Workers, 2000). Conversion therapy fails to meet criteria for an empirically-supported treatment. Researchers have reported that conversion therapy practices are ineffective in decreasing the likelihood of a future same-gender sexual orientation (Zucker & Bradley, 1995). In fact, research suggests that conversion therapy is associated with many negative outcomes for LGB clients, including increased level of depressive symptoms, frequent suicidal ideation and attempts, social isolation and anger toward family members, and decreased levels of self-worth (Haldeman, 2002; Serovich et al.,

2008). Although we understand that adolescence is a time of sexual fluidity and curiosity, these harmful practices are being used with adolescents who might be perceived as non-heterosexual or gender nonconforming (American Psychological Association, 2009b; SAMHSA, 2015). LGB adolescents are especially vulnerable and at risk for negative outcomes of conversion therapy such as family rejection, depression, health risks, homelessness, and death by suicide (American Psychological Association, 2009b; SAMHSA, 2015).

### **Responses From the Professional Community**

The APA’s 1998 Resolution on Appropriate Therapeutic Responses to Sexual Orientation describes the lack of efficacy conversion therapy. In 2000, the American Psychiatric Association adopted an official position statement opposing the practice of conversion therapy or any therapy that is based on the belief that LGB sexual orientation is a mental illness. The American Association of Marriage and Family Therapy and American Counseling Association also followed suit with statements (American Association for Marriage and Family Therapy, 2009; American Counseling Association, 2013). The Substance Abuse and Mental Health Services Administration (SAMHSA), with the support of APA, called for an end to the practice of conversion therapy for children and youth in 2015 (SAMHSA, 2015).

*Ethical concerns.* Ethical guidelines call for scientific bases for professional judgments, benefit from harm, justice, and respect for people’s rights and dignity. In 2015, the American Counseling Association Chief Executive Officer Richard Yep stated, “Our code of ethics is really grounded on ‘do no harm.’ Our feeling is that people who are exposed to sexual

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orientation change efforts are exposed to all sorts of harm” (Grisham, 2015). The APA’s Ethical Principles of Psychologists and Code of Conduct (2016) provide guiding principles to professionals in the field of psychology. Below are the important and relevant General Principles which should guide decisions to not conduct conversion therapy with LGB persons:

***Principle A Beneficence and Nonmaleficence.*** The General Principle reads, “Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally” (also see Standard 3.04 Avoiding Harm). The ultimate goal of psychologists and mental health professionals is to avoid or limit harm. Treatment should support and promote the health and well-being of those being served rather than further marginalize. Further, sexual minority youth are a vulnerable population who lack protections from involuntary and coercive treatment, as their caregivers have to make informed decisions about their mental health care. Caregivers should be provided with scientifically accurate information in order to make these decisions and reduce harm. Given the paucity of research supporting the efficacy of conversion therapy, the practice should be banned in order to abide by this general ethical principle.

***Principle C Integrity.*** The General Principle states, “Psychologists seek to promote accuracy, honesty and truthfulness in the science, teaching and practice of psychology.” The goal of conversion therapy is to alter or change a person’s sexual orientation to a heterosexual orientation. However, numerous studies have demonstrated this is ineffective. In addition, the General Principle of In-

tegrity, Standard 5.01 Avoidance of False or Deceptive Statements notes, “Psychologists do not knowingly make public statements that are false, deceptive or fraudulent concerning their research, practice or other work activities or those of persons or organizations with which they are affiliated.” In 2012, the APA disseminated guidelines for working with LGB clients which encourages the use of accurate information on sexual orientation and sexuality (American Psychological Association, 2012). Additionally, Standard 8.10 addresses avoiding deceptive research, as research about LGB people has been historically misused and misrepresented (see Herek, 1995; Herek, Kimmel, Amaro, & Melton, 1991; Russell & Kelly, 2003).

***Principle E Respect for People’s Rights and Dignity.*** The General Principle reads,

Psychologists are aware of and respect cultural, individual and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

Psychologists must be aware of the heterosexism and homophobia and the impact it has on LGB clients. The practice of conversion therapy posits that LGB individuals are mentally ill, inferior, or in need of repair or change, which—in addition to being incorrect—violates the dignity of LGB persons. This practice

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denies individuals with the acceptance, support, and nurturance that is essential to the therapeutic relationship.

**Principle D Justice.** The General Principle states, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence and the limitations of their expertise do not lead to or condone unjust practices." Psychologists may inhibit both explicit and implicit biases about LGB individuals. Again, conversion therapy is rooted in heteronormative and homophobic viewpoints about same-sex attraction. This Principle encourages psychologists to take precautions to reduce such biases, as not to cause harm or engage in incompetent practice. Standards 2.01 Boundaries of Competence and 3.01 Unfair Discrimination also address that psychologists should take precautions to ensure that their potential biases do not lead to unjust practices.

In addition to those guidelines, scholars have argued that conversion therapy is unethical because it is intended to change a marginalized group into members of the dominant group—essentially forcing LGBTQ individuals to conform to societal norms based on heterosexist and heteronormative assumptions that idealize and solely validate a heterosexual sexual orientation (Green, 2003; Jenkins & Johnston, 2004; McGeorge & Carlson, 2011; Oswald, Blume, & Marks, 2005; Serovich et al., 2008; Tozer & McClanahan, 1999).

*Lingering controversies.* As noted above, despite the lack of empirical evidence for conversion therapy and ethical guidelines informing professional judgment when considering such practice, mental health professionals continue to practice conversion therapy and views on conversion therapy are mixed. According to Tozer and Hayes (2004),

many mental health professionals either provide conversion therapy or refer clients to clinicians who offer such services. For instance, McGeorge, Carlson, and Toomey (2015) surveyed 762 members of the American Association for Marriage and Family Therapy (AAMFT) about their beliefs regarding conversion therapy. Although approximately 73% of participants reported it is unethical to practice conversion therapy, 20% reported that it is ethical to practice conversion therapy and it is possible (if presented the opportunity) that these individuals could practice conversion therapy in the future. In fact, 3.5% of participants endorsed having practiced conversion therapy.

### **Future Directions**

Where do we go from here? The field of psychology has progressed significantly in its treatment of LGB person since the removal of homosexuality from the DSM in 1973. In the APA's 1975 resolution, it urged "all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" (Conger, 1975, p. 633). However, future strides need to be made to promote affirming therapeutic practices (i.e., practices that are culturally-informed, evidence-based approach and do not pathologize sexual orientation or gender identity) for LGB individuals. For instance, the APA recommends providing relevant material concerning LGBT issues, as well as training in affirmative, evidence-based and multiculturally informed interventions for sexual minorities, in undergraduate programs, graduate training programs, internship sites, and postdoctoral programs (APA, 2009). Continued work must include advocating for these individuals in times of public policy reform in order to facilitate broader social change. Although biases

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and misinformation about LGB individuals continue to exist, psychologists and leading mental health organizations must attempt correct these ideals about LGB persons with accurate scientific knowledge, and competent and sound professional practice.

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## The Importance of Psychotherapists' Feminist Identification

*Jake Wolf, M.Ed.  
Lehigh University*



I am a therapist-in-training and I am a feminist psychotherapist. Just as it is important to identify my trainee status when I meet a client for the first time, I find it is equally important to identify myself as a feminist psychotherapist. Feminism has been defined and redefined a number of times over the years as the waves of feminism have evolved. Hartstock (1981) defined feminism in a way that has particularly clear applications to therapy. She says, "At bottom feminism is a mode of analysis, a method of approaching life and politics, rather than a set of political conclusions about the oppression of women" (p. 35). Over the past 50 years, feminist psychotherapists have developed models of psychotherapy that are in line with Hartstock's definition. My charge to psychotherapists who believe in understanding clients holistically and who believe in social equity is to outwardly identify themselves as feminists. It is important to have an understanding of why the term feminism is so important for making social equity a realistic goal, and part of this is understanding the history of feminist therapy in the field of psychology.

### **Roots of Feminist Psychotherapy**

Feminist therapy evolved with the rise of the second wave of the feminist movement in the 1960s as psychologists started to understand women's issues from a psychological perspective (Enns, Williams, & Fassinger, 2013). Early fem-

inists engaged in "consciousness raising" sessions where they talked about issues that they experienced as women (Brown, 2010; Enns et al., 2013). Consciousness raising sessions were a way for women to validate their experiences as women and were the earliest forms of feminist group counseling. Ideas like sexual harassment and sexual discrimination were simply not terms until women had the opportunity to get together and come to realize that the problems they were facing were not unique to them, but rather systematic (Brown, 2010). Feminist psychologists have recognized the ways that psychology as a discipline has been biased towards seeing White, heterosexual, cisgender, males as the psychological norm and those who do not fall within those categories are viewed as abnormal (Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972). Recognizing these biases within the field of psychology has been a major part of the push for further analysis of ways that bias plays a role in the work that psychotherapists do.

### **Feminist Psychotherapy and Intersectionality**

Feminist psychotherapists are constantly working to be aware of their own biases and how they might be inserting them into their work with their clients. A feminist psychotherapist is one who recognizes and values the role that intersecting social identities have in psychological distress. Feminist theory asserts that psychological distress is a

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reaction to a loss of social power and is therefore an adaptive response to maladaptive circumstances. Integrating these types of understandings into therapy work can allow psychotherapists to free up their own biases about the limits of human potential. Brown (2010) and other feminist theorists have asserted that feminist therapy can be helpful for folks of varying social locations as it allows clinicians to view clients as more complex and resilient beings and also allows clients to feel empowered to understand their own places in the system of power, privilege, and oppression.

This broader understanding of the differing ways that folks may experience things based on their differing social identities is what Crenshaw (1996) called intersectionality. This is the idea that our social identities are not simple laundry lists that can be checked off to determine the kinds of experiences that we might have as one type of person or another. Rather, social identities interact in a more dynamic and complex way. That is, the varying degrees of power and privilege that come with multiple personal identities interact to shape the types of experiences a person has. Crenshaw uses the case of a Black woman's experience of both racism and sexism. Her social identities as a woman and a person of color find her at the intersection of two marginalized identities in terms of her race and her sex. In Crenshaw's case, the woman is a cisgender, able bodied individual, which allows her certain privileges though there are other aspects of her identity that are marginalized or oppressed. This model should not be understood as saying that folks ought to be grateful for the privileged areas of their lives; rather, an intersectional approach can help us to understand that people's varying identities will shape their experiences in unique ways. The understanding ought

to be about how individuals' unique social locations might shape their experiences, meaning all individuals in any particular group will not have the same needs. This intersectional approach allows a more dynamic understanding of the various ways that people experience power and privilege. This is the type of feminism that will be the catalyst for social change.

### **Implications for Psychotherapists**

I want to challenge psychotherapists to outwardly identify themselves as feminists to their clients and their colleagues. Psychotherapists' feminist identification will help shed light on the egregious inequities inherent in the patriarchy, break down stigma surrounding the term feminism, and open the door for more therapeutic work surrounding issues that arise from the intersections of an individual's social identities. My goal is not to make everyone a feminist psychotherapist; rather, I hope to encourage more psychotherapists who embrace the values of gender and social equity to embrace a feminist identity for the benefits that it will have for them and their clients. Feminist identification is needed particularly in light of the sociopolitical climate surrounding issues of equality around the world.

There is a myth in our culture that we are currently in a "post-feminist" or "post-racist" era where movements toward equality are comparable to complaining. We are in the era of mocking "snowflakes," folks who celebrate their individuality and diversity, and people who need safe spaces literally and figuratively to talk about their issues or to simply exist. Opponents of social justice initiatives often argue that things are not as bad as they used to be and that we ought to just move on to focus on the "bigger issues" that we face. This "big-

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ger issues” argument misses the point that feminism is one of the ways that we can have a more nuanced understanding of the historical (and ongoing) inequities that exist because of gender, sex, sexual orientation, race, ethnicity, and the whole host of other cultural and social identities that we have as human beings. This is where feminist and humanistic theories sound similar: Feminists and humanists alike are interested in understanding the person as a whole and in the context of how they experience the world.

### **Feminist Psychotherapy and Humanism**

Humanism is about recognizing the inherent good in people and helping an individual to self-actualize in a way that makes sense for them. The humanist movement in psychology was born out of a reaction to the behaviorist movement and its emphasis on what was posited as observable and quantifiable truth. In theory, this reaction is very much in line with what feminists are talking about; there needs to be more of a focus on people as whole beings who exist in complex social, emotional, and political climates. Some might argue that it is not the term feminism, but rather humanism, that would be more effective at moving towards social equity. The argument might be that feminism is about women only and that it would be a detriment to anyone who does not fit the definition of a traditionally defined woman. However, rather than operating on the implied humanistic assumption that everyone has an equal opportunity to self-actualize, feminism explicitly recognizes that sexism, racism, and other forms of oppression make the playing field far from level. The third wave of feminism, with all of its flaws, is being pushed in a direction to include people of all intersectional social locations. Feminism is about valu-

ing the experiences of women and girls as well as those who do not identify within the gender binary, rather than placing more value on the experiences of men and boys. Using a term like feminism points out the historic inequality that has existed between those in the privileged and marginalized groups.

I often hear well intentioned folks say things like, “I’m not a feminist, I’m a humanist” on the premise that no one group of people ought to be treated better than another, even if the intention is to right a historic wrongdoing. The basic claim they are making is that all people ought to be treated equally regardless of who they are. To draw a comparison, the Black Lives Matter (BLM) movement drew considerable criticism for focusing on Black lives when opponents claimed that “all lives” mattered. It is the case that all lives matter; however, historically, there has been a systematic devaluing of Black lives. In this case, so much so that Black folks are being killed for being Black. Therefore, it is important to specifically focus on Black lives so as to balance this historic systemic injustice. This social movement is arguing that historically we have valued, as a society, other lives over Black lives—therefore, we need to try to shift the balance and change the social value that is placed on certain lives. If we continue to say that all lives matter, we are submitting to the status quo and not working to challenge systemic injustice. By the same logic, calling one’s self a humanist rather than a feminist is much like claiming that all lives matter. The idea of being a humanist or a post feminist is operating on the false assumption that we have achieved gender equality. Much like the BLM movement, the claim was not that White lives, or in this case non-female lives, are to be valued any less; rather, that the historic system-

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atic devaluing of non-White/non-female lives needs to be disrupted.

Sexist ideology has real implications for our society. The systematic devaluing of women and girls that is perpetuated by the media, policies, and culture is related to the increased rates of sexual violence, sex trafficking, domestic violence, and a variety of other harms that women and girls experience, and it contributes to a culture in which these things are permissible (Herman, 1984). The claim that all lives matter or that we should all be humanists are both idealistic and operate on patriarchal ideals that perpetuate myths of equality. The myth inherent in humanism devalues the real oppression of women and girls that leads to gender based violence. If we continue to minimize the value of identifying the issues inherent in the patriarchy, we are complicit in perpetuating the problems that it creates. I have to acknowledge, though, that there is an immense amount of hesitancy on the part of wonderful and caring people to outwardly adopt a feminist label because of the stigma attached.

### **Feminist Psychotherapy and Stigma**

It seems as though one of the things that needs to happen in the process of making feminism more accessible and helpful for people is working to destigmatize the word. Liss Hoffner, and Crawford (2000) found that even folks who agree with the ideas of gender equality struggle to identify as feminists because of the stigma or misunderstanding around what the word really means. Psychotherapists are in a position to non-judgmentally open conversations with clients. Feminism as a term has been through the metaphorical ringer since the 1960s, and has even been referred to broadly as “the other F word.” Terms like “man haters” and “Feminazis” are used to delegitimize and misinterpret the central ideology of feminism. The

pushback against feminism has been a largely reactive response from folks whose reductionistic understanding of the goals of feminism is perhaps misguided. Specifically, there are folks who view feminism as a threat to their social, economic, and political power because it values other voices as much as their own. Additionally, we must admit that, as with any major theoretical approach to social justice, there have been issues with feminism in its evolution. Feminism was not always inclusive of women of color, non-heterosexual, and non cis-gender women. The women’s movement has been criticized as a cause fundamentally focused on White, straight, middle class, and cis-gender women. Further, there are many feminists who still argue about the involvement of men in the feminist movement. In recent years, many feminist scholars have argued that a more inclusive feminist movement or an integration of feminism and multiculturalism would better promote equality and work toward destroying patriarchal structures (Williams & Barber, 2004). A more robust and inclusive understanding of feminism will help to provide a common language for folks to talk about and further the cause of equality. It seems to be the case that a combination of patriarchal pressure to conform, the growing pains of an ever-changing movement, and experiences of feeling ostracized have all served to stigmatize any associations with feminism. This has resulted in people being hesitant to embrace a label that could be detrimental to them socially, economically, and otherwise. Destigmatizing the term is an important step in the process toward social equity, and psychotherapists are in a unique position to take up that cause. One of the ways psychotherapists can do this is by identifying as feminists and by taking a feminist approach to their therapy work.

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## Next Steps

So why is it important for psychotherapists to outwardly identify as feminists? The work of de-stigmatizing the F-word begins with opening the dialogue about what the term means. One might not think twice about identifying as a cognitive-behavioral psychotherapist because that term seems to carry less political weight in our perceptions of how clients might judge the psychotherapist. We might even have a discussion about what therapy will look like, such as identifying cognitive distortions and completing homework assignments. As psychotherapists, we see this as a largely benign conversation, unlikely to put many clients off unless they have had negative experiences with a CBT psychotherapist in the past. However, identifying as a feminist or even as a feminist psychotherapist comes with more strings attached. Some folks may be more receptive initially based on their positive experiences with feminism and may seem the perfect fit. It is not for these clients that we need to dispel the myths and destigmatize the word. Openly identifying oneself as a feminist

and showing what feminism means can start the process of showing that this is a movement with a focus on legitimizing the experience of people who have not been in positions of power. This is a central goal of feminist therapy: empowering clients and validating their experiences in the world rather than pathologizing them because they do not fit within the dominant scripts. This understanding of feminism should not be taken as one that leads back to the argument that we ought to all be “humanist” rather than feminists. It is imperative that we flip the script and recognize that for too long a humanist understanding has been a veiled way of continuing to privilege the experience of those in power and oppress those without. Identifying and practicing in a way consistent with feminist values is imperative for empowering people to feel whole.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website. [www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)



## NOTICE TO READERS

**References for articles appearing in this issue can be found on the Society's website under "Publications," the "Bulletin."**

**Please click on the Bulletin issue for which you would like references. Go to the Table of Contents, and find "References." References for all articles in the issue will begin on that page.**

# INTERNATIONAL SCENE

## April Conference News

*Fen Liu*

*Guangrong Jiang, PhD*

*Hubei Oriental Insight Mental Health Institution*



Supervision and Ethics: The Conference of Professionalization of Psychological Counseling and Therapy was held by Clinical and Counseling Psychology Registration System, CPS, and Hubei Oriental Insight Mental Health Institution, and co-organized by The Society of the Advancement of Psychotherapy (Division 29, APA) from April 21 to 23, 2017, in Wuhan.



In addition to being the first time a thematic meeting focused on Supervision and Ethics theme was held in China, this conference promoted the standardization and professionalization of the mental health field. This process has raised great concerns and expectations from the society as a whole, as well as developing a lot in recent years. A total of 226 persons who are from the Chinese mainland, Taiwan, and the United States attended the conference, including four

former chairs of Taiwan Psychological Counseling Association, three consecutive chairs of The Society of the Advancement of Psychotherapy (Division 29, APA) from 2015 to 2017, as well as the majority of the rotating presidents of the Clinical and Consulting Committee, CPS.

During the three days, Chinese and overseas experts held deep discussions on the themes of the conference. The conference included 11 invited lectures and 2 thematic forums, including content such as Facilitating the Development of Psychotherapy Expertise, Network Counseling Ethics, Professionalization of Supervision, and so on. At the same time, eight evening workshops were conducted, with two workshops being held before and after the conference. In addition, 23 essay reports were accepted, which mainly talked about ethics of psychological counseling practice and research, as well as theory and practice of supervision. Experts and scholars from around the world gathered together to share ideas and offer advice and suggestions for the development of the professionalization of Psychological Counseling and Therapy in China.

*D29 Fellow Lauren Behrman, Professor Guangrong Jiang (Founder, Oriental Insight), and SAP President Jeff Zimmerman.*



**SOCIETY FOR THE ADVANCEMENT OF  
PSYCHOTHERAPY • APA DIVISION 29  
2017 Convention Program • Washington, DC**

**THURSDAY, AUGUST 3RD**

**Symposium (A): Supervision—Master Supervisors of Various Orientations  
Show and Discuss Their Supervision Session Videos**

9:00 AM - 10:50 AM • Convention Center Room 152B

**Chair**

Hanna Levenson, PhD

**Participant/1stAuthor**

Cory F. Newman, PhD

John C. Norcross, PhD

Carol A. Falender, PhD

**Discussant**

Hanna Levenson, PhD

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**Poster Session (F): Psychotherapy—Science, Practice and Advances—II**

11:00 AM - 11:50 AM • Convention Center Halls D and E

**Participant/1stAuthor**

Katherine E. Dorociak, MA

Kathryn V. Kline, BS

Xu Li, MEd

Tovah E. Weinrib, BA

Andrew M. Pomerantz, PhD

Eva A. Chiriboga, PsyD, MS

Igor Vasilj, EdS, MS

Shaakira Haywood, MA

Minnah W. Farook, EdS, MA

Lydia Arndt

Pei-Chun Tsai, PhD

Laura E. Jimenez-Arista, MA

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**Skill-Building Session (A): Paving the Way for Increased Resilience in Our  
Work As Therapists—A Skill Building Opportunity**

11:00 AM - 12:50 PM • Convention Center East Salon C 8

**Chair**

Thomas Skovholt, PhD

**Participant/1stAuthor**

Jo Quanbeck, MA

Meredith Martyr, MA

Kristen Nelson, MA

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**Symposium (A): When Therapists Do What They Are Taught Not to Do—  
Reassurance, Expressing Opinions and Role-Reversal**

12:00 PM - 12:50 PM • Convention Center Room 102A

**Chair**

Randolph B. Pipes, PhD

**Participant/1stAuthor**

Randolph B. Pipes, PhD

Caroline Burke, PhD

Michael J. Scheel, PhD

*Thursday, August 3rd, continued on page 41*

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**Symposium (A): Addressing Stigma and Increasing Psychotherapy Help-Seeking Behaviors in Adults**

2:00 PM - 3:50 PM • Convention Center Room 156

**Chair**

Joshua K. Swift, PhD

**Participant/1stAuthor**

Joshua K. Swift, PhD

Andrew Seidman, MS

Jonathan Goode, BS

Jake Park, BS

**Conversation Hour (A): Are We Doing This Right? Using Routine Outcome Assessment As a Training and Program Evaluation Tool**

3:00 PM - 3:50 PM • Convention Center Room 204C

**Cochair**

Norah Chapman, PhD

Brenda F. Nash, PhD

**FRIDAY, AUGUST 4TH**

**Symposium (A): Training Professional Chinese Therapists—When Severe Shortage Encounters Huge Need**

Fri 8:00 AM - 8:50 AM • Convention Center Room 103B

**Chair**

Dong Xie, PhD

**Participant/1stAuthor**

Ziqiu Li, PhD

Chun-Chung Choi, PhD

Zhen Li, MS

**Symposium (A): Alliance Ruptures and Repairs in the Early Therapy Relationship**

9:00 AM - 9:50 AM • Convention Center Room 140A

**Chair**

Cheri L. Marmarosh, PhD

**Participant/1stAuthor**

Catherine F. Eubanks-Carter, PhD

Cheri L. Marmarosh, PhD

**Discussant**

J. Christopher Muran, PhD

**Symposium (A): The Professional Is Political, or Is It? Navigating Identity in Therapeutic Practice and Supervision**

10:00 AM - 11:50 AM • Convention Center Room 140B

**Cochair**

Caroline Burke, PhD

Thomas Skovholt, PhD

**Participant/1stAuthor**

Kristen Nelson, MA

Jo Quanbeck, MA

Meredith Martyr, MA

*Friday, August 4th, continued on page 42*

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**Poster Session (F): Psychotherap—Science, Practice and Advances—I**

Fri 11:00 AM - 11:50 AM • Convention Center Halls D and E

**Participant/1stAuthor**

Jennifer Schaafsma, MA  
Mun Yuk Chin, MA  
Francisco I. Surace, MA  
Evan Zahniser, MA  
Mary Anne Messer, MS  
Jeffrey A. Paul, BA  
Lauren D. Holder, MEd

Jeana L. Magyar, PhD  
Kevin M. Kieffer, PhD  
Erin M. Van Seeters, BS  
Eva A. Chiriboga, PsyD, MS  
Andrew M. Pomerantz, PhD  
Joanna M. Drinane, MEd

**Business Meeting (B): Journal Editor Invited Luncheon**

12:00 PM - 12:50 PM • Marriott Marquis Washington Mount Vernon Square Room

**Business Meeting (B): and Awards Ceremony**

Fri 5:00 PM - 5:50 PM • Marriott Marquis Washington Marquis Salon 15

**Social Hour (S)**

6:00 PM - 6:50 PM • Marriott Marquis Washington Marquis Salon 4

**SATURDAY, AUGUST 5TH**

**Invited Symposium (A): Bringing Psychotherapy to Underserved Communities**

8:00 AM - 9:50 AM • Convention Center Room 144A

**Chair**

Jeffrey Zimmerman, PhD

**Participant/1stAuthor**

Kelly C. Harnick, PsyD  
Jairo Fuertes, PhD

Linda F. Campbell, PhD

**Discussant**

Beverly Greene, PhD

**Symposium (A): Therapist Effects**

10:00 AM - 11:50 AM • Convention Center Room 144C

**Chair**

Clara E. Hill, DrPH

**Participant/1stAuthor**

James F. Boswell, DPhil  
Michael J. Constantino, DPhil  
Timothy Anderson, DPhil

J. Christopher Muran, PhD  
T. Harold Chui, PhD

**Discussant**

Charles J. Gelso, DPhi

**Symposium (A): Cognitively Based Compassion Training—A Mindfulness Intervention for Survivors of Suicide Attempt**

Sat 12:00 PM - 1:50 PM • Convention Center Room 140B

**Chair**

Nadine J. Kaslow, PhD

*Saturday, August 5th, continued on page 43*

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**Participant/1stAuthor**

Devon LoParo, PhD

Lucy J. Allbaugh, MA, MS

Huaiyu Zhang, PhD

Natalie N. Watson-Singleton, PhD

**Discussant**

Nadine J. Kaslow, PhD

**Social Hour (S): Reception With the Masters**

Sat 6:00 PM - 7:50 PM • Marriott Marquis Washington, DC Hotel Marquis Salon 8

**SUNDAY, AUGUST 6TH****Symposium (A): Current Status of REBT—Evaluating the Theory, Model and Clinician Competency**

8:00 PM - 8:50 PM • Convention Center Room 158

**Chair**

Mark D. Terjesen, PhD

**Participant/1stAuthor**

Raymond DiGiuseppe, PhD

Kristine Lin, BS

Thomas Kelly, BA

Tovah E. Weinrib, BA

**Discussant**

Arthur Freeman, EdD

**Skill-Building Session (A): Applications of Positive Psychological Theories and Processes to Counseling and Psychotherapy**

9:00 AM - 10:50 AM • Convention Center Room 156

**Chair**

Jeana L. Magyar, PhD

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**Symposium (A): Summit on Master's Training in Psychological Practice—Current and Future Status**

Sun 10:00 AM - 11:50 AM • Convention Center Room 152A

**Chair**

Andrew T. Dailey, MS

**Participant/1stAuthor**

Linda F. Campbell, PhD

Frank C. Worrell, PhD

Jaime L. Diaz-Granados, PhD

Katherine C. Nordal, PhD

Catherine L. Grus, PhD

**Discussant**

Jeffrey Zimmerman, PhD

**Symposium (A): Existential and Cognitive Behavioral Couples Therapy—Different Heuristics, Amicable Companions**

11:00 AM - 11:50 AM • Convention Center Room 144C

**Chair**

Jerrold L. Shapiro, PhD

**Participant/1stAuthor**

Terence Patterson, EdD

**Discussant**

David B. Feldman, PhD

# CONGRATULATIONS TO THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY 2017 STUDENT PAPER AWARD WINNERS



## **The Mathilda B. Canter Education and Training Student Paper Award**

Jennifer Oswald

For her paper: A Qualitative Analysis of Clinician Attitudes and Experiences Learning and Implementing Transdiagnostic Evidence-Based Practices for Eating Disorders

Jennifer Oswald is a rising 4th year PhD student in Clinical Psychology at the University at Albany, State University of New York. She is a member of the Psychotherapy and Behavior Change Research Lab, under the mentorship of James Boswell, PhD. Her research interests include emotion regulation, mood and anxiety disorders, dissemination and implementation of evidence-based practices/empirically supported treatments, and the use of technology to deliver interventions and measure psychotherapy process and outcomes.



## **The Donald K. Freedheim Student Development Paper Award**

Melanie Love

For her paper: Dishonesty and Self-Concealment in Psychotherapy

Melanie Love is a rising fourth year doctoral student in clinical psychology at Teachers College, Columbia University. Her research with Dr. Barry Farber is focused on clients' secrets and lies in psychotherapy - that is, what do clients find most difficult to talk about honestly in therapy, and how can therapists better facilitate disclosure? This work will be the focus of an upcoming book co-authored with Dr. Barry Farber and Matt Blanchard titled *Lies and Secrets in Psychotherapy*, to be published by the APA Press. Melanie has done her clinical training at the Dean Hope Center for Psychological Services, Fordham University's Counseling and Psychological Services, and the Manhattan VA.



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

Seth Pitman

For his paper: Therapeutic Technique of APA Master Therapists: Areas of Difference and Integration Across Theoretical Orientations

Seth Pitman received his PhD from The Derner School of Psychology at Adelphi University and completed his internship at Massachusetts General Hospital/Harvard Medical School in 2017. While a member of the Adelphi University Psychotherapy Project under the men-

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torship of Mark Hilsenroth, he developed research interests in the areas of psychotherapy process, psychological assessment, and personality. He will begin the Adult Psychoanalytic Training Program and Fellowship in Hospital-Based Psychotherapy at Austen Riggs Hospital in September. He's excited to move to the Berkshires with his wife, Julia, and their dog, Sharky.



### **The Diversity Student Paper Award**

Hui Xu

For his paper: Cultural Congruence with Psychotherapy Efficacy: A Network Meta-Analytic Examination in China

Hui Xu is a doctoral candidate in counseling psychology at the Arizona State University. He is currently a pre-doctoral intern at the Iowa State University Student Counseling Services. He will be working as an assistant professor at Loyola University Chicago in Fall 2017. His research in psychotherapy science is focused on examining what contributes to therapy efficacy across various cultural contexts. In his leisure time, he enjoys traveling, sports, and any intellectual activity.

**Join us in honoring our student award winners at the Society for the Advancement of Psychotherapy Awards Ceremony, Friday August 4<sup>th</sup> 5:00 PM - 5:50 PM, Marriott Marquis Washington DC, Marquis Salon 15, to be followed immediately by the SAP Social Hour, in the Marquis Salon 4**



# JOIN US AT THE SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY AWARDS CEREMONY!

Friday August 4, 2017 5:00 PM – 5:50 PM  
Marriott Marquis Washington Marquis Salon 15

*We will honor our 2017 Professional Award Winners*



**Distinguished  
Psychologist Award**  
William Stiles



**SAP/APF Early  
Career Award**  
Rayna Markin



**Rosalee Weiss  
Lecturer**  
Jean Carter

*And our 2017 Student Paper Award Winners*

**The Mathilda B. Canter Education and Training Student Paper Award**  
Jennifer Oswald

**The Donald K. Freedheim Student Development Paper Award**  
Melanie Love

**The Jeffrey E. Barnett Psychotherapy Research Paper Award**  
Seth Pitman

**The Diversity Student Paper Award**  
Hui Xu

The Awards Ceremony will be followed by the SAP Social Hour  
6:00 PM – 6:50 PM • Marriott Marquis Washington Marquis Salon 4



## ATTENTION GRADUATE STUDENTS AND EARLY CAREER PROFESSIONALS

*You are invited to*

**“A Reception with the Masters—For Graduate Students and  
Early Career Psychologists”**

Saturday, August 5 • 6:00 PM – 7:50 PM  
Marriott Marquis Washington, DC Hotel  
Marquis Salon 8

Hosted by the Society for  
the Advancement of Psychotherapy (APA  
Division 29) at the 2017 APA Convention

*Come join:*

Catherine Eubanks  
Lillian Comas-Diaz  
Shalonda Kelly  
And many more...  
for drinks and conversation.

No RSVP needed, but please feel free to  
contact Dr. Leigh Ann Carter, SAP Early  
Career Domain Representative, at:  
leighacarterpsyd@gmail.com  
for additional information.

Come find out more about the Society and  
invite others to join!

You do not need to be a member of the  
Society/Division 29 to attend, but we will  
have membership information available on  
site for those who are interested in joining.

## INTERNATIONAL STUDENT FEATURE

### “Two Versions of Me”: What I Wish My Professors and Supervisors Knew About Being an International Student

Yu-ting Ching

Julia Harbell

Gwen Mitchell, PsyD

University of Denver



Since the mid-1900s, the United States has been the destination of choice for international students, and each year almost half a million international students enroll in American universities (Haynie, 2014).



These students typically arrive with clear academic and professional goals, but they may not have considered what it will be like to be functioning in a world where they rarely feel fully seen or understood. When these students leave their country of origin, they leave one world behind and yet do not quite belong to the new

world in which they have arrived. They have been accepted based on their academic aptitude but little else may be known about them. This transition has particular implications for international students in graduate clinical training programs in mental health.

#### Unique Challenges

Students who are entering clinical training programs are quickly asked to engage in nuanced, culture-bound activities aimed at promoting clinical skills. Newly arrived international students suddenly find themselves in a

place where they are speaking in a second language, adjusting to cultural nuances and engaging in some form of reflective practice. They are forced to negotiate an unfamiliar set of institutional and cultural rules while trying to build social connections with their host national counterparts. They must deal with unpredictable encounters, idiosyncratic communications, and problems of racial discrimination.

The current body of literature on international graduate students is primarily focused on academic experiences and achievements (Cole, 2010; Smith & Khawaja, 2011). A lesser body of research attends to the circumstances of their lives, circumstances that are affected by a number of different agents—educational institutions, faculty, supervisors, friend networks, and fellow graduate students (Gareis, 2012; Zhang & Goodson, 2011). The aim of this paper is to illustrate the personal and developmental experiences of a small group of graduate students enrolled in PsyD and MA psychology programs at the University of Denver.

By highlighting a collection of lived experiences, we hope to offer insight into the top three categories of concern: 1) language, 2) reflective practice, and 3) interpersonal connections. Based on these interviews, it appears these three areas of identity and functioning have significant impact on the individual

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identities of the international students. Specifically, by sharing the pain, struggle, joy, and hope of a few international students, we aim to highlight how the way they express themselves, understand themselves, and connect with others impacts the way they negotiate their identities and their relationships in graduate school. The desired outcome was to create a document that would capture the internal experience of international students in such a way as to help faculty and supervisors create learning environments that are not only safe, but mutually beneficial; a space where learning is reciprocal and bidirectional.

*Language as identity/personal ways of knowing.* It is generally agreed that language and culture are closely related. Language can be viewed as a verbal expression of culture. It is used to maintain and convey culture and cultural ties. Language provides us with many of the categories we use for expression of our thoughts, so it is therefore natural to assume that our thinking is influenced by the language which we use. The way in which individuals express and understand themselves is a huge piece of their identity. Asking international students how their native language impacts who they are and how they see the world should help faculty and supervisors get beyond translation issues into deeper facets of identity.

Our international students give support to the idea that, while at times language is indeed a barrier to connection and understanding, it can also be a gift. The difficulty is a non-native speaker can clearly see that the perception of themselves in other's eyes is often skewed by the language barrier—thus the impact of being misperceived by others leads one to struggle with the development of clear perception of self. What is described is a dissonance; limited shared vocabulary creates a distorted percep-

tion of self to self and others:

*So I feel like I speak English like a 10-years-old kid; when I speak Japanese I feel like a 30 year old man. I see two different personalities. I'd like my classmates know about it. When you don't speak English good people may think 'this guy is not really worth talking to'. I want to share but I struggle to understand how I can deliver my message properly. It takes time for me to understand what I want to say and how to express it. By then the topic has already gone. I imagine international students have good insight to share but don't for reasons that I just explained. Classmates see this guy that doesn't have anything to share. It's not always true. You shouldn't judge by the words but also you should try to draw out the insight.* —International student, country of origin Japan

*Every sharing is a new experience and challenge. . . Finding a balance is a strange feeling. The way people look at me makes me feel discouraged to ask questions and sometimes I feel like I am not smart enough.* —International student, country of origin Taiwan

For these students, language is intimately connected to identity. They experience two different versions of themselves: The version that thinks, speaks, and reflects in their native language, and the English version of themselves, restricted by shallow vocabulary and more consuming language processing.

Yet, as students in graduate psychology programs continually hear, therapy is about the process. The presence of international students enriches the process of communication within the classroom as all parties involved explore their relationship to self and others through language, sit with discomfort and con-

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fusion, and practice cultural navigation skills required in therapy.

*I always ask others to ask me to repeat or rephrase things. Sometimes I can see that this guy didn't understand me and just let it go. You can tell from a facial expression and where a discussion goes. Sometime I just repeat myself even though they don't ask. But sometimes I just let it go. It's still challenging to be really connected with someone talking but I am really happy to be asked. Someone who knows I am so happy to be asked, they ask. —International student, country of origin Japan*

*Reflective practice/different concepts of self.* Self-reflection is a concept to which many international students are not accustomed. When teaching about and prompting self-reflection, it is important to note that many international students do not understand what “self-reflection” means or what is being asked of them, and may have little knowledge about how to examine their perceived collective identity via individualistic identity prompts. International students should be given the opportunity to practice reflection at key points within their training, both on an individual and group basis, and receive appropriate feedback about how they are doing. Some of our participants expressed concern that there seems to be existing cultural stereotypes attached to international students regarding their ability to reflect:

*They don't get that self-reflection or self-awareness is associated with culture. —International student, country of origin Japan*

Self-reflection is integral to psychology programs and training, and the experiences of international students offer a poignant reminder of the cultural influence, perhaps even the culture-bound nature of such practice. For some, they

are being asked to reflect from a new center (that of the individual), and then share personal insights using a language level not sophisticated enough to accurately capture their truth:

*I am from collectivist country and so self-reflection was pretty challenging. It's not that I never had chance to reflect but just less opportunities to think about myself because society is more important than individual in our cultural mindset. —International student, country of origin Japan*

*I didn't always know if what I was sharing was too much or not enough. I would look around and just see blank faces and in my mind I was thinking 'stop talking' but I also knew this was a huge piece of the clinical training. — International student, country of origin Taiwan*

Despite feelings of discomfort, students recognized the value of self-reflective practice and described a willingness to engage with and learn from these experiences. Interestingly, one student described finding inspiration in the cultural divide and using American peers as models for self-reflection:

*[Fellow classmates] are really good at reflecting and sharing their reflections with others. I was so impressed by that and I just wanted to be like that. I took that as a good opportunity to do self-reflection but there is pressure because they are really good . . . When the topic comes to self-awareness or reflection it's hard. Sometimes partners are struggling to get something draw out from me so it feels like it might be a hassle to talk with me about some topics. I'd say that self-reflection is one cause of being, I don't know, left out. —International student, country of origin Japan*

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This student's experience highlights a place for reframing the cultural diversity from hassle to opportunity: an opportunity to practically engage the multicultural training students are receiving in their program, to explore their own reactions to communication challenges, and to process how cultural diversity plays out in therapeutically-minded conversations.

*Facilitating opportunities for meaningful interaction.* While international students simultaneously negotiate multiple dimensions of their own social identities as they deal with practical issues of language and cultural practices, they also have first-hand experiences with international and global issues that are often mere academic abstractions to many of their U.S. peers. Although international students discussed the challenges associated with negotiating these identities—and many mentioned distancing tactics and insensitive peer comments—they also shared experiences about how these difficulties contributed to more complex understandings of the world, of themselves, and of their relationships with others.

Students expressed appreciation for their immersive educational experience in the U.S., but also a need to connect with other international students. These connections are replenishing; students are able to return to the identity lost in translation, share experiences of being an international student, and gain respite from feelings of isolation:

*Connecting with students like me is like an oasis. Being around so many American is a really good environment to learn something but sometimes I need to get rest and so talking with friends who are struggling with the same issues, or same situation, sharing what you are facing and what you are*

*thinking under same circumstances was really helpful. It's like an oasis in the desert.* —International student, country of origin Japan

*I found it useful to meet and talk with other international students about what I was learning and how I was thinking about the course material. I only wish there are resources to help us connect with other international students and mentors so that we could talk more about what we are learning.* —International student, country of origin Hong Kong

It became clear that meaningful experiences of connection led to a sense of belonging which supported the international students' resilience and sense that they had something unique to offer in class or small supervision groups. When professors and supervisors signal social inclusion and facilitate participation, international students take the opportunity to share differing perspectives with the group:

*As an international student I bring to the table knowledge and a unique point of view that can differ widely from my American peers. English is my second language and used to be an obstacle to communication with my clients. However, I have the opportunity to be a role model showing that it is okay to seek help and that it's okay to say I don't know. If I don't pronounce the word correctly, it's okay to admit my mistakes and learn from the experience.* —International student, country of origin Taiwan

*I still experience cultural differences but I have more opportunities to learn from different cultures. I could speak for minority group and work on topics related to social justice. My language and cultural background can be my*

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*strength.* —International student, country of origin Hong Kong

engagement and enrichment, leading to the creation of common ground.

### Conclusions and Recommendations

Integration is an intentional process to create community, but it has become clear that it is not sufficient to simply bring people together, even in the same classroom. By encouraging domestic and international students to engage with each other in ongoing interactions, characterized by mutual respect, responsibility, action, and commitment, all students can thrive. Based on the narratives examined for this project, it appears successful integration should include the following: 1) active facilitation and recognition that difference can be a gift in the classroom, 2) engaged intercultural modeling by faculty, staff, and supervisors, 3) assessment, evaluation, and mindful reflection of intercultural and global competence at all levels of the institution (individual, classroom, school), and, possibly most importantly, 4) movement from “contact with” and “celebration of” cultures to deeper layers of

Too often programming highlighting international students is limited to the one-time, big event. This event, which often takes the form of an international student fair or show, can be good in celebrating international students’ contributions to a department and perhaps can help a domestic student learn a bit about another culture or cultures, but opportunities for meaningful and transformative learning also need to be strategically integrated and applied. Given this, we must work hard to go beyond the big annual event and integrate more frequent, highly-interactive opportunities for domestic and international students to connect within and outside the classroom.

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### The Pugilist & the Psychologist: Exploring the Impact of Becoming an Amateur Boxer on My Clinical Work

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As a psychologist, I encourage my clients to step outside of their perceived limits or comfort zones for the betterment of their mental and emotional health. In graduate school, my professors stressed the importance of collaborating with clients in cultivating their ability to imagine themselves living holistic and healthier lives—useful for encouraging both optimism in treatment and adherence to treatment goals designed to reach this better version of themselves. To be helpful to the client, the vision must be obtainable, even if this “alternative life” is not currently realistic due to the overall functioning of the client. Through therapeutic delivery of encouragement, criticism, and pacing, clinicians can help manage the client’s stress and encourage motivation to work toward this desired destination.

An additional dynamic of this process is the reconfiguring of the client’s conceptions of “success” and “failure” in both treatment and in life. In conversations with both children and adults, I have noticed many of my clients becoming increasingly risk-averse regarding clinical interventions as their clinical challenges or time in therapy increases. This hesitation or procrastination to fully engage in therapy can cause significant disruption

to the efficacy of treatment and it can cause further self-deprecating thoughts as clients blame themselves (or the clinician) for their lack of movement in treatment. With our privileged position on the “other side of the couch,” we often forget how difficult initiating drastic change can be and how daunting a task recovering from mental health challenges can be for someone so deeply impacted by these concerns.

#### **Failure in Sports as a Learning Tool for Therapists**

I struggled mightily with this when I was in graduate school as I was often frustrated by some of my clients’ lack of excitement over the potential for change and lack of consistent involvement in the process of change. Not only did I sometimes take their challenges in these areas as a negative reflection on my abilities as a psychotherapist, but I also may have allowed negative biases to creep in and impact my ability to be compassionate about their often-complex circumstances. While in the midst of this state, one of my supervisors at GSPP made a startling and random suggestion: I should try golf. After joking that every doctor should know how to play golf, the supervisor spoke about the true purpose of this suggestion. According to this professor, achievement-oriented adults like those in graduate school often maintain a high level of confidence

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and self-assurance by pruning tasks or activities with a high likelihood of failure from their lives. Although this behavior is healthy and appropriate for maintaining wellness, it can divorce these high achievers from experiencing and appreciating the totality of the learning process, including its inevitable setbacks, when attempting to adopt a new behavior or activity. In taking up this unfamiliar sport, my supervisor envisioned me being exposed to the frustration and angst caused by struggling with a new challenge, as well as cultivating skills and strategies to support perseverance in adherence to the activity and the practice of the activity. Although undergoing psychotherapy is different from golf, golf did provide a microcosm in which I could engage in this type of experimentation with my coping resources, frustration tolerance, and motivational attitude. Through this experience, I recognized that I was less equipped to deal with failure than I initially thought, and I was fortunate for the opportunity to recognize this area for growth within the context of a low-risk situation such as sport. This recognition then afforded me the opportunity to make conscious behavioral and cognitive changes to better support a more tolerant approach to challenges and frustration. Golf also provided me with the opportunity to be in the role of student, whereas my professional role often places me in a position of perceived or actual power. To be the one seeking support and knowledge in this particular situation provided a great juxtaposition with my daily task of facilitating growth in others through collaboration with my clients. Currently, I encourage all in my community, especially adults, to regularly engage in new and difficult activities to keep close to failure and to help see failure more as a helpful aspect of learning than an opportunity for self-deprecation or humiliation.

### **“So You Mean to Tell Me That My Therapist Punches People!?”**

In the spirit of my time learning golf some seven years ago, I recently took up another new activity to test myself physically and to grow emotionally. In early January of this year, I decided to participate in a pediatric brain cancer charity boxing program called A Bout to Benefit after being exposed to the charity by a close peer. This program specifically targeted adults new to the sport of boxing to help introduce them through coaching at a popular Boston area boxing gym. The charity experience would culminate in a black tie affair where 18 of the fighters would fight in front of their friends and family at a special Fight Night event approximately three months later. My initial interest in this contest stemmed from my love of the sport during my childhood and my curiosity regarding how boxing could provide unique opportunities for personal growth, especially given how the sport has been known to improve self-esteem and confidence (Kumar, 2015). Most people primarily think of the real physical and neurological dangers of the sport when boxing comes up in conversation, and that is an important reality (Reed, 2015), but the positive aspects of the sport deserve attention as well. In addition to physical benefits, boxing can also assist people by providing opportunities for emotional growth. Research has demonstrated that there are many important cognitive and emotion regulation skills that are necessary to grow as a boxer, such as self-regulation, conscientiousness, and openness to experience (Khani, Farokhi, Shalchi, Angoori, & Ansari, 2011), all of which would be useful for a therapist or a client.

### **Clinical Implications**

This experience would provide me with the opportunity to test those areas of my own functioning to observe how each

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area reacted to this stressor and provide information useful for strengthening my weaknesses and providing better awareness of my strengths. When assessing my conscientiousness, openness to experiences, and self-regulation, I would suggest that my strengths would be in openness to experience and conscientiousness while conversely, I would report that difficult sporting experiences could cause challenges with self-regulation. Before officially signing up for the event, I remember experiencing bouts of ambivalence and fear associated with the task. I remember worrying about embarrassing myself during the long training or on the fight night and I worried about the pain. I remember worrying about having to actually punch someone when violence has been so purposefully absent from my life as a known pacifist.

These hesitations were, in retrospect, similar to some of the common concerns that clients may have when they begin treatment. Most clients express some reservations about beginning therapy, and many of these reservations are related to the potential of the therapy being harmful when the client is already in a vulnerable state. In addition to having fears about therapy contributing to worsening of their symptoms, many in the community harbor numerous myths about therapists and the therapeutic process that contribute to individuals refusing treatment (American Psychological Association, 2017). To assist with transitioning through these feelings, we, as clinicians, need to emphasize the positives of the experience and the ways in which engaging actively and wholeheartedly in therapy can be beneficial, both in the short term and long term. Similarly, as I started this boxing process, I needed a helpful and understanding coach to help orient me to the sport of boxing and help me better un-

derstand the structure of the sport and soothe any rational or irrational concerns that I might have had about my participation.

At the gym, I found myself reflecting about how my coaching mirrored that of common therapist-client relationships, especially given how important the relationship is in the eventual outcome of both boxing and psychotherapy (Falkenström & Larsson, 2017). Like a client, I was heavily reliant upon my coach to help me acculturate to this new world of boxing and learn how to navigate unfamiliar jargon. In addition to expecting him to initially lead me in this journey, I was also cognizant of the trust building that would be essential in order for us to be successful and, more importantly, safe. At the beginning of our training, I believed that I needed to convince my coach that I was motivated for training and receptive to his teachings and, conversely, I needed my coach to convince me that he was knowledgeable about boxing and taking appropriate steps to ensure my safety throughout this process. The fear I felt at the inception of my training might be similar to the fear new clients experience as they transition into psychotherapy, especially if it is their first experience in psychotherapy. To continue to provide a successful transition into therapy, I can utilize this experience to remind myself to emphasize in my communications with clients that I will work diligently to ensure their emotional and physical safety. Additionally, I will also highlight my psychological knowledge and a willingness and eagerness to learn about the patient's experiences while also highlighting the potential positives that could come from successful implementation of clinical strategies and interventions.

After overcoming my initial fear of beginning my training, I had to cope

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with a boxer's relationship with physical pain. As a former collegiate lacrosse player and a finisher of the Boston Marathon, I am familiar with athletic pain, fatigue, and discomfort—but this was different. As many warned me before starting my training: Boxing is one of the most physically demanding sports on earth. In addition to needing incredible strength to land punches with force and to protect your body from incoming assaults, boxing also requires significant cardiovascular strength in order to “stay busy” during each of the three fast-paced rounds with limited rest in between. Each training session was more grueling than the next as our coach slowly introduced us mentally and physically to the realities of life as an amateur boxer and the pain accompanying that title. When reflecting upon my response to the pain, I was reminded about how all-consuming the pain was and how much it preoccupied my thoughts. As training sessions vacillated between easy and difficult, I found my mind drifting towards more pessimistic thoughts that undermined my goals during more difficult days at the gym. Several times I was able to notice the impact of this pain on my thought process and utilize learned cognitive restructuring processes to address these irrational thoughts. These situations reminded me how easy it is to allow irrational thoughts to creep into one's thinking while experiencing such a highly physiological response to stress. For example, I thought about how, when patients experience significant physical symptoms related to depression (e.g., lethargy), anxiety (e.g., panic attacks, high heart rate), or other mental health concerns, the patient could be more susceptible to thinking errors because of how difficult it is to ignore physical discomfort or pain. At work, I utilized this insight to

emphasize the compassion that I needed to have for not only the cognitive distress my clients were experiencing, but also the daily barrage of physical pain or psychosomatic discomfort they might be enduring due to their psychological health. Compassion for this specific area of their experience helped me focus on addressing those symptoms with a level of strength and effort commensurate to what I would expend working on cognitive or thought challenges. As my own training progressed, I found myself beginning to prescribe more psychosomatic interventions and suggesting more strategies that sought to reduce the bodily arousal or numbness in the lives of my clients, with the goal of assisting each in engaging more in thoughtful cognitive interventions.

**Conclusion**

Although I won two other fights, that particular charity fight did end in a loss by decision. Even though I was disappointed with the result of the contest, both the loss itself and the experience as a whole provided me with a great opportunity to learn more about myself as a person and as a psychologist. The lessons that I will take from this experience will continue to build empathy toward my brave clients and encourage me to engage in psychotherapy enthusiastically as their “coach” and team member. For myself, I will forever remember this experience as a test of my limits and an opportunity to try something different and challenging, a marker of the curiosity and ferocity for new experiences that I hope never dies and only grows as I get older.

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## EARLY CAREER

### Not Too Young, Not Too Old, Just ... Right? Experiencing Ageism in the Office as an ECP

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From as young as I can remember, adults were always asking me what I wanted to be when I was older. And being the future-thinker that I am, I always excitedly answered, “Rockette!

Lawyer! Doctor!” until I found my calling as a psychologist at the ripe old age of 14. I could not wait to go to college and embark on my journey of being a professional. Of course, at that time I was unaware of the importance of the journey over the destination, or that I could contribute any sort of value until I reached that destination of expertise.

As I grew, both personally and professionally, I noticed my self-confidence increase with each passing milestone—most notably, my transition from doctoral internship to post-doctoral fellow. While on post-doc, there *was* a difference. The expectation was to be a professional and not a trainee. This strangely seemed to flip flop as I became a licensed psychologist.

#### Unexpected Challenges

As ECPs, we bring a unique perspective to our respective workplaces. We know we do not know everything, but we feel comfortable enough knowing that our foundation is solid. I think the hardest adjustment, however, is remembering that our non-ECP colleagues do not know everything, either. We can learn from each other! I think this was difficult for me to remember for two reasons. The

first was that I had to adjust to my own identity as a professional. That one seemed obvious and was something I certainly anticipated. The second reason, something that took me by surprise, was that some colleagues talked to me in a way that not only pointed out differences in our ages and years in the field, but also made me feel as though I could not bring anything to the table. We would not tell trainees that their ideas or inexperience was a bad thing; rather, we would encourage them to find their voices and look at their vision as fresh and new. Why would we change our tune once that person becomes licensed?

Luckily for me (and hopefully for you, too!), I found a great support system with the other ECPs at work. I was glad that we could go through this time together, but was frustrated that we had to go through this at all. As it turns out, our experience was not unique. According to O’Shaughnessy and Burnes (2016), there are not enough resources to meet the specific needs of ECPs—and seasoned professionals may not even realize that these needs exist. As ECPs, we are not necessarily receiving crucial mentorship about navigating the professional world, the stresses of student loans, and licensing and credentialing. Instead, we tend to receive messages that being in the field for a longer amount of time will help us become better professionals, both clinically and administratively. While potentially well-intentioned, the

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assurance that we will “get it” in the future leaves many of us feeling unsupported now. In the study conducted by O’Shaughnessy and Burnes (2016), for example, a participant expressed her frustration with feeling patronized and having the more established therapists at her place of work shut her down for not buying into the “complacency” of that center’s norms (p. 801).

In an article with a title that captures this theme (“We’re Not ‘Kids’”), Novotney (2016) discusses how ECPs have experienced ageism in the workplace. Interestingly, the participants noted that these comments were “made in jest” (p. 52). However, I find it hard to imagine that being a plausible excuse if we reverse the roles and it were a younger individual making an ageist comment toward someone senior. Furthermore, because professionals tend to be obtaining their doctoral degrees at an older age than perhaps their senior colleagues did, their senior staff may inappropriately see them as incompetent or “young.”

While I do not believe any of this is necessarily intentional, we are bound to make the same mistakes as our predecessors if we do not learn from our own experiences. I know I will intentionally strive to forge my own path as I continue with my professional growth, and I will one day be on the other side of the discussion. I certainly would not like to replay this dynamic when I am no longer an ECP!

So what can we do as ECPs and what might be helpful from our non-ECP colleagues? In considering my own experiences as well as talking to other ECPs, I noticed the following themes emerging as suggestions for both ECPs and our non-ECP colleagues.

#### **Tips for ECPs**

*Continue to use your voice.* It is an important and valuable voice. We might need

to continue to hone the way in which we use our voices, but reminding our colleagues that we have something to say will be helpful in establishing our professional identities.

*Be clear about what is helpful and what is not.* For the most part, our senior counterparts do not want to belittle us and may be unaware that they are doing so. Let them know how this affects your ability to be a strong professional at your workplace. However, you can also let them know ways in which they can be helpful. Rather than coming off as a know-it-all, this allows you to create a firm boundary and potentially gain mentorship that can help you navigate the ins and outs of the field.

*Get involved.* There is not a lot of information regarding this issue for ECPs or more senior professionals who have ECPs on staff. Educate yourself about age discrimination in all its forms, and be aware of your own potential biases against older colleagues—and other ECPs! Let us do our part to ensure that members of the next generation of ECPs do not experience ageism at any stage of their careers.

#### **Tips for Non-ECPs**

*Use your own experiences.* Think back to what it was like when you were an ECP. What do you wish you had known, and how do you wish had been treated by your senior staff? You can help us break the cycle!

*Remember that ageism is discrimination.* Most of you probably attend or create talks and/or CEUs about discrimination in the workplace. Ageism, which includes comments made to those younger than you, is real and hurtful; if you would not engage in other types of discrimination, I imagine you would not want to engage in ageism or perpetuate

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intergenerational models of it. If you reflect on your own experiences of having been stereotyped or treated differently based on age, I hope this awareness can be useful to you in this context, too.

*Use your current experiences ... with flexibility.* You have much to offer, and ECPs would love to hear it! You know what has worked and what has not worked in your experience. Instead of simply saying that an idea will not work, help us to understand why, from your perspective, it is not likely to be successful. Also remember that your experience is your experience, not necessarily "the way it is."

### Conclusion

Early career is a time of great opportunity and substantial challenges. Some of those challenges could be ameliorated by ECPs and non-ECPs working together to value one another's opinions and contributions. The tips provided here will hopefully help each of us begin a dialogue about these important issues, paving a smoother path for all ECPs to come.

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## “Change Is the Law of Life”

Pat DeLeon, PhD

Former APA President



### Continuing Progress at the State Level

“On April 3, 2017, Idaho became the fifth state in the nation to allow prescriptive authority to psychologists. After three years of work by the Idaho Psychological Association, the legislation passed both houses without opposition and with only two nay votes. How did this happen? Here are a few of the factors that may have contributed.

- Psychiatrists negotiated with us. The shortage of prescribers in our state is the worst in the nation and physicians and legislators are aware that the situation is desperate in some rural areas. The physician chair of the House Health and Welfare committee became convinced by repeated meetings with our soft-spoken lobbyist that the training was rigorous. We learned that the rest of the medical association was leaning our way. The main concern of our colleagues in psychiatry was that the training be at least equivalent to that of an advanced practice psychiatric nurse practitioner (NP). They brought in an experienced NP to vet our training and the language of equivalence is written into the bill.
- One of our state universities agreed to put together a two year full-time masters in psychopharmacology program taught through the pharmacy program. We know that the training offered elsewhere is excellent but we couldn't convince our MD colleagues that it was equivalent to a full-time program. A full-time training where they could have input tipped the scales for them.
- We strongly believe collaboration is best for both patients and practitioners. We have written it into the law and have an advisory committee of psychologists, physicians and a pharmacist to assist our Board of Psychology on RxP issues. To move from a conditional certificate to a full certificate, two years of supervised prescribing past the masters is required. To work with children or the elderly, one of those years must be in that specialty.
- Our state association was involved and we received unflinching backing from our members, our Executive Director Deb Katz, our association President Page Haviland, and our lobbyist. A link to our full bill is: <https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2017/legislation/H0212.pdf>.
- We also have been asked why the most conservative state in the union would pass such a bill. Our answer is that the legislation is completely non-partisan. It appeals to liberals, conservatives, even libertarians. The core idea is that once we demonstrate need and can vouch for rigorous training, it comes down to free-market issues. Since we can prove that psychologists can prescribe safely, we then ask only that the playing field be level and that we be allowed to prove

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our worth. We request no money from the state nor do we ask for any guild protection. If the market works as it should, in a few years we should be able to demonstrate more practitioners, more widespread service, a movement into rural areas and a better fee structure.

- One unanticipated outcome: Three years ago we continuously were asked to define the differences between a psychologist, a psychiatrist and a counselor. We are not asked that so much anymore. Psychology appears to have established itself as a group of highly trained professionals looked upon with favor by our legislators. There are only a few hundred of us in this very rural state. It is deeply satisfying to see the profession become known and appreciated [Susan Farber, former IPA President].

An historical note—one of the initial RxP training programs involved the School of Pharmacy at the University of Georgia and Georgia State University faculty, pursuant to the vision of Dr. Linda Campbell, former member of the APA Board of Directors, and Cal VanderPlate. More recently, Dr. Judi Steinman at the University of Hawaii at Hilo College of Pharmacy provided RxP training for those in Hawaii and the Pacific Basin. In addition, Drs. Morgan Sammons and Robin Henderson report that the State of Oregon House of Representatives passed their RxP legislation unanimously this spring. Interdisciplinary collaboration *is* the future for psychology and for our nation's overall health care system.

#### **Developments at the Federal Level**

During a recent Give an Hour event, hosted by President Barbara Van Dahlen, USUHS psychology graduate student Elizabeth Belleau met VA Secretary David Shulkin and Harold Kudler,

chief consultant for mental health service. Among other issues, they discussed the exciting potential for active duty mental health graduate students to obtain supervised clinical experience within the VA—especially since these future colleagues personally appreciate the nuances of military culture and will themselves eventually become VA beneficiaries. HRSA reports that 30% of the new hires by Federally Qualified Community Health Centers (FQHCs) over the past two years have been Veterans. Dr. Heather O'Beirne Kelly, APA's Director of Military and Veterans Health Policy—a position created earlier this year by Interim CEO Cynthia Belar and President Tony Puente—recently had the opportunity to present testimony before the U.S. House Appropriations subcommittee with jurisdiction over the VA:

- The Department of Veterans Affairs (VA) is the largest single employer of psychologists, who work both as research scientists and clinicians committed to improving the lives of our nation's Veterans. As the largest provider of training for psychologists, the VA also plays a vital role in ensuring that the mental health workforce is equipped to provide culturally competent and integrated mental health services to Veterans and their families.
- VA psychologists play a dual role in providing care for Veterans and conducting research in all areas of health, including high-priority areas particularly relevant to Veterans, such as: mental health and suicide prevention, traumatic brain injury (TBI), substance abuse, aging-related disorders and physical and psychosocial rehabilitation. VA psychologists are leaders in providing effective diagnosis and treatment for all mental health, substance use and behavioral health

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issues. In addition, VA psychologists often receive specialty training in rehabilitation psychology and/or neuropsychology, which helps to improve assessment, treatment, and research on the many conditions affecting Veterans, including: post-traumatic stress disorder (PTSD), burns, amputation, blindness, spinal cord injuries and polytrauma. Equally important are the profoundly positive impacts of psychological interventions on the care of Veterans suffering from chronic illnesses such as cancer, cardiovascular disease, HIV and chronic pain.

Every day 20 Veterans commit suicide which is unquestionably a major public health tragedy that calls for innovative interventions. Secretary Shulkin has entered into a partnership with the Department of Health and Human Services to allow the assignment of U.S. Public Health Commissioned Corps members to provide direct patient care to Veterans in VA hospitals and clinics in underserved communities. During her testimony, Heather raised two related issues. She discussed psychology's historical leadership role in developing and providing telepsychological care (within the VA and the Department of Defense) and she recommended as an innovative strategy for addressing suicides by Veterans through enhancing access, continuity, and integration of care: "Granting specially-trained psychologists prescriptive authority analogous to that granted by the Department of Defense for almost 20 years, which will alleviate mental health-care access issues." After her testimony, one of the subcommittee members followed her out of the hearing room and stated that "I want that pilot program." Will an already prescribing USPHS psychologist be assigned?

### **A Vision for the Future**

In his prior position as VA Under Secretary for Health, Secretary Shulkin was instrumental in providing full practice authority for VA advanced practice registered nurses (APRNs) (with the exception of nurse anesthetists) as long as they were working within the scope of their VA employment. APRNs now can provide care, regardless of historical state or local legal restrictions, without the clinical oversight of a physician. This includes taking comprehensive histories, providing physical examinations; and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. It also allows APRNs to prescribe medications and make appropriate referrals.

Under the Secretary's leadership, in April of this year the VA announced its top five priorities which included Suicide Prevention—Getting to Zero. The number two priority was Improving Timeliness, highlighting the potential contributions of telehealth. The Department reported having established 10 Tele-Mental health hubs and 8 Tele-Primary Care hubs. Not surprisingly, 45% of telehealth services are for rural veterans. Overall, there were 2.14 million episodes of telehealth care provided to 677,000 Veterans, of which 336,000 were TeleMental health visits. Under the leadership of Drs. Robert Zeiss and now Ken Jones, the VA Office of Academic Affiliations has been providing significant support for psychology post-doctoral training initiatives. The VA has long fostered internship level training in psychology, with over 675 positions nationally located in 49 states plus Puerto Rico and the District of Columbia. Post-doctoral training did not truly take off until the 2000-2001 academic year, when the number of funded residency positions expanded from five to

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38. These numbers have grown steadily, with a particularly large increase in 2008-2009, when the positions increased from 117 to 204 in just one year. Currently, that number stands at approximately 440 annually—covering a wide range of clinical areas, as Heather noted in her testimony. Psychology is well positioned to capitalize upon, and provide leadership for, the exciting potential for innovation which the proponents of telehealth envision.

Dr. Art Kellermann, Dean of the School of Medicine at USUHS and a member of the National Academy of Medicine (formerly the Institute of Medicine), has similarly called for Embracing Telehealth while Rethinking the U.S.'s Military Health System:

“In deployed settings, the military health system uses telehealth to support health care providers working in small forward operating bases and on ships at sea. Global teleconferencing allows trauma experts across 12 time zones to regularly meet, discuss complex cases, and identify opportunities to im-

prove. Despite its success with telehealth overseas, the military health system was slow to adopt it at home due to stringent information security requirements and budgetary constraints. Section 718 of the NDAA [National Defense Authorization Act] directs the military health system to rapidly expand the use of telehealth in its clinical operations.”

Licensure mobility is critical to the effective use of telehealth services and psychology has been well served by the vision of Dr. Steve DeMers, CEO of the Association of State and Provincial Psychology Boards (ASPPB) in establishing their Interjurisdictional Compact (PSY-PACT). Drs. Linda Campbell and Fred Millan served as co-chair of the joint APA/ASPPB/APA/IT Task Force for Telepsychology Guidelines.

“And those who look only to the past or present are certain to miss the future.”

Aloha.



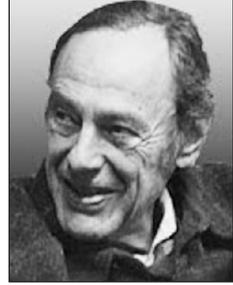
## NOTICE TO READERS

**References for articles appearing in this issue can be found on the Society's website under "Publications," the "Bulletin." Please click on the Bulletin issue for which you would like references. Go to the Table of Contents, and find "References." References for all articles in the issue will begin on that page.**

## REMEMBRANCE

### Remembering Eugene Gendlin December 25, 1926–May 1, 2017

Contact: Catherine Torpey  
The International Focusing Institute  
[catherine@focusing.org](mailto:catherine@focusing.org)



Eugene T. Gendlin, PhD, the American philosopher and psychologist who developed the mind-body connection practice called “Focusing,” died on May 1, 2017, at the age of 90 in Spring Valley, New York. His death was announced by the International Focusing Institute ([www.focusing.org](http://www.focusing.org)), which was founded in 1985 by Dr. Gendlin to promote the practice of Focusing and the philosophy behind it, which he called the “Philosophy of the Implicit.” Focusing is an experiential, body-oriented method for generating insights and emotional healing. Gendlin’s philosophy falls under the branch of philosophy called phenomenology. Significant influences on his philosophical work included Edmund Husserl, Jean-Paul Sartre and Maurice Merleau-Ponty. A nearly exhaustive library of his work is maintained by the Institute in the Gendlin Online Library.

#### **Dr. Gendlin’s Work Bridged Psychology and Philosophy, Academia, and Popular Self-Help**

Eugene Gendlin’s work was notable for how he bridged the fields of philosophy and psychology, as well as bridging serious academic work with popular self-help. He studied and taught philosophy at the University of Chicago, one of the world’s top academic institutions. While engaged in the study of philosophy, he became a student and colleague of one of the great minds in psychology, Dr. Carl Rogers, who was revolutionizing the study of psychotherapy at the University of Chicago.

Gendlin’s extraordinary intellectual gifts were matched by his extraordinary compassion for people. When he saw that the research he was conducting at the university could have profound meaning for the ordinary person, he wrote *Focusing* as a popular self-help book so that his discovery would not languish in academic circles. Perhaps his experience as a Jew escaping the Nazi occupation of Austria explains some piece of this great compassion. He recounted his family’s escape from the Nazis in an interview with Lore Korbei decades years after his escape. That interview is found at [https://www.focusing.org/gendlin/docs/gol\\_2181.html](https://www.focusing.org/gendlin/docs/gol_2181.html).

*Academic honors.* Gendlin has been honored by the American Psychological Association (APA) four times, and was the first recipient of the APA’s Distinguished Professional Psychologist of the Year award. He was awarded the Viktor Frankl prize by the Viktor Frankl Family Foundation in 2008. In 2016 he was honored with a lifetime achievement award from the World Association for Person Centered and Experiential Psychotherapy and Counseling and a lifetime achievement award from the United States Association for Body Psychotherapy.

Gendlin was a founder and longtime editor of the journal *Psychotherapy: Theory,*

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*Research and Practice* as well as the in-house journal of the Focusing Institute called the Folio, and is the author of a number of books, including *Focusing-Oriented Psychotherapy: A Manual of the Experiential Method*. The mass-market edition of his popular classic *Focusing* has been translated into 17 languages and sold more than a half million copies.

*Early studies in psychology.* He studied under Carl Rogers, the founder of client-centered therapy, during the 1950s, receiving a PhD in philosophy from the University of Chicago in 1958. Gendlin's theories impacted Rogers' own beliefs and played a role in Rogers' view of psychotherapy. (See <http://www.focusing.org/multimedia/carl-rogers.asp>) Under Rogers' guidance at the University of Chicago, Gendlin developed one of the first outcomes studies on psychotherapy.

In 1958, two psychologists at the University of Chicago Counseling Center (Kirtner and Cartwright) described how various clients presented their problems in the first therapy session. Based on these descriptions, they divided the clients into five types. They found that their typology predicted both the length of therapy, and whether therapy would be successful (Kirtner & Cartwright, 1958). For example, in a sample of 24 clients, they found that therapy was successful for every client in the first two of their five categories, and therapy was unsuccessful for every client in the last two of their five categories. They found, in other words, that specific client behaviors at the beginning of therapy predict outcome at the end of therapy.

This study raised many important questions; for example, whether failure-prone clients should continue therapy after the first session, or whether they needed some special intervention to

help them succeed in therapy. The importance of client behavior in therapy, and the questions it raised, were largely ignored until Gendlin and colleagues rediscovered them through a separate line of research.

*Early studies in philosophy.* In the mid-1950s, Gendlin was a graduate student in philosophy at the University of Chicago studying the relationship between concepts and implicit understanding (which he then called preconceptual feelings).

The philosophy that Gendlin was already formulating suggested that consciousness is a continuous process of conceptualizing implicit understanding. The word "dog," for example, implicitly refers to (includes, carries with it) many experiences with a certain kind of animal; otherwise the word wouldn't mean anything. In a sentence like, "the dog chased the ball," each word implicitly includes or refers to unsymbolized experience, so that we know implicitly what each word means, and thus what the sentence means.

We can think explicitly about any word in the sentence, but only if we stop thinking about the meaning of the sentence and start thinking about the meaning of the particular word; and in that case, our explicit definition of the word still depends on implicit understanding. In the sentence above, we can explicitly define the word "dog" ("a dog is a mammal often kept as a house pet"), but the words in our definition refer to other unsymbolized experience. Any one meaning can be made explicit, but only by reference to other implicit experience.

In the same way, when we think about a problem, we start with an explicit formulation that refers implicitly to a great deal of unsymbolized experience. We experi-

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ence what is unsymbolized as a “feel” about the problem or situation; and guided by this “feel” we symbolize (make explicit or explicate) this unsymbolized context, until we have a solution.

*The bridge between psychology and philosophy.* Unlike some philosophers, Gendlin wasn’t content just to think about this relationship; he wanted to observe people in the actual process of conceptualizing their experience, and he thought that psychotherapy would be a good place to look. Thus it happened that a graduate student in philosophy began training as a psychotherapist at the University of Chicago Counseling Center.

Gendlin expected to find therapy clients stating some problem conceptually, but then finding that their statement of the problem depended on some implicit understanding that they hadn’t conceptualized. Upon stating that implicit understanding, they would find that it depended on another implicit understanding that they hadn’t conceptualized, and so on. In this way, the client’s statements would refer continuously to the client’s implicit experiencing, and in so doing, would continuously lead toward a deeper understanding, and a resolution, of the initial problem.

Gendlin’s research articulated that psychological change is best understood as a process of finding and following one’s inner felt experience. He demonstrated that the client’s ability to realize lasting positive change in psychotherapy depended on their ability to access a non-verbal, bodily feel of the issues that brought them into therapy. Gendlin called this intuitive body-feel the “felt sense.” He studied how those successful clients accessed and articulated this felt sense, and developed Focusing in order to teach others how to do so. In 1978, Gendlin published his best-selling book *Focusing*, which presented a six step method for

discovering one’s felt sense and drawing on it for personal development.

Gendlin founded The Focusing Institute in 1985 to facilitate training and education in Focusing for academic and professional communities and to share the practice with the public. In 2016, its name was changed to the International Focusing Institute.

*Gendlin’s relevance to psychology and self-help.* Dr. Ann Weiser Cornell, one of the world’s foremost teachers of Focusing, says:

*Because of Gene Gendlin and his Focusing process, hundreds of thousands of people around the world are able to give themselves and others the kind of support for emotional healing that otherwise had been found mainly in psychotherapy. Gene developed Focusing as a way that anyone can learn to listen inwardly to the life direction that is found in the body, and he believed in empowering people to do their own emotional healing—themselves, in partnerships, and in communities. So from the very beginning he taught Focusing to anyone who wanted to learn it, and encouraged people to pass it along. From these roots has grown a worldwide grassroots movement of mutual support for positive change based on acceptance and inclusion, and a hopeful vision of what is possible for all living beings.*

Dr. Kevin Krycka, Professor of Psychology at Seattle University and member of the Board of Trustees of The International Focusing Institute, says:

*Influenced by his work with Carl Rogers, Gene Gendlin promoted psychotherapy as a revolutionary place where human beings do not only delve into their individual experience, but*

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also see their intimate connection to others and the world around them.

*Focusing counters our tendency to rush to conclude or judge. It counters any tendency to see others as tools to our own personal ends, because we are fundamentally interaction with others. Experience is always interaction, and therefore suffering is never just an individual phenomenon. It is always implicitly shared. Focusing-Oriented Therapists know that the healing that happens in psychotherapy is to return the person from the experience of isolation to the awareness of connection.*

Gendlin was a pioneer of “embodiment” in philosophy and psychology. Gendlin wrote in his book, *Focusing*:

*When I use the word “body” I mean more than the physical machine. Not only do you physically live the circumstances around you but also those you only think of in your mind. Your physically felt body is in fact part of a gigantic system of here and other places, now and other times, you and other people. In fact, the whole universe. This sense of being bodily alive in a vast system is the body and it is felt from inside.*

*Gendlin’s relevance to philosophy.* Gendlin regarded himself first and foremost as a philosopher and he brought a rigorous philosophical perspective to psychology. His approach was presented in his early book *Experiencing and the Creation of Meaning* and later developed into a comprehensive theory of the deep nature of life processes. His thought is most fully articulated in his masterwork *A Process Model*, soon to be published by Northwestern University Press.

Gendlin brought philosophy into societal matters by creating a way of thinking that can be applied to all of our most challenging societal issues, including the

environment and issues of multiculturalism. He sought to overcome the dualistic thinking found in much of the philosophy of the early to mid-twentieth century, by demonstrating what it means to think with body and mind. Students of his philosophy have found that when one engages experiential, embodied background and logic, surprising new thinking is available to them.

Dr. Donata Schoeller is a professor of philosophy and translated Gendlin’s master work, *A Process Model*, into German (with Christiane Geiser). She is a member of the International Leadership Council of the International Focusing Institute. Schoeller says of Gendlin:

*Gene Gendlin was a pioneer of what today is considered the “turn to embodiment.” He brought philosophy to societal matters at a time when others were content to be in the ivory tower of academia. He didn’t simply criticize the prevailing dualism of body and mind, but demonstrated what it means to think with body and mind. Philosophers talk now about philosophical practice, but Gene actually delivered one, through his great work, *A Process Model*, and through the development of the practice of *Thinking at the Edge*.*

*As a younger philosopher, it was an amazing experience for me to see the existential seriousness with which he did philosophy. He didn’t compromise with any easier agenda; he took 30 years to write his main work. He was willing to give up being hailed by academia in order to be true to his work. I am deeply grateful to him for his work and for his example.*

### **Thinking at the Edge**

From 1968 to 1995, Gendlin taught philosophy and psychology at the University of Chicago. There he taught a course

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on theory-building that later gave rise to a practice he called "Thinking at the Edge" (TAE). TAE is a fourteen-step method for drawing on one's non-conceptual, experiential knowing about any topic to create novel theory and concepts.

**Personal Life**

Gendlin was a Jew, born in Vienna, Austria, on December 25, 1926. He lived with his parents in the 9th district of Vienna, a very Jewish district at that time. His father was a doctor of chemistry, and had a business as a dry cleaner. The family left Austria because of the rise of the Nazism. They first escaped to Holland and later emigrated to the United States with his parents on the *SS Paris* on its last voyage to New York, arriving January 11, 1939. He went on to serve in the United States Navy and to become a U.S. citizen.

After leaving the University of Chicago, Gendlin and his wife, Mary Hendricks-Gendlin, moved to New York state in 1996. Mary worked closely with Gendlin and served for many years as the Director of The Focusing Institute. She died in March 2015.

Gendlin is survived by three children, Elissa Gendlin (from his marriage to Mary Hendricks-Gendlin), Gerry Gendlin, and Judith Jones (both from his marriage to Frances Gendlin).

**Awards**

1970:  
"Distinguished Professional Award in Psychology and Psychotherapy," from Division 29 of the American Psychological Association (Division of Psychotherapy)

2000:  
"Charlotte and Karl Bühler Award" (given jointly to Gendlin and The Focusing Institute), from Division 32 of the American Psychological Association (the Society for Humanistic Psychology)

2007:  
"Viktor Frankl Award of the City of Vienna for outstanding achievements in the field of meaning-oriented humanistic psychotherapy," from the Viktor Frankl Foundation

2011:  
"Distinguished Theoretical and Philosophical Contributions to Psychology," from Division 24 of the American Psychological Association (The Society for Theoretical and Philosophical Psychology)

2016:  
"Lifetime Achievement," from the World Association for Person Centered and Experiential Psychotherapy and Counseling

2016:  
"Lifetime Achievement," from the U.S. Association for Body Psychotherapy



## BOOK REVIEW

**Book Review of *From the Couch to the Circle: Group-Analytic Psychotherapy in Practice* by John R. Schlapobersky. New York, NY: Routledge, 2016, 491 pp. ISBN: 9780415672207.**

Nancy W. Kelly, PhD, LCSW  
The Center for Group Studies  
New York, NY



In the competition between therapy modalities in the United States today, group psychotherapy is clearly on the ropes. As I write these words, the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) of the American Psychological Association is considering another petition offered by APA Division 49 (Group Psychotherapy) to have group psychotherapy declared a “specialty” practice among psychologists. Despite research that amply demonstrates the overall efficacy and cost-effectiveness of group psychotherapy (e.g., Burlingame & Krogel, 2005), as well as a demonstrated body of knowledge that cannot be taught in a single graduate course, it is far from certain that APA will grant specialty status to group psychology. Compounding the problem is the fact that graduate psychology programs across the country continue to reduce or eliminate training in group psychotherapy.

As a faculty member at The Center for Group Studies, I am undoubtedly biased in favor of promoting clearly defined standards and specialized training for all clinicians who practice group psychotherapy. Like many clinicians, I can recount my own embarrassing stories of being thrown into leading therapy groups at a local agency with little more than a

semester of group training. But the most eloquent argument I can offer for the value of more extensive training may be found in John Schlapobersky’s book, *From the Couch to the Circle: Group-Analytic Psychotherapy in Practice*. In this beautifully-written practice manual—aimed at both practitioners of group therapy broadly and practitioners of group-analysis particularly—Schlapobersky has provided us with a deeper understanding of the hows and whys of group therapy that extends the reach of the iconic classroom text in groupwork, *The Theory and Practice of Group Psychotherapy* (Yalom & Leszcz, 2005). In its broad focus on the unfolding moment-to-moment process of therapeutic groups, *From the Couch to the Circle* directs our attention to the phenomenological aspects of groupwork, providing a critical addition to the foundational texts in the field of group psychotherapy.

One of the strengths that Schlapobersky brings to his writing is also one of the texts’ greatest challenges for an American audience. Schlapobersky is a Training Analyst, clinical supervisor, and teacher at the Institute of Group Analysis in London; his writing displays the clinical sensitivity and theoretical lucidity of someone who has spent many years immersed in a specific model of psychotherapy, albeit a model less familiar to North American clinicians.

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Group analysis, in contrast to the interpersonal model of group therapy more commonly practiced in the United States and Canada, is the predominant model of psychodynamic groupwork taught and practiced throughout Europe. The philosophical underpinning of group analysis renders its practitioners keenly interested in the power of group process to heal both individuals and the larger society. In the book's introduction, Schlapobersky provides a brief historical overview, locating the origins of group analysis in the "exchange of clinical perspective and theory that flourished in Frankfurt until 1933" (p. 12). He links the ideas of S. H. Foulkes, then director of Frankfurt's Psychoanalytic Clinic, to those of social philosophers Horkheimer and Adorno via the "two-way channel [that] was opened between philosophy and clinical practice" (p. 12). The author notes that both the Psychoanalytic Clinic and the Institute for Social Research were housed in the same building in Frankfurt, noting the "formative influence" of Horkheimer's institute on psychoanalysts such as Foulkes, Fritz Perls, and Erich Fromm. Driven from Germany into exile after 1933, Foulkes settled in England and continued his psychoanalytic work, the hallmark of which became his declaration that "psychological disturbance" within a group is properly "located as taking place in between persons," rather than "wholly confined to a person in isolation" (Foulkes, 1948, cited in Schlapobersky, 2016, p. 442). In short, Foulkes and his colleagues argued that the psychological wounding that occurs within groups (including the family group) is most effectively healed within groups. Schlapobersky's text is an extended demonstration of this radical principle of psychotherapy practice, and his interest in the reparative process of group therapy is ever-present:

Our quest is to penetrate the heart of stone that holds the secrets of inner injury.... [In] the forum of the group people can be more alive to the real, the lost, and the unacquainted in one another and can harvest gifts of adversity from the most unlikely sources. (p. 459)

In contrast to many books about group therapy, which "describe the vehicle, but not the journey or the destination" (p. 65), *From the Couch to the Circle* attempts to illustrate the intrinsic link between group theory and moment-to-moment practice through the use of 68 stories or clinical vignettes that are interspersed throughout the book's chapters. These vignettes, drawn largely from the author's own clinical practice over many years, are the beating heart of the book itself, providing both illustrations of the author's theoretical ideas and a deep sense of the emotionally-significant moment that pulls the reader in. While taking care to disguise the identities of group members featured in the vignettes, Schlapobersky makes clear that the group members are "the true "owners" of the experience described" (p. 466), and he has included only those vignettes for which he has obtained consent to publish from his former group members (a rather remarkable feat, given that some of the vignettes feature group sessions from different settings over a 20-year span). One of the more moving parts of the book is the last chapter, "Conclusion and the last word," in which the author reprints portions of letters from eight of his patients, sharing their reactions to the vignettes he had written and elaborating on the impact of their group analysis in their present-day lives. Throughout the book, the author's abiding respect and admiration for his patients, especially for the specificity of their experiences and the metaphors

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they use, provides a satisfying emotional experience for the reader-practitioner. Indeed, some of the clinical vignettes moved me to tears as I found myself resonating with memories of deeply-affecting moments in my own groups.

Aside from their emotional impact, these clinical vignettes also serve to illustrate some of the concepts that might be unfamiliar to an American practitioner. For example, in Chapter 4, "The language of the group: Monologue, dialogue and discourse," Schlapobersky differentiates between three primary modes of speech that operate in groups: "Monologue," he writes, "can be understood as a soliloquy, dialogue as the resolution of opposites or the search for intimacy, and discourse is the work of the chorus" (pp. 112-13). He maps the logical progression from monologue to dialogue to reparative discourse ("where an individual's multiple inner objects are externalized and encountered in the group") in the maturation of a psychotherapy group, then he deftly illustrates these concepts in vignettes in which both group members and the "conductor," or group leader, contribute to the group work unfolding in a particular session (p. 113). Returning to Foulkes' pioneering notion of a clinical method of "free-floating discussion" between three psychological objects (the individual, the conductor, and the group as a whole), Schlapobersky links his description of the three basic forms of group communication to Foulkes' understanding of a therapy group as both a relational and semantic field, in which "the group's productions [can be considered] as the equivalent of the individual's free association on the part of the group-as-a-whole" (cited in Schlapobersky, 2016, p. 127). Hence the author attempts to demonstrate the link between the linguistic productions of a therapy group with the reparative, relational potential of the group: "Free-float-

ing discussion" encompasses all three speech forms, he concludes, yet it is also "the means by which associative patterns are analysed and explored, new forms of meaning are constructed and a new sense of the individual emerges in the widening cycle of the whole" (pp. 131-32).

The sheer scope of the book's aims—purported to be accessible by everyone from psychotherapists with little group therapy experience to postgraduate trainees in the group-analytic model to policy-makers in mental health—makes *From the Couch to the Circle* feel like a rather daunting endeavor for the casual reader, as books with large ambitions often do. Nonetheless, the author's introduction does provide suggestions about which section each audience segment might find most accessible as an entry point, and the author encourages readers to jump around freely within the text, as their interests and training dictate. Thus a clinician interested in introducing groups into her agency's programming might focus more on the first seven chapters—the "Foundations" section of the book—while a group-analytic practitioner might find more to hold her interest in the "Dynamics of Change" section, comprised of Chapters 13 through 18, which focus on the "four domains" of communication (and the interplay between them), transference, projection, and the dynamic role of the group conductor. Two chapters are particularly note-worthy for teachers of group psychotherapy, namely, Chapter 6, "The range of applications in ten studies," and Chapter 7, "Methods applications and models." Chapter 6 describes an impressively wide range of applications of group analysis across 10 different practice settings, making clear the diverse appeal of the model for both short- and long-term therapy groups

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with different populations. Even more intriguing for teachers of group therapy, Chapter 7 offers a comparison of the group-analytic model to other psychodynamic models more widely used in North America, including the Tavistock model, Yalom's interpersonal model, the modern analytic model, and the Systems-Centered Therapy model. This chapter, based on earlier work written by Schlapobersky in collaboration with Malcolm Pines, compares a variety of common group formats along two basic axes or indicators, namely, "specificity of therapeutic goals" and "levels of leadership activity" (p. 201). The author's concise summary of the basic tenets of each of six common models is thoughtful and balanced, and few group practitioners will be surprised by the conclusions Schlapobersky draws from the "modest comparative exercise," yet the chapter offers an intellectually satisfying account of the shared premises

and divergent foci of the dominant contemporary models of psychodynamic group work.

Despite its seemingly narrow focus on the group-analytic model, *From the Couch to the Circle: Group-Analytic Psychotherapy in Practice* is a eloquent, deeply poetic book that will appeal to any group practitioner who wishes to become a more sophisticated thinker about how to create groups that become agents of healing. More broadly, the book belongs on the bookshelves of any clinician who enjoys the meticulous rendering of therapeutic work as it unfolds in the moment-to-moment presence of a truly gifted practitioner.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website. [www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)



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## MEET YOUR 2017 WEB TEAM

*Amy Ellis, PhD*  
*Website Editor*

Since its inception, the Society for the Advancement of Psychotherapy has always strived to reach its ever-expanding audience. However, following the re-design of our website in October 2014, we experienced an exponential increase in the number of visitors who are not only reading our content, but also accessing Society resources. This shows we are moving in the right direction and we are humbled by your support and engagement. If you have not yet had the opportunity to check out our website, please do so! ([www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org))

Our vision for the website is that it will one day be an enduring contributor of unique content to the Society's readership, as well as the community at large, alongside the *Psychotherapy Bulletin* and *Psychotherapy* journal. We are well on our way toward that goal. In 2014, we first began coordinated efforts to publish unique web-only features, resulting in 14 articles. This number has steadily increased since then with 27 articles published in 2015 and 22 articles in 2016. This year, through the dedicated efforts of Kourtney Lavallee, Associate Editor of Website Content, we have been able to publish our web features once per week, every Sunday. At the time of this writing, we already have 20 articles published or set to publish through May 2017, meaning that we are on track to double our past records.

The growth of our content has surely been a catalyst for the number of site visits we receive. In 2014, we had 34,481 unique individuals who visited our website and in 2015, this number rose to 60,528 users. This number almost dou-

bled again in 2016, where we had 115,627 unique visitors, representing a 50% growth rate year-over-year.

Even with these past three years, there is still work to be done. We have re-evaluated our current website model while focusing on how we can become a better leader in providing cutting-edge psychotherapy content, for both you, our members, and our readers. In the coming months, we will be redesigning our website layout, making it easier to find and search for content and articles. We will be sharing updates on this project as it progresses in the coming months.

We envision the website as a voice for the Society and the field of psychotherapy. That means we want to hear from YOU. If you have suggestions for improving the layout, desired content that you want to read, or feedback about anything at all, please reach out to me, Amy Ellis, at [amyellisphd@gmail.com](mailto:amyellisphd@gmail.com). If you are interested in writing for our website, please email Kourtney Lavallee, Associate Editor of Website Content, at [interneteditor@societyforpsychotherapy.org](mailto:interneteditor@societyforpsychotherapy.org).

We also welcome you to come interact with us on any of our social media pages. You can like us on Facebook ([facebook.com/psychotherapy29](https://www.facebook.com/psychotherapy29)), follow us on Twitter ([twitter.com/psychotherapy29](https://twitter.com/psychotherapy29)), connect with us on LinkedIn (<https://www.linkedin.com/company-beta/9310252/>), and you can now follow us on Instagram ([www.instagram.com/apadivision29](https://www.instagram.com/apadivision29)).

I am proud to introduce myself and my

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Web Team colleagues, Kourtney Lavallee, Nathan Daly, and Elizabeth Davis.

**Meet Amy E. Ellis, PhD,  
Website Editor**



I am currently an Assistant Professor in undergraduate psychology at Albizu University, co-Director of the Trauma Resolution & Integration Program (TRIP) at Nova Southeastern University, and I have a small private practice where I specialize in the treatment of trauma and eating disorders. As I've maintained involvement in the Society (I was previously the Associate Editor of Website Content), I have found a true "professional home" and community.

I am grateful for my dynamic web team who tirelessly works around the clock. A huge thank you to our Associate Editor, Dr. Kourtney Lavallee, who amazingly procures new Special Features faster than we can keep up with, and to our Student Website Editors, Nathan Daly and Elizabeth Davis, who have jumped on board seamlessly and have offered support, wisdom, and "muscle" to the inner workings of our small web team. I am also grateful to our Society President, Dr. Jeff Zimmerman, and our Publications Chair, Dr. Jeff Barnett, both of whom have been instrumental in the success of the website and have given us unquestionable support as we advance our website and team to the next levels. My sincerest gratitude is also extended to Tracey Martin, who has lent unending support to the website, myself and my team, and the Society as a whole. I am also eager to continue working with Dr. Lynett Henderson Metzger and her remarkable Bulletin team, as we move the Bulletin to an online-only version.

And of course, I am grateful to our Board members, our readers, and our Division members; this year is off to a great start, and I am excited to see what the next three years will bring us!

**Meet Kourtney Lavallee, BS,  
Associate Editor for Website Content**



I am the Associate Editor for Website Content (2017-2020), where I work on the strategic design of the website and advancement of digital outreach. I graduated from the University of Florida with a Bachelor's degree in Psychology and a minor in Women's Studies. I am currently working on a Doctor of Psychology in Clinical Psychology at Nova Southeastern University. My interest in the Society for the Advancement of Psychotherapy is based on the generality of psychotherapy. I believe this allows for a varying and enhancement of knowledge in psychotherapy. I hope to achieve a greater understanding of the technological aspects of psychotherapy as well as learning more about a variety of concepts in psychotherapy.

**Meet Nathan R. Daly, BS, Student  
Website Editor**



I am one of the Student Web Editors, where I work on social media strategies and broadcasting content. I graduated from Saint Louis University with a Bachelor's of Science degree in Psychology. I am currently working on a Doctor of Philosophy in Clinical Psychology at Nova Southeastern University. One thing about the Soci-

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ety for the Advancement of Psychotherapy that interests me is that it offers equally accessible trainings, continued education, awards/grants, and psychotherapy research. The resources offered by the Society serve to advance the academic discipline of psychotherapy and provide clinicians with an opportunity to hone their skills and share resources. As a Student Web Editor, I hope to familiarize myself with the process of publication and broadcasting. As the academic discipline of psychology relies more heavily upon cyber communication, it will be necessary for researchers and clinicians to become comfortable exchanging information, and treating clients, over the Internet. By working as a Student Web Editor, I hope that I can become intimately aware of this process by working with talented researchers and clinicians at the Society for the Advancement of Psychotherapy.

**Meet Elizabeth Davis, BA, Student Website Editor**



I am a Student Editor for Website Content at the Society for the Advancement of Psychotherapy. I work on managing website content and digital outreach. I earned my Bachelor's degree in psychology from Hendrix College in Arkansas, and am currently working on

my doctoral degree in Clinical Psychology from the University of North Texas. My current research is focused on the advancement of psychotherapy through the development of an outcome tracking measure for use in psychotherapy training clinics. I am thankful for the support that the Society for the Advancement of Psychotherapy has shown in the development of this research, and am excited for the opportunity to become more involved in the Society's priority to disseminate quality information about psychotherapy. In addition, I am looking forward to gaining a better understanding of the publication process through the Society, and learning more about the multiple ways through which the Society serves the larger community of psychologist researchers and practitioners. Through my current role with the Society, I will be assisting with website content, development, and publication. I started the position with a limited knowledge of web publication and social media management, and am eager to develop a greater expertise in this area while working to promote the Society for the Advancement of Psychotherapy. Additionally, I am excited for the opportunity to network with and learn from other professionals within the Society. My research has seen important support from the Society, and I am enthusiastic about this opportunity to support the Society's mission, and gain a greater understanding of its current priorities.



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**QUESTIONS OR COMMENTS?** Please contact Amy Ellis, Associate Editor for Website Content, at [amyellisphd@gmail.com](mailto:amyellisphd@gmail.com); or Lynett Henderson Metzger, *Bulletin* Editor, at [Lynett.HendersonMetzger@du.edu](mailto:Lynett.HendersonMetzger@du.edu).

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