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In This Issue

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PSYCHOTHERAPY BULLETIN

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CONTENTS

PRESIDENT'S COLUMN

Some Thoughts on Personal and Organizational Accountability

Rod Goodyear, PhD
University of Redlands

The release of the Hoffman Report several weeks before the APA convention immediately precipitated worried conversations about what it meant for our Association as well as about appropriate responses going forward. Many psychologists were concerned simply with understanding what had happened and what it meant; some quickly moved to propose answers (among the many thoughtful responses were those of Melba J. T. Vasquez and Ken Pope, reprinted elsewhere in this issue). Eventually, though, the burden for deliberation and action fell to the APA Council Representatives and, fortunately, our Society is well represented this year by Jean Carter, Jeffrey Magnavita, and John Norcross (with Armand Cerbone serving as well during this convention). The Council took several important steps, in particular passing a resolution with a number of provisions, including (a) redefining the term "cruel, inhuman or degrading treatment or punishment" in the 2006 and 2013 Council resolutions to align it with the U.N. Convention Against Torture and (b) asserting "that in keeping with Principle A (Beneficence and Nonmaleficence) of the Ethics Code to 'take care to do no harm,' psychologists shall not conduct, supervise, be in the presence of, or otherwise assist any national security interrogations for any military or intelligence entities" (American Psychological Association, 2015, pp. 5). This and other Council actions were important in helping our Association to establish a positive trajectory going forward.

One aspect of the pre-convention discussions that I found to be of particular interest was the notion of accountability. It was invoked a number of times, sometimes with the harder-edged phrase of "holding people accountable." I was especially attuned to this because I was preparing a presentation on the role(s) of accountability in psychology training (Goodyear, in press) that was forcing me to explore the concept in new ways. In doing so, I discovered fairly quickly that accountability is a relatively fuzzy concept, to the extent that it even has been characterized as "chameleon-like" (Mulgan, 2000, p. 555).

But despite that fuzziness, accountability remains an important concept, and how we understand it necessarily affects our responses to events described in the Hoffman Report and our expectations for both APA and the divisions to which we belong. Although the answers will vary, all conceptions of accountability speak to the sometimes-complex matter of who is accountable to whom and for what. I think that Burke's (2005) answer to the "to whom" question and Koppell's (2005) to the "for what" question have particular usefulness to us:

> We all understand that accountability often is "up" in the sense of being answerable to an employer, a statute, an accrediting body, and so on. But, in addition, Burke (2005) suggested that accountability *also* can be what he termed "within" (accountability to the profession itself with its

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norms, expectations and ethical codes), "down" (accountability to subordinates and, in the case of psychologists, to students) and "out" (accountability to other audiences, including the general public).

We also readily understand that accountability can concern the extent to which the accountable person or entity is complying with the demands of the authoritative entity (employer, statute, etc.). But Koppell (2005) suggested three additional categories of accountability: namely, that persons or entities can be accountable for the extent to which they (a) are forthright in disclosing salient information (*transparency*), (b) are compliant with rules or norms of the profession, such as ethics codes (*responsibility*), and (c) are attentive to the needs of the people being served (*responsiveness*). It is interesting, incidentally, to see the particularly close alignment between Koppel's category of responsibility and Burke's of "accountability within," and of Koppel's responsiveness and Burke's "accountability out."

To employ the Burke (2005) and Koppel (2005) categories creates a broad understanding of accountability. I think, though, that it is useful in considering what we want from APA and its divisions going forward. One "silver lining" in the Hoffman Report has been its directing our attention to these discussions, which the leadership of our Society is committed having. In fact, that is on the agenda for the Society's October meeting of its Board of Directors. As members have ideas or concerns that will be helpful in those discussions, I know that we all would welcome them.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

Find the Society for the Advancement of Psychotherapy at www.societyforpsychotherapy.org

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As noted by Dr. Goodyear in his President's Column, the Society for the Advancement of Psychotherapy finds itself in a time of great opportunity for self reflection and growth as we bring you the third edition of *Psychotherapy Bulletin*'s 50th anniversary year. This spirit infuses many of the articles you will find in the following pages, beginning with our Special Feature—Ethics and Public Interest, in which we reprint the eloquent and thought-provoking responses to the Hoffman Report by Drs. Vasquez and Pope. Former APA President Pat DeLeon also brings us his perspective in this issue's Washington Scene.

The reflective theme continues with a Psychotherapy Research piece on the use of self-forgiveness in therapy, and with observations on the 10-year anniversary of Hurricane Katrina from an Early Career psychologist. Other topics of interest to students and newer professionals include this issue's Clinical Notes With Dr. J, featuring tips on professional development, as well as student pieces on practicing self care, connecting in group work, and managing stress through humor. Rounding out our offerings for this time are articles on the inclusion of the supervisor in psychotherapy sessions, working psychodynamically with older adults, and applying interventions for youth at high risk for psychosis to Asian American clients, plus Book Reviews of Irvin Yalom's new *Creatures of a Day: And Other Tales of Psychotherapy* (2015) and Jeffrey Barnett, Jeffrey Zimmerman, and Steven Walfish (2014) *The Ethics of Private Practice*.

As always, don't miss our member features—including the Nominations Ballot!—and look for additional content on the Society's website (http://societyforpsychotherapy.org/). We welcome your ideas and input. The next deadline for submissions is November 1, 2015, and complete submission guidelines can be found in the back of this volume or online.

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SPECIAL FEATURE—ETHICS AND PUBLIC INTEREST

The Hoffman Report: Resetting APA's Moral Compass

Melba J. T. Vasquez, PhD, ABPP
Former President, American Psychological Association

In November 2014, the American Psychological Association Board of Directors hired an independent reviewer, former Inspector General and former federal prosecutor David H. Hoffman, J.D. of the Chicago-based Sidley Austin Law firm, to conduct a thorough and independent review to investigate the relationship between various activities of the APA and Bush Administration policies on interrogation techniques used on foreign detainees. On July 10, 2015, the report ("Hoffman Report," see http://www.apa.org/independentreview/APA-FINAL-Report-7.2.15.pdf) was released to the public. It described previously unknown and very troubling facts that led Mr. Hoffman to conclude that collusion among some APA staff and members with the Department of Defense led to a weakening of the expressed ethical values and principles of the association, and may have enabled the government's use of abusive interrogation techniques of foreign detainees.

Mr. Hoffman and his staff investigated the process of development of a specific policy paper, the 2005 Psychological Ethics and National Security (PENS) report, a document developed with the intention to provide guidance to military psychologists who asked for support in providing ethical processes in their involvement in interrogations. That report became a very controversial one over an 8-year period among members in the association, and was ultimately rescinded in 2013, after a series of resolutions and policy statements that more accurately reflected the values of the association and its members. The Hoffman Report found that the usual internal checks and balances in regard to the production of policy failed to detect the collusion and significant conflicts of interest in the development of the PENS report resulting in what he determined was a lack of meaningful field guidance for military psychologists.

One of the key points of debate and controversy has involved whether psychologists should participate in the interrogation of persons held in custody by military and intelligence authorities. One side suggested that psychologists should never be present for those, and even not present at all at such sites as Guantanamo and Abu Ghraib, especially given that abuses were endorsed as "legal" by the Bush Administration. Others believed that our behavioral science informed us that the most ethical and effective methods of interrogation included effectively building rapport, and that the presence of psychologists with that expertise and knowledge to facilitate this goal would help to protect detainees from abusive interrogations. Other diverse views addressed what types of involvement in what locations under what rules and oversight and for what purposes. Although the controversy continues, at the point of this writing, before the August 2015 APA convention in Toronto, where the Council of Representatives meets, the Board

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of Directors has recommended to the Council of Representatives that they adopt the following policy:

> to prohibit psychologists from participating in the interrogation of persons held in custody by military and intelligence authorities, whether in the US or elsewhere, but allowing them to provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible psychological effects of particular techniques and conditions of interrogation, and on other areas within their expertise.

The findings of the Hoffman Report are deeply disturbing; its impact has been a bombshell of seismic proportions for the APA and for psychology. The Director of the APA Ethics Office has been apparently fired from his job, the Chief Executive Officer (CEO) and the Deputy CEO have announced early retirements, the APA Executive Director for public and member communications has resigned, and certain members have been asked to step down from their governance activities. In addition, several APA members are reporting experiencing repercussions either in their work places, in the APA, or both.

APA member Linda Woolf (personal correspondence, July 21, 2015) described the Hoffman Report as a wake-up call for the APA. She stated, "As a gestalt, it highlights areas of needed reform, action, and self-reflection. However, as a Report, it is not without its problems (e.g., numerous statements of assumption; failure to interview key participants in APA's anti-torture efforts; omissions of testimony; the selectivity of information requested, etc.)." There is much to learn from reading the Hoffman Report carefully. Where does it identify facts that are of concern? Where does it provide interpretations that lack evidence?

Regardless of its imperfections, the Hoffman Report underlines the loss of an ethical focus on supporting fundamental human rights. Zimbardo (2007) made the point that the PENS report made several important contributions to the complex ethical issue of psychologists serving in working arrangements within the national security framework. Many of us were concerned about appropriate treatment of detainees who were not white (thus, vulnerable to racism), who were not Christian (and vulnerable to further bias) who were designated as "foreign combatants" (e.g., did not have rights to due process under the law as U.S. citizens), and who were feared for having potential information about future terrorism. This alerted us to be extra vigilant for this vulnerable population. The majority of those of us in governance believed that supporting the PENS report (not being aware of the behind the scenes collaboration with the Department of Defense personnel on wording in this report), including allowing for trained military psychologists to be present at interrogations would have protected detainees from torture and abusive interrogations. Many others believed that we needed to go further, and over the eight years following the release of the PENS guidelines, a number of individuals worked tirelessly to strengthen APA's position against torture both inside and outside of national security settings. Progress was made over time (see the Conclusion for a summary).

It will take a long time to sort out the problems identified in the Hoffman report, and many groups, including the APA Council of Representatives, our

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policy making body, will examine what happened, why it happened, what went wrong, and what is best for the organization in the future (personal communication, Linda Forrest, July 22, 2015). In the meantime, there are many lessons to be learned that reflect the ethical principles we have tried to impart in this book. . . .

Lessons Learned

The dangers of dichotomous us/them thinking. One of the problems has been the tendency to engage in our propensity to categorize, and join with one group or another. Opotow (1990) described how we form groups in a we/they dichotomy. This leads to a subconscious and automatic categorization of people into our "in-groups," those with whom we identify, and our "out-groups," those whom we see as being outside our realm of identification. People in our in groups are more highly valued, are more trusted, and engender greater cooperation as opposed to competition. We have more compassion and empathy for those in our in-group than for those in our out-group and are more likely to endorse and support those in this category.

On the other hand, people in our out-groups are implicitly conceptualized as "they," or the "other," and these categorizations affect behavior. We tend to treat out-group members as objects, in insensitive ways. At minimum, people in our out-groups are ignored or neglected; we tend to stop listening. . . .

Encourage Speaking Up, Listening Carefully, and Acting With Fairness

The influence of context. We must remember to be hyper-vigilant especially when the context is one of crisis. Our chapter on ethics in organizations reminds us that unethical acts may go unnoticed or unreported, and we may be particularly vulnerable to this at times of crisis. In this context, the emotional and political atmosphere following the 9/11 terrorist acts resulted in fear, grief and anger that eventually led the country to war and to the government's "legalized" use of torture and abusive interrogations at Guantanamo and Abu Ghraib. That context perhaps led many of us in the APA to fail to listen, engage in open communication, critically and thoughtfully analyze situations, to pause and reflect, and to fail to treat each other with respect.

Take care to not move too swiftly in those crises. The governance processes and procedures typically serve as a way to ensure that policies and reports are vetted, and that all voices are heard, as much as possible. Guidelines, resolutions, and reports are typically reviewed by APA Boards and Committees, key experts, divisions and state and provincial psychological associations, the Council of Representatives, and other interested parties for one or more rounds of comments. The process is long and tedious, but it works to allow concerns to be addressed, compromises to be made, and corrections to be incorporated. This process makes room for as many voices to be heard, respected, and included so that usually, a collective wisdom can be reached. Because information and knowledge evolves over time, some documents such as guidelines are required to be reviewed and updated every ten years.

The system also allows for a bypassing of the process in cases of emergency, such as when funds and other supports are offered after natural disasters, such as the 2004 Indian Ocean earthquake and tsunami, and the 2005 Hurricane Katrina in New Orleans.

Because of the perceived urgency of the need for guidance for military psychologists, in 2005, the movers of the PENS report bypassed the usual process and it

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was treated as an emergency event. The lesson learned here is that when the nature of the product contains many controversial and complex issues, we should not bypass the longer vetting process. . . .

Communicate to increase understanding. The nature of organizations is political. Competing interests within them have to be balanced through communication, debate, negotiation, and compromise. Sometimes debates take the form of win/lose, and in that context, debates can take a negative, destructive tone. Attempts are made to silence people by treating them with disrespect; at times, it seems that there is competition for individuals on all sides to be the meanest person in the debate. We must never lose sight that the primary goal of communication is to increase understanding. In any situation with competing interests, it is optimal if consensus is reached; if not, it comes to a democratic vote. However, destructive communications are never acceptable or appropriate. All voices should be heard; participants should listen carefully; and, the process should promote respect and fairness.

APA as an association for all psychologists. One of the wonderful things about the APA is that it is a broad tent that tries to provide a home for all psychologists. It is also a challenge in that many subspecialties and disciplines in psychology are varied and at times at odds. Did we try to bend over too far to consider the guidance needed by military psychologists? I tend to think not. What is more possible is that the perceived urgency leading to a suspension of usual processes allowed for secretive behind-the-scenes communications to have undue power. This does not mean that we should stop listening to the needs of the wide variety of psychologists; it means we must continue to consider how to work through the conflicts to produce good work, even when this takes time.

Respect the True Costs of Betraying Ethics

How do we prevent masking, reinterpreting, or justifying risky acts that may be unethical, or that represent flawed judgments, logical fallacies, and cognitive strategies of justification?

Engage in self examination. Many of us as individuals, and the APA as an organization, are in the process of engaging in self-examination. I am looking at my own actions while serving on the Council of Representatives (2004-2006), Board of Directors (2007-2009), and as president elect, president and past president (2010-2012). I have talked to several colleagues and friends who were also in leadership during this period, and we are examining what we did, what we didn't do, what we wished we had done, and to reconsider all of it in light of what has been described in the Hoffman Report (personal communication, Linda Forrest, July 22, 2015). How can we train ourselves to do so on a regular, ongoing basis in regard to any controversial issues that we address?

Seriously and carefully attend to conflicts of interest. Because of the importance of trust, standards that apply to public governmental officials should also apply to APA members and staff. They should be stringent, and require not only avoidance of conflict of interest, but also the appearance of conflict of interest.

Make amends and apologize. An important part of finding our moral compass to "right the ship" is to acknowledge our errors, neglect, missteps, and harm done. We have to stop and truly understand who and how we harmed others and offer specific apologies because that is the beginning of the healing process. Many of us, I included, experience regret, sadness, shame, and heartbreak.

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APA provided an apology in the first public announcement, "APA Apologizes for "Deeply disturbing" Findings and Organizational Failures; Announces Initial Policy and Procedural Actions to Correct Shortcomings" (July 10, 2015, see http://www.apa.org/news/press/releases/2015/07/independent-review-release.aspx). In an early publication of his September, 2015 *Monitor on Psychology* column, CEO Norman Anderson also apologized: "As your CEO, I want to express my deepest regrets for the events described in the report, which hurt us all tremendously."**. . . .**

Conclusion

. . . . Many colleagues have expressed optimism that in this crisis, there exists an opportunity for APA to grow and to learn as an ethical organization. Sandy Shullman, (personal communications, July 24, 2015) eloquently stated:

> … there are some great lessons here and also some great opportunities for many dedicated and talented people to break mindset about how you show up as a member of an organization and do your level and ethical best, which could ultimately lead our field to a much better place. I am not…minimizing the hurt and damage, but I know many great discoveries and moments of true progress followed on the heels of colossal mistakes. What we do with our recent knowledge and learning will ultimately determine the real impact of our current flaws and also the continued growth of our profession and discipline. Ethical behavior is indeed both evolutionary and revolutionary.

There is strong commitment to learn from terrible mistakes and to do everything to strengthen our organization to demonstrate commitment to ethics and human rights.

Working together, the Council of Representatives, Board of Directors, other members and the APA staff will continue to benefit society and improve people's lives. APA will find the moral compass to right its ship. . . .

If I value transparency, it is a good idea for me to practice it, so in the interest of transparency and self-disclosure of my perspective (or potential bias), it is important that readers know up front that I resigned from APA in 2008 over changes APA had been making in its approach to ethics. The Hoffman Report discusses these changes. I wrote that "I respectfully disagree with these changes; I am skeptical that they will work as intended; and I believe that they may lead to far-reaching unintended consequences." Both my letter of resignation online at http://kspope.com/apa/index.php and my articles and chapters (Pope, 2011a, 2011b, 2014; Pope & Gutheil, 2009) present my beliefs along with the evidence and reasoning that in my opinion support them.

Editor's Note:

Excerpted with permission from Appendix B of Ethics in Psychotherapy and Counseling: A Practical Guide, 5th edition by Kenneth S. Pope and Melba J. T. Vasquez, forthcoming January 2016. Copyright ©2016 by John Wiley & Sons. All rights reserved. No part of this excerpt may be reproduced or reprinted without permission in writing from the publisher. Full version may be accessed at: http://melbavasquezphd.com/HoffmanReport.pdf

The Hoffman Report and the American Psychological Association: Meeting the Challenge of Change

Kenneth S. Pope, PhD, ABPP
Former Chair, Ethics Committee of the American Psychological Association (APA) and the American Board of Professional Psychology (ABPP)

In 2014, the American Psychological Association (APA) made a monumental move toward more transparency. The organization took a courageous step unthinkable at any time in its 121 year history: It opened up to a former federal prosecutor, giving him access to all documents and personnel. APA hired David Hoffman and his colleagues at Sidley Austin LLP to conduct "thorough" and "definitive" investigation to document "what happened and why" (Hoffman et al., 2015, p. 1).

The Hoffman Report—online at http://www.apa.org/independent-review/APA-FINAL-Report-7.2.15.pdf—set off an ethical earthquake. The investigation uncovered emails and other documents containing linguistic tricks that mislead and manipulate, logical fallacies in ethical reasoning, biased ethical judgment, hypocrisy, and creative cheating that this book's five chapters focusing on critical thinking in ethics prepare us to recognize and avoid. These uncovered documents confront us with the challenge of change. The challenge brings questions. What changes, f any, need to occur in ourselves as individuals, in APA as an organization, and in the larger professional community? What internal and external forces, if any, will block, weaken, delay, or divert needed change? How, if at all, can we respond effectively to forces that resist needed change? How do we assess whether apparent change is real and meaningful?

None of these questions comes with a simple answer we will all agree with. All come wrapped in complex puzzles of practicality, politics, and fundamental values. None of the questions allows us easy escape. How we answer them—or fail to answer them—will determine whether we bring about needed change. This article takes a look at the questions and challenges that the Hoffman Report has brought to our doorstep.

What Does the Hoffman Report Have to Do With Each of Us as an Individual APA Leader, Member, or Outsider?

What does the Report have to do with us? Our shared human tendency when scandal explodes is to blame bad apples: "It's their fault! Maybe we made some well-intentioned mistakes, which we regret, but if you're looking for the real cause of this mess, it's them, not us." Bad apples come in three varieties: personnel, policies, and procedures. We toss the bad apples, find shiny new replacements, and think we've fixed the problem. Countless organizations make personnel moves (transfers, terminations, retirements that are forced or induced by hefty payments, and so on), vote to amend or replace policies, and create committees to cancel some procedures and issue new guidelines, finding only later that they've achieved little beyond good public relations and the illusion of needed change.

Or we can head into discrediting mode: "We chose the person we believed best suited to give us the definitive account of what happened, but he delivered a flawed report that is nowhere near de-

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finitive. He uncovered some damaging facts but we must bear in mind that he's not a psychologist. He did the best he could without understanding our profession, our organization, our history, our culture, or the way we do things. He made questionable assumptions and got some key things wrong. After all, it's just one outsider's opinion."

Answering the question "What does this have to do with us" requires us to move beyond our human tendency to deny, discredit, or dismiss what we do not want to know or be known. We may find that harder than usual in this case. The Hoffman Report documents years of improper behavior. But it also documents that for years APA as an organization and some APA defenders denied, discredited, or dismissed revelations of this improper behavior as they appeared in newspapers, professional journals, books, reports from human rights organizations, and other media. Changing habitual behavior that has settled into a familiar routine is rarely easy for any of us.

Moving beyond our shared tendency to shield ourselves from unwanted information and personal responsibility allows each of us to learn what the report has to do with us as an individual. If we can summon the courage and resolve to look without squinting or flinching away, the Hoffman Report can serve as an ethical mirror. When we take the time to read it in its entirety and deep detail, the report teaches us something about ourselves and helps us take a personal ethics inventory. When we take time to read the detailed report, we begin to see the complex relationship between what we did or failed to do and the events that the report documents. When we take time to read the report, it points the way to effective change, in ourselves and in our profession. If we set it aside unread or settle for second-hand summaries, we turn the ethics mirror to the wall and imagine a more personally flattering picture.

What Could Each of Us Have Done Differently?

Reading the Hoffman Report prepares us to struggle with one of its fundamental challenges: Answering the questions: What could I have done differently as an APA leader, member, or outsider? How does my answer to that question help me decide what to do from this point forward? No matter what our position or circumstance, each of us can think of things we might have done, or done better. Only the delusional can gaze into the Report's mirror and see ethical perfection. Only those needing an ethics ophthalmologist will notice merely a handful of things they could and should have done or done differently over the days, weeks, months, and years covered in the Hoffman Report.

Struggling with this challenge is hard, often painful work. It takes time—not a sprint and perhaps not so much a marathon as a continuing daily run. And aren't we all tempted to cheat, sleep in, or go easy on ourselves? We all know how to put denial, discrediting, and dismissing to work when searching for our own ethical disconnects, flaws, weaknesses, and violations. Politicians master this art of pseudo-self-examination.

We can use the Hoffman Report to hold ourselves personally accountable for all the things we might have done, or done differently. This puts us in a better position to join with others in our diverse communities from our small informal groups and networks to large national and international professional organizations to bring about needed meaningful change in our profession in all its diversity.

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What Do We Want Our Ethics and Our Ethics Enforcement to Be?

The Hoffman Report challenges us to decide what kind of ethics each of us believes in and whether we are willing to be held accountable. A fundamental question is: Do we want professional ethics or guild ethics. Professional ethics protect the values that its members affirm as greater than self-interest and protect the public against misuse of professional power, expertise, and practice. Guild ethics place the interests of the guild and its members above the public interest, edge away from providing actual accountability, and draw on skilled public relations to resemble professional ethics.

The Hoffman Report documents that for over 15 years, APA had turned its ethics policies and enforcement procedures toward protecting its members from public accountability. In the words of the report, APA "prioritized the protection of psychologists—even those who might have engaged in unethical behavior—above the protection of the public" (p. 63). The Association made this switch to "a highly permissive APA ethics policy based on strategy and PR, not ethics analysis" (p. 16) well before the detainee controversy, all the way back to the 1990s. The Report provides accounts of extraordinary interventions to undermine the process of adjudicating ethics complaints and protect high-profile or well-connected members dating back to the mid-1990s. Depriving people who file formal complaints of a fair hearing and a just resolution can serve guild interests but it can also encourage members and nonmembers alike to believe that voicing ethical questions or concerns that might reflect badly on individual members or damage the organization's interests "will at best come to nothing" (Pope, 2015, p. 144).

The strategy of offering protection to psychologists, "even those who might have engaged in unethical behavior," instead of professional ethics and accountability, was designed to keep members from leaving APA and to attract new members:

> APA leaders had decided in the 1990s…that APA's ethics policies and practices had been too aggressive against psychologists, and that a more protective and less antagonistic ethics program was appropriate. They wanted…much less emphasis on strict rules and robust enforcement of disciplinary complaints…. [A new ethics director] was hired specifically to pursue an ethics program that was more "educative," and he fulfilled these goals. During his tenure [2000-2015], APA disciplinary adjudications plummeted, and the focus shifted to "supporting" psychologists, not getting them in trouble—a strategy consistent with the ultimate mission of growing psychology. (Hoffman et al., 2015, p. 307-308)

APA had turned away from its responsibility to protect the public. The Hoffman Report quotes the APA's Ethics Director's statement that the role of APA Ethics "is not protection of the public and that protection of the public is a function for state licensing boards" (p. 475). APA embraced this model of ethics and modeled it for students, trainees, its members, state psychological associations, and the national and international community for 15 years. . . .

APA's new ethics, based on "First, do no harm to psychologists," created a public relations problem. How could the Association explain to the public that protecting the public from the harm that can result from unethical assessment, therapy, counseling, forensic practice, research, publication, teaching, and so on, was not its concern, that the function of

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APA ethics "is not protection of the public and that protection of the public is a function for state licensing boards"? The answer had the simplicity of Orwell's double-speak: war is peace, ignorance is strength, freedom is slavery—"To advance its PR strategy, APA issued numerous misleading statements that hid its true motives, in an attempt to explain and justify its ethics policy" (Hoffman et al., 2015, p. 15).

But what are our true motives—yours and mine? What do each of us see when we look in the mirror? What are our own personal ethics? To what extent are they public relations, more appearance than practice? How much time do we spend searching for ways to strengthen them and eliminate gaps, flaws, and contradictions? How rigorous are we in holding ourselves accountable to these ethics? What would we do if we knew we could get away with it and no one would find out?

When we struggle with these highly personal questions, we put ourselves in a better position to join with others to think through how to use the Hoffman Report to strengthen the ethical culture and practices of psychologists and our diverse groups, networks, and organizations. . . .

Where Do We Go From Here?
The Hoffman Report challenges us do some critical thinking about:

- What each of us might have done or what might we have done better
- What our own ethics are and whether we are willing to hold ourselves accountable through a realistic method of enforcement
- What we do to deny, discredit, or dismiss what we don't want to see or believe

When complicity with torture, violations of human rights, misleading the public, and other vital matters are at stake, organizations must address not only personnel, policies, and procedures but also the powerful incentives from inside and outside the organization, sources of institutional resistance to change, conflicting ethical and political values within the organization, and issues of institutional character and culture that allowed the problems to flourish for years, protected by APA's denials.

Organizations facing ethical scandals often publicly commit to admirable values such as accountability, transparency, openness to criticism, strict enforcement of ethical standards, and so on. These institutional commitments so often meet the same fate as our own individual promises to a program of personal change. We make a firm New Year's resolution to lead a healthier life. We pour time, energy, and sometimes money into making sure the change happens. We buy jogging shoes and a cookbook of healthy meals. We take out a gym membership. We discuss endlessly what approaches yield the best results. We commit to eating only healthy foods and to getting up five days a week at 5 a.m. for an hour of stretching, aerobics, and resistance exercises. But one, two, and three months later, the commitment to change that had taken such fierce hold of us and promised such wanted, needed, and carefully planned improvement has loosened or lost its grip.

Decades of research and case studies in organizational and individual psychology show that major change is hard to achieve and maintain over the long haul. Distractions grab attention and drain our will. Old habits return. Temptations hit at unguarded moments. Memories of the need for change fade. Imaginary change starts to look like the

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real thing. We find that the more things change, the more they remain the same.

How can we hope to tell if what we are doing is creating meaningful change? Pseudo-change often appears *only* in public statements, pledges of improvement, personnel turnover, the formation of committees, new organizational charts, and discussions. Meaningful change is often reflected in measurable progress. We can look to see if all our discussions, statements, and activities are creating meaningful, measurable progress.

For example, the Hoffman Report documents a wide range of improper behaviors involving conflicts of interest, improper handling of ethics complaints to protect psychologists, issuing misleading statements that hid true motives, to name but a few, as well as activities related to torture and violations of human rights.

Now that the Hoffman Report has awakened our profession, if none of the diverse improper behaviors violates any ethical standard in the APA Ethics Code, that may tell us something. If any of the diverse improper behaviors violates any standard in APA's code, and neither the APA Ethics Committee, nor any state psychological association or state psychology licensing board that has adopted APA's ethics code as enforceable, takes action sua sponte (on its own initiative) or in response to a formal complaint, that may tell us something. These and other measurable signs of meaningful change (e.g., whether APA and its elected officers representing the membership publish formal corrections or retractions of factually incorrect statements appearing in journals or press releases that denied, discounted, or dismissed reports of improper behavior, just as researchers fulfill their ethical responsibility to correct the formal record) can hold a mirror up to both our own individual and our psychological community's ability and willingness to meet the challenge of change. . . .

Editor's Note

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NOTICE TO READERS

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Self-Forgiveness Therapy for Overcoming Interpersonal Offenses

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A solid base of empirical evidence demonstrates that therapeutic interventions to promote *forgiveness of others* have a host of benefits for clients (Wade, Hoyt, Kidwell, & Worthington, 2014). In contrast, little is known about how to promote *forgiveness of self* among therapy clients. This is a significant gap in our knowledge of therapy, given the connections between self-forgiveness and wellbeing. Specifically, a recent meta-analysis found that self-forgiveness is associated with lower levels of shame, depression, and anxiety and greater levels of general mental health and life satisfaction/meaning (Davis et al., 2015). In addition, self-forgiveness is positively associated with perspective taking or empathic concern toward the person hurt by one's actions (Woodyatt & Wenzel, 2013) and conciliatory behaviors toward the person hurt (Hall & Fincham, 2008), providing evidence for interpersonal benefits as well.

Because of these intra- and interpersonal benefits of self-forgiveness and the fact that offending or harming others is a common human experience, we see self-forgiveness as a worthwhile therapeutic goal for a segment of clients. Indeed, most therapists can probably recall clients who seemed unable to move past hurts they caused to others through things like relationship infidelity or poor parenting choices. For clients who remain locked in self-condemnation, self-forgiveness may provide a process by which to move on. However, prior to our publication (Cornish & Wade, 2015b) in this area, we were unable to find research testing the effects of individual therapy interventions designed to promote self-forgiveness.

We previously defined self-forgiveness as a process by which a person "(a) accepts *responsibility* for having harmed another; (b) expresses *remorse* while reducing shame, (c) engages in *restoration* through reparative behaviors and a recommitment to values; and (d) thus achieves *renewal* of self-respect, self-compassion, and self-acceptance" (Cornish & Wade, 2015a, p. 97). In that publication, we provide a therapeutic process model to guide clinicians in working with clients on self-forgiveness. In Cornish and Wade (2015b), we present the results of a pilot test of an individual counseling intervention based on that therapeutic model. Here, we will provide an overview of the main results of that study. In addition, we provide previously unreported analyses of change over time for both delayed and immediate treatment participants to further examine the effects of the intervention on state self-forgiveness.

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Participants

Participants were 26 adults living in Midwestern communities (n = 20 women [77%]; mean age = 36) who wanted to receive therapy to work through their unresolved feelings about an interpersonal offense they committed against another person. Similar to the demographics of the area, most participants were European American (n = 21; 80.8%). Participant offenses were categorized as violations of trust (n = 12; 46.2%), verbal and/or physical abuse (n = 6; 23.1%), relationship neglect (n = 3; 11.5%), disrespect/humiliation (n = 2; 7.7%), relationship abandonment (n = 2; 7.7%), and other (n = 1; 3.8%). Mean time since the offense was 118 months (9 years and 10 months; range = 3 months to 59 years).

The Treatment

The intervention tested in this study was developed by the first author (Cornish, 2014) and included 8 weekly 50-minute individual counseling sessions. The manualized treatment was adapted from interventions to promote forgiveness of others (Greenberg, Warwar, & Malcolm, 2008; Worthington, 2001), with specific adjustments made due to aspects unique to self-forgiveness (e.g., reducing shame while acknowledging responsibility). The intervention is grounded in Emotion-Focused Therapy (Greenberg, 2002) and incorporates our process model of self-forgiveness (Cornish & Wade, 2015a). The full intervention manual can be obtained in the first author's dissertation (Cornish, 2014).

After establishing an initial therapeutic relationship, the intervention helped clients accept appropriate responsibility for their actions. This was done through honest discussions of what happened and identification of the needs, wants, and/or motivations that contributed to the offense. In addition, clients who struggled to accept responsibility (this was rarely the case) engaged in a two-chair exercise in which the part of them trying to shift blame was reconciled with the part of them willing to accept responsibility while showing compassion toward the self. On the other hand, clients who struggled with shame and self-condemnation (much more typical of participants) used the two-chair exercise to express the critical, self-condemning part and then worked to reconcile it with the side that needed compassion in the face of wrongdoing.

Regarding restoration, clients engaged in a two-chair exploration that helped them reconnect to values violated by the offense and increase their confidence in living up to those values in the future. In addition, clients engaged in an empty-chair exercise in which they imagined apologizing to the person hurt by their offense. Then, clients identified specific steps toward making direct or indirect amends for their offenses and worked on short-range steps as a homework assignment.

The sessions toward the end of the intervention were devoted to replacing remaining negative emotions with self-acceptance and self-forgiveness. Therapists helped clients engage in an imagery exercise in which they imagined their cold, bitter feelings of self-condemnation being replaced with warm feelings of self-forgiveness and self-compassion. The non-judgmental, caring stance of the therapist throughout the intervention was also designed to assist the client in acting toward the self in a similar way. Finally, clients wrote letters to themselves expressing self-forgiveness and self-compassion.

The treatment was provided by eight different therapists who were seeking a doctoral (n = 7) or masters (n = 1) degree

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in the counseling field. Therapists had an average of 698 hours of direct clinical experience at the start of this study (*SD* = 336; range = 300-1250). Therapists received a 6-hr training on the intervention and they received weekly supervision from a licensed psychologist while working with participants.

Primary Measures

Assessment of specific offense. During their screening appointments, participants wrote a brief description of a specific offense they committed against another person, on which they would focus during the course of their intervention. Participants referred to this offense when answering the self-condemnation and self-forgiveness measures.

Self-condemnation. A 4-item measure created by Fisher and Exline (2006) was used to assess self-condemnation for the offense (e.g., "When I think about this incident now, I feel hateful toward myself"). Cronbach's alpha was .83 in the current sample.

Self-forgiveness. The 17-item State Self-Forgiveness Scales (SSFS; Wohl, DeShea, & Wahkinney, 2008) was used to measure self-forgiving feelings, actions, and beliefs about the offense (e.g., "As I consider what I did that was wrong, I show myself acceptance"). The original 4-point scale (Wohl et al., 2008) was expanded to a 7-point scale (1 = *not at all*; 7 = *completely*). Total scale scores can thus range from 17 to 119, with higher scores indicating greater self-forgiveness. Cronbach's alpha was .94 in the current study.

Psychological distress. The 28-item Clinical Outcomes in Routine Evaluation outcome measure (CORE; Evans et al., 2000) was used to measure general psychological distress (e.g., "I have felt overwhelmed by my problems"). Cronbach's alpha was .94 in the current study.

Self-compassion. The Self-Compassion Scale—Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) was used to measure participants' trait self-compassion ("When I'm going through a very hard time, I give myself the caring and tenderness I need"). Cronbach's alpha was .73 in the current study.

Procedure

Recruitment and selection. We recruited participants through newspaper ads and flyers. Potential participants could schedule a screening appointment if they indicated they (a) were at least 18 years old, (b) could recall an offense they committed against another person about which they had unresolved feelings, (c) had committed that offense at least 3 months ago, (d) were not currently receiving therapy, (e) and were willing to spend 8 weeks on a waitlist before starting treatment if randomly assigned to do so.

Participants attended a screening appointment, at which time they provided informed consent, completed Time 1 (i.e., screening) questionnaires, and participated in a structured interview with the first author to establish eligibility. Eligible participants were randomly assigned to condition, resulting in 15 assigned to the immediate treatment condition and 11 assigned to the delayed treatment condition.

Immediate treatment condition. Participants in the immediate treatment condition started the intervention on the next available appointment that worked with their schedule. Time 2 assessment for this condition was immediately following the final session (i.e., post-treatment) and Time 3 assessment (i.e., follow-up) occurred two months after the final session.

Delayed treatment condition. Participants in the delayed treatment condition spent eight weeks on a waiting list prior to be-

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ginning the treatment. Time 2 assessment for this condition was immediately prior to the first counseling session (i.e., post-waitlist), Time 3 was immediately following the final session (i.e., post-treatment), and Time 4 (i.e., follow-up) occurred two months after the final session.

Results

As reported in Cornish and Wade (2015b), 21 participants (81%) completed the intervention; attrition did not differ between conditions (n = 2 [18%] from delayed treatment; n = 3 [20%] from immediate treatment). All analyses reported are for treatment-completers, but analyses using the last-observation carried forward method resulted in the same conclusions.

Overview of main findings. As reported in Cornish and Wade (2015b), we found that controlling for Time 1 (screening) scores, participants in the immediate treatment condition had significantly lower scores on state self-condemnation and general psychological distress and significantly higher scores on state self-forgiveness and trait self-compassion at Time 2 (post-treatment) than did participants in the delayed treatment condition at Time 2 (post-waitlist). Estimated between group effect sizes at Time 2 ranged from moderate (Hedge's g = 0.71 for trait self-compassion) to large (Hedge's g = -1.21 for state self-condemnation). We also found that, after controlling for psychological distress at screening, pre- to post-treatment increases in state self-forgiveness predicted lower psychological distress following treatment (Cornish & Wade, 2015b).

Change over time. For this paper, we also examined change in self-forgiveness over the entire course of the study for both immediate treatment and delayed treatment participants. Figure 1 presents change from screening through follow-up on state self-forgiveness, separated by condition.

To statistically examine this change over time, we conducted repeated measures analyses of variance (ANOVAs) with time as the only independent variable, followed by post-hoc dependent samples t-tests to determine when significant change occurred. Because we had

Figure 1. Change From Screening Through Follow-up on State Self-forgiveness

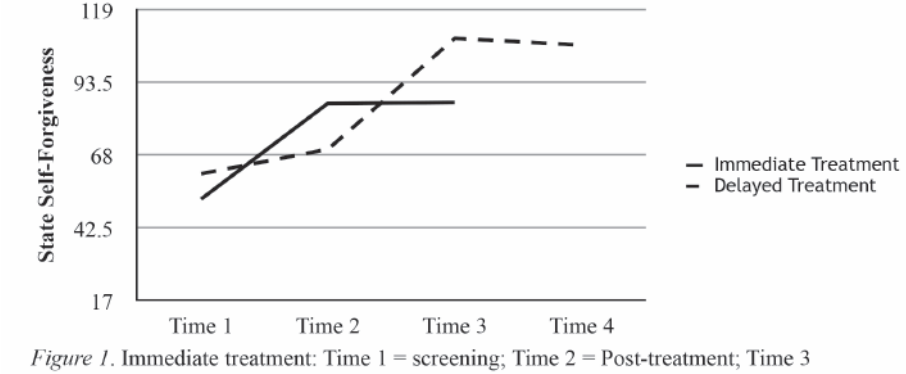

Figure 1. Immediate treatment: Time 1 = screening; Time 2 = Post-treatment; Time 3 = Follow-up. Delayed treatment: Time 1 = screening; Time 2= Post-waitlist; Time 3 = Post-treatment, Time 4 = Follow-up

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three time-points for the immediate treatment condition and four time-points for the delayed treatment condition, we conducted separate analyses by condition. One participant from each condition who completed the treatment did not complete the follow-up questionnaire. We thus only included the 19 participants for whom we had complete data in these analyses (11 in immediate treatment, 8 in delayed treatment).

The repeated measures ANOVA for the immediate treatment condition was significant, Wilk's $\lambda = .277$, $F(2, 9) = 11.73$, $p = .003$. Post-hoc dependent samples *t*-tests revealed a significant increase in state self-forgiveness from screening ($M = 52.5$, $SD = 20.9$; Time 1) to post-treatment ($M = 86.1$, $SD = 28.5$; Time 2), $t(10) = 5.00$, $p = .001$, and no significant change from post-treatment ($M = 86.1$, $SD = 28.5$; Time 2) to two-month follow-up ($M = 86.4$, $SD = 31.6$; Time 3), $t(10) = 0.10$, $p = .93$.

The repeated measures ANOVA for the delayed treatment condition was also significant, Wilk's $\lambda = .164$, $F(3, 5) = 8.47$, $p = .02$. Post-hoc analyses revealed no significant change in state self-forgiveness from screening ($M = 61.4$, $SD = 25.2$; Time 1) to post-waitlist ($M = 70.0$, $SD = 25.7$; Time 2), $t(7) = 1.63$, $p = .15$, or from post-treatment ($M = 108.9$, $SD = 6.5$; Time 3) to follow-up ($M = 106.5$, $SD = 10.6$; Time 4), $t(7) = -0.59$, $p = .58$. There was, however, a significant increase in state self-forgiveness from post-waitlist ($M = 70.0$, $SD = 25.7$; Time 2) to post-treatment ($M = 108.9$, $SD = 6.5$; Time 3), $t(7) = 4.35$, $p = .003$. Thus, participants did not experience changes in self-forgiveness as a result of time (that is, during the waitlist), but participants in both conditions experienced an increase in self-forgiveness over the course of the intervention, a therapeutic benefit that was maintained at follow-up.

Discussion and Conclusion

Although this study is limited by its small sample size and waitlist-control design, our results provide initial evidence for the effectiveness of this intervention. Results demonstrated the intervention was beneficial for both offense-specific emotional responses (state self-condemnation and state self-forgiveness) and overall wellbeing (trait self-compassion and psychological distress). In addition, the finding that increased self-forgiveness during the intervention predicted lower psychological distress following treatment provided additional evidence that focusing on self-forgiveness for a specific offense may have benefits for clients' more general wellbeing. Many participants in this study had been struggling to forgive themselves for years—even decades—before making progress in this treatment program. Given the initial results found in this research, we hope increased attention will be paid by researchers and clinicians on how best to promote self-forgiveness with therapy clients.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

[1] In addition to several student and career awards, The Society for the Advancement of Psychotherapy regularly provides funding for research through two competitive grants—the Norine Johnson, Ph.D., Psychotherapy Research Grant and the Charles J. Gelso, Ph.D., Psychotherapy Research Grant. One Norine Johnson, Ph.D., Psychotherapy Research Grant of up to $10,000 is awarded each year for a project designed to study psychotherapist factors that may impact treatment effectiveness and outcomes. As many as

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three Charles J. Gelso, Ph.D., Research Grants of up to $5,000 are awarded each year for projects designed to study psychotherapy process and/or psychotherapy outcome. This year, the Psychotherapy Research feature articles will present brief reviews of some of the studies that have recently been funded through these grants.

Authors' Note:
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Inclusion of the Supervisor in the Therapeutic Setting

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There is a great deal of consensus that supervision is an essential part of the psychotherapeutic process. Diverse factors have been identified which contribute to making supervision well-functioning. Those factors are concentrated in the supervision alliance (Bernard & Goodyear, 2014). We know that the relationship of support and trust between the supervisor and the supervisee, in addition to a good agreement regarding the goals and tasks, favor supervision having positive effects. However, we still need to improve our practice and research much more in order to find stronger evidence and, above all, to guarantee the tasks of supervision are translated into more sustainable therapeutic benefits for patients (Watkins, 2011). To improve our practice, it is necessary to develop innovative procedures in this field.

We present some ideas on the supervision format we have been implementing in our clinical practice and with which we have observed some interesting benefits for patients and therapists. It consists of incorporating a supervisor in some moments of the therapeutic process. The background of this practice dates back to a proposal that Montalvo formulated (1973) in the framework of interventions in family therapy. This involved the presence of the supervisor during sessions, at first behind a one-way mirror, seeking to reinforce two fundamental principles of the systemic approach of psychotherapy: 1) introducing an element that would allow for an impact in the family situation that favors the r econstruction of the system; and 2) activating procedures of change through a participating agent capable of regulating the directiveness of the therapeutic intervention. The procedure gained acceptance beyond systemic therapy. In time, the use of video cameras extended the capabilities of live supervision, making it possible for long-distance use and multiplying the use of this tool.

In recent years we have developed a supervision format inspired by those pioneering efforts. It consists of setting up a system of sessions in which the supervisor works with the patient with or without the primary therapist being present. This setup is advisable in clinical situations in which the patient presents with severe symptoms or highly dysfunctional behavior (especially with patients who suffer, for example, from a personality disorder or a bipolar disorder), often as part of a sophisticated treatment approach involving some combination of individual, group, family

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sessions, and medication. In the context of such complexity, adding special sessions with a supervisor is not an extraneous factor for the patient. With appropriate planning and clear communication regarding the goals of this intervention, patients tend to perceive this additional component as another resource used in their treatment.

While the patient tends to see this treatment component as a sign of maximum care and attention on the part of the therapeutic team, the therapist may also find it beneficial in a variety of ways. For example: a) the inclusion of a supervisor in some sessions can help reduce the therapist's tension through being able to share the anxiety caused by the high severity of the client's symptoms; b) reviewing the content of each session with the supervisor can help revise and redefine the work plan for future sessions; and c) the direct interactions of the supervisor with the patient can facilitate the supervisor's understanding of the counter transference aspects of the supervisee with that patient. In the case of approaches with multiple components and settings, including supervision can be of great help in reinforcing in the patient the idea of the distinct members of the team working in collaboration and, at the same time, in making the interactions between the professionals more fluent.

Of course, this approach can cause confusing situations to arise both for patients and supervisees. To avoid confusion for patients, it is essential to present the proposed format clearly, and to ensure that the therapist consistently provides the necessary security. It tends to be of great help to introduce the possibility of this type of intervention at the beginning of therapy, framing it for the patient as a resource that could be used throughout the treatment. Therapists, in turn, can have negative feelings because of the supervisor's direct contact with the patient. Feelings of anxiety and insecurity can be generated in supervisees/therapists over fear of receiving poor evaluations of their work. This situation will obviously be especially intense when there is a lack of openness between the supervisor and the supervisee (particularly when the supervisee lacks confidence in the work and/or the supervision and keeps secrets about some aspects of the treatment). For all these reasons, supervisors should employ the resource of actively including themselves in the sessions only after having verified that the therapist feels sufficiently secure and at ease with their intervention to proceed. This means to say that therapists have a secure support base on their supervisors.

Another potential source of anxiety for the supervisee when this technique is employed is the fear that the patient considers the intervention of the supervisor to be of better quality than that of the therapist. This fear of feeling devalued in comparison to the supervisor—which is quite a natural feeling—could be countered by the supervisor maintaining an encouraging attitude, clarifying the supervisor's role in this intervention, and working to ensure that the supervisor does not exceed the limits of that role. Supervisors should make every effort to transmit to the patient a consistent message that they are a member of a team with the therapist, that they know the patient's history and are aware of the therapeutic process unfolding in treatment, and that their function is to collaborate to enhance that treatment, not to question or undermine the therapist.

That said, we can reflect on the usefulness of this approach. First, patients usually recognize the benefit of being able to count on an additional perspective, specifically that of an expert who can per-

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haps observe aspects of the therapy that the routine of the therapeutic work makes difficult to see. In our experience, including a supervisor generally results in a better evaluation of the therapeutic process. Moreover, this strategy reinforces patients' understanding that they are being treated by teams, not isolated therapists, and that their primary treatment providers have important back-up for their work. Patients may be intrigued or excited by the opportunity to meet with someone they do not see regularly, and may use the time with supervisors to communicate aspects and questions that are not usually part of their sessions. This could be something that happens spontaneously, or patients may deliberately choose to take this approach, preparing what prior to the session. Both methods are valuable, beyond the dynamic impact of the supervisor's presence and any intervention that may be employed directly.

What should the work plan be for these sessions between the supervisor and the patient? Obviously, first of all to help update the therapeutic process. The supervisor may operate as an agent of change, jump starting progress in a way that enhances the therapeutic work. This could take the form of activating the principles of motivational interviewing when a patient is going through a critical zone in the therapeutic process. The supervisor may collaborate in strengthening the alliance to facilitate improvement in the therapeutic relationship and to detect early signs threatening the alliance. The supervisor can be a privileged moderator to help the patient reflect on how the treatment is going. This could include asking questions regarding the relationship between the patient and the therapist. In this sense supervisors can also be privileged observers of relational difficulties that therapists perhaps do not register adequately, but which prevent them from formulating case accurately and completely in the supervisory space. Conversely, a supervisor working directly with a patient may conclude that some of the patient's characteristics feel more complex and difficult to approach than previously observed in exchanges held with the therapist in the supervisory session. The supervisor's discovery that the patient has certain resistance issues or difficulty confronting powerful change processes may lead to a re-evaluation of the efforts carried out by the therapist up to that moment in the treatment. And, of course, many other types of discovery are possible when this treatment structure is employed.

This links up to another point of maximum interest in supervision. Even though supervision by definition is an activity in which a professional with more expertise helps a therapist with less experience to perform the task of therapy, it is important for supervisors themselves to be open to recognizing aspects of the treatment not previously taken into account, new theoretical questions, and technical resources that are believed to be creative methods of approaching a clinical case. The supervisor should be a facilitator for growth and development, avoiding the appropriation of truth. Being within the therapeutic space tends to be of help in that sense. This phenomenon is similar to what happens in many occasions in the process of teaching and learning. The teacher is oriented to forming and preparing the student in one discipline, but the student might propose a fresh point of view, distinct and creative, that offers a new observation lens, a different method of approach, or a distinct way of looking at a problem.

When we instruct therapists on the convenience of employing this work system, and when we plan the therapeutic programs to include this resource, some fundamental operative questions arise: a) What is the convenient frequency for planning sessions where the supervisor is present?; b) Can the patient request ses-

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sions?; c) Is it more effective to implement these sessions at critical points in the therapeutic process?; and d) In what cases is it useful for the therapist to participate in a session with the supervisor? These are not the only questions, but they sum up most of basic concerns, and we will address each of them, below.

What Is the Convenient Frequency for Planning Sessions Where the Supervisor Is Present?

As we have pointed out previously, this procedure is especially useful in the case of treatments with patients with high dysfunctional severity, which generally corresponds to medium- or long-term approaches. There are no pre-established guidelines regarding the frequency with which these sessions should be planned, but some general criteria should be considered. On one hand it is convenient for the first session to take place once the early therapeutic alliance has been implemented. Subsequent sessions should be distributed over time so that they do not become burdensome or distract from the work.

Can the Patient Request Sessions?

Patients can request a session with the supervisor; this in fact can constitute a sign that they have incorporated the procedure as a resource within the therapeutic process. However, the therapist should not always automatically respond to that demand by setting up a special session. Before that request is answered affirmatively, examining the circumstances and context in which it comes up will be important.

Is It More Effective to Implement These Sessions at Critical Points in the Therapeutic Process?

Of course, sessions with the supervisor may be particularly useful at certain junctures in therapy, such as when threats of a rupture in the therapeutic alliance arise, traumatic episodes occur or are uncovered, the patient faces loss or breakdown in the organization of personal experience, orthe patient engages in acts of destruction or other behaviors associated with vital risk factors. Critical events linked to life circumstances, generally related to important changes in work, the home, civil status, etc., will also be taken into account.

Nonetheless, it is important that these sessions with the supervisor not be restricted to critical situations, and that their utility throughout the entire therapy process be acknowledged.

In What Cases Is It Useful for the Therapist to Participate in a Session With the Supervisor?

Generally speaking, it is helpful for the therapist to also be present during the first sessions that include the supervisor directly. This reinforces the idea that the treatment involves a working team and can facilitate communication between the patient and the supervisor. This trialogue (three-way conversation) among the patient, the therapist/supervisee and the supervisor can be enriching and lay the groundwork for later success. Once treatment has advanced, sessions in which the therapist does not participate are particularly useful, especially when the therapist can observe the sessions live.

This framework may be more feasible for use with certain therapeutic orientations, such as systemic, than others, such as psychodynamic. From the integrative perspective we are using in our clinical work, this approach is turning out to be a valuable treatment enhancement. It is likely to be a useful trans-theoretical resource, if supervisors and therapists will apply the necessary adjustments for each specific theoretical approach. In addition, this represents an important open door for additional research.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

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Working With Older Adults and Dementia: Incorporating Contemporary Psychodynamic Thought[1]

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The Chief of the Geriatrics and Extended Care Service at my facility commonly describes geriatric medicine as a discipline whose art is managing complexity. In kind, as geriatric mental health providers we, too, routinely wade into cases featuring interrelated psychological and neuropsychological issues, medical and pharmacological concerns, and complex psychosocial factors, all embedded in a historical context that usually predates us. Moreover, in some cases we may face the added challenge of interpreting and ameliorating psychological distress in individuals who cannot even speak for themselves—those with advanced dementias. Given this, I often find it helpful to work from a theoretical integrationist position, as doing so allows access to ideas from multiple theoretical perspectives. These can be woven together into a conceptualization that best captures the complexity of the case, and intervention strategies derived accordingly. Alongside CBT, behavioral analysis, and family systems theories, principal among these sources for me are contemporary psychodynamic approaches.

There are clear undercurrents that in years past have pulled our field away from thinking about older adults through a psychodynamic perspective. Many readers of this article may recall that in 1905 Sigmund Freud himself expressed his view that adults over the age of 40 or so did not make good candidates for psychoanalysis (Freud, 1905/1953). While decades of research, clinical work, and theoretical evolution have proven him soundly wrong, barriers to working with older adults from a psychodynamic perspective remain. In her 2005 paper, Dr. Jolyn Wagner offered some thought provoking insights into this issue. First, she identified persistent ageist assumptions in the field that discourage specifically taking a psychodynamic approach to older adults. These are that older adults develop psychic rigidity, lose their sense of investment in the future, develop an excessive attachment to the past, and undergo a weakening of life fulfilling drive. Second, she described more broadly the way in which such assumptions, based as they are in linear, stage models of lifespan development, become reified into unquestioned truths. As an antidote, she cited the work of Coates (1997), who advised us to conceptualize human development instead "in the context of multiple transactions between self and other across different domains with consequences that can not be predicted a priori" (p. 45). Finally, and perhaps closest to home, so to speak,

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Wagner alluded to the unique, and sometimes daunting, countertransference issues that can arise in working with older adults. The opportunity for these to emerge is especially ample when engaging psychodynamic perspectives, with their emphasis on fundamental human needs, fears, and longings.

I noted previously that sometimes in geriatric care we are asked to provide assistance for individuals with dementia, including those in the advanced stages. In this work we rely especially heavily on the treatment team, whose members in turn look to us for insight into what might lie behind challenging behavioral issues in this population, and what strategies might help reduce them. We often employ the ABC method of behavioral analysis here, and for good reason. Also, though, I think it can be helpful to add some basic psychodynamic thinking to the mix, as it allows us to develop a deeper understanding of the subjective emotional experience of dementia. It is this that can, I believe, be most helpful to other staff in truly understanding the needs of the person with dementia.

I have found that in an inpatient environment the concepts of object relations can be applied in especially useful ways. Briefly, as I am using it, the term "object relations" refers to our need for seminal emotional connectedness with others, and how this need is met in increasingly complex and interactive ways as we develop as humans. Indeed, neuroscientists have confirmed that human attachment is a fundamental survival mechanism that functions *throughout* the life span. Such relationships give us our sense of presence and identity, and facilitate the growth and maintenance of our abilities to cope with the internal and external demands of our world. In other words, humanization is an ongoing, reciprocal process. Not surprisingly, the human brain itself has evolved to exist and thrive in a social context. We possess complex, multimodal neural networks dedicated to social cognition, "mirror neurons" being just one example.

In my experience, even in people with advanced dementia, this powerful need for safe relationships can remain intact for a long time, long after the higher cognition that once facilitated attachment behavior has crumbled under the weight of neurofibrillary plaques, Lewy bodies, cerebrovascular insults, and other neuropathologies. The great risk is inadvertent interpersonal and emotional abandonment of individuals with dementia by others, which has been shown to lead to premature decay. In particular, Thomas Kitwood (1999) has written extensively about the therapeutic milieu (or lack thereof) in long term care units, and specific interpersonal strategies that staff can use on a day-by-day basis to reach out to people with dementia, to try to keep them attached. Caregivers can become new "self-objects," almost an "ego prosthesis" (Cheston & Bender, 1999). Thus, how we interact with people with dementia can provide and support the structure of their experiences, including that of themselves.

In the remainder of this article I will attempt to demonstrate briefly with some examples. I do so with the words of Wagner (2005) cited above in mind. In this material we can see and hear the human drives for a sense of connection, safety, purpose, and resolution exerting themselves, even for individuals in more advanced stages of dementia. The first case is that of a gentleman with whom I worked for many months, a resident on our dementia care unit. He regularly wrote notes as best he could given his aphasia, and forwarded them to me through the nursing staff. They chronicled his experiences as his illness pro-

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gressed. His family has given me permission to use the quotes that follow.

In the early months of our work, he was focused on being a spokesman for what he and his fellow residents were enduring. He found meaning in this, a sense of continued relevance and dignity based in what he could do for us. In one of his notes he wrote (syntax/spelling corrected), "I have done everything I can think of to get more attention for dementia of all sorts. Please now give me a chance to learn all I can about this disease. My spelling and other crazy things are happening to make this far more difficult than necessary." I used to tell him that by helping me understand his experiences with dementia he was, in turn, helping me help other caregivers do the same. In a way, he was a teacher and I was his student. My effort was to validate and support his continued sense of purpose and value for as long as possible, a palliative approach.

One of his greatest fears about having dementia was that it would ultimately lead him to be a "monster," a frightening shell of his former self. Because of his aphasia he had trouble expressing himself at times, especially when upset. In moments of frustration he would become agitated and shout. Some staff did not know how to react to this and would instinctively disengage and move away. After one of these incidents he wrote to me (syntax/spelling corrected), "One of the saddest things about this malady is when I speak up. When people are around everyone runs when I raise my voice or move too quick. This is really sad for me and those around me." Confirmation of his sense of himself as devolving into a "monster" was coming inadvertently through interactions with those around him.

My second example is a gentleman who I met initially, and for only a few times, when he was admitted to our facility for a brief respite stay. He was then readmitted to our facility for long-term care a year later. Not long after his admission for long-term care his beloved spouse died. I had a brief occasion to meet with his wife during his earlier respite stay, but not to any significant degree. Following his admission for long-term care, it soon became evident that he was closely attached to me, to a degree that was beyond what our prior time together would seemingly warrant. He would regularly remind me (and himself) that I had known his spouse.

Viewed through the lens of object relations, my prior experience with him and his wife, although objectively brief, allowed me to serve as a form of a "transitional object" for him, which facilitated my efforts to help him adjust to being on the unit again (Loboprabhu, Molinari, & Lomax, 2007).

There are many ways in which psychodynamic ideas can be applied in working with older adults. My goal here has been only to whet the appetites of any who might be interested, and encourage them to join the effort. Old age is known to be a time of great complexity. My belief is that this offers not only an invigorating challenge for us as clinicians, but also a great well of resources for us from which to draw in our work.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

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CLINICAL NOTES WITH DR. J

How Jay Z Taught Me to Be a Better Early Career Psychologist

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"I'm not a businessman, I'm a business, man!"
(Jay Z, 2005)

When the great hip-hop philosopher, Jay Z, uttered these famous words on Kanye West's 2005 single, *Diamonds From Sierra Leone* (Remix), I am fairly certain that he was unaware of how salient and motivating these words could be for early career psychologists. In this lyric, Jay Z was bragging about how big he had become as an artist and how he takes particular care and control over his brand and the ways in which he conducts his business related to his art. Whereas other artists may see themselves as *a part* of the genre, Jay Z finds success in setting himself *apart* from his peers via successful marketing campaigns that capitalize on his eccentricity and originality. Jay Z and other artists work diligently to not only hone their crafts but also cultivate unique brands that broadcast their nuanced sounds to their audiences, encourage other talented artists to collaborate with them on new projects, and excite their followers into continued investment in and consumption of their art. Popular and well-established psychologists are no different. Successful psychologists also invest considerable time into manicuring their brand in order to attract clients and further their own research and community involvement. These psychologists learn early that, even though they may be employed by a specific hospital or clinic, they are their own businesses, due to the exceptional and intimate interactions that they have with their consumer bases. In psychology, customer service, consumer trust, and clinical results are essentially interconnected because there are few business transactions in which there is such an intimate connection between the "business" and its customers.

Clinicians who dedicate thoughtful time and financial resources into marketing themselves correctly have the opportunity to experience more success in their careers. Thoughtful and authentic branding can positively serve the clinician by helping the practitioner attract clients who fit their treatment methodologies, align with their clinical specialties, and are more likely to be treatment adherent to their specific clinical protocol. This opportunity for improved therapeutic fit could then lead to increases in career satisfaction and productivity. Conversely, psychologists who neglect branding or engage in broad marketing opportunities are vulnerable to blending into the community of capable local psychologists and becoming overshadowed by other clinicians who are more visible.

For early career psychologists, brand building is often an underappreciated responsibility or an afterthought. Given

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the amount of time and effort that is spent getting out of school and fulfilling national and state licensure requirements, it is no wonder that some early career psychologists are weary of taking on this supplemental but professionally beneficial task. Additionally, graduate school programs may not offer classes or seminars on the business of psychology, and this lack of knowledge can further separate the "haves" from the "have nots" in terms of those who are capable of actively incorporating business and marketing knowledge into their professional persona and those who only passively respond to situations that force them to make business decisions. Neglecting this process can negatively impact the trajectory of an individual's career by contributing to reduced referrals and other missed opportunities that can stall or impede advancement. This article will present several initial steps that early career psychologists can take today to help begin to market themselves as great treatment providers for members of their community and as tremendous resources for other clinicians in their community.

Invest an Hour a Day in Your Future

Plan your work, work your plan. Early career psychologists and professionals in general should dedicate an hour a day to planning for the future and organizing their careers. By dedicating this hour a day to career advancement, early career psychologists will have unadulterated time to engage in a variety of tasks that will prepare them for future opportunities, such as reviewing or editing CVs, networking with colleagues and other referral sources, preparing for presentations, and pursuing continuing education. Over the course of a year, an early career psychologist who follows this plan will have utilized 365 hours to plan for the future—and that is a substantial amount of time that can lead to significant professional gains. The important aspect of this one-hour-a-day investment is that it must be consistent. Although one hour per day appears easy, there are many distractions that could derail anyone from missing this investment; thus, it is important to carve out that time and render it nearly "untouchable" in your calendar or daily planner.

Review Your CV

You spent all that time writing it, but have you ever really looked at it? Every early career psychologist should have a CV by now, but many may not see it as a perpetually useful tool that can still yield benefits after one gains employment. Reviewing your CV can provide you with a great perspective on your experiences and the populations you have served. Often early career clinicians might market themselves in a particular way but, upon review of their actual experiences, might realize that they are more qualified or interested in serving a different population. It is also incredibly important to know what is on your CV in order to be able to quickly and accurately reference your experiences in conversations with potential employers, patients, and colleagues. In addition to your CV being a great resource to review the trajectory of your career so far, it is also a great resource to help begin to find buzzwords or themes to craft the narrative about your unique brand of psychotherapy. To assist with discovering these buzzwords, it would be helpful to take your CV and highlight terms that come up frequently. For example, when I scanned my CV, the words that appeared the most frequently were "autism," "child," "advocacy," and "race." After collecting these words, I can now use them consistently to talk about my training, my experiences, and my areas of focus. Additionally, I can now make sure to highlight these terms

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on any marketing materials that I create so that I craft a consistent and targeted message to the community about my capabilities and interests as a psychologist.

Google Yourself

Admit it: You Google people, we all do. Whether it is a potential romantic partner, a colleague, or a prospective job candidate, people often Google each other before meeting in order to have a basis of information about an individual and explore the ways in which they are represented on the World Wide Web. While my colleagues and I were on internship at Cambridge Health Alliance/Harvard Medical School, our Training Director, Dr. Pat Harney, Googled each of us to demonstrate the common ways in which patients would gather knowledge about their clinicians. It was this exercise that highlighted to all of us the ways in which information about ourselves (some of which we had been aware of, and some of which we had not) was available to the general public. Whether it was accolades from college sporting events, dating profiles, previous clinical presentations, or articles, anything and everything was available to those who were interested in searching. The experience at internship was reminiscent of a previous experience with a friend who Googled herself before a job interview and was mortified to discover that one of her peers posted a picture of her engaging in excessive drinking—and it was one of the first results that appeared in her search results. Thankfully my friend was able to contact her friend and have the picture removed. Individuals should similarly investigate their web presence and take the necessary steps to have their friends or family remove images or information that might harm their professional reputation. If there is something problematic that cannot be removed, having an active professional web presence and a large number of search results may at least help dilute the negative material, so that it appears farther down and is more likely to be overlooked in a casual inquiry.

Be Your Own Therapist

Kanye West once said that one of his greatest regrets in life was that he would never get to see himself give a concert and enjoy that experience as just a fan. Although this is a truly unfortunate paradox for Mr. West, empathy and the ability to shift perspective are useful tools for artists to continuously cater their performances to their fans and have successful interactions with their consumers. As a psychologist, imagining yourself as your own patient can be a powerful tool for further appreciating the ways in which you are present in the therapeutic space. To accomplish this goal, a great question to ask yourself is what is it like to be in the room with you as a clinician. Given your therapeutic modality and other interpersonal, cultural, and environmental variables, therapeutic relationships can vary considerably between various practitioners. Early career psychologists should dedicate time to reflect upon the aspects of themselves that they would like to leverage to accentuate their particular therapeutic modality, contribute to a healthy therapeutic alliance, and make psychotherapy a sustainable and beneficial experience for both clinician and client. When I engaged in this type of thoughtful reflection while building my own brand, I realized that I wanted to highlight a sense of thoughtfulness and relatability to my patients and coworkers. To this end, I decided that accomplishing my goal of presenting as relatable and thoughtful would require a particular type of investment in the lives of my patients. Examples of this additional action includes recognizing their significance in my life by striving to remember and celebrate important milestones in their lives by bringing in

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small treats for a child's birthday or asking a patient about a big presentation or performance at the next therapy session. To be successful with this goal, I have to dedicate time outside of work to keep track of my patient's lives in a way that goes beyond what is typically needed to do appropriate psychotherapy, but I consider this a worthy investment due to the ways in which it leads, most notably, to a lower no-show rate and thus more opportunities to engage in therapeutic work with the patient.

Choose Wisely: Bragging vs. Highlighting

If you've got it, let people know. We, as psychologists, have a horrible time with self-promotion, as we are often guilty of doing too much or too little. Additionally, as early career psychologists, we are hesitant to engage in any behavior that could be misconstrued as braggadocios or self-righteous by either our patients or our colleagues given our seemingly tenuous existence and "newborn" status as a professional in the field. So, how do we straddle the line between highlighting the skills that we have spent considerable time and effort to cultivate and being perceived as overly confident? It all comes down to the delivery. When one is speaking from a client-centered position and within one's own competency, it is more difficult to sounds overly self-congratulatory or self-centered. When speaking with colleagues, think about the "3 am phone call." When applying for jobs after college, my father presented me with the idea of the "3 am phone call." This image relates to the idea that, when interviewing for a potential job or when giving a professional presentation, individuals should present themselves as *the person* to call when there is a 3 am crisis. To be that person, an individual will not only need to be particularly competent with regard to work, but also present in a way that can help dissipate the emotional stress associated with the given situation. Similarly, patients are often looking for a psychologist that they can call upon for that 3 am moment when they are alone, in crisis, and without a solution in sight. By coming to patients' aid during these trying times, psychologists are not only able to engage in one of the most rewarding aspects of their careers, but are also able to establish a sense of reliability and trust that furthers the therapeutic relationship and can lead to additional referrals and customer satisfaction.

Although this list might seem burdensome and long, incorporating even a few of these highlighted suggestions will be beneficial for young psychologists and begin to provide them with a greater feeling of self-efficacy and empowerment regarding their careers. Fellow early career psychologists: Take control and power over your career; doing so will not only benefit yourself but also your patients and the community. *Be a business, man.*

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

EARLY CAREER

Ten Years Later: Reflections From a Post-Katrina Transplant

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I moved to New Orleans for my predoctoral clinical psychology internship, two months prior to the fifth anniversary of Hurricane Katrina. While I was still settling into a city with unique culture, and having my first experience with the summer humidity, I was quickly exposed to the strong sense of community within the city. However, I was hesitant to discuss the hurricane with anyone who did not initiate such discussion. I felt as though it was too sensitive a topic and that I could not possibly understand what it was like to have endured that experience.

With the fifth anniversary approaching, the media coverage was in full effect. On television, images that I am sure I had seen while living in Denver, at the time of the storm, had a different effect on me. These were images of hundreds of people outside of the Convention Center, just down the street from where I reside. When I saw them in 2010, especially images of the water outside of Tulane University Medical Center where I work, I began to really picture what it might have been like had I been there. I remember talking to a psychologist colleague of mine who had remained at the medical center during the hurricane. I was amazed at what he had experienced, and the role he had taken on, including dealing with the challenge of finding patients who they could not contact and who were in need of follow-up oncology care. Additionally, I knew about the Danziger bridge shootings (in which police officers fired on unarmed civilians; see Cornish, 2015) and had seen the images of people trying to walk over the bridge. I frequently drive over this bridge, and many times have thought about what it might be like to be denied the ability to cross over into the city and vice versa, and having loved ones on either side you could not contact.

Personal experience with Hurricane Isaac, a category 1 storm, allowed me to gain some perspective. About two days prior to the predicted landfall of the storm in New Orleans, I was set to take my Psychology licensure examination. I had prepared extensively, as for any Board exam, but when I showed up at the testing center there was a note on the door that it was closed. I remember feeling angry that nobody bothered to call me—but I also remember eventually thinking that it was really a minor inconvenience compared to what people went through with Katrina. I was also fortunate not to lose air conditioning during Isaac, and thought about the fact that August is the most humid month in New Orleans, and that Katrina occurred during this time.

Secondary Effects

I recently had the opportunity to watch the documentary *Big Charity* (Glustrom, Johnson, & Rierson, 2014), regarding the

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history of Charity Hospital, the oldest continually-running hospital in the United States, and its closure following Hurricane Katrina. I found the film to be highly educational, as I had not known about the politics involved in preventing Charity Hospital from re-opening despite it having been cleaned and physically ready for service within five days of the storm. For example, I was unaware of allegations that this was viewed as an opportunity to build a new hospital that State officials had hoped to begin building prior to the storm, and to potentially use FEMA money to do so.

I also learned from *Big Charity* that there were many tragic secondary effects of the storm, one being an increase in crime and deaths related to lack of available mental health treatment. The fact that those inpatient psychiatric units never re-opened left people with serious mental illness without a place to go for treatment. One such story focused on a woman with severe mental illness who was initially picked up, sent home with nowhere to go for services, and killed a police officer that same day. When I was completing my internship, I spent part of my time working in an inpatient psychiatric hospital, 45 minutes outside of the city. My supervisor and other adult psychology faculty members had completed their inpatient adult mental health rotations at Charity Hospital, and I remember wishing that we had services downtown, both to address the profound needs of the area and because it made for convenient training within a medical corridor. Following Katrina, such services never re-opened downtown.

As a clinician it has been difficult to witness the dearth of mental health services and consistent cuts in funding. When I moved to New Orleans, it was apparent that there was already a lack of services. About two years ago, funding was cut at the inpatient psychiatric hospital where I had worked, requiring patients to travel even further for treatment, when treatment was available at all. Having completed training in anxiety and with colleagues with strong backgrounds in trauma treatment, I am constantly saddened by the fact that there are so few places that offer such services, again, due to lack of mental health funding.

Another potential secondary effect, which I have gleaned from speaking to people who also lived here before the storm, is the perception that there has been an increase in the homeless population. Through discussion with community members, I have consistently heard the hypothesis that this can be linked to budget cuts for mental health services. It would certainly be interesting to see the difference that could come with increased funding.

Media Coverage

For both the five- and ten-year anniversaries, I have witnessed immense anger about the amount of media coverage given to Hurricane Katrina. It is apparent that frequent coverage reminds people of the tragic series of events that resulted in the levees failing following the storm, and how poorly rescue efforts were handled after the levees broke. Recent images on television certainly serve this function. In fact, they reminded me that, when I originally watched the footage in 2005, never having been to New Orleans, I was shocked that such a tragedy and lack of response could occur in the United States. I know many others felt this way, especially citizens of New Orleans, and a sense of disbelief and betrayal lingers among colleagues and clients.

I have also witnessed positive reactions to the media coverage, much of which has focused on the resiliency of the peo-

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ple and the region, including rebuilding efforts and successes, population growth, and improvements in the educational system. In five years, I have noticed improvements in infrastructure, such as making New Orleans a safer place for cyclists with additions of bike lanes. In terms of the educational system, I have been told that the storm and its aftermath provided an opportunity to develop charter schools through the New Orleans Recovery School District, which includes the first all-charter school district in the nation, paid by taxpayers, but run independently by a board of directors. Entrepreneurism has also increased, with many young people wanting to be part of the rebuilding process and making New Orleans their home. Tourism appears to be doing well. There is something meaningful about showing visitors to the city areas of devastation to help them understand the passion behind wanting to New Orleans to thrive again, when many were pessimistic about rebuilding in a city that is below sea level.

Unfortunately, it is hard to ignore the fact that many areas have either been slow to rebuild or have been left as they were, and I do not know what will happen with many of these vacant buildings. I remember my first visit to the ninth ward. The Make it Right Foundation (http://makeitright.org/where-we-work/new-orleans/), founded by Brad Pitt, works to build safe and sustainable housing in the area most impacted by Hurricane Katrina, but I was shocked by how deserted the area was, and by seeing the symbols and numbers on the homes referring to number of people they found, dead and/or alive.

Relevance to Being a Clinician

I return to the initial feeling I had as a clinician-in-training—the worry that my clients would think, "How could you possibly understand?" I have since been reminded, likely through clients' willingness to discuss their experiences, that as clinicians it *is* unlikely we have had the exact same experiences, or responded in a similar manner, as many of our clients. We do our best to understand their experiences, whether they are going through cancer or lived through Hurricane Katrina. We can do so by listening, empathizing, and not making assumptions about their experiences.

For clinicians who were in New Orleans both prior to and post-Katrina, it is especially important to be aware of the potential to make judgments about clients' responses to the anniversary, the way others have chosen to commemorate the event (or not), and the subsequent media coverage. For example, the subject of "Katrina parties" is highly activating to some people, clients and clinicians alike. A therapist with strong feelings on the matter may have a client in session who plans to attend one these parties as a coping method. The challenge for therapists is to manage their own triggers and assess whether this is a positive coping mechanism for their patients. Conversely, the therapist might feel that celebrating how far the community has come will be beneficial for the client, but the client may feel differently. It is important that therapists respect their clients' needs, and recognize warning signs if they are struggling to do so.

I quickly learned that "the storm" and specifically "after the storm" was a part of the vocabulary of most New Orleanians'. This terminology is frequently used by patients during clinical interviews, regardless of the degree to which they perceive themselves having been impacted personally by Hurricane Katrina. Their lives changed in some way, even if solely related to overall changes in the community. I have listened to dif-

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ficult information about storm experiences from clients; some stories are so tragic I have had a hard time picturing what occurred. But, as a therapist, I believe it is so important to listen to the stories, even the hard ones.

In Summary

Moving to New Orleans around the fifth anniversary of Katrina, and having spent five years there, I have gained a vast amount of knowledge about being a clinician and working with patients who have experienced a natural disaster. I've been afforded numerous clinical opportunities to sit with my own mixed reactions to media coverage, while simultaneously assessing my clients' coping methods.

I have witnessed a variety of reactions to the storm. As a psychologist in New Orleans, I have had the honor to get to know many members of the community, and to learn about the overall resiliency of the community. There is obviously a long way to go in terms of increasing mental health funding, and many who lack the opportunity or encouragement to attend therapy. It remains important to continue fighting for availability of such services. But the residents of New Orleans have set an example of maintaining motivation to rebuild what has been lost despite continual barriers. Amid varied reactions to media coverage, I hope people can see that they can experience anger and upset over how the disaster unfolded and how the response was handled, and at the same time have hope that we can learn from such mistakes to enhance disaster relief for the nation.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

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2016 NOMINATIONS BALLOT

Dear SAP (Division 29) Colleague:

The Society for the Advancement of Psychotherapy (APA Division of Psychotherapy, 29) seeks nominations of creative individuals and great leaders! We would like both new and experienced voices to advance our increasingly important work on behalf of psychotherapy. The SAP Board encourages candidates from diverse backgrounds to seek nomination.

NOMINATE YOURSELF OR SOMEONE YOU KNOW TO RUN FOR OFFICE IN SOCIETY FOR THE ADVANCEMENT OF PSYCHOTHERAPY (APA DIVISION 29)

The offices open for election in 2016 are:

• President-elect
• Domain Representative for Early Career Psychologists
• Domain Representative for Science & Scholarship
• Domain Representative for Diversity
• Council Representative (2)

All persons elected will begin their terms on January 2, 2017

A Domain Representative is a voting member of the Board of Directors. The open positions will be responsible for initiatives and oversight of the Society's portfolio in the respective Domains. Candidates should have demonstrated interest, expertise, and investment in the area of their Domain.

The Division's eligibility criteria for all positions are:

1. Candidates must be Members or Fellows of the Society.
2. No member may be an incumbent of more than one elective office.
3. A member may only hold the same elective office for two successive terms.
4. Incumbent members of the Board of Directors are eligible to run for a position on the Board only during their last year of service or upon resignation from their existing office prior to accepting the nomination. A letter of resignation must be sent to the President, with a copy to the Nominations and Elections Chair.
5. All terms are for three years, except President-elect, which is one year (and then proceeds to President for one year and Past President for one year).

The deadline for receipt of all nominations ballots is October 3, 2015.

As per the Society's Bylaws, you may email your nominations to: assnmgmt1@cox.net. Please put SAP/DIVISION 29 NOMINATIONS in the subject line the email. You may also fax your nominations to: 480-854-8966, or mail to Society for the Advancement of Psychotherapy, 6557 E. Riverdale St., Mesa, AZ 85215

If you would like to discuss your own interest or any recommendations for nominations, please contact the Society's Chair of Nominations and Elections, Dr. Jeff Zimmerman, drz@jzphd.com.

Sincerely yours,

Rodney Goodyear, Ph.D.	*Armand Cerbone, Ph.D.*	*Jeff Zimmerman, Ph.D.*
President	President-elect	Chair, Nominations & Elections

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Youth at Clinical High Risk for Psychosis: Considering Intervention Strategies for Asian American Clients

Huijun Li, PhD
Florida A&M University

Schizophrenia is a catastrophic mental disorder, affecting about 1% of the world population. Psychosis is especially traumatic for affected individuals and their families because the peak onset of psychosis, especially in schizophrenia, occurs between 18 and 30 years of age, often interrupting development just as teenagers transition into adulthood ("Schizophrenia Facts and Statistics," 2010). The illness impairs many aspects of daily functioning, and the morbidity and mortality associated with it is serious, including high rates of suicide and a reduced life span of up to 25 years (Insel, 2008; "Schizophrenia Facts and Statistics," 2010). Schizophrenia is ranked as one of the most burdensome of all illnesses because it begins in young adulthood and its course is often chronic. Recent research suggests individuals can be reliably identified as "at risk" for later manifestation of a psychotic disorder because of a characteristic prodromal period. This pre-psychotic period usually lasts between two to five years before the onset of florid psychotic symptoms, and is typically characterized by a decline in academic and social functioning, mild cognitive decline, and attenuated/subclinical psychotic symptoms (Giuliano et al., 2012; Keshavan et al., 2003). Individuals at clinical high risk (CHR) for psychosis demonstrate an average rate of transition to psychosis of about 35% over three years and 20% at one year follow-up in the most recent meta-analyses (Fusar-Poli et al., 2012). The CHR phase has emerged as a critical period in the early intervention and prevention of psychosis (Addington, 2007; Yung, 2007).

CHR for psychosis can be identified by the Structured Interview for Prodromal Syndromes (SIPS) and a scoring rubric, the Scale of Prodromal Symptoms (SOPS) (McGlashan, Walsh, Woods, 2010).The SIPS/SOPS identifies helping-seeking young adults between ages 14 and 35 who meet one or more of the following three categories of CHR for psychosis:

1. Attenuated Positive Symptom Prodromal Syndrome (APS): Characterized by milder psychotic-like symptoms that have developed or increased in the past year such as new sensitivity to sights and sounds, hearing whispers that a person realizes are not real, or getting confused about whether something is real or part of a dream. Individuals who experience this syndrome are distinguished from those with fully psychotic symptoms by the fact that they maintain a degree of insight that the experiences and concerns are in their own minds.
2. Genetic Risk and Deterioration Prodromal Syndrome (GRD): Characterized by having a genetic risk for psychosis (first degree relative with a psychotic disorder or the individ-

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ual's symptoms meet criteria for schizotypal personality disorder) and a recent drop in daily functioning equivalent to 30% drop in Global Assessment of Functioning rating.

3. Brief Intermittent Psychotic Symptoms Prodromal Syndrome (BIPS): Characterized by the experience of fully psychotic symptoms that are brief (occur less than an average of 1 hour per day, 4 days per week) and have developed within the past 3 months.

Research on effective treatments for CHR for psychosis is new and evidence in this area is limited. However, based on data from 15 studies (n = 1394; Schmidt et al., 2015), early intervention generally significantly reduced conversion rates at 6- to 48-month follow-up compared to control conditions. In addition, both psychological and pharmacological interventions significantly helped prevent conversion to psychosis. The following overview summarizes major evidence-based intervention approaches to CHR for psychosis, and briefly considers the implications of each for work with Asian American clients.

Cognitive Behavior Therapy

Cognitive behavior therapy (CBT) is among one of the most frequently used and researched psychosocial intervention strategies for CHR for psychosis. CBT strategies help youth identify and challenge distorted or unhelpful patterns of thinking that impact psychological well-being and behavior, and even slow down conversion to psychosis (Morrison et al., 2012; Rietdijk et al., 2010). CBT takes the manualized treatment format and has been used to reduce symptoms, normalize psychosis-like experiences and prevent a catastrophic evaluation of the psychotic-like symptoms from happening. CBT also employs behavioral treatments and homework assignments to teach people to tolerate psychosis-like experiences and reduce emotional discomfort.

Considering CBT for Asian American clients. Limited research has been done to examine the effectiveness of CBT with Asian American youth with CHR. Li and colleagues, using a case illustration approach, demonstrated the effectiveness of CBT with a young man from Chinese American background (Li, Friedman-Yakoobian, Min, Granato, & Seidman, 2013). In order to obtain parent support and enhance patient (youth) engagement in therapy, the clinicians consulted a Chinese American mental health professional. Subsequently they took consideration of the emphasis of academic achievement of Chinese culture and focused on improving functional outcome—school performance and symptom reduction. Six months later, the patient reported symptom reduction and grade improvement. Parents were also satisfied with the treatment outcome.

Family Intervention

Early psychosocial intervention for CHR for psychosis youth may be strengthened by involving family members in treatment. First, CHR individuals are often adolescents living with their parents, and parental involvement may enhance the young person's access to mental health services. Second, the evolution of subclinical psychotic symptoms may be affected by family stress (Miklowitz et al., 2014). Recent research used psychoeducational and home outreach approaches, focusing on enhancing CHR individuals' skills for managing symptoms, with family members as support and allies in this process. This psychoeducation with family support treatment approach has evidenced greater improvement in subclinical positive symptoms over six months than a brief treatment oriented toward symp-

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tom prevention (Miklowitz et al., 2014). Thus, interventions that emphasize enhancing family relationships may have potential efficacy in helping individuals at high risk for psychosis.

Family based interventions tend to include: 1) psychoeducation sessions to assist the individual at high risk and family members to develop a personalized prevention plan. This plan includes summarizing and evaluating stressors associated with subclinical psychotic symptoms, as well as potential coping strategies (e.g., pleasant event scheduling, relaxation exercises); 2) communication enhancement training, in which youth and family members practice skills for expressing positive feelings, active listening, requesting changes in another person's behavior, communicating with clarity, and expressing negative feelings; and 3) problem solving sessions in which they learned to break down larger problems (e.g., "We have to stop fighting") into smaller ones (e.g., "We need to use lower tones of voice"), generate and evaluate solutions, and develop a solution implementation plan (Miklowitz et al., 2014).

Considering family-based intervention for Asian American clients. Asian American parents are heavily involved in their children's well-being (Li et al., 2013). Family members, rather than the patient, decide when and where to seek help, and what kind of treatment a child will receive (Yang, Wonpat-Borja, Opler, & Corcoran, 2010). Therefore, family interventions for youth with CHR for psychosis can be critical in helping the affected individual. More research needs to be done on the effectiveness and efficacy of this approach with Asian American youth and their families; however, the model's emphasis on family education and empowerment would seem to be a potentially good fit culturally to facilitate engagement with the treatment plan.

Cognitive Enhancement/ Remediation Strategies

Impairments in cognition are often present in children who later go on to develop schizophrenia (Giuliano et al., 2012; Woodberry, Giuliano, & Seidman, 2008). Impairments in cognition are key rate-limiting factors to functional recovery from psychotic disorders and include deficits in psychomotor speed, memory, attention, reasoning, and social cognition (Nuechterlein et al., 2004). There is compelling evidence from recent meta-analyses that psychosocial approaches to cognitive remediation are effective in schizophrenia (Wykes, Huddy, Cellard, McGurk, & Czobor, 2011), and studies using cognitive remediation therapy for CHR for psychosis have been emerging. These approaches generally involve some form of computerized practice of cognition (e.g., attention, memory, processing speed) designed to improve functioning. For example, a psychosocial cognitive rehabilitation known as Cognitive Enhancement Therapy (CET) substantially improves both social cognition and employment rates among patients with early course schizophrenia (Eack et al., 2009; Eack et al., 2011). The effects were maintained at one year follow up after the end of treatment (Eack, Greenwald, Hogarty, & Keshavan, 2010).

CET is a comprehensive, developmental approach to address social and non-social cognitive deficits in psychotic disorders. CET targets social-cognitive impairments in perspective-taking and emotion regulation through computerized training in basic neurocognitive processes, and the use of social-cognitive rehabilitation groups (Hogarty et al., 2004). The efficacy of CET for remediating social-cognitive impairments in perspective-taking and emotion regulation in schizophrenia presumably reflects an underlying change in frontal-temporal brain function and connectivity during the course

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of treatment, made possible by the plasticity of the human brain (Vinogradov et al., 2012). CET may also protect against gray matter loss, and even support frontal-temporal gray matter growth in service of social-cognitive enhancement in schizophrenia (Eack et al., 2010).

Another strategy to improve cognitive functioning in individuals at CHR for psychosis is targeted cognitive training (TCT) (Hooker et al., 2014) or cognitive remediation therapy (Piskulic, Barbato, Liu, & Addington, 2015). This computer-based cognitive training approach is intense and evolves from easy to progressively more difficult practice of a certain cognitive skill, such as memory, processing speed, and attention. It is geared toward improving cognition and daily functioning in individuals with schizophrenia, and has shown evidence of effectiveness (Wykes et al., 2011). Two pilot studies with youth and young adults at risk for psychosis showed effectiveness in improving processing speed and role functioning (Hooker et al., 2014; Piskulic et al., 2015).

Considering CET for Asian American clients. Many parents from Asian backgrounds place significant emphasis on their children's school and work performance (Li et al., 2013). A therapy that targets patients' cognitive abilities should be more acceptable to parents and youth at risk for psychosis. Research is warranted to examine cross-culture differences in terms of CET treatment acceptance and outcome among people from different cultural backgrounds.

Omega-3

As noted above, early intervention may limit the need for medication for youth with CHR for psychosis, as preserved insight in these individuals may help them to benefit from psychosocial interventions. When symptoms persist and cause disability despite initiation of psychosocial intervention, medications can help. There are several promising research trials of antipsychotic medications and a few interesting studies supporting efficacy of omega-3 for reducing transition to psychosis in CHR for psychosis patients (Amminger et al., 2010). Amminger and colleagues (2010) administered a daily dose of 1.2 g omega-3 polyunsaturated fatty acids (Omega-3 PUFAs) for 12 weeks while the control group received a placebo of coconut oil (polyunsaturated fatty acids free). Omega-3 PUFAs significantly reduced positive symptoms, negative symptoms, and general symptoms, and improved functioning. A more recent study (Amminger et al., 2013) also showed that omega-3 PUFAs significantly improved functioning and reduced psychiatric symptoms, compared with placebo. Side effects did not differ between the treatment groups. A study examining timing of in the use of omega-3 fatty acids found significant effects on the amplitude of the reduction in general and total Positive and Negative Syndrome Scale (PANSS) scores after the first four weeks of treatment; a reduction of positive symptoms and a lower mean PANSS positive score after eight weeks; and a significant drop in negative symptoms and significantly higher mean scores in global functioning at 12 weeks (Smesny et al., 2014).

Considering Omega-3 for Asian American clients. Given concerns over medication side effects and the potential stigma of having a child who needs to take psychiatric medication, supplements like omega-3 may be perceived as less detrimental by Asian American family members—again, an important consideration in light of the role parents play in deciding their children's treatment (Li et al., 2013).

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Summary
The worldwide scientific focus of schizophrenia research has increasingly shifted to early intervention. The goal of early intervention is reduction in illness progression and morbidity and, in time, development of viable preventive interventions. The most recent approach has focused on the "clinical high risk" (CHR) for psychosis, the period of imminent risk for developing psychosis in adolescents and young adults when brain, neurocognitive, and social and role functions tend to show illness-related deterioration. It is important to get to know research-based intervention strategies to help individuals with CHR for psychosis, which may improve treatment outcomes. Many of the interventions described above show promise for use with Asian American clients. More research and clinical case studies are needed to examine cultural influences and nuances in providing culturally relevant treatment approaches to youth at risk of psychosis.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

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STUDENT FEATURE

What Group Taught Me About Deeply Connecting

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As I reflect on my graduate school journey, I can recall that I was unsure of what my supervisors meant by "deeply connecting" with my clients. I assumed my role as therapist was to refute irrational thoughts, identify behavioral patterns, and reconcile parental misattunement. However, it would take two years as a group facilitator to truly understand what deeply connecting meant, and how my subjectivity was a piece in this therapeutic puzzle. According to Teyber and McClure (2011), interpersonal dysfunction originates from a history of systemic and familial experiences that produce a template of thinking and relating which provokes unworkable patterns of being with others and behaving in the world. Interpersonal Process Theory is a beautifully integrated ensemble of theories with original references to John Bowlby's (1969) Attachment Theory. This theory includes the influential work of Mary Ainsworth, whose "Strange Situation" study (1978) identified four distinct attachment styles (secure, dismissing/avoidant, preoccupied/anxious, unresolved). While their work often refers to the bond between mother and child, modern interpretations of this theory emphasize the importance of affect regulation. Schore and Schore (2008) posited that "early emotional transactions with the primary object impact the development of psychic structure, that is, how affective attachment communications facilitate the maturation of brain systems involved in affect and self regulation" (p. 9). This exact process is seen as the catalyst of change in Interpersonal Process Theory, and is called the corrective emotional experience. In addition, present contributors to the understanding of attachment styles in psychotherapy, such as David J. Wallin (2007), highlight the importance of the therapist's own attachment style. Together, this provides a fascinating question of what this all may look like when there are seven different people in the room together.

The group with which I was involved was created to provide a safe space for individuals to become aware, process, and change how they experience relationships with others. When I accepted a position as co-facilitator, I did not anticipate the full spectrum of experiences I would have for the next two years. While level of functioning varied, all members shared the experience of painful relational dynamics. Each member entered the group with a personal history of events and persistent ways of handling interactions like conflict, misattuned communication, receiving compliments, and confrontation. Based on previous lived experiences of misattunement, members had mental templates intertwined with fear that inhibited them from what they desired most, interpersonal closeness. As you can imagine, members' out-of-room ways of relating slowly entered the group field. When my co-facilitator, Christina Aegerter, MA, and I began

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working with the group, we added three new members. As time elapsed, a number of changes, processes, and connections began to emerge. Yalom (2005) provided eleven elements to the group therapy process that he called the "therapeutic factors" (p. 1). While all eleven occurred throughout our time together, there were four that I believe contributed most to the success of interpersonal growth in this group.

Before we added new members, the group consisted of two veterans who had been active for a number of years. They had seen a number of people come and go including several pairs of co-facilitators. As each new member entered, the therapeutic factors of universality and instillation of hope surfaced. Yalom (2005) argued, "Members of homogeneous groups can speak to one another with a powerful authenticity that comes from their firsthand experience in ways that therapists may not be able to do" (p. 8). This was certainly true as our veteran members shared their experiences of being in group and how each grew over time. Their genuineness and candor mitigated skepticism and cultivated confidence in new members. This authenticity and vulnerability allowed for new members to begin feeling safe enough to share their own difficulties and reasons for joining the group in the first place. As co-facilitators, Christina and I aimed to contain this process by bridging members' shared lived experiences in the hope of solidifying a secure base.

Toward the beginning of our second year of group, attachment styles and reenactments of primary family dynamics began to materialize. This comes to no surprise to group therapy researchers as "the group becomes a social microcosm as the 'outside' relationship lives of clients are quickly manifested in their 'inside' relationships with other group members and the therapists" (Chen & Mallinckrodt, 2002, p. 311). Avoidant and preoccupied/anxious attachment styles emerged as misunderstanding between members and splitting of co-facilitators occurred. A specific incident of the former transpired when one member, who often monopolized the group, spotlighted another member's uncommon behavior of speaking up multiple times throughout session. Although the monopolizing member's intention was to show gratitude, the other member's preoccupied attachment system became activated as historical experiences of feeling invisible and unvalued manifested in the here-and-now. The first time this incident occurred, the injured member did not respond initially. However, Christina and I noticed that the group member had withdrawn from group both covertly and overtly. Although we attempted to bring attention to this behavior during session, the group member predictably deflected, reporting being simply exhausted from the week.

According to Yalom (2005), "The therapy group resembles a family in many aspects: [T]here are authority/parental figures, peer/sibling figures, deep personal revelations, strong emotions, and deep intimacy as well as hostile, competitive feelings" (p. 15). After the event occurred on two more occasions, the injured member shared how these comments hurt, bringing back memories of feeling invisible or unvalued by family members. Christina and I moved in and facilitated a conversation on intention versus impact while validating both parties' experiences of feeling misunderstood. However, the monopolizing member reacted to Christina differently than she did with me. We were able to understand this in the context of an earlier incident in which I had expressed

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my hurt feelings toward the group member. Because the interaction was between a member and co-facilitator, Christina thoughtfully intervened, but was experienced by this member as controlling. Yalom (2005) spoke to how, if group leaders are seen as parent figures, they may draw responses associated with these early attachment figures. Indeed, the monopolizing member would later describe having re-experienced a controlling and dismissing caregiver with Christina. Yalom (2005) precisely argued, "Working out problems with therapists and other members is also working through unfinished business from long ago" (p. 16). Christina would continue working diligently with the monopolizing member by providing her a corrective emotional experience by accurately validating and mirroring this member's affective experiences.

When I attended Dr. David J. Wallin's workshop (April, 2015) on therapist attachment in psychotherapy, I could not help but think about my own process in the group. Part of his workshop examined the attachment style of the therapist and how reflecting on this means "taking into account the therapist as a whole person" (Wallin, April, 2015). What I appreciated most was when he refuted the "all-good therapist" myth, permitting therapists in the room to acknowledge that they, too, have histories. He facetiously quoted Irwin Hoffman (2011), noting, "Let's not forget this simple truth: We are also the patients. This is a large self-help group" (Wallin, April, 2015). Dr. Wallin posited that, as humans, we all have events, emotions, and vulnerabilities from which we disassociate that may have origins in early attachment experiences with parental figures. He argued that by being mindful of our own attachment styles we can become fully present when enactments occur in the room. He said, "Therapy heals when the new attachment relationship can allow the core vulnerabilities of the client and the therapist to be engaged—and successfully managed" (Wallin, April, 2015). As I reflected on my own attachment style and patterning, I vividly recalled becoming activated when Christina and I lost group members early in our roles. When a group member decided to leave, I blamed myself. Dr. Wallin suggested that, "Focusing on enactments can allow us to recognize how our own attachment patterns may be compromising our efforts to create for the client a new and healing attachment relationship" (Wallin, April, 2015). So, in those moments where members confronted each other aggressively or reported dissatisfaction with the group, I realized I was colluding with the process by failing to acknowledge disruptions and injuries instead of recognizing our participation in enactments and collaboratively finding ways to work through them.

When I reflect on the last six to eight months of group, I genuinely believe Christina and I became more aware of our own subjectivity in the group dynamic. I can recall various moments when we candidly shared how members may have inadvertently injured one of us with a flippant comment, and then repaired that particular client-therapist relationship. We received feedback from members about their appreciation for our active participation, and for a facilitation style that allowed them the security to be vulnerable. In many ways, despite the power differential in the room, we also inadvertently became fellow members with them. What we offered specifically was the opportunity to model corrective interpersonal behaviors that members had never seen or experienced before. What I found most beautiful was when members would

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then bravely practice those same behaviors with each other. I believe this is what Yalom (2005) was referring to when he spoke about group cohesiveness. He stated, "The deeply felt human experience in the group may be of great value to the individual; even if there is no visible carryover, group members may still experience a more human, richer part of themselves and have this as an internal reference point" (p. 63). We saw many examples of this type of cohesion in our group, such as members expressing concern and worry about a members' absences, clarifying intentions and speaking openly about experiencing hurt feelings within the group, and supporting one another through personal relational difficulties. As a facilitator, I, too, walked away from certain sessions feeling moved or that I had learned something from other members, and this process fostered connection between the group and myself.

When Christina and I told the group that we would be leaving to pursue internship, every member stepped into that discomfort and shared with us not only their fears of change, but also their genuine appreciation for our time as facilitators. I recall Christina and I both tearing up, expressing our gratitude to the group and the hope that they would continue their growth with the new co-facilitators. Writing this essay became an emotional reflection of what this group has taught me about deeply connecting. Because, while the corrective emotional experience can often feel restricted to the therapist-client dyad in individual therapy relationships, this exact phenomena occurs between facilitators and members as well as amongst members in the group dynamic. I have witnessed genuine care and concern for one another among group members, including powerfully emotional reparative moments. Members have accurately mirrored each other's experiences, validated one another's affect, and have taken ownership of their own ways of being. For myself, in-the-room enactments with members have provided me opportunities to foster pseudocorrective experiences as I, too, practice interpersonal behaviors of vulnerability, clarification of intentions, and conflict resolution. And, as is so often the case in therapy, saying goodbye to this group has provided a beautiful corrective experience for all parties involved.

Being a co-facilitator has allowed me to connect with myself in a completely different way, and has challenged me to step into that same discomfort with which the people sitting around me struggled each week as well. These experiences have given me voice, courage, and permission to thoughtfully engage with the narratives that often get in our way, as people and as clinicians. I am thankful for the amazing opportunity to work with a talented co-facilitator like Christina, and blessed to be able to personally witness how members of our group family have become deeply connected with each other.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

Author's Note:
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STUDENT FEATURE

5 Tips to Begin Practicing Self-Care: An Open Letter to My Fellow Graduate Students

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In a previous practicum, I was an intake counselor. To help connect clients with long-term care, I often asked them about their counselor preferences. Some requested to work with a specific gender or someone with experience working with their presenting issue. In one particular instance, the client stated a preference for therapists who know "how to take care of themselves." Upon reflection, the concern underlying the request was an obvious, but often overlooked, one: If my therapists do not seem capable of caring for themselves, how are they going to take care of *me*?

The client's words resonated with me. During that time, I was not taking care of myself, and it had never occurred to me that my ability to take care of myself was directly related to a client's ability to trust that I could function as an effective therapist. Indeed, as graduate students, we are tasked with taking care of so much. Oftentimes, we are the holders of precious cargo. We are graduate students, in the delicate limbo between the academic and professional worlds. We hold our dreams and future hopes alongside our fears of the unknown. We are researchers, holding ideas that could change the future and how we operate within it. We are clinicians and healers, holders of secrets that individuals dare not utter to others, tasked with helping facilitate change. We are teachers, full of passion and knowledge, passing on what we know and who we are to a new generation. We are advocates, using our voice and empowering our clients and communities to use theirs, too. Sometimes, in the midst of writing papers, taking exams, conducting research, preparing curricula, seeing clients, and attending meeting after meeting, we can lose sight of the sacredness of our work. More than ever our work asks us not just to attend, but also to be *present*. These tasks require more than physically showing up. To be effective, we must be emotionally, physically, mentally, and spiritually available.

Living Self Care

Becoming fully present and maintaining a stance of availability invites a deeper conversation about how to actually take care of ourselves. While we may hear the phrase "self-care" in our graduate programs often, and while we all know that it is important to take care of ourselves, it can be easy to let self-care slip as the items on the to-do list grow with ferocity. Below, I will discuss five ways to make self-care a reality rather than a platitude. This list is neither linear nor exhaustive. Most importantly, I am not writing as an expert. I am writing as a fellow graduate student who is grappling with how to take care of myself amidst everything else that vies for my attention. Personally, I do not define self-care as just something that we do; I conceptualize it as a way of being. It is my hope that my musings will serve as

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an inspiration for you along your journey, while also serving as a good reminder to myself to continue fusing these principles into my daily life with intentionality.

Realize it's all a choice. So often I think about my life in terms of "all the things I have to do." In reality, although circumstances may constrain our options, we are beings full of empowered choice. You and I have made the choice to enter into graduate school, with its accompanying set of guidelines, duties, and responsibilities. While we may not have known all the various consequences and manifestations of our choice, we still moved forward and ventured into the unknown. We committed. When I talk to friends who are not in graduate school, I sometimes find myself rattling off about how busy I am, how much there is to do, and all that is being expected of me. While this may be accurate, one large piece of the puzzle is missing. I have chosen this environment and this sacrifice. Other choices—to be a lawyer or a parent or a salesperson—come with their own shares of expected and unexpected outcomes. When I get into the space where I feel like my program is happening to me, I become disempowered. I lose a connection to the commitment that I made. I am reminded of the phrase: "Obligation is the death of love" (Richards, 2013). While we do need to accomplish certain things in order to receive the degree we are seeking, we are not obligated. I chose this surprising and difficult journey for deep and personal reasons. I do not *have* to complete the paper, the practicum, the research project. I *choose* to do it. I choose to do it all. And when I connect to that choice, I reconnect with a sense of freedom and agency.

Know thyself. I am always so fascinated by the many differences in what people find enjoyable, invigorating, and soothing. To help others connect to themselves, we must know how to connect to ourselves. This means knowing what works for us individually. While this may sound simple, it is actually an intricate process because it means being open, curious, and nonjudgmental. What worked for you yesterday may not work for you today. Truly wanting to know yourself takes times and patience. It takes stopping and attending to emotions, thoughts, circumstances. There are times on my long drive home that I have spent the entire time tuning in to how I was feeling. I am thankful for my long drive: When I lived closer to campus, I often figured out how I was feeling when discussing my day with my partner. "Wow, you sound angry," or "It sounds like a tough day," he would say. Often, I was unaware that this had been the case, because I had been running from one place to another until that conversation. Now, I remind myself to check in more often.

Each day, we navigate a multitude of roles, each with its own set of rules, guidelines, and expectations. In one day, I can go from teacher to supervisor to leader to student. Something that happened at the beginning of my day may well still be waiting to be addressed at the end of it. Make time to know yourself—not in some big, abstract way, but in practical everyday ways. Know the situations, persons, and dynamics that can be triggering for you, and know what is particularly soothing when you are activated. Again, different moments will call for different ways of caring

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for yourself. Take the time to experiment and be patient, as it will be a process of trial and error.

Make it part of your routine without being rigid. We already have a lot to do, so I am hesitant to espouse that self-care *also* be added to our to-do list. It feels wrong. However, I know that life is busy and that if we do not set aside time for specific things, often we let that time slip away. This step is about finding a way to carve out the time needed, without taking the care out of self-care. When I first began my program, I joined a service at a nearby gym where I had regular appointments for chiropractic care and massages. However, I would feel anxious about cramming those monthly appointments into my schedule. I would often get more worked up about having this set, recurring appointment on my schedule than the stress it was intended to relieve. I kept the membership but let go of the appointments. I have accepted that my life is flexible and that making time for self-care, for me, will be a more organic process. Now, I make notes to myself about things I miss doing and would love to do soon. Doing so puts them on my radar and I am more likely to engage in those activities sooner rather than later. You do not have to pencil in a monthly massage or a specific activity to be taking care of yourself. Are you listening to what you may need? Once you know, can you find the time to make it happen? Do you have a list of options for things you can do in five minutes (mindfulness, going outside, breathing, watching a funny cat video) versus things you can spend an hour on (massage, cooking a meal, meeting a friend for lunch)? Find what works for you and your schedule while being mindful not to make self-care another duty.

Learn to say yes, by saying no. Remember number one? If life is a choice, then choose carefully. The graduate student motto can be to pile on responsibilities in the quest for building up your vita. However, there is a cost to saying yes and adding more. We can become depleted. We can lose connection with our loved ones. We can lose a sense of connection to ourselves. While there are many temptations to get involved in everything during graduate school, resist by engaging in what is most meaningful for you. The things we care deeply about often feel less like work. They give our lives meaning and fulfillment. The things that we said "yes" to because others were doing it, our advisor wanted us to, we thought we *should* be doing, and so forth, are precisely the types of things that sap our cognitive and emotional energies. Have you ever realized how hard it is to motivate yourself to do something you are truly dispassionate about? Within our programs, we cannot say no to certain projects or requirements, but there are many things we can choose not to take on and there are many options for fulfilling some requirements.

This is particularly true outside of our programs. Learning to speak to family members, friends, significant others, and loved ones about our graduate experience and what we can and cannot give at certain times can be difficult to do, but these honest conversations are a way of saying yes to our needs during this limited time. Graduate school will not last forever, but the boundaries we are setting with others are building a foundation for our lives beyond these years. This isn't about being rigid and denying the reciprocal, generous relationships we cultivate

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with others. It's about communication and cultivating a sense of generosity with self. If we are not able to say no to others and yes to our own needs, we are going to come up against this same issue at work, home, and beyond. Again, it's about perspective. Rather than seeing setting boundaries as saying no to others, think of it as saying yes to yourself. Honor the commitment you made by being mindful of where you invest your time and energy. Allow others to support you by being clear about what can be expected of you and what you might need from others.

Support others. This brings me to the last point—supporting others. The people within a program create and police its culture. For self-care to become more practiced, it must begin with us practicing it and encouraging others to do so. When we are not taking care of ourselves, we cannot understand those who are. I cannot tell you the number of times someone has asked me to attend a meeting and responded negatively when I said I could not because I had a yoga class to teach or attend. I have long abandoned trying to explain the importance of the yoga practice to my life and stability and, while I could perhaps expect that response from a person in a position of authority, it feels so different coming from a peer. When is the last time someone noticed that you appeared stressed and asked about what could be helpful? More importantly, when was the last time you checked in with a colleague and asked about how they are taking care of themselves or offered to do something with or for them? I have been on teams where who you were or how you were doing as a person did not appear to matter as long as the work was done. Fortunately, I have been on other teams where communication about what was happening for each of us and a sense of shared responsibility for each other's wellbeing was tangible. In fact, the latter type of group got more done. So often we are on our own track, running full speed ahead. What if we saw our programs as relay races, where the efforts of one person could directly be passed onto the next? I challenge you to begin with yourself and then carry that same level of support, care, attention, and intentionality into supporting your peers.

Summary

We have chosen a sacred path and we have the ability to make an incredible impact. Let's begin with taking care of ourselves with the same compassion, generosity, and kindness with which we can change the world.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

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STUDENT FEATURE

The Application of Dark Humor in Stress Reduction: The Creation of a "Cards Against Psychology" Game for Psychology Graduate Students

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Graduate students in health service psychology may be uniquely vulnerable to stress due to simultaneous academic and clinical demands, including a constant focus on self-reflection. Indeed, professional development is highly correlated with personal growth for these students. A recent American Psychological Association study revealed that 87% percent of graduate students in psychology struggle with symptoms of anxiety, and 67% with symptoms of depression (Willyard, 2012). While many studies have demonstrated that dark humor is an effective way to help graduate students in other fields better manage stress symptoms (e.g., Rowe & Regehr, 2010), this approach has not yet been applied to graduate students in health service psychology. Therefore, the present project was created to encourage the use of dark humor to reduce stress in psychology graduate students.

Literature Review

Figley (2002) indicated that chronic exposure to secondary traumatic stress, caused by treating traumatized individuals, leads to deficits in the ability to empathetically work with others. Figley further recommended that maintaining successful self-care is vital in managing this stress. In fact, DeAngelis (2002) suggested that psychologists are particularly vulnerable to stress, and while they promote self-care practice for their clients they do not utilize similar strategies themselves. Multiple studies support the high level of stress graduate students experience. A survey of 281 clinical psychology trainees carried out by Cushway (1992) indicated that three quarters of students reported being moderately or very stressed.

Dark or black humor (*humour noir*) makes light of morbid, and often controversial or taboo, themes as a way of coping with the absurdity of the world (see, e.g., O'Neill, 1983). This kind of "gallows humor" may be used by indi-

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viduals in high stress situations to bond and manage stress. In a literature review of multiple studies covering various professionals who regularly work with traumatized individuals, Rowe and Regher (2010) identified several "rules" for how dark humor is used. The authors suggested that being able to use humor to re-evaluate a situation was extremely important in preventing burnout and managing stress among professionals in crisis situations, which is similar to a study by Gross and John (2003) that found emotional regulation strategies useful in managing stress among graduate students. Rowe and Regher also stated that professionals from multiple disciplines frequently use dark humor as a way to bond as a group.

Method

Ten doctoral health service psychology interns in an APA accredited consortium used a collaborative approach to generate a dark humor game called "Cards Against Psychology." The game was adapted from the popular "Cards Against Humanity" game (available without charge under a Creative Commons license; https://cardsagainsthumanity.com/) and follows the same rules and format of the original game. "Cards Against Psychology" intentionally pokes fun at psychology graduate training by using politically incorrect content. The game is comprised of two sets of cards, prompts, and responses. Rules of the game are described in Appendix A. Both prompt and response cards are included in Appendix B.

Ten interns were present at a brainstorming session during their research seminar, where all ideas were considered and documented in a shared electronic file. Each card in this set is unique and created specifically for the use of dark humor for clinical psychology graduate students. Interns were given the right to anonymously veto or edit any of the cards that were included on the shared file. The editing phase took several weeks to allow more time to process the information on the cards, given the sensitivity of some of the material. The cards were finalized after all members of the group approved the document.

Discussion and Recommendations

"Cards Against Psychology" is meant as a positive self-care experience, but there are important limitations to consider. The game utilizes dark humor, which some students may either find offensive or unhelpful. Care and sensitivity should be given to those students with different perspectives. If there are difficulties within a group while playing the game that are based on different senses of humor or cultural perspectives, an open discussion can occur to promote group cohesiveness, bonding, awareness, and understanding. When using this game, it is critical to establish positive intent. The game should be played from a place of humor, not of malicious intent, mocking, or cultural insensitivity. Care should be taken when deciding where to play this game in addition to confidentiality considerations.

The interns involved in this project found many benefits to this game as well. Being in graduate school presents unique challenges and stressors, many of which may be mitigated with self-care such as the use of dark humor, as described above. To optimize benefits, the cards may be tailored to the complexities and caveats of the individuals' specific graduate program and/or clinical experience. This can lead to a bonding experience for those creating the game. Lastly, the creation and use of this game can illicit productive and positive conversation. The nature of the game can allow a space, which is different from the classroom or supervision, to openly

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engage in dialogue about sensitive issues with decreased fear of saying the wrong thing, personal disclosure, or feelings of walking on eggshells.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

Appendix A: Rules

To start the game, each player draws seven white "answer" cards. The player "who cried last" begins as the Card Czar, and plays a black "question" card. The Card Czar reads the question aloud to the group. Each player answers the question by passing one white "answer" card, face down, to the Card Czar. The Card Czar shuffles all of the answers, reads them out aloud, and picks their favorite. Whoever played that answer gets to keep the Black Card as one point. After each round, a new player becomes the Card Czar (usually in clockwise fashion), and every player draws back up to seven cards. The first player to reach five "question" cards is the winner. If this game is being played as an expansion to the original "Cards Against Humanity," players can win up to nine cards.

Appendix B: Cards

RESPONSE CARDS (WHITE)	
• Freudian slip	• The doorknob confession
• Erotic countertransference	• Sexually transmitted diseases
• Violent countertransference	• Poor form quality
• Free Xanax	• Getting excited when you see a CONTAM
• Affordable care act	• Doing therapy when suffering from NORO virus
• Wardrobe malfunction	
• Student loans	• Sharting at an internship interview
• Internship	• Running into your client at a sauna
• APPIC	• Little t trauma
• AAPI	• Giving your partner a Rorschach
• Personal reaction papers	• Diagnosing family members
• Multicultural awareness	• Clinically indicated happy hour
• White privilege	• Inappropriate touching by a supervisor
• Ethical dilemma	• Early memories
• Caffeine	• Bibliotherapy
• Running into your client at a sauna	• Masturbation for sleep hygiene
• Educational privilege	• Sleep
• Suicidal hitchhikers covered in blood	• I just want to feel better.
• Crisis call at 4am	• Self-made teddy bear porn.
• 40 person process group	• Petting my arm hair like a cat
• Friday afternoon crisis appointments	• Chasing down child clients
• Poor hygiene	• My client escaped
• Patients who fart	• My semen smells funny
• High on 'shrooms when answering on-call	• Long pauses
• Poop on the couch	• Awkward silence
• And then he started masturbating	• Flight into health
• Put your penis back in your pants	• Accidentally re-traumatizing
• Truth is better than fiction	• Flooding
• Getting stabbed with a pencil	• Corrective emotional experience
• Long term psychodynamic therapy in hospice	• Experiential avoidance
• My underlying racism	• Reframing
• "I'd rather see a real doctor"	• Creative hopelessness
• Your growth edge	• Client Facebook friending
• Fucking self-care	• Personality traits
• Inappropriate self care	• Is it normal?
• Drinking	• Inappropriate boundaries
• Binging on junk food	• Over-sharing
• Hearing the client through the wall	• Adderall as tonic for the brain
• 8 hr. Netflix binge	• Not knowing which pronouns to use
• Goddamn white noise machines	• A 19-page suicide note
• Your training director casually mentioning twerking	• Making a splash with suicide
• Resting bitch face	• Stimulants

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PROMPT CARDS (BLACK)

I'm not a doctor yet, but I suggest you try _____.

_____ is/are often given to fertilize the brains of children.

What you tell your supervisor when he/she says you need more self care.

Your ____ is making me feel unsafe.

Running into a client _____ while _____.

It's all your father's fault that you _____.

_____, You'll never believe it!

What might this be?

(Question) How does that make you feel? (Answer) Like _____.

_____, Tell me more about that.

When on endless plane trips for internship interviews don't forget to pack_____.

There seems to be a relationship between lack of sleep and _____.

I've come to the conclusion that your dream means _____.

Let's continue to process _____.

_____: A gift in unusual wrapping paper

You seem to be struggling with _____.

When your client wants to hug you, avoid it by _____.

Have you tried _____ to cure your crippling social anxiety?

If I were _____ and I came in wearing a mask, would you have sex with me?

After encountering _____, WHOOPS accidental phobia.

I reframed _____ to _____.

When your client gives you a gift you should_____.

I know we made a break-through because _____.

Difference between Bipolar I and Bipolar II.

My classmate became offended when I told them "_____"

When a client no-shows I _____.

After a long day, I remembered _____ while in the shower.

Research indicates _____ is the best self-care for graduate students.

How does that make you feel?

WASHINGTON SCENE

"EDUCATION IS THE MOST POWERFUL WEAPON..."

Pat DeLeon, PhD
Former APA President

Interprofessional Collaborative Practice: One of the fundamental tenants of President Obama's Patient Protection and Affordable Care Act (ACA) is that quality care requires respectful collaboration among the various health care disciplines. Our colleagues in pharmacy have been on the cutting-edge of this evolution with the Departments of Defense (DoD) and Veterans Affairs (VA), under the leadership of Toni Zeiss, affirmatively demonstrating its contributions. The National Alliance of State Pharmacy Associations (NASPA) convened a workgroup to build upon relevant recommendations from the National Governors Association (NGA), emphasizing the importance of alignment with pharmacists' considerable education and training. They took the approach that rapid innovation in education, training, technology, and evidence-based guidelines necessitate a collaborative practice framework that is flexible and facilitates innovation in health care delivery, especially at the practice level.

Give an hour—An inspirational vision. Earlier this year I had the opportunity to attend the launch of Give An Hour's new initiative, *The Campaign to Change Direction*, which focuses upon how our nation views and talks about mental health/behavioral health issues. First Lady Michelle Obama was the keynote speaker with active participation from the highest level of leadership within DoD and VA, as well as numerous Wounded Warriors. A national public awareness campaign has been launched featuring Mrs. Obama. On July 21, 2015, while addressing the Veterans of Foreign Wars (VFW), the President himself urged all American to learn the five signs that may mean someone you know is in emotional pain and might need help: Personality Change, Agitation, Withdrawal, Poor Self-Care, and Hopelessness. Currently 18% of Americans have a mental health condition and 90% of those who die by suicide have a mental disorder. If one remains until the very end of the film *Love & Mercy*, one will see that as a nation we are finally moving towards viewing emotional issues in the same manner as physical ailments, as the First Lady urged. Barbara Van Dahlen, PhD, President and CEO of Give an Hour, credits her inspirational vision to her young daughter's concern 10 years ago about how the nation has historically treated (or forgotten its responsibility for) homeless veterans. Immediate family members do have a major impact upon our life journeys.

An interesting aspect of the Hoffman Report. Having been interviewed by David Hoffman and one of his colleagues, I made a special point of carefully reading, and admittedly re-reading, the entire 542 page document. Since my 2000 APA Presidential term, I have been away from the governance, feeling that it is time for our next generation. I can understand how the process might have unfolded. I learned many of the specifics enumerated in the report for the first time. My sincerest congratulations to

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Past-President Nadine Kaslow for being willing to pursue this independent review which, in my judgment, was an act of true courage. Personally, I could never condone torture in any fashion, a conviction I am confident that the vast majority of our colleagues strongly support. One vividly remembers the messages passed on by one's grandparents – "Those were your relatives whom you see hanging for public display." My wife and I were on the National Mall participating in the unfortunately small anti-war demonstration the night before the President acted. These are important issues for all Americans. Although lengthy, I would strongly urge everyone to read the entire Hoffman report—there is much to be learned which must never be forgotten.

The report describes psychology's long history of involvement with the Department of Defense (DoD). During World War I, on the day that Congress declared war on the German Empire, APA President Robert Yerkes convened a meeting of a group of psychologists to discuss how psychology could assist in the war effort. A special meeting of APA's Council established 12 committees to assist the government in addressing psychological problems, including committees on the psychological examination of recruits; psychological problems of incapacity, including those of shell shock; and, recreation in the army and navy. One of the largest endeavors undertaken with the assistance of psychologists in support of the war effort involved the administration of tests to assess potential recruits. The Army administered a battery of tests similar to the Binet-Simon intelligence scale to more than 1.7 million recruits to attempt to differentiate between potential recruits who were unsuitable for service, those who would be suitable privates, and those who could serve as officers. During World War II, the effort to assess potential recruits expanded, and by 1945 more than 13 million people had been screened. A number of prominent psychologists also developed an intensive program designed to assess the suitability of a candidate seeking to serve in the Office of Strategic Services (OSS), which had been created by President Roosevelt as the agency responsible for intelligence collection, espionage, subversion, and psychological warfare. Psychologists' participation in the war effort led directly to the creation of the modern APA. Throughout the Cold War, psychology had a close relationship with the military.

The G.I. Bill strengthened the profession of psychology both by expanding enrollments in institutions of higher education and by allowing some returning soldiers to train to become psychologists and join APA. The military also drove a major expansion in infrastructure supporting clinical psychology. Over time, the military and the VA created a demand for psychologists to care for soldiers and veterans with mental and emotional problems. Psychology had an important influence on the development of military doctrine regarding interrogations. Beginning by at least 1956, the military forbade the use of tactics it deemed coercive in interrogations.

Quoting directly from the Report. "The very substantial benefits APA obtained from DoD help explain APA's motive to please DoD, and show that APA likely had an organizational conflict of interest, which it needed to take steps to guard against. DoD is one of the largest employers of psychologists and provides many millions of dollars in grants or contracts for psychologists around the country. The history of DoD providing critical assistance to the advance-

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ment and growth of psychology as a profession is well documented, and includes DoD's creation of a prescription-privileges 'demonstration project' in which psychologists were certified to prescribe psychiatric drugs within DoD after going through a two-year training course…."

"The APA Board also asked three sub-questions…. The third sub-question was 'whether any APA action related to torture was improperly influenced by government-related financial considerations,' including grants, contracts, or prescription-privileges policy for military psychologists. As described above, the substantial financial benefits in the form of employment, grants, and contracts that DoD provided to psychologists around the country had a strong influence on APA's actions relating to the PENS Task Force (and therefore 'relating to torture'), since preserving and improving APA's relationship with DoD (including the benefits to psychology that flowed from it) formed an important part of the motive behind APA's actions. We did not find that APA was motivated by a specific contract or grant, or that APA itself actually received any substantial grants, contracts, or other payments from DoD during this period. The financial motivations for APA related to the substantial benefits that flowed from DoD to the profession of psychology."

"As for the prescription-privilege program, we found that APA believed that this program has provided a very substantial benefit to psychology and APA, because obtaining prescription privileges in order to better compete with psychiatry was one of APA's leading priorities for many years. DoD's 'demonstration project,' created in 1991 and in place through 1997, which was initiated principally by Pat DeLeon (APA President in 2000) and his boss, Senator Daniel Inouye (D-HI) and his Chief of Staff, psychologist Pat DeLeon (APA President in 2000) [sic], allowed psychologists to have prescribing privileges in DoD and other federal locations, and created a two-year certification program that could be recognized by a state that authorized properly-certified psychologists to have prescription privileges like psychiatrists. Approximately ten psychologists were trained and certified through the DoD demonstration project, including Debra Dunivin. The demonstration project thus served a crucial unlocking function for psychology and APA, since it established the legitimacy of a prescription-training program outside of traditional medical school, thus providing a strong answer to the traditional critique from psychiatrists that the only way to be trained in prescribing psychiatric medications was to graduate from a traditional four-year medical school."

"We do not believe that by 2005, APA officials were realistically seeking or expecting anything further from DoD on the topic of prescription privileges. Nor do we believe that APA officials actually worried that a failure to curry favor with DoD would cause DoD to reverse course on prescription privileges by, for instance, disallowing previously-certified psychologists from continuing to prescribe medication when they treated DoD personnel. Thus, we do not believe that the prescription-privileges issue was a significant 'financial consideration' for APA in taking the actions it took in 2005."

"Nevertheless, it is clear to us that the way in which DoD had supported psychology in crucial ways in the prior years, including through the prescription-privileges program, played a fun-

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damental role in APA feeling motivated to curry favor with DoD. This was less of a function of APA seeking something concrete with regard to a specific contract or program (like prescription privileges), but more of a function of APA knowing very concretely how willing and able DoD was to provide large-scale support to psychology as a profession – now and perhaps in the future in unknown ways. This was support that APA did not want to risk jeopardizing by taking a position that was at odds with what APA perceived as DoD's clearly stated preferences within the PENS process."

On pages 83 to 85 of the report, the authors provide a comprehensive overview of the DoD "demonstration project" (PDP). "In 1999, the U.S. General Accounting Office ('GAO') found that PDP graduates were well-integrated into the Military Health Service, that they held positions of responsibility and treated a broad spectrum of patients, carrying patient caseloads that were comparable to those of psychiatrists. It found that most of the graduates had been granted independent status, which allowed them to operate with only the same level of review as psychiatrists at their locations. The GAO further found that the graduates were evaluated as good to excellent, both by their clinical supervisors, and an outside panel of psychiatrists and psychologists, and found no evidence of quality problems in their credential files. However, the GAO also found that the PDP program was more costly than the Department of Defense's traditional mix of psychiatrists and non-prescribing psychologists, and stated that the impact of the program on combat readiness was minimal at best." We would strongly urge all psychologists to carefully review the entire Hoffman report. You may agree or disagree with its conclusions; clearly, reasonable colleagues do. Nevertheless, it is a fascinating document.

" . . . Which You Can Use To Change The World" (Nelson Mandela).

Aloha.

BOOK REVIEW

Book Review of *The Ethics of Private Practice: A Practical Guide for Mental Health Clinicians* by Jeffrey E. Barnett, Jeffrey Zimmerman, & Steven Walfish. New York, NY: Oxford University Press, 2014, 192 pp. ISBN: 978-0-19-997662-1.

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The Ethics of Private Practice (Barnett, Zimmerman, & Walfish, 2014) is, indeed, "a practical guide," intended for all manner of mental health practitioners. It quite comprehensively addresses the ethical, legal, and professional conduct issues that may present themselves in the particular context of private practice. The authors, psychologists each, have striven to provide a volume that will generally apply to all clinicians, including psychologists, psychiatrists, social workers, counselors, and all who are legally authorized to practice. While the authors do address ethical matters that will be of relevance to broadly clinical (yet non-psychotherapeutic) practice—such as psychological testing or psychopharmacology—the predominant focus of the book is on the clinician engaged in the private practice of psychotherapy.

This well-organized book appropriately begins with the ethical issues of starting out in private practice, covering specifics of training and licensure requirements, including pre-licensure supervisory requirements, choices about location and setting, and other practical and ethical considerations clinicians will face at the very beginning of their professional lives. It then proceeds to consider, in detail, the nuts and bolts of an ethical clinical practice, including confidentiality and other boundary issues, record keeping methods and requirements, the role of third parties, and financial policies and procedures. The book also includes sections on staff and office policies—useful both for clinicians considering joining or starting a group practice, advertising and marketing matters, continuing professional development—including required continuing education, engagement in scholarship and peer consultation, as well as the value of personal psychotherapy and other forms of consultation for most, if not all, clinicians, whether they are struggling or thriving. The book concludes with a chapter on "leaving" a given practice, and this pertains both to leaving a group practice or retiring from one's own.

Each chapter usefully includes a section entitled, "Pitfalls to Avoid," and gathers together "relevant ethics code standards" for the particular subject area. Some chapters include handy checklists such as the "Release of Information Checklist" (p. 91) or the "End-of-the-Business-Day Lockup Checklist" (p. 133). A couple of chapters even include convenient sample documents: a "Sample Termination Letter" (p. 55) and an "Ethics Quiz for Staff" (p. 132). The authors have usefully in-

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cluded a detailed table of contents enabling the reader to quickly and easily navigate to relevant sections, and they also utilize bullet point summaries when applicable. The overall effect of reading this volume is feeling that you have three experienced, practical-minded mental health professionals at your disposal and on your side, helping you to do the right thing in relation to your patients and your profession.

The Ethics of Private Practice (2014) is written in a clear, conversational style. Reading the book is like taking a good, reasonably concise, weekend-long continuing education workshop on the ethical issues of being in practice, complete with a good set of handouts and references. You feel that you are in good hands and that—if you follow the authors' clear and straightforward recommendations—your practice will be successful and you will significantly decrease the likelihood of ending up in some sort of legal or ethical morass. The authors repeatedly lend support to the idea that the proactive investment of attention and energy to ethical practice will pay dividends in the long run. And the authors convey the task of such ethical professional conduct in a manner that is approachable rather than intimidating or arcane. Professional readers who are uncertain or confused about the ethics of specific practical matters are likely to feel supported rather than judged by the authors; this book is thus likely to help them get onto the right track. And the book does a fine job of steering clear of any particular theoretical bias.

The audience for this book would range from advanced graduate students in the mental health disciplines to senior clinicians with much experience. The book will be approachable to all, but there is invariably something to be learned from proceeding comprehensively through the various topics that fall under the rubric of ethical practice. The authors' stance is consistent with the view that no single practitioner, even the most well-trained, moral, and wise among us, can be in possession of complete mastery of all of the ethical issues that may arise. The authors appropriately recommend engaging in collegial dialogue and seeking experienced consultation when there may be incompleteness of knowledge. Their user-friendly tone of advocacy increases the likelihood that readers will avail themselves of such consultation.

The ethical perspective taken by this book is soundly mainstream. The authors seem to have no particular ambition to focus, for example, on managed care's derisive impact on psychotherapeutic practice or on the erosion of professionals' autonomy and patients' privacy that such "management" has had. For a more pointed focus on the challenges of the managed care environment and its impact on the ethics of psychotherapeutic practice (particularly psychodynamically oriented psychotherapy), one might look to Sperling, Sack, and Field's (2000) *Psychodynamic Practice in a Managed Care Environment*. For a more absolutist perspective on ethical issues pertaining to confidentiality in the clinical situation, one might read Bollas and Sundelson's (1995) treatise, *The New Informants*. Nor do the authors aspire to venture into detailed ethical consideration of such topics as boundary violations in work with character disordered patients or countertransference ambiguities encountered in intensive, long-term psychotherapeutic treatments. For these subjects one might turn to Gabbard and Lester's (1995) *Boundaries and Boundary Violations in Psychoanalysis* and Hirsch's (2008) *Coasting in the Countertransference*. Instead, the au-

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thors of *The Ethics of Private Practice* set out to provide the ordinary clinician with the basic tools to navigate the domain of private professional practice. This is a worthy—if not heady—endeavor, and the book delivers, fulfilling its promise as a "practical guide."

There is no bad advice to be found in *The Ethics of Private Practice* (2014); the authors know the pragmatics of the field, identify relevant ethical principles, and apply sound and well-supported guidance for the reader to assimilate. The main shortcoming of the book may also be one of its strengths. At 192 pages, it is a streamlined, approachable resource. But this brevity means that the book is not as exhaustive as it might have been in the provision of fully comprehensive information for private practitioners. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA; U.S. Department of Health and Human Services, 1996) is certainly mentioned often in this volume, but a reader might expect a more thorough handling of the practicalities of navigating HIPAA compliance in the private practice context. The book is uneven with regard to its offering of practical advice and documentation. Too often the reader is referred to outside sources rather than being provided the information or document sample directly. The book would have been much more useful if it had included more sample documents than it does. A standard private practice "Consent Form," including necessary HIPAA information, which could be customized by the clinician and distributed at the start of each new initiation of psychotherapy, would have been welcome. Similarly, if I want to opt out of serving as a Medicare provider, something more and more clinicians are choosing to do, I can find a sample of the required Medicare "opt-out letter" (Association of American Physicians and Surgeons, 2012) pretty easily on the Internet, but it would have been helpful of the authors to include such a sample in the book. And it is easy enough to dig up a standard "Consent for Release of Information" form for use in private practice, but why not make it easy on those starting out practice by having a lengthy appendix and putting an example of such a form, and others that might regularly be used, in it for easy appropriation?

Another limitation of *The Ethics of Private Practice* (2014) is a completely understandable one: The book shies away from getting into specific legal mandates and jurisdiction issues since there is variability with regard to mental health law and professional practice depending on where the clinician is in practice. The book appropriately suggests further research on the part of the reader to ensure that the particular locale is taken fully into account.

One area of surprisingly sparse coverage is that of technologically-mediated forms of psychotherapy. It is widely observed that psychotherapists are increasingly meeting with some of their patients by telephone and video-conference (such as FaceTime and Skype). As a result, there are numerous ethical and legal ambiguities that are emerging at an accelerating pace. Some examples: How should jurisdiction issues be conceived of when the practitioner is in one state and the patient is in another? What are the differences in terms of efficacy of in-person versus technologically mediated, remote sessions? And if technologically-mediated sessions might make psychotherapy possible for some people for whom it would otherwise be impossible, but we are still concerned about the possible inferiority of working remotely, how should the ethics of this dilemma be

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sorted out? For a further, in-depth consideration of these issues, one might look to Russell's (2015) *Screen Relations*, but one will not find this being addressed in *The Ethics of Private Practice* (2014).

In summary, this is a sound and useful book, one worthy of addition to the bookshelf of any aspiring or current private practitioner. It is an approachable guidebook to the rewarding and, unfortunately, increasingly hazardous domain of psychotherapy in private practice. It is not a stand alone book, but it aptly manages to cover most of the professional ethical issues the private practitioner is likely to encounter.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

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BOOK REVIEW

Book Review of *Creatures of a Day: And Other Tales of Psychotherapy* by Irvin D. Yalom. New York, NY: Basic Books, 2015, 215 pp. ISBN 978046502964.

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In his new book, *Creatures of a Day* (2015), Irvin Yalom explores the topics that we have come to expect of him, existential psychotherapy and authenticity. The format used by this master storyteller and therapist to describe remembrances of patients in treatment is also familiar from other of his writings, like *Love's Executioner* (Yalom, 1989). What is unique about this collection of ten tales of psychotherapy is the candid introspection Yalom offers on how being a therapist growing older has transformed his work and thinking. At 84, Yalom could easily fade into retirement, confident we would remember him for the many accomplishments in his life. Instead, he chooses to practice, think, and write in the landscape of old age. In *Creatures of a Day,* Yalom not only apprises us about the ordinary experiences of being a very mature therapist, but he observes that aging provides an especially advantageous perspective for inquiry with patients into the concepts of existence and nonexistence. Death is grappled with from nearly every angle: the impending death of a patient, the impending death of the therapist, the death of patients during therapy, the death of others significant in the patients' lives, and the death of those significant in the therapist's life. In each of these instances, Yalom shares how he works to encourage patients to encounter their fears of death and accept their existence in a relationship with a sharp, reflective, and aging other. A brilliant and prolific writer and committed existentialist, Yalom is able to not only describe his experiences and perceptions from his advanced years but make this wisdom entertaining and accessible to individuals across the spectrum of age.

In *Creatures of a Day* (2015), Yalom documents his experiences of what it is to become older as a therapist. He certainly highlights the enjoyable and everyday elements of this process. For instance, in "On Being Real" (2015), he lets a patient into the vividness of a simple moment of gratitude he had with his wife of many decades: "Believe it or not, looking at the end of life has some positive effects. I wanted to tell you of an odd experience I had a few days ago. It was about six o'clock, and I saw my wife at the end of our driveway reaching into our mailbox." Yalom has an image of losing her, but then "there she was, alive, radiant, in the flesh, flashing her beautiful September smile. A warm flush of joy washed over me. I felt grateful that she and I were still alive, and I rushed to embrace her and to begin our evening walk. … I'm saying that anticipating endings may encourage us to grasp the present with greater vitality"

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(pp. 27-28). Other of Yalom's experiences as an aging therapist are especially poignant, like refusing to clear out his pre-HIPAA file drawers jammed full of notes on patients who either never returned or who had long since died. He describes the not unusual tendency at his age to forget faces and names, especially outside of the consulting room, and worries that former patients will be hurt if he does not remember them or the details of their time together. He acknowledges the "yawning abysses in [his] knowledge of current medicine" as science and technology have long surpassed his training 60 years prior. Lastly, we learn about Yalom's internal reactions to the microaggressions to which others have inadvertently subjected him based on his age, like asking him whether he is *still* taking on patients or assuming a wisdom and comfort with death by virtue of being older.

Perhaps the most striking phenomenon of aging as a therapist that Yalom illuminates for us is the increased freedom and risk-taking in doing psychotherapy that he has experienced. Yalom's earlier work shows his proclivity toward earnestness with patients, but in *Creatures of a Day* (2015), many of the turning points of the therapy come after he uses disclosure to break down barriers to intimacy and accelerate the work of therapy. In the same chapter "On Being Real," Yalom is working with a young professional who had been repeatedly deprived of powerful mentors through death and loss. More recently, this man's self-assurance was stolen away with the revelation that one mentor died by suicide. Learning this truth buckled the patient's reserve with the thought that if he himself aspired to be like this man, then he was too capable of taking his own life. Yalom's solution was not to become the new strong father figure, but instead to encourage the patient toward greater closeness with him as a vulnerable and particularly mortal other. With this invitation, the patient asked Yalom what he was thinking in the session. Yalom narrates the thoughts in his head at this moment:

> Twenty or thirty years ago such a question would have truly rattled me. But as I've matured as a therapist, I've grown to trust my unconscious to behave in a professionally responsive manner, and I know full well that it is not so much *what* I say about my thoughts that is important but rather *that I am willing to express them*. (p. 23)

Quite openly, Yalom imparted what had entered his mind at that moment was a comment he had seen on a microblogging app for secrets (a web program where members leave short anonymous messages for all other users to read). It was posted by a worker at Starbucks who described slipping customers decaf when they were rude. The genuineness of this remark and the honesty it took to reveal helped the patient realize that everyone has secrets they either keep to themselves or find a space to share in an act of closeness and spontaneity. The patient saw that in his fractured reality it is better to live in the authentic but precarious presence of others.

Indeed, offering up his proclivity for anonymous microblogging is not the only risk that Yalom admitted to in these tales of therapy. For example, in other chapters, he shares with a patient his annoyance with his ophthalmologist for telling him he is "right on schedule" for reading glasses, embraces the challenge of a terminally ill and financially insecure patient who questions why a successful psychiatrist needs to charge so much for his services, revises his own self-protective statement to a patient that he is not tired after a hard session,

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and routinely asks patients whether he and they are being "bold enough" in the relationship. Younger therapists may often find themselves afraid to make such disclosures for fear of breaking an implied rule of therapeutic abstinence or crossing a boundary with patients by sharing their own experiences. Wielding his age instead of yielding to it, Yalom's intent is to use the confidence he has gained with age to help remove the isolation that others experience, especially when they are approaching and contemplating death. Of course, relational closeness has always been at the heart of Yalom's approach in individual therapy, but now in this volume he views it and contextualizes it through the lens of his own aging and death, a lens that is anything but presbyopic.

Even with his focus on existence and intimacy, Yalom (2015) shows us that opportunities for authenticity can emerge out of unpredictable spaces and times. In "Get Your Own Damned Fatal Illness," Yalom (2015) regrets that he was away at the time his patient Ellie passed. Surprisingly, in the absence of contact with Yalom, she demonstrated the most faceted experience of authenticity. At Yalom's prompting, Ellie, a fellow writer, had recorded her recollections of each session. Yalom revisited these reflections when he knew he would never see her again. To his amazement, she had been communicating a deeper level of experiencing that he had missed in their therapy meetings and in his original reading of the anecdotes. When Yalom and she agreed that he would write a chapter about their time together, Ellie's only stipulation was that he use her real name. In writing case studies, we are faced with the choice of disguising the identity of our patient or obtaining consent from that person (Samstag, 2012). Ellie consented to full disclosure in order not to lose crucial parts of her and the meaning she created in interaction in her life with real others and actual events. Ellie, in consenting to reveal herself, achieved a genuineness in the tale of her life that can now be witnessed by more than her therapist, but by all of her future readers. In this way, she was, as her own words described, a "pioneer of dying" (p. 170) to others.

Whereas *Creatures of a Day* (2015) gives us insight to the experience of aging in our field and to how we might blend existentialism and authenticity in our practices, some factors might also limit how easily applicable the messages of these stories are to other therapists. First is the not inconsequential status of Irvin Yalom himself. Many patients in this book had heard of Yalom through his books and media interviews, sought him out for consultation, and literally climbed mountains to get to his hilltop home office. It is true that patients often make equally great but relative sacrifices to see their therapists and esteem them in unique ways. But it is likely that Yalom's presence and gravitas, even paired with his informality and genuineness, are likely to have changed the interaction with his patients in ways that might not reproduce easily. Second, most of Yalom's stories are about patients in short-term therapy, often consultations of one to four sessions. The relatively brief encounters in many of Yalom's narratives might also not have the same qualities and characteristics as might be found in longer-term relationships with individuals. Disclosure might not be as powerful in therapeutic relationships in which the parties know each other well and are consistently authentic by virtue of their length of time together. In a longer-term therapy, dying may sometimes need to be experienced as loss to be grieved as opposed to an opportunity for closeness. Lastly, aside from some indications in a few of the

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tales, the experience of culture and death was little examined. Death takes us all, but our cultural identities are likely to moderate our understanding and orientation toward it. It may then be best to see this book as a collection of exemplars of human encounters around existence and realness by a true master of these principles. We might at the same time remember that the relationships we experience in our own consulting rooms are likely to be creatures of a different but equally valuable day.

In his celebrated career as a psychotherapist and author, Yalom has emphasized the centrality of the relationship and existential authenticity, has welcomed and shaped future generations of psychotherapists, and has shared the subjectivity and intimacy of the therapy process with millions in treatment and out. *Creatures of a Day* (2015) intervolves each of these accomplishments from the vantage of a therapist in late life. With increasing age, therapists will seek to draw from Yalom's wisdom about how to be and how to broach the ideas of mortality and realness with our patients. Younger therapists may use these stories to do the same, but they may need to work harder to connect with these issues given the tendency of younger individuals to avoid thinking about death (Burke, Martens, & Faucher, 2010). Individuals involved in programs and services that deal with the imminence of death, like psycho-oncology or palliative care, may find this book especially helpful for their own work and to recommend to patients. Educators teaching thanatology or existential thought may similarly find the vignettes promote thought and discussion. Finally, like the majority of Yalom's works, *Creatures of a Day* (2015) can appeal to most anyone, as it shows a man facing a time in his life in which death is ever nearer, and how he best lives, works, braves, and heals in recognition of this fact.

References for this article can be found in the online version of the Bulletin published on the Society for the Advancement of Psychotherapy website.

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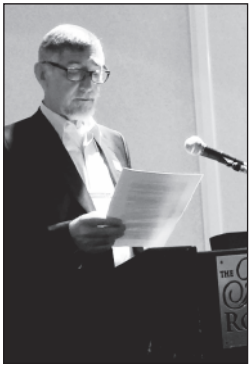
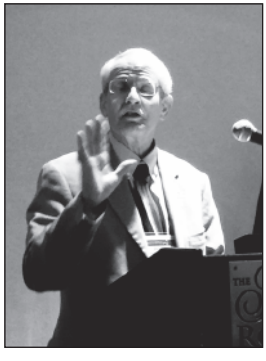


SAP 2015 President Rod Goodyear welcomes attendees to the ceremony

Awards Chair Ray DiGiuseppe introduces Douglas Snyder, recipient of the 2016 Distinguished Psychologist Award



Distinguished Psychologist Douglas Snyder

Distinguished Psychologist Douglas Snyder with Ray DiGiuseppe

Stephanie Budge receives the APF/SAP Early Career Award

Xu Li receives the Mathilda B. Canter Education and Training Student Paper award

Marilyn Cornish receives two awards from SAP: the Donald K. Freedheim Student Development Paper award, and the Student Diversity Paper award.

Stephanie Hoover, recipient of the 2015 Charles Gelso Grant, with President Rod Goodyear, Charles Gelso, and Awards Chair Ray DiGiuseppe

Edward Teyber and Faith McClure Teyber receive the Psychotherapy Most Valuable Paper Runner-up Award

Jeffrey Magnavita receives his Fellows certificate from President Rod Goodyear

Elizabeth Reynolds Welfel receives her Fellows certificate from President Rod Goodyear

Lauren Behrman receives her Fellows certificate from President Rod Goodyear

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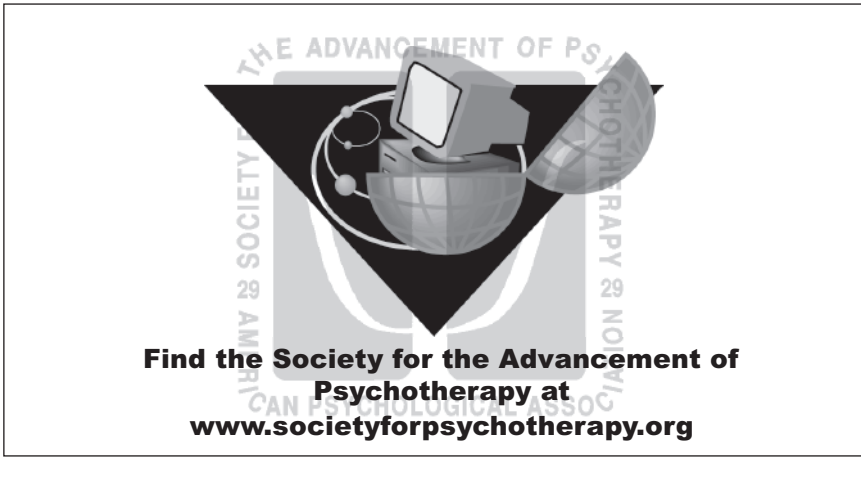

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