

# Psychotherapy

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## In This Issue

### Special Feature

*Closing the Gap Between Research and Practice:  
The Two-Way Bridge Initiative*

### International Feature

*Sculpting Psychotherapy Integration in Argentina:  
The Aiglé Project 1977-2016*

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### Psychotherapy Research

*Clinicians' Self-Judgment of Effectiveness*

### Education and Training

*A Collaborative Study of Development in  
Psychotherapy Trainees*

### Psychotherapy Practice

*In the Hot Seat: Applying Intensive Short-Term Dynamic  
Psychotherapy (ISTDP) to Couples Counseling*

### Ethics

*New Guidelines and Best Supervision Practices*

### Early Career

*Forgiving Hoffman*

### Diversity

*Life Experiences of Young African American Men  
and Clinical Interventions*

### Student Feature

*How to Beat the Stress:  
Psychology Graduate Students' Adaptive and  
Maladaptive Coping Strategies*



2015 VOLUME 50, NUMBER 4

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**CONTENTS**

President's Column .....2  
*Appreciations*

Editors' Column .....3

Special Feature .....5  
*Closing the Gap Between Research and Practice:  
The Two-Way Bridge Initiative*

International Feature .....9  
*Sculpting Psychotherapy Integration in Argentina:  
The Aiglé Project 1977-2016*

Psychotherapy Research .....15  
*Clinicians' Self-Judgment of Effectiveness*

Education and Training .....21  
*A Collaborative Study of Development in  
Psychotherapy Trainees*

Psychotherapy Practice .....26  
*In the Hot Seat: Applying Intensive Short-Term  
Dynamic Psychotherapy (ISTDP) to  
Couples Counseling*

*Psychotherapy With the Wealthy: Some Frame  
and Countertransference Issues* .....31

Ethics .....35  
*New Guidelines and Best Supervision Practices*

Clinical Notes With Dr. J .....40  
*Steal This Metaphor! Using Superheroes to Support  
ADHD Medication Compliance in Young Children*

Early Career .....44  
*Forgiving Hoffman*

Diversity .....49  
*Life Experiences of Young African American  
Men and Clinical Interventions*

Student Section .....55  
*How to Beat the Stress: Psychology Graduate  
Students' Adaptive and Maladaptive Coping  
Strategies*

*This Time It's for Real* .....59

Washington Scene .....61  
*From Our Experience We Gain Knowledge*

Book Review .....65  
*Abbass, A. (2015). Reaching Through Resistance:  
Advanced Psychotherapy Techniques*

References .....81

Appreciations

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It was my good fortune to serve as President of the Society during this past year. I leave that position with a great deal of appreciation for the exceptional work being done and for the learning opportunities this role has afforded me.

I knew that the Board of Directors would be there both for support and to ensure that nothing inadvertently went "off course." In fact, this was more than borne out. The people you as members have chosen to lead our Society are exceptional in their dedication to the Society as well as in the wisdom and creativity that they employ in governing it. This is certainly true as well with our Administrator, Tracey Martin.

The visible evidence of this work is to be seen in the exceptional quality of our journal, our *Bulletin*, our web page, our convention programming, our webinar series, and in the Society's grants and awards. But as well, there are many less public ways in which the Board is actively at work promoting the Society and its mission. They deserve our appreciation.

My own particular focus this year has been on examining and implementing ways to increase the Society's presence as a global organization. To this end, we appointed an International Affairs Task Group (co-chaired by Fred Leong and Patrick Leung) that has been instrumental in really moving us ahead. The Board of Directors has approved the creation of an International Affairs Domain,

which will shortly be brought for vote to the membership as it will require a by-laws change. We are off to an excellent start and I know that as President and President-elect, respectively, Armand Cerbone and Jeff Zimmerman are committed to continuing this global push.

I would offer, though, that to become an intellectually vibrant global Society we will need to become more effective in ensuring that the exchange of ideas becomes (in the words of my colleague, Changming Duan) a two-way street. That is, ideas about psychotherapy change mechanisms and procedures need to flow not only *from* the United States, but also *to* the United States. This idea exchange can occur in a number of ways, including particularly ensuring international content in our convention programming, on our web pages, in our journal, our webinars and in this *Bulletin*. I am pleased, therefore, that in this issue of the *Bulletin* Beatriz Gómez describes the work of the Aiglé Foundation, which has become highly influential throughout Latin America. As Dr. Gómez notes in her piece, Dr. Héctor Fernández-Alvarez, one of Aiglé's co-founders, was recently selected as the recipient of the 2016 APA Award for Distinguished Contribution to the International Advancement of Psychology. I would like to add my personal congratulations, and I look forward to learning a great deal more about psychotherapy as it is practiced around the world.

In short, I have been personally and professionally enriched by this year as the Society's President. I am very appreciative for having had the opportunity.



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Welcome to the final issue of the 50<sup>th</sup> volume of *Psychotherapy Bulletin*. The past 12 months have brought their share of change, challenge, and opportunity to the field, and we are pleased to wrap



up the year with a broad selection of articles and items of interest to Society for the Advancement of Psychotherapy members. We are delighted to bring you this issue's Special Feature, *Closing the Gap Between Research and Practice: The Two-Way Bridge Initiative*, which will be published simultaneously in the December issue of *Clinical Psychologist*, the newsletter for the Society for Clinical Psychology (Division 12). And, in what we hope will be the beginning of a trend, we offer an International Feature, this one exploring the history and work of the Aiglé Project in Argentina (we would like to extend a special invitation to our international readers to submit their ideas for articles, as well). Throughout this issue of the

Bulletin, you will find a variety of articles related to practice, training, and early career perspectives, as well as Society business. Make sure to check out our "Student Section" for pieces on adaptive and maladaptive coping strategies in graduate school and a psychologist's reflections on seeing his first client.

Please visit the Society's website (<http://societyforpsychotherapy.org/>) for additional content, and to give us your ideas and input. The next deadline for submissions is February 1, 2016, and complete submission guidelines can be found in the back of this volume or online.

Best wishes in the New Year.

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## SPECIAL FEATURE

### Closing the Gap Between Research and Practice: The Two-Way Bridge Initiative

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Psychology researchers have long lamented that practicing therapists do not make use of research findings in their clinical work. For their part, clinicians have argued that much of what researchers have studied has not adequately addressed the issues that they confront in their practices.



This gap between research and practice continues to exist, even in the face of growing external pressures for empirical accountability among policymakers and insurance companies.



There undoubtedly are numerous reasons for this long-standing gap. Clinicians and researchers live in different professional worlds. Researchers seek to advance the field and are involved with publications and research grants, whereas clinicians are concerned about what works best to help specific patients and are involved with referrals and in-

surance reimbursement; in addition, there exist few forums where the two can interact. Despite training models that seek to prepare psychologists in scholarship, science, and practice, the existence of these overlapping, yet separate, domains can result in a disconnect within the profession.

Another possible reason for the clinical-research disconnect is the fact that the two worlds have historically been connected by a “one-way bridge”: Researchers attempt to disseminate their findings to clinicians, but the voices of practicing clinicians typically go unheard.

Most research on the efficacy of psychotherapy has involved clinical trials carried out on interventions for treating various clinical disorders, resulting in what has been called *empirically-supported treatments* (ESTs). Although the findings of these clinical trials have provided important information for clinicians, they unfortunately do not offer all the information needed in using these treatments in clinical practice. Applying

*continued on page 6*

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these findings to clinical practice often involves modification and, among other things, dealing with patients' cultural values, beliefs, and preferences.

The use of randomized controlled trials (RCTs) has been modeled on research evaluating the efficacy of new drugs. Once a drug has been shown to be effective in two clinical trials, it is approved by the FDA for clinical use. There is, however, a mechanism in medicine whereby practicing physicians can report back to the FDA about their clinical experiences—particularly the difficulties they encounter when using these empirically supported medications in practice. Up until recently, no similar mechanism has been available for psychotherapy interventions demonstrated to have efficacy based on RCTs. The clinical feedback from those in the field, in our opinion, is critical to effectively shape clinical science.

In 2010, the first author was elected President of the Society of Clinical Psychology, Division 12 of APA, and began a presidential initiative to build a Two-Way Bridge between Research and Practice. The initiative established a mechanism whereby practicing clinicians could provide researchers with feedback about their clinical use of ESTs whose efficacy was supported by RCTs. We may usefully conceptualize such clinical observations as offering what is known in the sociology of science as “the context of discovery” (Reichenbach, 1938). Specifically, these clinical observations can help to point to those mediating, moderating, and contextual variables that were missing in clinical trials, but which nonetheless are important for the effective application of these interventions in practice. In 2011, the Two-Way Bridge initiative became a collaborative effort together with Division 29 (Society for the Advancement of Psychotherapy) when the fifth author was

serving as president.

In supporting this Two-Way Bridge initiative, the Society of Clinical Psychology and the Society for the Advancement of Psychotherapy appointed a diverse subcommittee to spearhead the effort. In addition to the first author as Chair, the committee consisted of: Louis Castonguay, Jairo Fuentes, Jeffrey Magnavita, Michelle Newman, Linda Sobell, and Abraham Wolf. In our initial survey of practicing clinicians, which was internationally advertised and conducted online, therapists were asked to report on their experiences in using Cognitive-behavioral therapy (CBT) in the treatment of panic disorder (at the time, CBT was the only approved EST for this clinical problem). In addition to the questions asked of all participating clinicians, we also requested information about certain key classes of variables that they found to interfere with the clinical effectiveness of CBT in treating panic in actual practice, including:

- variables associated with patient symptoms
- patients' other problems or characteristics
- patient expectations about treatment
- patient beliefs about symptoms
- patient motivation
- social system (home, work, other)
- problems/limitations with the intervention procedure
- therapy relationship issues

The reason we wanted to know about factors that interfered with the successful treatment in clinical practice was to identify those variables that would provide important issues for therapy researchers to investigate. In addition, identifying factors that could interfere with successful treatment could also

*continued on page 7*

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provide valuable information to practitioners that could enhance their clinical effectiveness.

Since the initial survey of therapists on their experiences in dealing with panic disorder patients, the Two-Way Bridge initiative has looked at clinical experiences associated with the use of empirically supported treatments in dealing with social anxiety and general anxiety disorder. The findings of these three surveys, together with the supportive comments by two internationally known therapy researchers—Dianne Chambless and Tom Ollendick—have appeared in the journal *Behavior Therapy* (Chambless, 2014; Goldfried et al., 2014; Jacobson, Newman, & Goldfried, 2016; McAleavey, Castonguay, & Goldfried, 2014; Ollendick, 2014; Szkodny, Newman, & Goldfried, 2014a; Wolf & Goldfried, 2014). The published results are also posted on the Two-Way Bridge website ([www.stonybrook.edu/twowaybridge](http://www.stonybrook.edu/twowaybridge)).

The following survey focusing on PTSD has been conducted, analyzed, written up, and submitted for publication:

Lauren E. Szkodny, Michelle G. Newman, and Marvin R. Goldfried (2014b): The Use of Empirically Supported Psychological Treatments for

Posttraumatic Stress Disorder in Clinical Practice.

When this survey is published, its availability will be announced on various listservs and the Two-Way Bridge website.

The overall objective of the Two-Way Bridge initiative is to call attention to the importance of having a mechanism whereby the dissemination of clinical observations can be sent to therapy researchers. In doing so, what gets created is a productive synergy, allowing *both* clinicians and researchers to have a voice in forming a consensus, and in jointly developing practice guidelines. The potential is for the advancement of psychological practice, with research in psychotherapy being informed and advanced by clinical practice, thereby leading to future research that is timely and that has greater clinical relevance.

**Editors' Note:** This article is being simultaneously published in *The Clinical Psychologist*, the official publication of Division 12.

**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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**CONGRATULATIONS TO THE 2016  
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**Héctor Fernández-Alvarez** has been selected as the recipient of the American Psychological Association (APA) 2016 Award for Distinguished Contributions to the International Advancement of Psychology.

This award is in recognition of his sustained and enduring contributions to international cooperation and to the advancement of knowledge of psychology.



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### Sculpting Psychotherapy Integration in Argentina: The Aiglé Project 1977-2016.

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#### **An Introduction to Aiglé**

Aiglé Foundation is a 38-year-old non-governmental organization (NGO) that focuses on the professional development of mental health practitioners and the delivery of clinical and community services. *Aiglé* is a classical Greek word that means “shining,” “radiant,” or even “illumination.” Today, *aiglé* is the term used for the torch carried by Olympic athletes. The clearest definition is an everlasting flame.

Aiglé was founded by Héctor Fernández-Alvarez with a group of colleagues during harsh conditions in Argentina. In 1976 the country had been taken over by a military government at the height of military repression and became a hostile environment for dissent and for psychology. In this climate, the founders initiated Aiglé as a space of freedom to develop knowledge and clinical practice, and began a systematic, close contact and collaboration with psychologists overseas. As Consoli, Corbella, and Morgan Consoli (2013) point out, this international engagement became the “oxygen” that sustained the group at a moment when the circumstances were quite asphyxiating and dangerous.

The first decade of our development (1977-1987) was devoted to giving shape to the project. Perhaps the most novel feature was the organizational structure of the project itself. We became a cohesive group based on trust, mutual collaboration, efforts in conflict resolution and work, work, work. We tended to a

broad spectrum of patients suffering from a wide range of clinical conditions and representing a broad cross-section of the Argentine society. These experiences provided the basis for much study and research.



In the 1990s Aiglé became a full-fledged institution. It joined the NGO sector as a self-managed and self-supported foundation and has remained so to this day. Our staff increased in number and we traveled throughout our country and abroad. Being exposed to other places and environments enabled us to incorporate new knowledge, better confront and deal with our proposals, and build an invaluable network of researchers and practitioners.

Over time, we reached a level of recognition that filled us with pride and satisfaction. At present, Aiglé focuses on the professional development of mental health practitioners and the delivery of clinical and community services—both informed by an active research program that evaluates the process and outcome of training and care. We developed a theoretical model tailored to our practice and as a common basis for our multifarious activities.

*continued on page 10*

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A graduate training program is conducted jointly with public and private universities and with an agreement with the Ackerman Institute for the Family, New York. Training is delivered in Buenos Aires and in eight cities in the country. Faculty members of Aiglé also travel regularly to teach in other countries in Latin America and Spain. Established exchange programs for graduate students also exist with institutions. Psychologists and psychiatrists from Chile, Colombia, Ecuador, Guatemala, Paraguay, Uruguay, and Venezuela, as well as Italy, Spain, and the United States of America, annually engage in professional practicum and internship programs at our institution.

Research work started early on. The institution conducts research in collaboration with other academic centers in the country and abroad and takes part in multi-site research programs. The activities in this area are characterized by strong communication between clinicians and researchers and efforts to translate knowledge into clinical applications and training aims across an extensive range of interests, including the study of clinical problems such as obsessive-compulsive disorders, single-case studies, and the integration of different theoretical approaches. Special efforts have been devoted to the development and study of personal style of the therapist as a construct; after 20 years, this development well illustrates our integrative perspective of psychotherapy and the productiveness of collaborations across national borders.

Since 1992, the institution has published the journal *Revista Argentina de Clínica Psicológica*, indexed and/or abstracted in international databases, which includes papers from all over the world. From its beginning, the journal became an important media for the dissemination of cutting-edge psychological knowledge

for Spanish-speaking readers. The journal has been particularly instrumental in facilitating a fruitful interchange of ideas in clinical psychology.

Last, but by no means least, the institution is committed to social outreach, providing professional help to food kitchen centers, teenage mothers' shelters, hospitalized children, and elderly people, as well as psychological care to populations with limited economic resources.

Today, a large network of therapists in the country follows an integrative philosophy in practice, training, and research based on the values of openness and collaboration. Aiglé has centers throughout Argentina, as well as in Guatemala and Spain.

Our ongoing commitment to the discipline has been underscored most recently by Héctor Fernández-Alvarez being recognized as the recipient of the APA 2016 Award for Distinguished Contribution to the International Advancement of Psychology.

However, we never stop being aware of the challenges that the future may hold for us. We know we have to continue innovating in order to prove ourselves and keep growing. The need to continue to develop is one of the growing pains in any organizational project. Being aware of the difficulties and prepared to overcome the inevitable crises has always been part of our strength—just as the human component remains our substance.

### **Why Integration?**

Aiglé was founded at a time when psychoanalysis was, in our country, dominant in the field. This resulted in rich intellectual production and the sparking of the collective imagination of

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Argentines to the point that they became some of the largest consumers of psychotherapy. Psychotherapy was expanding in the world and the different approaches were contributing to the growing and diverse demand. Practice-related, theoretical, and training needs called for greater openness and clinical flexibility. It was in this cultural and scientific environment, and looking to both preserve traditional methods while simultaneously moving toward new ways to channel our work in the field, that Fernández-Alvarez (1992, 2008a) developed the Aiglé Model of Integrated Psychotherapy. Proposing a model based on integration meant, at first, being pushed to the margin in our field. Fortunately, a few years later the landscape of mental health began to transform. The renovation of models and therapeutic approaches created another environment, and the word “integration” came of age (Fernández-Alvarez, 2008a). This process was facilitated by the regular visit of well-known North American and European professionals who conducted seminars and workshops. Argentine therapists, on the other hand, fed on developments abroad, developing new and unique versions of these practices in their own work (Fernández-Alvarez, 2008b).

In the first issue of the *Revista Argentina de Clínica Psicológica*, Safran (1992) described the barriers to psychotherapy integration and viewed different therapeutic orientations as cultures. The author stated that the process of integration can proceed through engaging in a dialectical process in which adherents to different worldviews discuss their relative positions in an open-minded way. The development and maintenance of a truly integrative spirit should be the goal of the integrative movement (Wachtel, 2010). As Gelso (2011) pointed out almost twenty years after: “It would seem that the days when it was seen as nearly

sinful to draw from different theories... are thankfully gone” (p. 184). Although, some caution needs to be taken since there is no solid empirical evidence indicating integrative treatments are superior to single-theory treatments.

By integration, we mean not just a method, but an attitude and philosophy: an ongoing dialectical process between “the one and the many,” between the similar and different, between me and us. Integration is at the heart of our *modus operandi*, in all the dimensions influencing psychotherapy practice.

### **How Do We Integrate in Psychotherapy?**

Psychotherapy practice is a combination of clinical experience and evidence based knowledge, an application of clinical methods, and interpersonal relationship.

The Aiglé Integrated Psychotherapy Model was developed to provide a common basis for all treatments and, at the same time, a tailored plan for each clinical condition. The model allows treatment planning with different goal levels, ranging from addressing symptoms to personality patterns and communication problems with diverse therapy formats: individual, family, couples and/or group therapy, and/or with other treatments (e.g., pharmacotherapy, nutrition therapy, social assistance).

The model examines clinical problems in the light of two main axes: 1) a vertical (or synchronic) one related to the type of process, to explain the genesis and maintenance of the pathological processes, involving development and personal history; and 2) a horizontal (or diachronic) one, involving the individual-context interaction (Fernández-Alvarez, 2008a; Fernández-Alvarez, Gómez, & García, 2015).

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The overall objective is to expand awareness and to increase functional processing. The four traditional modalities provide different perspectives for a constructive psychological transformation. Psychodynamic approaches focus on the dynamic reactions; cognitive-behavioral approaches focus on behaviors and dysfunctional cognitions; humanistic approaches focus on the person as a whole, emphasizing self-consistency and personal decision making; and systemic theories focus on interactive systems' influence (Längle & Kriz, 2012). Cognitive psychology is the basis for the integration of these perspectives into our model, and diverse procedures were selected to accomplish goals agreed upon by patients and therapists as part of the construction of a strong therapeutic alliance.

The optimal match between therapist(s) and patient(s) is central to our work model. In referring to specialized therapists, we take into account the presenting problem, patients' characteristics, and the professional and personal characteristics of potential therapists.

### **Aiglé and the World of Integration**

From its beginnings, psychotherapy integration stemmed from the desire to look beyond school boundaries to see what could be learned and how patients could benefit from a broader approach. It eventually developed into a consolidated movement in the 1980s (Norcross & Goldfried, 2005). Psychotherapy Integration was substantially strengthened by an international association, the *Society for the Exploration of Psychotherapy Integration* (SEPI), which was founded in 1983.

SEPI is an international, interdisciplinary organization. The aim of the organization is to promote the development of psychotherapies that integrate theoretical orientations, clinical practices, and

diverse methods of inquiry. The organization encourages the participation of members from diverse cultures, regions, countries, racial/ethnic backgrounds, and religions. In 1990 we began to spread the word in Argentina and the region. In 1994 SEPI held its annual Conference in Buenos Aires, the first time ever in a Latin American country. Héctor Fernández-Alvarez, who was Coordinator of the Regional Latin-American Network, became the Chairperson of the Program Committee and Beatriz Gómez, the Organizing Committee Chair.

A fruitful relationship between SEPI and Aiglé continued up to the present day. Fernández-Alvarez serves as chair of the Education and Training Committee and in 2016 Beatriz Gómez will be the first non-North American President of SEPI. This means a meeting point between Aiglé's continuous interest in building integration and SEPI's continuous interest in expanding its outreach. The next SEPI Conference will be held in Dublin, Ireland, in June, 2016. Beatriz Gómez, together with an enthusiastic group forming the Program Committee and an active Executive Committee integrated by SEPI's founders and by international members, foresees an exciting meeting at Trinity College. The aim is sharing clinical work, research findings, and educational practices. The organizing committee welcomes participants with a quotation attributed to W. B. Yeats: "There are no strangers here, only friends you haven't yet met." This is precisely how integration is meant.

In Latin America, Fernández-Alvarez together with colleagues from Chile, Ecuador, and Uruguay founded the *Latin-American Association of Integrative Psychotherapy* (ALAPSI) in 2006, aimed at promoting clinical interchange and communication between therapists and

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training institutes in the region. It is noteworthy to point out that psychotherapy in Latin America faces difficult community conditions. In many situations, it is necessary to use a broad array of resources to meet the needs of populations with scarce resources. This goal is the driving force for the development and interchange of a variety of approaches and procedures among therapists of the region. The Association will be holding its next conference in 2016 in Argentina.

**Towards More/New Integration**

As Gelso (2011) stated, “the term, integration, may be defined as the combining or putting together of different elements into some broader element or whole. Such integration may be seen as a sign of the maturation of a field or body of knowledge” (p. 182). It involves sculpting integration in a variety of ways: Establishing connection between different domains of knowledge and practice, fostering the joint work of mental health practitioners, and facilitating collabora-

tion of practitioners and researchers. As Goldfried (2010) stated, this “collaboration [may] serve as the organizing force for integration [in this] century” (p. 395).

In the near future, professionals will be entrusted to increase health promotion, primary care, community programs, and efficient treatments to reach all populations, especially the ones who do not currently have access to psychological services. Continuing to build integration is a promising avenue in this direction.

We continue working in Aiglé, and though we certainly face difficulties, it is consistently rewarding. Sculpting integration is an open-ended endeavor; while we do so, we keep passing on the torch.

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



**NOTICE TO READERS**

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

**CONGRATULATIONS TO THE RECIPIENT OF THE SOCIETY  
FOR THE ADVANCEMENT OF PSYCHOTHERAPY 2015 DIVERSITY  
RESEARCH GRANT FOR PRE-DOCTORAL CANDIDATES!**



**Jay N. Bettergarcia, MA**, is currently a doctoral candidate in the Counseling, Clinical, and School Psychology PhD program at the University of California, Santa Barbara. Jay's scholarly interests include non-dominant narratives in trans\* communities, transgender-affirming therapy, process and outcome research with diverse clients, receptiveness and resistance to teaching and training about diversity-related topics, and the policy implications of research. Jay also earned an MA in social psychology from San Francisco

State University studying the research methods for capturing accurate data about transgender and gender diverse individuals in the social and medical sciences.

**Title of project:** *Effects of therapist reactions to client's transgender identity on the therapeutic relationship: An analogue study*

**Abstract**

Transgender and gender non-binary (TGNB) individuals seek mental health counseling for a variety of reasons (Bockting, Knudson, & Goldberg, 2006), however, their experiences of therapy are not always positive, and some experiences are quite negative (Rachlin, 2002). The present study investigates how a therapist's response to transgender identity exploration affects the therapeutic relationship. An analogue design was used to assess TGNB participant's perceptions of a therapist across three mock therapy videos: transition affirming, non-binary affirming, and non-affirming interactions. Over 600 TGNB participants rated the therapist's expertness, likability, trustworthiness, and the session smoothness, depth, positivity, and arousal. The goal of the study is to understand how slight variations in the therapeutic encounter and the TGNC participants desire to transition or not transition may effect their perceptions of the therapist and the therapeutic interaction. This study provides a more nuanced understanding of affirming therapeutic services with transgender and gender non-binary individuals and will be used to train mental health providers.

**The Society for the Advancement of Psychotherapy (Division 29)  
Diversity Research Grant for Pre-doctoral Candidates**

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

The Division may award annually a \$2,000 Diversity Research Grant to a pre-doctoral candidate (enrolled in a clinical or counseling psychology doctoral program) who is currently conducting dissertation research that promotes diversity, as outlined by the American Psychological Association (APA). According to the APA, diversity is defined as individual and role differences, including those based on age, gender, sexual orientation, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status. The application deadline for next year is April 1, 2016, and interested applicants should email the Diversity Domain Representatives, Jairo Fuertes, PhD (jfuertes@adelphi.edu) and Beverly Greene, PhD (bgreene203@aol.com). For further information, please visit the Society's website (<http://societyforpsychotherapy.org/members/awards/diversity-research-grant-pre-doctoral-candidates/>).

## Clinicians' Self-Judgment of Effectiveness

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Department of Psychological and Brain Sciences,  
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### Background

Research has demonstrated significant between-therapist variability in both process (e.g., working alliance) and outcome (e.g., symptom reduction), pointing to the so-called therapist effect (Baldwin & Imel, 2013). Although still in its infancy with regard to empirical scrutiny,

thinking in this area has largely assumed that more effective therapists possess specific characteristics that foster consistently positive processes and outcomes with all of their clients. The possibility that therapists possess strengths and weaknesses (e.g., certain therapists are more effective with certain types of clients) has received less attention from both researchers and therapists themselves. As therapists, if we assume that we are generally and equally effective with all of our clients, this will likely have implications for our decision making and client care (e.g., the clients we choose to see, referrals that we make [or do not make], whether or not we seek feedback, and our use of outcome measurement to guide treatment).

Previous research has shown that when asked about their general effectiveness, most therapists report that they are more effective than the average therapist (the so-called “Lake Wobegon ef-

fect”; Walfish, McAlister, O’Donnell, & Lambert, 2012). Furthermore, when based on clinical judgment alone (compared with actuarially guided judgments), therapists are much less accurate in predicting whether or not a particular client will deteriorate or drop out of treatment (Hannan et al., 2005). To date, research in this area has primarily focused on global measures of outcome. However, some research suggests that therapist effectiveness may differ across problem domains (Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Kraus et al., 2015). Thus, investigations of therapist effectiveness (and, consequently, “therapist effects”) and the accuracy of therapists’ judgments of their own effectiveness may benefit from greater specificity.

For example, Kraus et al. (2011) demonstrated that the majority of therapists in a large naturalistic sample had clients who demonstrated improvement in multiple domains of psychopathology and functioning (measured by the Treatment Outcome Package, TOP; Kraus, Seligman, & Jordan, 2005). However, the precise domains in which these improvements were observed differed among therapists; certain therapists had clients who consistently demonstrated improvements in depression, while others had clients who consistently demonstrated improvements in social functioning. Therefore, there may be a specificity or “matching” factor that

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helps explain the relative effectiveness of different therapists, as well as the accuracy (or inaccuracy) of therapists' judgments of their own effectiveness. Furthermore, inconsistent with therapists' belief in their overall effectiveness with their clients, Kraus et al. (2011) found that many therapists have at least one area in which they demonstrate reliable deterioration with their clients. These findings were largely replicated in another large therapist and client sample (Kraus et al., 2015), yet this more recent study applied a risk-adjustment model that accounted for diverse client characteristics, similar to the approach taken by Saxon and Barkham (2012).

If it is true that therapists are differentially effective with their clients, it is crucial to find methods to help therapists predict with whom they are likely to be more or less effective. Given the limitations of therapist self-ratings of general effectiveness and clinical judgment alone, there is a pressing need for more robust methods to assess therapist effectiveness in treating different problem domains. Employing a multi-dimensional outcome tool has immense promise for harnessing the potential specificity of therapist effectiveness in the service of enhancing client care. Consequently, the goals of this mixed methods study are to examine (a) therapists' predictions regarding their own effectiveness with particular types of clients, by comparing perceptions of effectiveness across a number of domains (including working alliance formation and symptom reduction) with data derived from multidimensional routine outcome monitoring (ROM), and (b) the factors that contribute to therapists' judgments regarding their effectiveness, or lack thereof, with particular clients.

### **Method**

We are recruiting psychotherapists ( $N=40$ ) practicing in community mental

health care (CHMC) settings. There are no specific exclusion criteria beyond willingness to comply with study procedures. We anticipate that the final therapist sample will resemble that from our previous work on therapist effects in community settings (Kraus et al., 2011; Kraus et al., 2015), with therapists averaging 10 or more years of experience. Various training backgrounds will also be represented, including, but not limited to, psychologists, mental health counselors, social workers, and clinical nurses.

### **Measures**

*Treatment Outcome Package* (TOP; Kraus et al., 2005). The TOP will serve as the primary outcome measure, and its subscales will form the basis of therapists' domain specific effectiveness predictions. The TOP evaluates behavioral health symptoms, functioning, and case mix variables. It consists of 58 items assessing 12 symptom and functional domains (risk-adjusted based on case mix assessment): work functioning, sexual functioning, social conflict, depression, panic (somatic anxiety), psychosis, suicidal ideation, violence, mania, sleep, substance abuse, and quality of life. Global symptom severity can also be assessed by summing all items or by averaging the z-scores across each of the 12 clinical scales. Domain-specific symptom severity is quantified as the risk-adjusted individual z-scores for each clinical scale. The TOP has been shown to have excellent factorial structure, as well as good 1-week test-retest reliability across the 12 scales. It is sensitive to change while possessing limited floor and ceiling effects. The TOP also has demonstrated good convergent validity.

*Working Alliance Inventory, Short Form* (WAI-S; Tracey & Kokotovic, 1989). The 12-item WAI-S assesses three dimensions of the therapeutic relationship outlined by Bordin (1979): (a) agreement on

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goals (goals), (b) agreement on how to achieve these goals (tasks), and (c) the affective relationship (bond). A total alliance score can also be calculated. Internal consistency is strong, with *alphas* ranging between .89 and .98.

*Effectiveness Predictions.* We will obtain two types of ratings to examine the stability or variability in self-ratings across the 12 TOP domains and the WAI-S. One rating will be a Likert scale rating of effectiveness across all TOP domains. For example, "In treating your clients' symptoms of DEPRESSION, would you say you are: (1) *Always ineffective* to (7) *Always effective*?" (middle anchor [4] *Inconsistently effective*). The working alliance item will ask about their effectiveness at establishing a positive working alliance with their clients. These ratings will allow us to see if some therapists truly see themselves as "generalists" who are good at most things, or how many self-rate more as "specialists." The second type of rating will be a rank ordering of relative effectiveness across the 12 TOP domains (e.g., most effective in treating depression, followed by anxiety, substance use, etc.).

### **Procedure**

Volunteering therapists first complete the symptom domain and working alliance prediction items (along with a general information questionnaire). Addressing our first research question, we then select the predicted highest- and lowest-rated domains for each therapist. We will then compare how these therapists perform across multiple clients (minimum  $n=5$  per therapist) in their caseloads with regard to their clients' reported alliance ratings and outcome scores in these problem domains. We also will conduct comparisons across all therapists and their respective clients to see if therapists indeed reliably produce better alliances and outcomes in the domains of client functioning for which

they see themselves as being more effective, relative to domains in which they perceived themselves as being less effective. Addressing our second question, we will also ask a random subset of therapists ( $n=15$ ) via semi-structured interview about the factors that contributed to their judgments regarding their effectiveness, or lack thereof, with particular clients. These responses will be examined qualitatively with consensual methods.

### **Anticipated Outcomes**

Despite emerging evidence indicating potential domain specificity in effectiveness (Kraus et al., 2011; Kraus et al., 2015), we anticipate finding more generalist tendencies than specialist tendencies in self-ratings, which also reflects the current and historical state of clinical training. However, given the lack of research in this area, the aims of this study are largely exploratory. If therapists are not accurate prognosticators (e.g., have clients who fail to demonstrate either positive alliances or improvements in domains that were self-perceived to be particular strengths), this would support the importance of providing therapists with multi-dimensional feedback via routine outcome and alliance measurement and perhaps helping them to consider additional training or supervision in particular areas. Conversely, if the results run counter to this, it would suggest that therapists might be good at predicting their areas of relative competence. In our view, effective therapists possess a balanced view of their relative strengths and weaknesses in addressing particular problem areas and clients. This awareness should lead them to work more often with particular clients, to seek particular training experiences that address areas of relative struggling, and/or to limit their practices to specialty areas of known efficacy. A thera-

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pist's relative accuracy in making these determinations has important implications for client care, the use of measurement tools, and better understanding of the nuances of the therapist effect.

### Lessons Learned

We would like to end this article by "meta-communicating" about the process of implementing this research. As noted, this study is being conducted in routine community mental health settings and involves both therapists and their clients. This research does not involve archival data (e.g., secondary analyses of de-identified routine outcomes data) or a university-based clinic staffed by graduate student trainees. We are in no way diminishing research involving archival data or research that is conducted with graduate trainees. We have conducted, and will continue to conduct, such research. However, for this particular study, we elected to adopt a community-based participatory research approach. In doing so we have faced various obstacles to study implementation and have only recently reached the initial recruitment phase. These obstacles were not entirely unanticipated. We have written elsewhere about potential barriers to the implementation of ROM and process research in community treatment settings (see Boswell, Kraus, Miller, & Lambert, 2015; Castonguay, Boswell et al., 2010; Castonguay, Nelson et al., 2010).

One consequence of a truly collaborative approach to community-based research is that participants play multiple roles and partnering institutions must navigate those roles when reaching formal work agreements. For example, a CMHC may have multiple layers of internal review that are completely removed from an academic institution's internal review board (IRB). Perhaps not surprisingly, these boards may have unique concerns regarding the study

procedures, and the solution for one problem that is raised by organization A may directly contradict a demand from organization B. Furthermore, because they are not research institutions, many CMHCs do not carry a federal wide assurance number, which may be a requirement for some academic institutions to engage in collaborative research. In short, the complexities of this research approach require a high degree of open communication and considerable patience. Thankfully, more academic institutions are seeing the value of community-based and community-engaged research and are becoming less inclined to rigidly apply old rules to new methods. Fortunately, we have also received tremendous support from Division 29 throughout this process, and we are extremely grateful for this.

**Authors' Note:** We are honored and delighted that we were awarded the Norine Johnson Psychotherapy Research Grant by Division 29 of the American Psychological Association (APA). This generous grant provides a unique opportunity to study therapist factors, which is an area of research that is rarely supported by external funding. We are fortunate to have this support to further our research program on therapist effects and measurement-based care in routine treatment settings.

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

<sup>1</sup>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,

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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 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.

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A graphic featuring a globe, a computer monitor, and a stethoscope. The text 'FOR THE ADVANCEMENT OF PSYCHOLOGY' is at the top, 'SOCIETY FOR THE ADVANCEMENT OF PSYCHOLOGY' is on the left, 'PSYCHOLOGY' is on the right, and 'CAN PSYCHOLOGICAL ASSO' is at the bottom.

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## **Division 29 Psychotherapy** Of the American Psychological Association (APA)

### **CALL FOR NOMINATIONS**

#### *Distinguished Psychologist Award*

The APA Division of Psychotherapy invites nominations for its 2016 *Distinguished Psychologist Award*, which recognizes lifetime contributions to psychotherapy, psychology, and the Division of Psychotherapy.

**Deadline is January 31, 2016. All items must be sent electronically.** Letters of nomination outlining the nominee's credentials and contributions (along with the nominee's CV) should be emailed to the Chair of the Professional Awards Committee, Dr. Rodney Goodyear, at [rodk.goodyear@gmail.com](mailto:rodk.goodyear@gmail.com)

#### **Call for Nominations**

#### *Division 29 Award for Distinguished Contributions to Teaching and Mentoring*

The APA Division of Psychotherapy invites nominations for its 2016 *Award for Distinguished Contributions to Teaching and Mentoring*, which honors a member of the division who has contributed to the field of psychotherapy through the education and training of the next generation of psychotherapists.

Both self-nominations and nominations of others will be considered. The nomination packet should include:

- 1) a letter of nomination describing the individual's impact, role, and activities as a mentor;
- 2) a vitae of the nominee; and,
- 3) three letters of reference for the mentor, written by students, former students, and/or colleagues who are early career psychologists. Letters of reference for the award should describe the nature of the mentoring relationship (when, where, level of training), and an explanation of the role played by the mentor in facilitating the student or colleague's development as a psychotherapist. Letters of reference may include, but are not limited to, discussion of the following behaviors that characterize successful mentoring: providing feedback and support; providing assistance with awards, grants and other funding; helping establish a professional network; serving as a role model in the areas of teaching, research, and/or public service; giving advice for professional development (including graduate school postdoctoral study, faculty and clinical positions); and treating students/colleagues with respect.

**Deadline is January 31, 2016. All items must be sent electronically.**

The letter of nomination must be emailed to the Chair of the Professional Awards Committee, Dr. Rodney Goodyear, at [rodk.goodyear@gmail.com](mailto:rodk.goodyear@gmail.com)

## EDUCATION AND TRAINING

### A Collaborative Study of Development in Psychotherapy Trainees

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*Svenja Taubner, Ph.D.*  
*University of Klagenfurt, Austria*

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*Örebro University, Sweden*



In an era when many in our field are preoccupied with defining the nature of empirically supported psychotherapies (e.g., American Psychological Association, 2006) and empirically supported therapy relationships (e.g., Norcross, 2011), it was only a matter of time until those responsible for training therapists began to ask whether there are yet any empirically supported methods and modes of psychotherapy training that reliably stimulate and support the development of trainees and candidates (e.g., Strauss, 2015). Logically, the question would go something like this: How can empirically supported relationships be formed to provide clients with empirically supported therapies, other than by therapists who have

been trained with empirically supported methods?

#### **Background to Research**

About five years ago, questions like this became so salient for many belonging to the Society for Psychotherapy Research (SPR) that a special interest section was organized to foster research on this topic, taking as its name the “SPR Interest Section on Therapist Training and Development” [SPRISTAD; Society for Psychotherapy Research (SPR), 2011].

SPRISTAD members began to meet regularly at international and regional confer-

*continued on page 22*

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ences, and discussed how the limitations of current research on training and development could be overcome. One of the key limitations stems from the relatively small number of trainees in research-oriented training programs, so that local projects typically must use small samples. Discussion led to the view that this limitation could be surmounted by combining local resources through conducting a collaborative multi-site study.

Another practical constraint is the limited amount of time in which studies must be done, leading to widespread reliance on cross-sectional designs that compare groups of trainees at different levels, rather than following the same trainees as they progress through the program. Even when funding can be obtained, the term of research grants is often shorter than the course of training, and the masters or doctoral students enlisted as research assistants have a habit of graduating and launching their own careers. However, surmounting this second limitation also seemed possible through a collaborative project by combining the amounts of time that independent researchers are able to contribute to it. For truly interested researchers, the intrinsic reward of meaningful inquiry and the social reward of intellectual collegiality would be enough to sustain a project long enough to allow a longitudinal research design.

The actual idea to conduct a collaborative, multisite, longitudinal study of development in psychotherapy trainees was inspired by a recently published review of studies on training and supervision completed by Hill and Knox (2013) for the sixth edition of the *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*. In particular, inspiration came from the following recommendation made by the authors after surveying the literature:

Multisite longitudinal studies need to be conducted, including careful recording of amounts, types, and quality of training and supervision. In such stud-

ies, the amount and quality of personal therapy, personal relationships, and major life events also need to be recorded, because such variables likely interact with the effects of training and supervision. By collecting data at multiple sites, researchers would have large samples, and so would have enough power to investigate the effects of sites, types of training, supervisor characteristics, trainee characteristics, and client characteristics. Given that multisite studies have now been conducted for psychotherapy (e.g., NIMH TDCRP, NCCTS), we have models for how to conduct such research for training and supervision. (p. 803)

### **Evolution of the SPRISTAD Study**

A decision was taken by SPRISTAD members attending the 2012 international SPR conference (in Virginia Beach, Virginia) to design and implement a collaborative multi-site longitudinal study with colleagues who volunteered their time, energy, and ideas. Initial planning for the project was delegated to the SPRISTAD Steering Committee (at that time: Orlinsky, Strauss, Hill, Castonguay, & Carlsson), with a report to be made at the following year's conference.

**Goals.** The Steering Committee framed the *goals for the study* of development in trainees as therapists to include: (1) tracking progressive changes over time in trainees as therapists; (2) identifying factors that tend to facilitate or impede trainee development; and (3) doing so using quantitative and qualitative data gathered from a large number of psychotherapy trainees of varied types in a wide range of training programs.

**Definitions.** Some key concepts in this formulation were explained as follows:

1. *Professional development* involves learning and gaining proficiency in the *psychotherapist role*, both in terms of therapist *role-identity* (self-experience as a

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therapist) and in terms of therapist *role-performance* (working with clients in therapy). Thus, evidence of development ought to be seen both in (a) constructive evolution of the trainee's *role-identity* in interactions with the therapist's typical "role-others" (e.g., clients; supervisors; professional colleagues), and (b) in progressive enhancement of the trainee's *role-performance* as an effective participant in therapy (Rønnestad, Orlinsky & Wiseman, in press).

Accordingly, the study aims to track the development of individual trainees over time by assessing role-identity and role-performance, with specific attention to differential *degrees, rates, and patterns* of development over time. Similarly, because development was defined as "gaining proficiency" as well as "learning," candidates in advanced, as well as initial, professional level training programs will be included in the study.

2. The factors that most directly *facilitate and/or impede* trainee development should in practice be detectable (a) in characteristics of *training programs* in which trainees are enrolled (e.g., theoretical orientations; instructional methods; faculty cohesiveness and morale); (b) in characteristics of the *clinical settings* where trainees are supervised and practice (e.g., difficulty and number of trainee cases; quality of supervisory relationships); and (c) in characteristics of *trainees* themselves (e.g., age; personal background; attachment style; current quality of life). Accordingly, information concerning the three areas of potential influence on development will be systematically gathered in this study.
3. Methodologically, the SPRISTAD study is a *systematic exploratory and inductive* inquiry designed to provide a realistic depiction of trainee development, and to detect the types of training experience that are significantly and differentially related to professional development among therapists in training. Data relevant to trainee

development and the factors that facilitate or impede development will be drawn both from trainees' reports of their experiences as participant-observers and from assessments by outside observers (e.g., supervisors). To provide the richest set of observations, research instruments will include both systematic structured-response measures and open narrative-response questions, providing material both for *qualitative and statistical analyses*.

**Instruments.** The work of designing research instruments to obtain the specific information sought for the study came next. This took another year of extensive consultation with colleagues and feedback from trainees in various settings about the relevance of the questions we asked to their experiences in training, practice, and supervision. Ultimately five instruments were created, three of which will be "core" instruments that all participants will use, while two will be available as "optional" instruments for use by colleagues having a special interest in the supervisory process.

The "core" instruments include: (1) a *Training Program Description Form*, completed by the training director or a senior staff person at each participating training program to define salient characteristics of the training environment; (2) a *Trainee Background Information Form*, completed by participating trainees on entering the study to describe aspects of their lives and selves that will not or are not expected to change over time; and (3) a *Trainee Current Practice Report*, the "longitudinal" instrument to be completed by participating trainees at intervals to track changes over time in their role-identity and role-performance as therapists.

The starting point for work on the *Training Program Description Form* (TPDF) was an instrument that was previously developed and used by Strauss and colleagues (2009) in Germany to survey the training programs for therapists in their country. This was ed-

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ited, abridged, and adapted for use by a broader variety of training programs in an international context: programs that offered initial or advanced professional training, that were university-based or sponsored by independent institutes, that were identified with different mental health professions, and that represented multiple theoretical orientations.

Work on the *Trainee Background Information Form* (TBIF) and the *Trainee Current Practice Report* (TCPR) began by drawing on items from the *Development of Psychotherapists Common Core Questionnaire* (DPCCQ; Orlinsky & Rønnestad, 2005; Orlinsky, Rønnestad & Willutzki, 2010). Items from the DPCCQ reflecting *stable* therapist attributes formed the initial nucleus of the TBIF, and items reflecting *varying* aspects of practice formed the heart of the TCPR (the longitudinal measure). The DPCCQ itself has been used extensively in cross-sectional surveys over the past 25 years. Data have been amassed by members of the SPR Collaborative Research Network (CRN) from more than 11,000 therapists at all career stages in different mental health professions, using varied theoretical orientations, and in a wide range of countries. The CRN database currently includes about 2,000 early career therapists who can be compared in many respects with the SPRISTAD study trainees. Final versions of the TBIF and TCPR benefited from extensive discussion with SPR colleagues at meetings in Brisbane, Australia; Oxford, England; and Memphis, USA, as well as feedback from trainees who volunteered to pilot-test the instruments.

These “core” instruments will be accessed online privately by study participants anywhere in the world via connectivity with a central SPRISTAD web data manager, eliminating the time consuming (and error prone) process of coding responses from paper-and-pencil format to a computer database. Parallel versions of the instruments will be available online in multiple languages, and have already been or are being mounted in

Danish, Dutch, English, Finnish, German, Hebrew, Italian, Lithuanian, Norwegian, Portuguese, Romanian, Slovenian, Spanish, and Swedish.

The SPRISTAD study further includes two “optional” instruments that focus on trainees’ role-performance in particular treatment cases, in contrast to the TCPR which focuses on a trainee’s overall experiences in current practice. The *Trainee Case Progress Report* (TCPR/c) and the parallel *Trainee Supervisor’s Progress Report* (TSPR) are adapted from the TCPR, and are intended for longitudinal (repeated measure) use. The two case-level instruments will also be made available online in multiple languages. The basic difference between them is that the TCPR/c represents the *trainee’s view* of the case, while the TSPR represents the *supervisor’s view* of the case, providing a “stereoscopic” view of the trainee’s work from two largely independent observational perspectives, as well as a unique perspective on the supervisory relationship.

#### **Current State of the SPRISTAD Study**

As of November 2015, partners in the Collaborative Study of Development in Psychotherapy Trainees include approximately 50 SPRISTAD members, who were affiliated with more than 35 universities and training institutes in 18 countries (including the United States). As collaborators, they will act as *local research site coordinators* for their own training programs, and in some cases also as *regional research co-coordinators* for nearby training programs that do not have a SPRISTAD member on staff. Online data collection will start soon, first in English and German, and then in other languages, at training programs that opt to become local research sites.

Local research site coordinators will (a) help training programs that agree to participate gain ethical approval for the SPRISTAD study from the institutional review boards

*continued on page 25*

(IRBs) at their own or an affiliated institution (e.g., a nearby participating university); (b) invite trainees and supervisors at their programs to participate in the study; (c) serve as ombudsman to answer questions and concerns, and ensure that the personal and ethical interests of participants are protected; (d) maintain regular communication with the SPRISTAD research committee (SPR, 2011).

Programs, trainees, and supervisors will be provided with detailed information about what the study will involve for them and will be asked to give their informed consent before they are given their own private access to the online research instruments. The SPRISTAD research committee will contract with *training programs* that participate, (a) assuring local research site coordinators the right to use data collected at their sites (with appropriate protections for confidentiality) for their own research projects, and (b) assigning to the SPRISTAD committee responsibility for maintaining a cumulative aggregate database and coordinating other aspects of the study (e.g., organizing collaborative data analyses and joint publication of shared data). *Trainees and supervisors* who participate will have access to all the data that they contribute, enabling them to individually track and reflect on their training and practice experiences over time.

**Invitation to Collaborate**

If you believe it is important to learn about the transformations that occur as individuals progress through training as psychotherapists, and about the factors that facilitate or hinder their development, we invite you to join as a collaborator in the SPRISTAD study.

If those in your training program believe it is important to learn which aspects of training are most (and least) helpful to varying types of trainees at various levels of training, we invite your program to participate as a research site in the SPRISTAD study.

If you are a Director of Clinical Training who wants to show that your program is engaged in a meaningful, scientifically productive form of self-study, together with comparable programs and leading researchers in the field, we invite your program to take part in the SPRISTAD study.

Finally, if you would like to receive more detailed information about any aspect of our Collaborative Study of Development in Psychotherapy Trainees, we invite you to send your questions by email to the SPRISTAD Research Committee at: therapistdevelopment@gmail.com.

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



**NOTICE TO READERS**

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## PSYCHOTHERAPY PRACTICE

### In the Hot Seat: Applying Intensive Short-Term Dynamic Psychotherapy (ISTDP) to Couples Counseling

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Collaboration is at the heart of all psychotherapy models. Therapists collaborate with their clients to achieve desired outcomes. And therapists often collaborate with other therapists – to coordinate care, provide consultation, and develop their clinical skills. It is this last form of collaboration that brought the two of us together to solve problems common to our couples work. When we met, Catherine Lockwood was an American Association of Couples and Sex Therapists (AACAST) accredited Couples and Sex Therapist with over 20 years of experience in the field. I was a relative newcomer to the profession. We met in a course on Intensive Short-Term Dynamic Psychotherapy (ISTDP; Davanloo, 1989) held at UCLA. This course began an extremely exciting time of discovery and innovation in our work.

If it is possible to fall in love with a model of psychotherapy, we both fell hard. ISTDP is a visually and viscerally exciting model. Most ISTDP clinicians videotape their work to improve the timing, dosage, and precision of their interventions, and to review exactly what occurred in a given session. This means that therapists new to the model have a unique opportunity to observe the work

of master clinicians achieving in-session results that look (to the novice) like magic, or close to it. In class, we observed clients on video leaning into intensely painful feelings in undefended and deeply moving ways. And we observed clients encountering long-buried memories and images that often emerged in rapid, detailed, and stunning succession. As newcomers, it was thrilling to witness both the artistry of the process and the end results, which, when viewed on time-lapse video, appeared utterly dramatic. It was undeniable to the viewer that a deep and profound transformation had taken place for these clients.

Shortly after, Catherine and I enrolled in three-year ISTDP core training programs. We began to consult with each other on cases and collaborate on ways to integrate the most effective elements of ISTDP with couples therapy. As ISTDP was originally designed for work with individuals, we found a scarcity of information in the professional literature on the subject of ISTDP and couples therapy (exceptions: Have-de Labije, 2006; Solomon, 2001). Both of us were excited by the prospect of applying a new metapsychology and set of interventions to a series of common difficulties encountered in our work with couples. This paper is a distillation of our research, refinements, and ongoing experimentation, which culminated in a joint presentation (Lockwood & Ikemoto-Joseph, 2015) to members of the

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long-running Couples & Sex Training program developed by Dr. Walter Brackelmanns at UCLA's David Geffen School of Medicine.

In this paper, we aim to share our experience with collaboration, innovation, and the cross-pollination of theoretical models. But first, we thought it useful to provide our readers with a brief overview of ISTDP.

A Brief Introduction to Intensive Short-Term Dynamic Psychotherapy (ISTDP)  
Dr. Habib Davanloo's groundbreaking development of ISTDP in the 1960s has inspired a deeply passionate legacy of researcher-practitioners who continually expand, debate, elucidate, and innovate on Dr. Davanloo's original model (Abbass, Town & Driessen, 2012; Johansson, Town, & Abbass, 2014; Malan & Della Selva, 2007; Neborsky, 2006).

ISTDP operates on the principle that early ruptures in the bond between parent and child lead to intense, complex feelings and impulses that are pushed out of awareness by anxiety and defense mechanisms. Over time, adaptive defenses once necessary for survival become maladaptive to healthy emotional regulation and generalized to all relationships. It is this intra-psycho conflict between unconscious feelings and impulses and the defenses erected against them (resistance) that leads to symptom formation, including psychiatric disorders, functional and somatic disorders, relational difficulties, and self-defeating behaviors (Abbass, 2015; Davanloo, 1989; Have-De Labije & Neborsky, 2012).

Clinicians trained in ISTDP collaborate with their clients to recognize and relinquish self-defeating patterns of defense, especially defensive barriers against emotional closeness. Treatment often begins with the clinician addressing the tactical defenses clients put into operation to

keep the therapist at an emotional distance. The ISTDP clinician encourages intimacy in a direct and honest way, which strengthens both the therapeutic alliance and the client's emotional capacities (Frederickson, 2013; Kuhn, 2014).

Equally important is the ISTDP clinician's ability to help clients healthily regulate their underlying anxiety, which increases when defenses are confronted and relinquished. Working collaboratively in this precise and attuned way quickly builds client capacity, which allows for the breakthrough of long-buried affect and repressed memories in what Davanloo (1995) terms an "unlocking of the unconscious." Once mobilized, these intense feelings, memories, and related attachment ruptures can be deeply processed and healed. This careful restructuring of emotional regulatory capacity together with intense breakthroughs of unconscious affect lead to rapid symptom relief and characterological change, as well as increased self-compassion and improved relationships (Malan & Della Selva, 2007).

### **What Exactly Do We Mean by Anxiety and Defense?**

In our opinion, one of the most revolutionary features of ISTDP is its precise understanding and attention to the physical ways in which anxiety manifests in the body and how anxiety functions together with defense to regulate core affect. We have observed that most clients are unaware of how anxiety is channeled in their bodies. In ISTDP, clinicians are trained to carefully monitor (and teach their clients to monitor) precise symptoms of anxiety (Frederickson, 2013), so as to work within the client's optimal "window of tolerance" (Ogden, Minton, & Pain, 2006; Siegel, 1999).

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ISTDP clinicians track anxiety in four major channels. The first and healthiest channel is the patient's voluntary or striated muscles. Anxiety in this channel frequently manifests as deep sighs, tensing, clenching, and fidgeting. We also monitor anxiety in the sympathetic nervous system, which takes the form of dry mouth and throat, racing heart, sweating, cold hands, or shivering. With the parasympathetic or smooth muscle system, the patient might report dizziness, drowsiness, nausea, diarrhea, urgency to urinate, constipation, acid reflux, and sudden loss of muscle tension (e.g., wobbly legs). Cognitive perceptual disruptions may appear as incoherent, delayed or racing thoughts, or reports of visual disturbances, such as tunnel vision, or auditory disturbances, such as tinnitus. Symptoms in these last two channels—the parasympathetic system and cognitive perceptual functioning—indicate the client has exceeded his or her window of tolerance and can no longer healthily regulate anxiety. In other words, he or she has gone over a safe anxiety threshold, and the therapist must intervene immediately to reduce anxiety (Frederickson, 2013; Have-de Labije & Neborsky, 2012).

Why is this important? Because high, unregulated anxiety can exacerbate somatic and depressive symptoms and invite intense projections and misalliance. At lesser levels, it prevents healthy emotional experience and triggers destructive defenses that push others away, including intimate partners and the therapist. The most common defenses we encounter in couples therapy are blaming, criticizing, justification, dismissing, explosive discharge of affect, distancing (also known as withdrawal or stonewalling), sarcasm, intellectualization, rationalization, ignoring, devaluing, dismissal, giving behavioral instructions (e.g., "You shouldn't feel

that way!"), playing the victim and, in extreme cases, dissociation. It goes without saying that if both partners are in an anxious, defensive state, they cannot contain and metabolize their own feelings, let alone the feelings of their partner. In such cases, empathy, healthy co-regulation of affect, and intimacy are impossible.

### **Why Couples Enter Couples Therapy**

In our experience, when couples enter therapy, a great number of them will cite "communication issues" as their presenting problem. Rarely have we observed that couples suffer from an inability to communicate. Rather, they have difficulties in regulating intense feelings, and as a result they become trapped in destructive patterns of dealing with their feelings and each other. Many great couples clinicians, researchers, and theorists have observed similar behavioral patterns with couples, and have detailed them in evocative terms. For example, Susan Johnson (2004) describes repetitive patterns of relating in terms of "Negative Interactional Cycle," while John Gottman (1993) describes certain fixed, hostile interactions as "The Four Horsemen of the Apocalypse." To our mind, all skilled couples therapists seek to apply interventions in a coherent way to interrupt destructive relational patterns and encourage in their place healthy attachment longings and intimacy.

### **An ISTDP-Based Approach to Increasing Intimacy and Repair in Couples**

At its heart, ISTDP can be described as an attachment-system-repair therapy. As ISTDP clinicians who also treat couples, we began to identify the most powerful components of ISTDP that could be applied to interrupt negative interactional patterns while removing barriers to emotional intimacy and facilitating re-

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pair between partners. In this paper, we will address two of these components: The first is the systematic restructuring of the couple's patterns of anxiety and defense, and the second is the positioning of the therapist as a temporary transference figure (M. Skorman, personal communication, February 24, 2015).

### **Restructuring Anxiety and Defense With Couples**

One of the advantages of ISTDP is its ability to show clients in real time what is getting in their way—which, from our perspective, is a reciprocal pattern of anxiety and defense that blocks vulnerability and complex feelings, which in turn blocks intimacy.

For example, when Partner A begins to detail her frustrations with Partner B, the therapist can help both partners observe that Partner B's anxiety is being channeled into his striated muscles and sympathetic nervous system in the form of full body muscle tension and a dry mouth, which then results in the defenses of intellectualization and breaking eye contact, which he deploys in an attempt to regulate both his rising anxiety and his underlying feelings of anger and sadness.

These precise, moment-to-moment interventions work especially well because they keep the focus on what is happening emotionally in the room. With the help of the therapist, the couple's anxiety and defense patterns can be directly observed by both partners and restructured on the spot. If skillfully applied, this approach has the advantage of doing real-time repairs to the couple's capacity to healthily co-regulate anxiety and complex feelings. Also, helping the couple to observe together their precise emotional and physical responses in vivo allows them to see their problem from an entirely new, neurobi-

ological perspective, which serves to interrupt their habitual pattern of attacking and then distancing from one another.

Our unique challenge was how to systematically introduce anxiety-defense work into our therapy with couples. The most natural solution was to engage in small blocks of restructuring with one partner at a time in full view of the other partner. This only made sense after establishing a mutual understanding of the couple's problem, including the specific ways in which each partner contributes to their painful interactional pattern vis-à-vis anxiety and defense. At that point, we could consistently link the partners' real-time responses back to their presenting problem, while encouraging them to use a healthy alternative.

Finally, we found that asking the observing partners to recap what they have just witnessed is a powerful aid in bolstering empathy and consolidating new learning. We then ask the couple to practice co-observing and using their healthy alternatives between sessions.

### **Taking the Transference Heat**

It goes without saying that couples enter therapy with a deep reservoir of feelings toward each other (and usually toward past attachment figures). Often, these feelings are of such intensity that exploring them safely is difficult. One or both partners may lash out against, verbally pummel, or devalue the other in the therapist's presence, which usually requires the therapist stepping in to play the role of mediator, interpreter, or traffic cop, in order to prevent iatrogenic damage.

In our collaborations, we began to adapt ISTDP interventions to draw fire away from the partner under attack, by redi-

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recting it into the relationship with the therapist (in psychodynamic terms, “in the transference”). Rather than halt, interpret, or reframe the attack, we would invite the partner to precisely examine the physiological manifestations of the intense feeling under observation, while helping to distinguish between the feeling of anger, anxiety, and defense (e.g., discharging, venting, lashing out). This shift in focus from interpersonal conflict to intra-psycho exploration invariably leads to the mobilization of feelings toward the therapist, which are subsequently explored in the same manner and then linked back to the couple’s presenting problem. Care is taken to let the other partner know that there will be an opportunity to do the same investigation with the therapist.

In our experience, this intervention, if done with skill, offers the following advantages: (1) It prevents in-session damage to the partners and further damage to their attachment bond without diffusing the intensity of feeling; (2) It improves the partners’ capacity for self-observation and emotional regulation; (3) It offers the couple a new, intra-psycho understanding of their interpersonal problems; (4) It interrupts the couple’s repetitive, negative interactional cycle; and (5) It lets the observing partner see that the problem is not occurring only in relation to him or her, but in relation to others as well.

There are, of course, many psychodynamic therapies in which the therapist encourages and then interprets the patient’s positive and negative transference feelings; in our experience, however, few models so vigorously position the therapist in the transference hot seat. The therapist’s willingness to “take the transference heat,” especially when confronting patient barriers to intimacy and

engagement, is a key feature of ISTDP that we have found highly effective in our work with couples. When combined with anxiety and defense restructuring, transference work can significantly de-escalate negative interactional patterns and accelerate intimacy and healthy co-regulation of affect within the couple.

### **A Final Word on Collaboration and Sharing Best Practices**

We would like to re-emphasize that our work is an ongoing learning process and that what we have presented here is not a complete therapy. Rather, we view our work as a form of collaboration and cross-pollination in which we seek to apply powerful elements of one modality to improve our work in another. In our efforts to coherently integrate ISTDP into our work with couples, we have discovered areas of enormous potential in addition to certain roadblocks and challenges.

Needless to say, we are excited by the ways ISTDP can add considerable value to couples therapy. Working together on utilizing two different modalities has also increased our awareness of the value of sharing aspects of theoretical modalities and clinical experiences as they might apply to different treatment units, populations, or theoretical orientations. We imagine you, too, are encouraged when therapists from different schools of thought share best practices, and in so doing work collaboratively to bring the highest value to ourselves and our patients. We would welcome your comments or questions at Catherine-LockwoodMFT@gmail.com and Reiko-JosephMA@gmail.com.

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



## Psychotherapy With the Wealthy: Some Frame and Countertransference Issues

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My practice is located in an enclave that includes some of wealthiest people in the state and country. Wealthy people flock like seagulls to live and play in the sun by the Pacific Ocean. Over the last 15 years, more than half of my practice has been comprised of patients<sup>1</sup> who I would characterize as “very wealthy.” For the previous 25 years of practice, about a third were members of this group or a rung below, “wealthy/well-off.” By the arbitrary term “very wealthy,” I mean they earn between \$400,000 to over \$1,000,000 per year, live in homes that are valued at \$3 to \$10 million or more, and have a net worth of between \$10 million to a few hundred million dollars.

My intention is to present a brief snapshot of some of the frame and countertransference issues that arise with this population. I am cognizant of the fact that the generalizations I make do not necessarily pertain only to this group but may equally be applied to others. For example, the statements I make below about the tendency of the wealthy to break the therapeutic frame may also be applied to narcissistic patients who may not be wealthy (Fischer, 1989).

Secondly, although some generalizations may sound critical, I have long enjoyed working with this group, partly because they are, in my experience, some of the most intelligent, accomplished, and interesting people that

could ever present for treatment. It was largely because of working with this population that I wrote a book on healthy ways of dealing with the psychological and practical issues related to family financial inheritance issues. I became aware of how often the mismanaged division of inherited money and possessions by siblings and the unconscious roles played by family members led to strife and broken relationships preceding, during, and following an inheritance event (Hendlin, 2004).

My therapeutic style has gradually changed over the decades from one of being more technique-oriented (for example, Gestalt “empty-chair” work and enacting parts of a dream, guided sensory awareness experiments, and Ericksonian hypnosis) to a more conversational way of “being with” patients that tends to be more cognitive and less emotionally evocative than the early years. But, borrowing from the psychoanalytic tradition, one of the aspects that has *not* changed is taking the therapeutic frame seriously (Langs, 1973).

Procedurally, 40 years later, I continue opening the consulting room door on time and ending sessions on time. I continue charging full fee for cancellation without a 48-hour notice and I raise my fee a small amount every year. Since I do only out of pocket fee-for-service, I continue my longstanding policy of asking that the fee be paid at the time of service. I’m less rigid about patients’ lateness and much more open to sessions done by phone. And I now take advantage of

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existing technology by using texting for some appointment scheduling. I have a rather old school, straight psychotherapy and consulting practice, in that I no longer do any psychological testing and have not for the last 15 years.

Phenomenologically, I continue to be fascinated by synchronicity (Jung, 1952/1993), the vagaries of random (or cosmically determined) good and bad timing in life events, coincidences, unconscious slips of tongue, everyday manifestations of wonder, irony, and absurdity, and the role of unconscious motivation. I continue to infuse my conversational inquiry into patients' ways of making sense of their inner and outer worlds by gently offering psychodynamic interpretations when I believe they may be useful. And because a lifetime of sitting and movement meditation has taught me to stay grounded in the present, I am never far from bringing patients back to the here-and-now of our intersubjective relationship.

### **Frame Issues**

Very wealthy patients are used to being masters of their universe. One form this takes is their expectation of others catering to them, including their service providers. A typical belief they have is that "throwing enough money" at any kind of problem will usually resolve it (Glick, 2012). Because they are used to being in control, some like to test the usual limits in psychotherapy that non-wealthy patients more readily accept. They are not always compliant in honoring treatment frame limits, such as establishing and honoring a regular appointment time, showing up promptly, ending the hour at the appointed time, or giving sufficient notice when canceling.

It is sometimes difficult for very wealthy patients to allow the therapist to be in charge. They tend to assume a therapist could not possibly decipher aspects of

their self-presentation of which they are not already aware. One way I have dealt with this tendency is by making an early insightful connection that helps them understand themselves or their behavior in a new way. This demonstrates quickly and conclusively that gaining new awareness is not only possible but can begin in even the initial treatment hours. This engenders their early trust and usually makes them interested in learning more.

Very wealthy patients are quick to request special consideration, such as after-hours and weekend calls when anxious, "emergency" appointments when there is no real emergency, or being "squeezed" in at the last minute when it is convenient for them rather than the therapist. For example, while working on this article, a patient sent me a text wanting immediate phone contact. He had already been waiting to hear from me for about four hours, as I happened not to have access to his two earlier text messages. I told him to call me and we had a half hour on the phone to quell his anxiety about saying goodbye to a woman he had been dating for a month by whom he was feeling smothered. Although this was not a real emergency, I try to be responsive in the same way a concierge physician would be available to his patients—because that is what very wealthy people *expect* in the way of prompt and attentive service. In a way, they want you to be a therapist-in-waiting—never far away and always ready to serve.

If the wealthy are busy and unable to make it to the consulting room, they expect to be able to call in for the appointment. Psychotherapists uniformly complain that wealthy patients are inclined to view their psychotherapists as highly skilled members of a personal en-

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tourage, easily let go of on a whim, as with any other service provider (Konigsberg, 2008).

The cost of paying full fee for an hour that is cancelled late (or not cancelled at all) is not valued by very wealthy patients the same way it is for those who feel the pinch when having to pay for late cancellation. The negative consequence of devaluing the amount paid (because it means relatively little to them) is that it does not tend to act as a deterrent to late cancellation. The positive consequence is that the therapist is usually paid the cancellation fee without complaint or disagreement. In fact, some patients easily prefer paying for a session that is cancelled late than facing their resistance by coming in when they are confronting difficult and uncomfortable treatment issues. It is considered just another way to utilize money to avoid unpleasantness.

Other frame issues that may arise include noncompliantly paying when they wish, rather than at each session; expecting access to the therapist's cell phone number or email address; or wanting to text the therapist to change an appointment rather than calling the office to do so—all behaviors reflective of a belief that paying for service entitles one to the privilege of convenience on one's own terms.

For example, I saw one man who made a fortune running a hedge fund. He did not want to write a check to pay my fee on a weekly basis as everyone else does. Nor did he want to pay me for a month in advance, requiring only one check. No, he demanded that it be on his terms, since there was no one else in his life who asked him to pay for a service on a weekly basis. We explored his resistance to complying with my fee policy. He made it clear that he was typically sent a bill at the end of the month for services

rendered and did not want to be inconvenienced by having to think about writing a weekly check, as he did not carry a checkbook with him, preferring to have an assistant pay his expenses. I understood this as his way of making sure he dictated the terms of payment, as he was used to doing with others. By doing so, he was evening the score so that he could allow himself to get help from me without feeling too dependent. Instead, he would make me dependent on him for payment. He said to me, "I'm worth \$40 million. You don't have to worry about being paid."

This led me to reflect how, in the early years, I had some problems when I allowed the fee to accumulate, and decided I did not want the hassle of billing at the end of the month. In this case, it was clear he could afford the treatment and that my not pressuring him to pay each week was a small sign of my trusting him. I decided that forcing this issue with him was not worth risking the relationship. So I let him pay when he wanted, which was usually within a reasonable time, and allowed him to feel the degree of dominance that he was used to in most of his business and personal relationships. He actually stayed in treatment for some time and made good progress. This was one of those incidences when I chose not to let my policy become so rigid that I could not bend to accommodate the other.

### **Countertransference Issues**

For the psychotherapist working with the wealthy, the most obvious and pervasive countertransference issue is envy. In listening to the details of how members of this group think, feel, and live, one comes to appreciate the meaning of F. Scott Fitzgerald's (1926) truism that, "The rich are different than you and me." The ongoing requirement of work-

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ing successfully with very wealthy patients is the containment of one's envy so that it does not interfere with the process of therapy. Contradictory and complex reactions to the personalities presented and their systems of valuing money and experiences are part of what must be negotiated in working with this population (Konigsberg, 2008).

This becomes somewhat easier to manage after years of listening to stories of phenomenal conspicuous consumption, lavish entertainment, luxury travel, and the freedom of choice and opportunity that wealth has to offer, the likes of which is initially difficult to believe. Early fascination with stories of opportunity gone wild might turn into occasional flashes of loathing or contempt as I imagined how I would enjoy the experiences being talked about. This might also lead to the thought of how much "better" I would choose to spend the money, if I had it. At times, feelings of contempt seem to act as a defense against accepting my envy and a sense of "unfairness" about how some of these people were "undeserving" of their wealth.

Because of the common arousal of envy in the therapist, one may consciously and unconsciously defend against it by being more flexible with wealthy clients in terms of one's policies (Wahl, 1974). Therapists may also hold back from offering interpretations or being overly confrontive so as not to risk threatening the relationship (Olsson, 1986). This was why I proceeded carefully with the patient mentioned above before being willing to make an exception in my fee policy.

Another common reaction by the therapist is a sense of artificial ego-inflation in privately knowing that important, intelligent, creative, and financially successful people are trusting one's expertise and experience and paying for one's help. This inner pride may take the form of the fantasy to break confidentiality and reveal to family, friends, or colleagues the names and stories of famous personalities, star athletes, and important business people that one treats in order to impress them.

Perhaps one of the most important lessons learned by psychotherapists in working with very wealthy people is the perennial truth about the limitations of money in resolving the existential issues that confront everyone. Money cannot stop the body from the natural process of aging, sickness, or gradual decay and death. It cannot prevent or solve the messiness of attachment, disappointment, and abandonment in human relationships. Nor can it impede the flow of moment-to-moment choices and responsibility for the consequences of them, or sharing the welter of common fears and desires. It will not obliterate trauma from the past or apprehension about the future, nor will it solve the riddles of creating meaning in life or what happens after death. But from the wealthy person's perspective, all of these issues can be made more palatable by using their resources.

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

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



## New Guidelines and Best Supervision Practices

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Clinical supervision has changed dramatically in the past decade. First came the recognition that clinical supervision is a distinct professional practice that requires specific training. This represented a critical change from the previously unspoken assumption that all supervisors were, by virtue of their status, competent—an assumption that elicited



strong emotional responses from both supervisees and supervisors who experienced less than competent supervision. Supervision was historically undertaken without specific training, with supervisors practicing, for better or worse, what they learned from their own supervision experiences. Over time, it became apparent that, due to the implicit power differential, poor supervision has the potential to do significant harm. In fact, Ellis and colleagues (2014) identified specific instances of harm reported by surprisingly many supervisees. Further, Wrape, Callahan, Ruggero, and Watkins (2015) reported that supervisors who were more recent graduates may be associated with better client outcomes, perhaps in part because of the value placed on modern supervision training.

Another major development is the adoption of two new sets of supervision guidelines: The American Psychological Association (APA) Guidelines for Clinical Supervision of Health Service

Psychologists, produced by the American Psychological Association (APA, 2014; APA, 2015), and the Association of State and Professional Psychology Boards (ASPPB) Supervision Guidelines for Education and Training Leading to Licensure as a Health Service Provider (ASPPB, 2015). Approval of the guidelines for practice (APA, 2014; APA, 2015), and for regulatory purposes (ASPPB, 2015), are giant steps forward.

The purpose of this article is to present views of best practices, through the lens of these new supervision guidelines and from the perspectives of supervisor and supervisee.

Both sets of guidelines were built upon the concept of competency-based supervision, an approach to supervision that enhances accountability and is applicable to all supervision models, including those that are psychotherapy and supervision theory-based. The APA (2014) Guidelines for Clinical Supervision of Health Service Psychologists define competency-based supervision as:

a metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local / cultural clinical setting (adapted from Falender & Shafranske, 2007). Competency-based supervision is one approach to supervision;

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it is metatheoretical and does not preclude other models of supervision. (p. 5)

The APA Guidelines contain assumptions underlying supervision and sections describing the various aspects of supervision: supervision competence; diversity; supervisory relationship; professionalism; assessment, evaluation and feedback; professional competence problems; and ethical, legal and regulatory issues.

Focus in the ASPPB guidelines (2015) is on regulatory issues and ethics, and the structure, definition, and components of supervision are consistent with the APA Guidelines. Supervision,

a distinct, competency-based professional practice, is a collaborative relationship between supervisor and supervisee that is facilitative, evaluative, and extends over time. It has the goal of enhancing the professional competence of the supervisee through monitoring the quality of services provided to the client for the protection of the public, and provides a gatekeeping function for independent professional practice (Bernard & Goodyear, 2014; Falender and Shafranske 2007). (p. 5)

Explicit attention is given to supervisor competencies, knowledge, skills, and attitudes and values requisite for supervisor performance. For example, attitudes and values include respect, sensitivity to diversity, empowerment, and valuing ethical principles. Training for supervisors is outlined as responsibilities and regulatory guidance for supervision practice.

The new guidelines provide authentication and validation that there are specific practices of clinical supervision essential for supervisee growth, competence, enhancement of clinical practice, and, ulti-

mately, the protection of the public. These guidelines set a standard of practice for clinical supervision. The guidelines may be used not simply as a roadmap, but also to support supervisors and administrators obtaining the requisite time and resources for provision of clinical supervision. The guidelines were also designed to inform practice through provision of strategies for implementation, along with a review of the relevant literature and evidence support for each aspect. The fact that both practice guidelines and regulatory guidelines are available, and that their emergence was so close in time, provides impetus for empowering change in supervision practice (APA, 2014; APA, 2015; ASPPB, 2015).

Both sets of guidelines address the power differential in the supervision process. They provide structure to discuss the multiple roles of the supervisor, the priorities, and the role of transparency in assessment, feedback, and evaluation. The ensuing dialectic between supervisor and supervisee is potentially transformational, instilling the groundwork for collaboration.

An additional assumption of both sets of guidelines is that diversity is infused into all aspects of professional practice. Diversity competence is not limited to understanding and reflecting on diversity dimensions between the client(s) and the supervisee(s), but of the supervisor as well. Culturally responsive supervision identifies and appreciates cultural aspects of client presentation and the client-supervisee relationship, as well as cultural layers *within* supervision (Burkard et al., 2006). In practice, focus may be more on race and gender (Sohelian, Inman, Klinger, Isenberg, & Kulp, 2014) rather than on the multiple diversity/multicultural identities (Falender, Shafranske, & Falicov, 2014). Mis-

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understanding and strain can arise when supervisors mistakenly assume they understand diversity and background characteristics and belief structures of the client (Singh & Chun, 2010); when supervisors mistakenly assume they know diversity and background characteristics of the supervisee (e.g., ethnicity, country of origin, immigration history, religion, sexual orientation), supervisees could feel misunderstood or even hurt. There is a fine line between cultural knowledge and cultural stereotype when assumptions are made. Supervisees are empowered to identify cultural nuances between supervisor and supervisee and between supervisees in group supervision (Chin, Petersen, Nan, & Nicholls, 2014). Even when supervisors correctly identify supervisees' cultural identities, especially whose cultural background characteristics are a minority group, supervisors would be better advised to avoid cultural assumptions because 1) cultural knowledge should be used as a guide to navigate one's cultural identity, not to define it; and 2) the intersection of multiple minority identities create a unique integrated cultural identity, as cultural individuals cannot be divided into its summed parts (Meyer, 2003). In culturally competent supervision, supervisees feel empowered to address cultural encounters in therapy, especially when they need to engage in difficult conversations such as when they are working with a client who holds values or beliefs that conflict with their own views.

Recognition of the importance of the establishment and quality of the supervisory relationship, evident in both guidelines (APA, 2015; ASPPB, 2015), has been associated with multiple outcomes of effective supervision. Supervisors specify roles and expectations of supervisees and themselves, promoting a clear and open dialogue about boundaries in the supervisory relationship and

giving supervisees an opportunity to collaboratively discuss their values, goals, areas for growth, challenges, and their expectations for the supervision and training program. When supervisors engage in regular assessment and evaluation of the development and effectiveness of the supervisory relationship, supervisees can more honestly and effectively address any differences or difficulties, always mindful of the power differential in those relationships. The quality of collaboration focuses on encouraging supervisees to provide input and to recognize it. For the supervisee, it is critical to address countertransference and ruptures in therapeutic relationship; supervisees may be hesitant to openly discuss these in supervision as they may negatively influence performance evaluations. A strong supervisory relationship potentially creates a safe environment for supervisees to voluntarily engage in disclosure of personal reactivity in therapy and to examine parallel process in the therapeutic and the supervisory relationships. An assumption is that reflective practice and self-assessment are ongoing processes in supervision, by both supervisor and supervisee.

A strong supervisory relationship facilitates—and is facilitated by—ongoing constructive and direct feedback. From the supervisee's perspective, constructive feedback linked to specific competencies promotes professional and personal growth by identifying the supervisee's strengths, as well as areas for growth, and leads to the revising and updating of training goals. The competency standards serve as an anchor, facilitating the supervisor's ongoing assessment and evaluation regarding areas on or above target for competent development, and those not at the expected level. Collaborative competency-

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based evaluation can strengthen the supervisory relationship when supervisors recognize supervisee's strengths and areas for growth, monitor the trajectory of supervisee's progress, and value supervisee's self-assessment and feedback on the experience of supervision. The transparency facilitated through anchored feedback allows the supervisee an opportunity to address performance and identify specific strategies to gain competence. Constructive evaluation serves ethical and legal functions in effective supervision. Regular engagement in evaluation also increases the quality and frequency of the supervisee's ability to self-assess. The concept of bidirectional feedback provides the opportunity for the supervisor to model a reflective and proactive response to receipt of input on supervision (Falender, Shafranske, & Ofek, 2014).

The new supervision guidelines may require paradigm shifts or foster growth and development of emerging practices. Understanding supervisor priorities may be a significant cognitive shift for supervisees, as they often are implied, but unstated. The guidelines assume supervision occurs in a respectful, collaborative supervision relationship with responsibilities placed on both supervisor and supervisee. This may be another transformation, as it requires skill to acknowledge the reality of the hierarchical, power relationship of supervision, and to facilitate and welcome supervisee collaboration. To create collaboration requires genuinely welcoming supervisee input and perspectives, as well as different practices or approaches.

The influence of professional and personal factors (e.g., values, attitudes, beliefs, and interpersonal biases) on supervision may be another area in which there are theoretical and practice differences, yet one which remains an essential aspect of supervision. Main-

taining the distinction between supervision and personal psychotherapy is essential and requires training to address supervisee reactivity, countertransference, or personal factors in clinical work, without crossing the line to become the supervisee's therapist (Falender & Shafranske, 2004).

An essential component of both sets of guidelines is the supervision contract. The supervision contract is essentially an informed consent document that is a formalization of the supervisory relationship or alliance. During the process of collaboratively developing the contract, the supervisor engages the supervisee through discussion of supervisee and supervisor expectations, standards, roles and responsibilities, and setting-specific regulations. Limits of confidentiality may include normative disclosures to graduate schools, training committees, and regulatory boards, as well as disclosures required to fulfill the supervisor's highest duty of protecting the public. Optimally, the supervision contract will also address specific expectations regarding preparation for supervision (e.g., video review, documentation, agenda creation); how parties will navigate potential multiple relationships in the local setting; expectations for identifying and dealing with emergent situations; and under what circumstances and how the supervisor is to be contacted outside of scheduled supervision times.

Ethical decision-making is described as a standard of practice to be enacted after the ethical dilemma is identified. The development of goals and tasks grows out of the contract discussion and the supervisee's self-assessment on the competency benchmarks or alternative tool. As progress is briefly tracked in supervision sessions, goals and tasks are revised and updated as the supervisee

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attains them. A sample contract is included in the ASPPB guidelines (2015, Appendix IV, pp. 56-57). An outline for the contract is also included in the APA guidelines (2014, pp. 24-25).

To transform supervision in keeping with the APA and ASPPB guidelines, the supervisor must attend to knowledge, skills, and attitudes regarding supervision, and must self-assess competence.

With this comes the opportunity for the elevation of supervision toward increasingly evidence-supported practices, systematic quality, and the highest level of protection of the client and of the supervisee.

**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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### Steal This Metaphor! Using Superheroes to Support ADHD Medication Compliance in Young Children

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Child therapy presents the unique opportunity for creativity amongst therapists and psychiatrists due to the limited knowledge children possess about the therapeutic process, emotions, medications, and a variety of other aspects of psychotherapy. It is a tremendous responsibility for a child's therapist to utilize age-appropriate communication to educate a child regarding his or her diagnosis, possible treatment options, and how to be actively engaged during their own treatment. One area of communication with children that is especially important is providing a context for the interplay between psychotropic medication, psychotherapy, and the patient's own involvement in clinical care.

When beginning psychotherapy with a patient, especially a child patient, one of the most important aspects of the initial conversation is to provide realistic expectations regarding what to expect from therapy. Similarly, when a psychiatrist is initially prescribing medication to a child, the psychiatrist will engage in a conversation with the child where they will most likely discuss 1) the rationale for prescribing the specific medication, 2) the expected dosage, 3) possible positive changes that might occur as a result of incorporating the medication into the treatment protocol, and 4) what side effects the patient should be cautious of when beginning

the medication. Although my role as a psychologist does not involve making critical decisions regarding medication, I, too, have a crucial role to play when one of my child patients begins medication. My role is twofold: I am not only an additional source of communication and feedback between the psychiatrist, patient, and family, but I can also serve as a tool to support medication compliance and adherence to the psychotropic treatment protocol. Since joining the MGH Child/Adolescent Outpatient Psychiatry team nearly a year ago, I have had the tremendous opportunity to collaborate with truly talented and creative psychiatrists. As a result of these collaborations, I have grown in my ability to communicate with my patients regarding the importance of medication compliance and adherence, especially in the lives of children we see frequently in our clinic: those children who have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013), 5% of children in the United States meet criteria for ADHD, and these children comprise a significant portion of the cases that many child psychologists work with in their clinics or private practices. ADHD consists of a variety of symptoms that impair executive functioning, such as distractibility, inattention, impulsivity, poor planning,

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poor organization, procrastination, and poor time management. For children especially, these symptoms are often significantly detrimental to the ability to successfully navigate emotions and manage given responsibilities throughout the course of the day, such as academic tasks or following directions given by others. In addition to these symptoms impacting an individual's attention during performance-based tasks, ADHD often has a negative impact on a child's ability to maintain appropriate and healthy peer relationships (Strine et al., 2006) and children with this diagnosis are more likely to experience accidents and injuries due to their executive functioning challenges (Leibson, Katusic, Barbaresi, Ransom, & O'Brien, 2001). Emotionally, children with ADHD are at increased risk for aggression, depression, social isolation, and conduct concerns when compared to the general population, and ADHD medication has been shown to decrease the severity of these observed behaviors and emotions (Semrud-Clikeman, Pliszka, & Liotti, 2008).

According to the most recent best practices for ADHD report from the American Academy of Pediatrics' Subcommittee on Attention-Deficit/Hyperactivity Disorder Steering Committee on Quality Improvement and Management (2011), these children will experience the best opportunity for positive change regarding their ADHD symptoms via a combination of behavioral psychotherapy and medication. Although this standard of care is well known within the psychiatric community, many children fail to receive or maintain both aspects of treatment, and therefore are susceptible to receiving suboptimal or less-than-ideal treatment for their ADHD symptoms. According to recent research by Thiruchelvam, Charach, and Schachar (2001), children's adherence to often-prescribed stimulant medication fell over the course of three years, with ad-

herence reaching 81% at the end of year one, 67% at the end of year two, and 52% by the end of year three. This specific research also identified several factors that influenced whether a child would adhere to the prescribed medication protocol: Those who were younger or experiencing more significant distress were more likely to continue taking medication. Although it is easy for me to promote psychotherapy to children impacted by ADHD, given my role as the orchestrator of that specific treatment modality, there is much that can be done to advocate to both the patient and the patient's family to remain engaged and compliant with psychotropic medication and care. This is especially important given the complex beliefs and perceptions many parents often harbor about psychotropic medications and how it is often a difficult family decision to agree to administer drugs to child (Jackson & Peters, 2008).

And so, this is where superheroes comes into play...

While working with a particular patient this year, I was having difficulty teaching the patient 1) the importance of taking his medication for ADHD, and 2) the importance of recognizing when his medication had ceased working. It was important for both his treatment team and his parents to help him gain more insight into his executive functioning challenges in order to avoid unintended negative behavioral or emotional consequences and to further support him with self-initiating interventions. While collaborating with this patient's psychiatrist, I proposed the metaphor of Batman and Robin to help provide a language to speak about the relationship between the patient and his ADHD medication. In this metaphor, the patient is the superhero (because, honestly, everyone

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dreams of being a superhero), the ADHD medication is the sidekick, and the stressors of the day (e.g., homework, music practice, distracting classmates, etc.) are the villains. Written below is an example of how I might explain the metaphor to a child who recently began a medication regimen for ADHD:

*Hey Billy, I spoke to Dr. Mickey Mouse last week and he told me that you began to take medication to give you a little extra support with paying attention and I think that is great. Although it is often difficult to remember to take your medication everyday or to understand how it works, I want to give you a quick story to help you remember how to take your medication and to recognize when your medication might be out of your system at the end of the day. Are you ready to hear it? Great. So, imagine that you are Batman...how cool would that be?! I want you to imagine yourself as Batman because Batman is a pretty talented dude: He is smart, respectful, strong, caring, and he has a ton of cool gadgets. Now, imagine that your ADHD medication is Robin, Batman's sidekick. Robin is dependable, consistent, loyal, and is a great ally to Batman who has been able to save him from trouble many times in the past. Well, when you take your medication in the morning, it is almost like you are Batman and you call Robin in the morning to provide you back up to help clean up the mean streets of Gotham. But, in your case, you are not fighting criminals or doing anything like that. You and Robin are fighting to pay attention in class and be more mindful of your behavior. Think about it this way: Can you think of some things that distract you in class or at home? Those distractions are like the villains that Batman and Robin fight in the comics and movies because they keep you from being successful or enjoying yourself. So, when you take your medication, you have backup to help you fight those villains and you do not have to spend as much energy fighting those villains on your own or get too frustrated when fighting them alone, like you might have*

*been in the past. On days that you forget to take your medication, you can still fight those villains, but it will be harder and more difficult because you do not have Robin to rely on. Another important thing to realize about Robin is that he does not get paid overtime, so he only works for about eight hours a day, just like most ADHD medications. So, when you take your medication in the morning, know that you will probably only be able to have Robin help you for about eight to nine hours a day before he goes home. When he goes home for the night, as he will every night, it will mean that you will need to recognize that he is unavailable and that you, Batman, will need to once again fight those villains on your own. Using Batman and Robin might be a great way for you and your parents to communicate about your medication. Maybe your dad might say something like "Don't forget to take Robin to school with you this morning," or your mom might say "Billy, it seems like you're having a little bit more difficulty paying attention, do you think that Robin might have gone home for the night already?" This way, we can talk about your medication in a cool code without having you worry about other people hearing your business. How does that sound to you?*

This metaphor has been useful to help accomplish several goals, including promoting self-efficacy in the child, encouraging the child to be increasingly responsible for personal medication compliance, utilizing mindfulness and metacognition to recognize when the medication is no longer active in the child's system, and being able to approach medication adherence in a fun and manageable way. This metaphor also provides the family with a cool way to talk about the ADHD medication that may help shield the child from the unfortunate potential of stigma when talking about the medication in more explicit terms (i.e., while in public). I have found this metaphor works well

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with most young children, given how popular superheroes and comic book mythology are in our society, and there are a variety of characters from which to choose if your patient has a gender preference, for example. Additionally, by identifying as a strong fictional character, the child may start to embody some of the positive traits of this individual and therefore grow in terms of self-esteem and tolerance for stress.

Metaphors like this one exist all around us and they are extremely useful in the implementation of psychotherapy to children, especially given how much of their learning occurs through fables, parables, and other types of narrative expressions. As clinicians, we have the

opportunity to invest in our own creativity and the creativity of our patients to make therapy fun and help it come alive in the therapeutic space. And, more importantly, we should share these metaphors with our colleagues and the rest of the clinical community to help cultivate a common language we can all use to better reach the children and families we serve. So, go ahead and steal this metaphor and put it to good use. If you have a great metaphor you would like to share, please post on Twitter and use the hashtag: #stealthismetaphor.

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## EARLY CAREER

### Forgiving Hoffman

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I have been thinking a lot recently about the concept of forgiveness, probably because, truth be told, I am not very good at it. If resentment really is “like drinking poison and then hoping it will kill your enemies,” as Nelson Mandela has been said to caution (Durando, 2013), then I’m pretty sure I should be dead by now. On the contrary, in popular culture, forgiveness is everywhere. Countless self-help books, magazine articles, and afternoon talk shows all purport to have found the secret to forgiveness, as if it were the Holy Grail. Similarly, researchers from various disciplines of psychology have shown us the benefits of forgiveness, including overall psychological well-being and better interpersonal relationships (e.g., Webb, Colburn, Heisler, Call, & Chickering, 2008), and have even studied treatment interventions specifically designed to foster forgiveness (Enright & Fitzgibbons, 2015). Psychology is of course not alone in the study of forgiveness, as religion, philosophy, and science have all wrestled with this idea since the time of the ancient Greeks (Hughes, 2015).

In particular, psychologists have weighed in on the forgiveness front through attempting to identify situational and dispositional predictors as well as positive outcomes of forgiveness. For example, clinical and counseling psychologists have explored the implications of forgiveness for patient well-being (e.g., Freedman, Enright, & Knutson, 2005; Wade, Worthington, & Meyer, 2005). De-

velopmental scholars have studied intrapersonal changes in the ability to forgive throughout the lifespan (e.g., Allemand, 2008; Enright & the Human Development Study Group, 1994). Social psychologists have studied how attributions (Struthers, Eaton, Santelli, Uchiyama, & Shirvani, 2008), perspective taking (Takaku, 2001), justice (Karremans & Van Lange, 2005), and other aspects of the situation facilitate forgiveness. Personality theorists have explored the role that various dispositions, such as the Big Five (McCullough & Hoyt, 2002), play in forgiveness. Organizational scholars have examined how aspects of the organizational context, such as relative hierarchical status (Aquino, Tripp, & Bies, 2001) and justice climate (Aquino, Tripp, & Bies, 2006; Tripp & Bies, 2009), influence forgiveness. Lastly, relationship experts have explored the dynamics of forgiveness within marriage (Fincham & Beach, 2002; Fincham, Paleari, & Regalia, 2002) and family contexts (Hoyt, Fincham, McCullough, Maio, & Davila, 2005). As a result, an overwhelming body of forgiveness literature has amassed from a plethora of psychological fronts, so much so that you would think we would all be experts on forgiveness by now. Nevertheless, as a society, as individuals, and perhaps as a profession, we still struggle with the same question that first set researchers out on the path of studying forgiveness: *How and why do people forgive, especially when they have every right to be angry?*

There are certain iconic and heroic individuals in recent history who just seem

*continued on page 45*

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to get this forgiveness thing more than the rest of us. Moreover, these individuals forgive in the face of terrible human atrocities. Consider, for example, Nelson Mandela, who on February 11, 1990, was freed from nearly 30 years in prison for speaking out against the South African apartheid government. Mandela spent the first 18 of his 27 years in jail at the brutal Robben Island Prison, a former leper colony off the coast of Cape Town. Here, he was confined to a small cell without a bed or plumbing and forced to do hard labor in a lime quarry. As a Black political prisoner, he received less rations and fewer privileges than the other inmates. Not only was Mandela denied basic human rights by the government entrusted to protect them, but he was also severely punished for wanting those rights. Yet Mandela, who had every right to emerge from prison violently angry, mistrustful, and hungry for vengeance, put aside resentment to negotiate the end of apartheid in South Africa with the very people who were once his enemies (Nelson Mandela Foundation, 2015).

Mandela went on to become the first Black President of South Africa. As President, he established the Truth and Reconciliation Commission (TRC) to investigate human rights and political violations committed by both supporters and opponents of apartheid rule (Nelson Mandela Foundation, 2015). The TRC helped victims find peace and forgiveness following apartheid (Tutu, 2000). For example, one unnamed young girl witnessed the police, under apartheid, ambush her family's car and kill them in a gruesome manner, then set the car on fire. When, at a TRC hearing, the young girl, now a teenager, was asked if she would be able to forgive the people who did this to her family, she answered, "We would like to forgive, but we would just like to know who to forgive" (The Forgiveness Project, 2010).

Nelson Mandela inspired a divided nation with deep and painful wounds to forgive and reconcile. Moreover, he inspired the world, as we all watched in awe and wondered, if we were so wronged, would we be able to transcend our situation and truly forgive?

Similarly, the novel *Unbroken* tells the true story of a former Olympic runner, Louis Zamperini, who became a lieutenant in the United States army during World War II (Hillenbrand, 2010). While on a search mission, Zamperini's plane crashed over the ocean 850 miles south of Oahu, killing eight of the 11 passengers on board. Zamperini was one of three survivors left adrift at sea for 47 days with little food or water. These men survived off of rainwater and raw fish caught in the ocean. They were forced to face starvation, shark attacks, and Japanese bombers. At last, their raft finally drifted to land and the two surviving men thought they were saved. Unfortunately, rather than a miracle, this land turned out to be a nightmare, for they had drifted onto the Marshall Islands and were captured by the Japanese. They were held in captivity, severely beaten, and mistreated until the end of the war in August 1945 (CBS Interactive, Inc., 2014; Hillenbrand, 2010).

Zamperini reported that, while a prisoner of war, he was especially tormented by one particular prison guard named Mutsuhiro "Bird" Watanabe, who was later included in General Douglas MacArthur's list of the 40 most wanted war criminals in Japan. When Zamperini first returned home, after being released from captivity, he had nightmares about the "Bird" and was consumed with fantasies of revenge. However, he said all that changed when he became a Christian Evangelist and learned the importance of forgiveness. Zamperini even traveled back to Japan

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to tell his ex-prison guards in person that he had forgiven them. Yet, there remained one prison guard Zamperini never came face-to-face with again. Although Zamperini wanted to meet with the “Bird” to tell his former torturer he had forgiven him, the “Bird” refused to meet with Zamperini. What happened to this reportedly violent and sadistic ex-prison guard? When the war ended, the “Bird” took refuge in a cave until being pardoned and then went on to become very wealthy—selling, of all things, life insurance (CBS Interactive, Inc., 2014; Hillenbrand, 2010).

Zamperini was wronged, terribly so, over and over again, for many years. The fact that his primary torturer was pardoned, never held accountable for his actions, and free to walk the streets as a wealthy man, feels simply unjust. However, in a CBS special that interviewed the “Bird” and Zamperini separately, Zamperini was the one seen carrying the Olympic torch with a wide smile on his face, appearing genuinely happy, full of life, and at peace. On the other hand, the “Bird” was seen walking alone down a grey street, appearing lifeless, lonely, and haunted (CBS Interactive, Inc., 2014). Did forgiveness save Mandela and Zamperini from a life filled with rage and fantasies of revenge, a life defined by their perpetrators and the horrible acts committed against them, or did it just let very bad people off the hook?

In life and in death, Mandela and Zamperini personify forgiveness, resilience, compassion, and acceptance. Both of these men seemed so free and unburdened by the past and is this not how we all want to feel in some way? If Mandela could forgive his country for such a flagrant abuse of power, for all the years of racism and oppression, and Zamperini could forgive his prison guards for tor-

ture (not to mention life itself for putting him on that plane that crashed in the first place), then surely I should be able to forgive just about anything. Yet forgiveness, so revered in the abstract, tends to be difficult to execute in everyday life, when we feel hurt, betrayed, and wronged. The just world theory suggests it is a natural human inclination to want to believe the world is a fair place (Lerner & Miller, 1977). Sometimes, our anger, our withholding of forgiveness, is the only recourse we feel we have to set the world back on a just path when a perceived wrong has been committed.

It was within this context of considering the role of forgiveness in my own personal life that the now infamous Hoffman Report (Hoffman et al., 2015) was brought to light. In this review, evidence for “the secret coordination between several APA leaders and the Department of Defense that resulted in the lack of a clear and consistent anti-torture stance, limited guide for military psychologists in the field, a failure to uphold an appropriate conflict-of-interest policy with regards to the PENS Task Force on military interrogation, and a lack of appropriate checks and balances that could have revealed these significant problems” emerged (American Psychological Association, 2015, p. 1). Furthermore, some American Psychological Association (APA) members and other critics were “privately and publically discounted for raising concerns” (APA, 2015, p. 1). The contents within the Hoffman Report have shaken the foundation upon which our trust in the APA is built and have led to strong reactions and further reviews and committees. Since the release of the Hoffman Report, it has been reported that APA has spent somewhere around \$4 million in related costs (as reported by APA Council of Representatives).

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Some Early Career Psychologists (ECPs) have expressed to me that they feel personally betrayed by an organization that they were led to believe was safe to trust. After all, APA is supposed to look out for human interests, model ethical practices, and do right by its members and society-at-large. Many ECPs may have had qualms about APA before the Hoffman Report, but for the most part there was still trust in the basic integrity of the institution. The disillusionment that these ECPs experienced after reading the events outlined by Hoffman represents a great loss. For some ECPs who already felt disconnected from APA, the Hoffman Report only enhanced their feelings of disconnection from a large amorphous organization that does not seem to support their values.

Through various personal conversations with current and former APA members, it has become clear to me that the Hoffman Report has elicited strong, yet varied, reactions. Some feel strongly that gross wrong doings were done by APA staff and volunteers. From this, they feel betrayed and angry. Others question the accuracy of certain parts of the Hoffman Report and feel that either they or someone they know and respect, was wrongly accused. They feel unfairly attacked and on the defensive. Some feel that underlying the actions outlined in this report were anti-Muslim sentiments and an inadequate attention to diversity, feelings that lead to a lack of safety within the institution. Still others are outraged that, in the upheaval over the Hoffman Report, the memory of those lost on 9/11 seems to have been missing from the discourse. What if that \$4 million APA reportedly spent went to the families of those killed on 9/11, they may ask? Although the exact source of the injury varies, it is striking how the Hoffman Report has left such an open wound for so many people.

We are all now left with the question of how to bandage our wounds so they can heal. Do we demand more retribution, perhaps calling for more people identified in the report to step down from leadership positions, even banning them from APA? Do we save our money and leave APA all together? Do we seek vengeance and retribution in an effort to try and make these wrongs right? Will punishing those responsible make the world feel just again? Moreover, how exactly do you identify who is "responsible" when blame can be portioned out in so many ways? The Hoffman Report, in many ways, has left us with more questions than answers.

Still, I dare suggest there remain additional questions that perhaps we need to eventually ask ourselves. When is the time, if such a time exists, for us (you and/or I) to forgive? And who, exactly, are we forgiving? APA leadership at the time the events outlined in the Hoffman Report took place? Hoffman himself for writing it? Those who "knew" or "should have known," for not acting? Ourselves, perhaps, for our ignorance or blindness? These questions will become increasingly important over the months and years to come. Now that the wool has been removed from our eyes, there is no putting it back—and there are no easy answers. Despite all the research on the positive benefits of forgiveness and the real-life inspiring stories of forgiveness, it is still hard to stomach. If we forgive, will it send a message to the world that we condone, or are in some way complicit with, the actions taken by others involving torture and deception? Do we even have the *right* to forgive, in light of those who suffered more direct harms? And, if we do forgive, what exactly does this mean in terms of moving forward and for the future of APA?

*continued on page 48*

Forgiveness is a personal choice, one that each of us must make for ourselves. As I contemplate my own ability and willingness to forgive in this context, I ask myself what feels like a very old and familiar question, why and how should I forgive when I feel as if I have every right to be angry? The *why* part of this question is relatively simple for me to answer for myself: Because I do not want the poor choices of a few to define me as a psychologist or as an APA member. I do not wish to hold on to feelings of anger that only leave me feeling powerless and connected to events and peo-

ple that I want to move past. The latter part of the question involving *how* to forgive is where I get stuck. How exactly did Mandela and Zamperini forgive the very individuals and institutions responsible for inflicted them with deep emotional and physical wounds? I honestly do not know the answer to this. I wish I did. I think it has something to do with not wanting to suffer any more.

**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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## DIVERSITY

### Life Experiences of Young African American Men and Clinical Interventions

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Throughout its history, the United States has been plagued by acts of bias and discrimination against African American men, including modern forms of racism such as media misrepresentation, microaggressions, macroaggressions, and racial profiling, many of which are dismissed by both victims and perpetrators (Sue et al., 2007, 2008). During the past two and a half

years, several disturbing incidents involving Black males throughout the country have captured media attention and given light to explicit acts of discrimination and mistreatment at the hands of law enforcement officials (see "Freddie Gray Death: Protesters Highlight Other Police Deaths," 2015). Family members, friends, neighbors, classmates, communities, and the nation were left to wonder and worry. In addition, mental health clinicians were left to console and attempt to make sense of how to act as responsible and trusted professionals—without unknowingly perpetuating stigmas or pathologizing the African American community.

Accurate data on police shootings are difficult to obtain. A May 2015 *Washington Post* article noted that fewer than 3% of U.S. police agencies have opted to re-

port shooting fatality statistics to the Federal Bureau of Investigation (FBI) since 2011, leading to significant underestimates of incident rates; the *Post's* own analysis for the year to date suggested numbers more than twice those of FBI estimates (Kindy, 2015). As of August 8, Black men (who constitute 6% of the U.S. population) represented 40% of unarmed individuals killed by police in 2015, and were seven times more likely than White men to be fatally shot by police while unarmed (Somasekhar, Lowery, Alexander, Kindy, & Tat, 2015). In addition, violent incidents continue to occur and new information about past incidents comes to light on a seemingly daily basis (see, e.g., "Police Brutality, Misconduct and Shootings," n.d.). Although a comprehensive analysis of police violence toward African American men is beyond the scope of this article, several well-publicized recent cases illustrate the pervasiveness and salience of this topic. On February 26, 2012, Trayvon Martin, an unarmed Black teenager, was shot and killed in Sanford, Florida. On July 17, 2014, Eric Garner, a 400-pound Black man, died while placed in a chokehold and slammed against the sidewalk by NYPD police. On August 9, 2014, Michael Brown, an unarmed Black teenager, was shot and killed by a White police officer in Ferguson, Missouri. On April 12, 2015, Freddie Gray, a 25-year-old Black male, died

*continued on page 50*

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of a spinal cord injury allegedly caused by unnecessary physical force inflicted by arresting officers in Baltimore, Maryland. On March 18, 2015, Martese Johnson, a 20-year-old University of Virginia undergraduate student, was thrown against the pavement and sustained a head wound that required 10 stitches prior to being taken into custody by Virginia Department of Alcoholic Beverage Control officers on charges of obstruction of justice and public intoxication. Racial profiling seemed to instigate each of these incidents, and resulted in egregious outcomes including death and psychosocial consequences for each victim and his respective community.

Therefore, in the wake of these recent events, we have chosen to shed light on the stressors of African American men, in particular, regarding their emotional well-being and how this population manages both conscious and unconscious threats of institutional racism and social discrimination. We will use current events to illustrate the theoretical framework, and deconstruct appropriate ways in which mental health clinicians may engage and interact with individuals, groups, and communities in a socially-conscious and culturally-sensitive manner. Young, African American men are fraught with several demands, as they transition and negotiate throughout each stage of life (Harris, 1995). These demands involve completion of high school education, securing a job, and developing a sense of manhood, while coping with powerful societal and systemic forces of racism, prejudice, and stereotypes on a daily basis. The purpose of our approach is to facilitate conversation and encourage thoughtful ideas for best practices and clinical competence when working with African American men.

When discussing the experience of discrimination within a psychological

framework, it is important to first take into account the reality of living with daily *microaggressions*—subtle acts of discrimination of which the actor is typically unaware, such as passive-aggressive comments, judgmental statements, or patronizing evaluations. Discrete forms of microaggressions include microassaults, microinsults, and microinvalidations (Sue et al., 2007, 2008). Microassaults are often conscious and characterized by derogatory statements; microinsults are often unconscious and characterized by rude or insensitive comments; and microinvalidations, which also tend to be unconscious, are characterized by exclusionary comments or attitudes. *Macroaggressions* are sometimes distinguished from microaggressions and predominantly involve overt, purposeful acts of discrimination (Donovan, Galban, Grace, Bennett, & Felicie, 2013).

The predominant consequences of racial microaggressions and macroaggressions—particularly those which are pervasive and culturally embedded—include exhaustion, frustration, fatigue, diminished sense of control over environment, and general discomfort (Brown et al., 2000). Likewise, depression and anxiety are often the result of race-related stress (Landrine & Klonoff, 1996; Donovan et al., 2013). It is also common to feel emotionally detached or numb following a traumatic event, such as unprovoked discrimination, physical assault, or mistreatment (Smith, Allen, & Danley, 2007). The discrete and subtle manner in which discrimination tends to be executed by perpetrators, compared to explicit acts and incidents throughout history, are arguably more distressing and disturbing to comprehend. However, in the above-mentioned cases including Trayvon Martin, Eric Garner, Michael Brown, Freddie Gray, and Martese Johnson, the explicit nature of racial profiling is equally alarming.

*continued on page 51*

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### Responsibility of Professionals

As mental health professionals, it is important to understand the life experiences and social contexts of young African American men when engaging them in the therapeutic process. Race has a potential impact on every stage of an African American man's life, including access to quality education, job placement, income, risk for incarceration, and role fulfillment as the patriarchal head of household (Hall & Pizarro, 2011). It is critical to examine the intersection of multiple identities, including race, gender, age, the sociocultural context in which these identities are imbedded, and the impact of these identities on the psychological functioning of members of this group.

### Invisibility Syndrome Paradigm

Franklin (1999) proposed the *invisibility syndrome paradigm* as a model to explain the life experiences of African American men. Invisibility, in this context, refers to the common feeling of African American men in cross-racial situations where their individual characteristics, talents, capabilities, and worth are unseen and unrecognized due to racism. As Franklin wrote:

There are seven dynamic elements to the invisibility syndrome paradigm that represent the intrapsychic process in feeling invisible...For example, as a result of a given racial slight or cumulative encounters with them, (a) one feels a lack of recognition or appropriate acknowledgment; (b) one feels there is no satisfaction or gratification from the encounter (it is painful and injurious); (c) one feels self-doubt about legitimacy—such as “Am I in the right place; should I be here?”; (d) there is no validation from the experience—“Am I a person of worth?”—or the person seeks some form of corroboration of experiences from another

person; (e) one feels disrespected (this is led to by the previous elements and is linked to the following); (f) one's sense of dignity is compromised and challenged; (g) one's basic identity is shaken, if not uprooted. (pp. 763-764)

This sense of invisibility may cause an African American man to doubt his existence and self-worth. Hence, “sanity checks” are often required and used to obtain corroboration from other African American men in order to validate feelings and experiences among a racist society (Franklin & Boyd-Franklin, 2000).

### Cool Pose Paradigm

In contrast with the invisibility syndrome paradigm, *Cool pose* refers to an overall style of demeanor, dress, content and rhythm of speech, gesture, walk, stance, and interpersonal dynamics (Aymer, 2010; Harris, 1995) that reflects a tradition of manhood and originates from traditional African culture (Hall & Pizarro, 2011). It is a mechanism and identity that is often adopted by African American men to help minimize the impact of living in an oppressive environment and survive the consequences of aggression, both on the micro- and macro- levels (Aymer, 2010). With unequal educational and socioeconomic opportunities, African American men are often unable to meet the standards of manhood, as defined by European American men and associated with power, wealth, and status (Hall, 2009). As a result, maturing young African American men are faced with two choices: to accept their compromised social status and assigned image as violent, provincial, and intellectually challenged, or to create their own sub-cultural concept of manhood. To fulfill their ideal manhood, young men often adopt the cool pose. Those who have the

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willpower and/or family support system to overcome this subculture of masculinity do not subscribe to cool pose; however, they are often rejected by peers within their communities (Hall, 2009). For young African American men who are not concerned much about masculinity and who achieve academically, cool pose presents additional challenges to success (Hall, 2009).

The costs that come with cool pose, or the African American concept of manhood, sometimes outweigh the benefits it brings (Harris, 1995). While the rituals of cool pose are utilized to cope with the psychological impact of masculine concepts defined by mainstream society and buffer stressful life experiences resulting from institutionalized racism, they often interfere with young African American men's assimilation process to mainstream society (Hall, 2009). More significantly, cool pose has been linked to higher rates of delinquency and homicide involving young African American men (Hall, 2009; Hall & Pizarro, 2011). When exposed early to inferiority stereotypes, African American boys will sometimes internalize the idea that, in order to gain acceptance and respect from their peers, they must act out and perform below their intellectual capacity. Likely related to that, research indicates that African American adolescents are overrepresented in the criminal justice system (Hall, 2009). For example, in a study which examined more than 700 homicide incidents in Newark, New Jersey, Hall and Pizarro (2011) found that young Black males were likely to be involved in homicides sparked by cool pose, either as a victim or as an offender.

### **The Impact of Majority Society**

It is important to acknowledge not only how African American males respond to their environment, but also how they

perceive their environment—particularly when they are not among the majority. Of significant note is how African American males feel among their counterparts at work or in academic settings. Researchers in several studies have noted the profound impact of social support and involvement with religious groups on enhancing the psychosocial well-being of African Americans (Smith et al., 2007). When such protective factors are limited, psychosocial well-being is inherently compromised and may cause individuals to feel vulnerable or more threatened than usual by subtle microaggressions and explicit macroaggressions. For example, Smith et al. (2007) found that approximately 40% of the stress among a sample of African American college students was caused by racial microaggressions and societal problems related to a marginalized learning environment.

### **Intervention**

How do mental health professionals help young African American men overcome their sense of invisibility and avoid detrimental consequences that often accompany their identification of sub-cultural concept of manhood? Interventions could be approached through psychotherapy, therapeutic support groups, and engagement of support systems.

To help young African American men see their true selves, it is critical to identify, recognize, and affirm individual strengths in the therapeutic process (Aymer, 2010). Through therapy, at early stages of their lives, young African American men can be encouraged to identify their own value systems, make life choices that are consistent with their values, and achieve personal goals without being subject to those set by others. Therapists should assist young men with how to explore and construct their

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own meanings of manhood that supersede the notion of masculinity defined by the mainstream society and their cultural groups (Hall, 2009).

Franklin and Boyd-Franklin (2000) proposed that therapeutic support groups can complement psychotherapy and be an effective intervention when working with young African American men to address their experiences of invisibility. Therapeutic support groups provide an environment for these young men where their experiences can be validated and alternative adaptive coping strategies can be learned through sharing between group members. Furthermore, groups can also help cultivate a healthy sense of brotherhood that is supportive and empowering to the members.

In addition to being familiar with literature and materials related to cool pose and Black-male masculinity, Hall (2009) proposed that professionals working to facilitate the success of young African American men in society be encouraged to:

1. Assess the class, social, and familial circumstances of young African American men.
2. Be cognizant that young African American men, when in crisis or experiencing strong emotions, are likely to be sensitive to issues that appear to challenge their manhood and/or status among their peers.
3. Seek assistance from support systems within ethnic and cultural communities.

Indeed, resources from systems surrounding these young men should be mobilized and utilized in order to reach maximized effectiveness in the therapeutic intervention with members of this group. Family, peers, school, and community are critical components that can be engaged to assist with the design and implementation of group-oriented

activities that are of interest and benefit to clients. Therapists can also advocate for the establishment of culturally-based programs and services that are aimed to help these young men cultivate a sense of belonging and security within society (Harris, 1995).

**Conclusion**

Overall, African American men living in the United States encounter frequent social challenges as a consequence of embedded cultural biases surrounding race and gender. We have identified recent incidents that illustrate some of the most devastating effects of discrimination and racial profiling in recent history. In addition, we have identified notable factors, including microaggressions and macroaggressions, and how they interface with the daily livelihood of African American males and the communities in which they reside. Further, we discussed the *invisibility syndrome paradigm* and the *cool pose paradigm* to demonstrate ways in which African American males have been shown to adapt and manage their social environment. Furthermore, we proposed ways in which mental health clinicians might facilitate treatment with clients and support psychosocial well-being and appropriate development. Finally, we provided suggestions for how clinicians can encourage clients to engage with their respective communities, as well as seek support from similar and dissimilar counterparts. These steps should assist mental health clinicians in fulfilling their professional responsibility to nurture culturally-competent practice and to discourage stigmas that devalue individuals, leading to better outcomes for all.

**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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Deadline is April 1, 2016

## STUDENT SECTION<sup>1</sup>

### How to Beat the Stress: Psychology Graduate Students' Adaptive and Maladaptive Coping Strategies

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#### Introduction

No matter the perceived preparedness, there is no way to predict the transitional stress that ensues when beginning a post-baccalaureate education.



As third-year graduate students in a doctoral level program, it was not long ago that we first encountered the multiple stressors of managing school responsibilities and financial obligations while ensuring time for social support and maintaining family ties. Effective time management became an art form, requiring a balance of both interpersonal and intrapersonal coping strategies. Our personal experiences of learning this ever-shifting balance left us contemplating: How do other students cope with the daily stress of a demanding graduate training program?



A vast amount of research concentrates on the strains that students face in graduate school, including finances/debt, anxiety, academics, and poor work/school life balance (e.g., El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012; Fuenfhausen & Cashwell, 2013; Schlemper, 2011). Upon entering graduate

school, students immediately gain an understanding of the stressors, but many continue to grapple with stress management skills. The literature remains scarce in examining the coping strategies utilized by psychology graduate students, despite the understanding of the impact of stress on students' work efficacy and quality of life. Gaining knowledge on how to effectively cope with these stressors is an important aspect for developing students' professional identities and can decrease the chance of developing burnout or professional impairment (Barnett, Baker, Elman, & Schoener, 2007; El-Ghoroury et al., 2012). High levels of stress in psychology graduate students has been empirically linked to increases in alcohol/substance abuse, less satisfaction and engagement with their careers, and overall life dissatisfaction (Smith & Moss, 2009). Additionally, using adaptive coping strategies to prevent burnout can reduce students' psychological distress, possible suicidal ideation/behaviors, depression, and anxiety (Smith & Moss, 2009).

Coping styles are classified into either interpersonal or intrapersonal domains. Within each domain, the strategies used are either adaptive (i.e., helpful or healthy approaches to stress management) or maladaptive (i.e., unhelpful or

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unhealthy). The overarching goal of re-mediating stress in graduate school is to employ adaptive coping strategies essential for healthy functioning to reduce adverse outcomes as suggested by Barnett et al. (2007) and El-Ghoroury et al. (2012).

From the few studies that have addressed specific adaptive coping skills among graduate psychology students, the most commonly discussed interpersonal strategies include interacting with fellow peers, receiving personal counseling/therapy, and obtaining support from significant others, while healthy intrapersonal coping has traditionally been understood to include elements such as self-care, exercise, effective organizational skills, introspection, and meditation (El-Ghoroury, et al., 2012). Collectively, both interpersonal and intrapersonal strategies should be employed to reduce the negative effects of stress in training.

Anecdotally, we noticed similar trends in our own experiences. In our psychology training program, first year doctoral students must complete a professional development seminar, a bi-weekly one hour course focused on transitioning students into the fast-paced, time consuming, and demanding environment of graduate school. This seminar discusses topics such as professional identity, burnout, self-care, study skills, debt/financial strains, and adaptive coping strategies. Despite this training, we observed ourselves and other students participating more often in unhealthy and maladaptive coping behaviors, which include excessive alcohol intake, unhealthy eating patterns, and poor sleep habits. Were our stress management strategies any different from students in other psychology training programs?

The purpose of the current study research was to expand the literature on the intrapersonal and interpersonal coping styles utilized by psychology graduate students, whether positive or negative, in an attempt to cope with the stressors related to their training. Our aim is to understand the methods students use to cope with stress. Different from El-Ghoroury et al. (2012), we provided participants with an opportunity to qualitatively list and explain their coping behaviors, in the hopes that we would receive a more comprehensive picture of students' coping strategies.

### **Methods**

*Participants.* Masters and doctoral students ( $N = 84$ ) in American Psychological Association (APA) accredited psychology programs were recruited for this study through email requests to training directors and division Listservs. A nationally representative sample of students, ranging from first year masters/doctoral students to final year interns, responded to the survey. Demographic information suggests the majority of participants identified as Caucasian (79.57%), female (74.19%), and heterosexual (70.97%), with ages ranging from 21 to 66.

*Measures.* As part of a larger mixed methods study, participants were asked to qualitatively assess their coping strategies and life satisfaction while in graduate training. Examples of questions included: "What coping strategies have you found to be effective in reducing stress?" and "What coping strategies have you found to be effective in raising your level of general life satisfaction?"

### **Results**

A grounded theory of qualitative analysis was conducted, in which themes were derived from reviewing the total

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number of participants' responses (e.g., Hsieh & Shannon, 2005). A number of interpersonal and intrapersonal coping strategies emerged from the qualitative analysis. First, intrapersonal coping strategies were named; these included engaging in self-care, exercise, useful organizational strategies, and utilizing introspection/mindfulness techniques. Students noted self-reflection and meditation as invaluable skills to manage the effect of stress, physically and mentally. In addition to endorsing beneficial coping strategies for stress reduction, students also admitted to using maladaptive intrapersonal coping approaches. These strategies included drinking alcohol, engaging in sedentary behaviors, and avoiding academic activities.

Second, a number of interpersonal themes were discovered. Students reported associating with peers, seeking support from advisors, attending personal therapy, and relaxing with significant others as effective sources of external support to manage their stress. Despite the positive responses touting social support easing graduate students' stress levels, many students disclosed that graduate school restricts time with romantic partners, strains familial relationships, and causes financial tension. In addition, a majority of students identified poor faculty relationships and cohort tension as barriers to utilizing such forms of interpersonal coping; these factors were also sources of stress.

### **Conclusions**

Data from the current study suggest a number of intrapersonal and interpersonal adaptive and maladaptive coping strategies used to manage the significant stress of graduate training in psychology. Adaptive intrapersonal coping themes primarily included exercise and use of mindfulness meditations. Adaptive interpersonal coping strategies included connecting with peers, engaging sup-

portive faculty, attending therapy, and spending time with significant others. Participants reflected on their awareness of maladaptive coping strategies as well, including increased alcohol use and intrapersonal avoidant behaviors related to school work that could interfere with academic success. While social support was largely seen as positive, students cited how the busyness of graduate school impeded time and relationship satisfaction with family and friends. Lacking support from faculty was also a source of stress and a barrier to interpersonal coping within training programs.

The current study results were similar to previous research on coping strategies among graduate students in psychology. As mentioned previously, the El-Ghoroury et al. (2012) survey did not utilize qualitative methods; however, there were several similarities and differences across both studies. Similar to El-Ghoroury et al. (2012), seeking support from friends and mentors, receiving personal psychotherapy, and regular exercise were cited as adaptive coping strategies reported by participants. Unlike El-Ghoroury et al. (2012), alcohol use and the avoidance of academic activities was frequently endorsed by the current study's participants. Conversely, themes of utilizing spiritual resources, talking to a physician, and spending more time on school were not endorsed by the current study participants.

Educating students and training programs on the importance of developing and maintaining adaptive coping strategies seems to increase students' life satisfaction during graduate training in psychology. To provide practical support, we would like to offer a few primary methods for students and training programs to begin promoting strategies backed by current research. First, al-

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though there are many resources to access mindfulness meditations, two useful websites that may provide direction to students are:

<http://health.ucsd.edu/specialties/minfulness/programs/mbsr/Pages/audio.aspx> (University of California San Diego Health, 2015); and [https://contextualscience.org/free\\_audio](https://contextualscience.org/free_audio) (Association for Contextual Behavioral Science, n.d.).

Second, it may be helpful for students to have honest conversations about work/life balance with partners and friends to communicate the importance of their relationships as well as how their school stress affects them personally and interpersonally. Finally, it is important for training programs to be aware of the negative effects of poor student-faculty interactions and perceived cohort tension. Graduate training programs or student groups within the program may focus on supporting effective development and utilization of peer-peer and faculty-student professional relationships. Utilization of these resources by students and training programs could decrease student stress, have a positive influence on graduate students' training experiences, and reduce the likelihood of burnout or poor career satisfaction (Barnett et al., 2007; El-Ghoroury, et al., 2012).

Graduate training in psychology is comprised of many rewarding experiences but can be fraught with stress related to difficulties experiencing satisfaction with life and career development. It is hoped the information provided will initiate conversations within the profession of how students and training programs can work together to provide the highest quality of training, within a supportive framework that promotes adaptive coping, satisfaction with life and career development, and a unifying program climate.

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

<sup>1</sup> This article was adapted from Kersting, H. M., Gorzynski, A. J., Chapman, N. C., Mitchell, N., Ball, K. L., & McCurry, F. (2015). *Interpersonal coping strategies among psychology graduate students*. Poster session presented at the Annual Convention of the American Psychological Association, Toronto, Canada, and Gorzynski, A. J., Kersting, H. M., Slone, N. C., Ball, K. L., Mitchell, N., Schager, J., & Alvey, H. (2015). *Intrapersonal coping strategies among psychology graduate students*. Poster session presented at the Annual Convention of the American Psychological Association, Toronto, Canada.



## STUDENT SECTION

### This Time It's for Real

*Michael Hendery, PsyD*  
*Southern New Hampshire University*



My first session with a real, live psychotherapy patient<sup>1</sup> was at a university counseling center in New England. I was in my second year of graduate school. My only previous experience that even resembled doing therapy was limited to interviewing my classmates as pretend patients. In those role-plays, everyone was agreeable and talkative. They gave extensive family histories with almost no prompting, and they all got better, no matter how awkward or imprecise my intervention.

It was an unusually hot day at the beginning of the fall semester, the day that we would be getting our first clinical intakes. I was dressed in what I determined to be a “therapist outfit”: blue button down, muted tie, the one blazer (wool) that I owned. I sat in the break room sweating it out with a few other externs. We were talking, engaging in nervous chatter, awaiting the intake forms for our 9 a.m. sessions. We wondered what kind of first patient to expect; roommate issues, homesickness, or a breakup from a high school relationship were the predicted themes. These felt like problems we could manage with the limited training we had thus far completed. Anything more complicated would have, well, complicated things.

At 10 minutes ‘til 9 a.m., one of the front desk staff came in with a clipboard. The room went quiet as she walked over to the table where I was sitting. She handed the paperwork to a colleague next to me.

I felt some temporary relief as my fellow intern read through the intake.

“What’d you get?” I asked.

“Eating disorder,” she said.

“Ooh,” I managed, not even sure what I was trying to convey.

A minute later another staff person came in and walked right to me. She gave me a clipboard with several pages attached—my first case. My heart sank into my stomach. My hands were visibly shaking when I read through the intake, which included the presenting problem, some general family background, and medical history. She wrote that her primary reason for seeking counseling was that she recently found out that she was pregnant, it was very much unplanned, and she was terrified.

“Ooh.”

Out in the waiting room, a young woman sat, her foot shaking like a jackhammer, matching the rhythm of my heartbeat. Gripping the clipboard with white knuckles, palms sweating, I walked her back to my office and asked her to have a seat on the couch. She picked up a pillow and held it across her lap. We were about three feet apart, but the space felt cavernous. I crossed, and then uncrossed, my legs twice in the first five seconds. Just as I was going to ask her the initial question, one that I already knew the answer to, (i.e., “What brings you in today?”), she surprised me with a question of her own:

*continued on page 60*

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“How old are you?!”

It was the way she said it. It sounded like an accusation. In that instant, I felt the floor drop out from beneath me. In my head, I was in a free fall. I had simulated this first interaction several times, but this question was never part of the narrative. I had been feeling fragile going into this session, but now I felt fraudulent.

I mentally poured over the articles and textbooks we had read in my training, I considered each of the role plays we had done in classes the previous semester, and I could not remember ever discussing or reading about how to answer such a question.

And it’s such a simple question: How old are you? It’s probably one of the most common questions any of us have encountered. Most two year olds can answer it. But this was different. There were *implications* to this. What was she *really* asking? Was she expecting someone much older? Was she simply making small talk because she was nervous about getting into her own problems? Did she even have the right to know my age? How would this affect the therapy relationship? What if she had asked me about my religious affiliation, my weight, my favorite sports team? How would I answer these questions? I could just say a number, then move on. I could ask her how this made her feel, because isn’t that the therapist-y thing to say? I could stare at her in an awkward, painful silence. I could tell her, “just kidding, I’m not really your therapist,” and bolt out the door, never turning back.

Keep in mind, all of this—all the rapid thoughts and the crushing uncertainty—happened in a manner of seconds. Like a driver in a car twisting across a sheet

of ice, time had slowed down and my perceptions had heightened. Then, another second later, the realization: She wanted to know if I was actually qualified to help her. She was a scared teenager, filled with dread and confusion, and determining whether she could entrust in me, moments ago a stranger, her most pressing fears and vulnerabilities.

Of course, I was wondering the same thing.

Could she trust me with all of this? Would someone with more experience know exactly what to do with her? Could I really help her? She threw out the initial feeler, “how old are you?” and after a momentary crisis of confidence, I saw it for what it was. An answer to her question came into focus for me and I managed this response:

“You probably wouldn’t believe me if I said I’ve been doing this for thirty years.”

She laughed, a little. I was being evasive, but trying to be honest about her concern. I followed up with this:

“You might be wondering if you can trust me, or if I can help you. I don’t really know the answer to that, but here we sit. We’d have to start talking first to figure any of this out.”

She then took the pillow from her lap and placed it beside her. She sighed, and looked out the window. Then she turned back to me, her eyes glistening.

We were both ready to begin.

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

### From Our Experience We Gain Knowledge

Pat DeLeon, PhD  
Former APA President



#### **A Seasoned Perspective, Perhaps**

One of the advantages of becoming “senior” is developing an appreciation for how long fundamental change actually takes. Today’s insights are often the musings of the past. In 2003, the Robert Wood Johnson Foundation (RWJ) published one of its anthologies, *To Improve Health and Health Care*. RWJ began operating as a national foundation in 1972 and by 2003 had grown into the nation’s fifth-largest foundation, with assets of \$8 billion. Its mission is to improve the health and health care of all Americans. The then-retiring CEO reflected: “What drew me to medicine was a desire to do good, which came out of a family background steeped in humanism and social justice.... At the Foundation, we’re trying to improve access to care, create better-end-of-life care, reduce smoking, and the like. The results are hard to measure. Many factors contribute to the problems we are addressing.... One realization I’ve come to is that we tend to overemphasize strategy and underemphasize execution. A key component of execution is leadership.... I’ve come to rely less on academics as a stimulus for social change. It’s much more obvious to me that grassroots movements and the media and politics are very, very critical.... I think one of the unattractive aspects of our country is the relative lack of concern about the less fortunate.... I think we kid ourselves when we think there is one big lever. Social change is very hard work. The media—especially TV—has so much power, for better or worse....”

“In the health area, we’re becoming more aware that many of the determinants of health lie outside the health care system. They depend upon personal behavior. Yet we have a nation that’s becoming more overweight and less physically active, and there’s growing evidence that physical activity may be as important in preventing illness and improving functioning as not smoking. Trying to change personal behavior, however, is very, very hard. We’re also beginning to understand that being connected to one another may have an important role in health.”

#### **Notes From the Uniformed Services University of the Health Sciences (USUHS) Health Policy Seminar**

This Fall during our Uniformed Services University of the Health Sciences (USUHS) health policy seminar, LTG Patricia Horoho, the 43<sup>rd</sup> U.S. Army Surgeon General (and the first female and first non-physician SG in its history—which dates back to July, 1775) expressed a similar view as to the importance of focusing upon the behavioral and psychosocial elements of health care, including sleep, nutrition, and exercise. Both of these health policy visionaries noted the importance of being willing to take risks and of appreciating the social and political context within which one is operating. The clinicians of tomorrow must appreciate, and effectively respond to, the ever-changing health care environment of today and that of the future.

*continued on page 62*

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LTG. Horoho's Congressional testimony: "Long term success in Army Medicine lies in our ability to effectively impact the 'Lifespace.' It is in the Lifespace where the choices we make impact our lives and our health. We understand the patient healthcare encounter to be an average interaction of 20 minutes, approximately five times each year. Therefore, the average annual amount of time spent with each patient is 100 minutes; this represents a very small fraction of one's life. It is in between the appointments—in the Lifespace—where health really happens and where we desire a different relationship with Soldiers, Families, and Retirees. We need to reach beyond the physical boundaries of our medical treatment facilities. In other words, we want to partner with those entrusted to our care during the other 525,500 minutes of the year where people are living their lives and making their health choices."

During the seminar, she also addressed the critical issue of paying for preventive and behavioral health services. Under her leadership, the Army has established an accountability metric which focuses upon patient outcome determinations, such as one's body mass index (BMI), and thereby allows the system to provide "credit" to the health care facility and provider for the broadly defined health services rendered. This is a highly innovative approach which could well serve as a model for other governmental entities, as well as the private sector, over the next several years. The bottom line, "The Times They Are A-Changin'" and as a nation we must be responsive to the most up-to-date knowledge learned and not remain blindly wedded to the past, no matter how comfortable that might seem.

*Systemic movement towards integrated systems of care.* One of the far-reaching philosophical orientations embedded

within President Obama's Patient Protection and Affordable Care Act (ACA) is the development of *systems* of seamless care, rather than relying upon historic practitioner-oriented, fee-for-service care. The Patient-Centered Medical Home and the Accountable Care Organization provisions of the law (in neither of which is psychology expressly enumerated in either the statute or implementing regulations) are envisioned as vehicles for providing a wide range of broadly defined health services which are to be delivered by interdisciplinary teams of providers, emphasizing prevention and wellness care, while utilizing cutting-edge technology. The Commonwealth Fund (CWF) recently released a report noting that the percentage of federally qualified community health centers (FQHCs) exhibiting medium or high levels of medical home capacity almost doubled between 2009 and 2013, from 32% to 62%. The greatest improvement was reported in patient tracking and care management, although their ability to coordinate care with providers outside of their system, especially with specialists, had reportedly been diminished.

The Obama Administration estimates that since the March 23, 2010, enactment of the ACA, which heavily relies upon Medicaid as its reimbursement mechanism, approximately 16.4 million uninsured people have gained health coverage with over 12.3 million Americans having been added to the Medicaid and CHIP roles. As Katherine Nordal has consistently stressed during her exciting APA/APAPO annual state leadership conferences, Medicaid remains the single largest payer for mental health services. FQHCs provide comprehensive primary care, behavioral health services, and dental care to all patients regardless of their ability to pay or their health insurance status. Created during the Great Society Era of President Lyndon John-

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son, they are located primarily in medically underserved areas and are regarded as a core component of the health delivery system for low-income and minority populations.

In 2012, 21 million patients, the majority of whom were either uninsured (36%) or publicly insured (49%), made 85.6 million visits to the nation's nearly 1,200 FQHCs operating in 8,500 sites. For example, in Hawaii each of the islands has at least one FQHC; one even offers innovative prescribing psychologist services. In addition to clinical health services, the center staff provide patients with insurance eligibility and enrollment assistance, case management, language interpretation, and transportation services. They also provide access to the nonmedical services that many low-income people need, such as nutritious food and supportive housing. The CWF survey found that a greater percentage of centers that serve as medical homes provide whole-person care, including mental health and dental services, which can improve patients' overall health status and their ability to take care of themselves.

CWF identified 12 core functions indicative of medical home capability across six domains: patient access and communication, patient tracking and registries, care management, test and referral tracking, quality improvement, and coordination with external providers. A health center was considered to have high medical home capability if it could perform at least nine of the 12 core functions, medium capability if it performed six to eight functions, and low capability if it performed fewer than six functions. Between 2009 and 2013, the percentage of centers exhibiting high medical home capability more than tripled. In 2013, most centers (62%) reported a medium or high level of medical home capacity, whereas in 2009 only 32% did.

Transforming a practice to a medical home can be an arduous and painful process, with the changes required being disorienting and demanding to staff. Nevertheless, CWF found that 47% of health centers that met the definition of high medical home capability reported improved or much improved provider and staff satisfaction over the past two years, compared with only 39% of those with medium capacity and 27% of those with low capacity. Those with high medical home scores also reported improved or much-improved ability to recruit and retain physicians, nurses, and support staff. This suggests that while high staff turnover may be a barrier to effective transformation, it is not necessarily a symptom of the transformation process itself.

*A grand vision.* Two of the true pioneers of the psychopharmacology movement, Elaine LeVine and Elaine Foster, have recently joined together to address the challenge of Global Mental Health. According to the World Health Organization (WHO), half of all countries in the world have less than one psychiatrist per 100,000 people and a third of all countries have no mental health programs at all. While access and quality of care issues are extremely critical within the United States, they are even more striking in middle- and low-income countries. Our two colleagues have undertaken to provide expanded training for mental health providers worldwide utilizing the WHO concept of "task shifting." Through expanded training for the health care workforce, the goal is to empower less specialized health workers, such as counselors and social workers, to better assist those in need.

In many countries, there are few medical practitioners or doctoral level psychologists available to provide care, and the populations they serve are so vast that they are often not able to provide day-by-day care services to their patients.

*continued on page 64*

Task shifting allows a mental health worker to make recommendations to a primary care provider regarding treatment options, based on augmented training in psychopharmacology, from a psychobiosocial perspective. The mission of their recently-established non-profit organization, RxP International, is to provide training in psychiatric medications as an adjunct to the many types of therapies that can be used in place of medicine. Helping midlevel practitioners gain the information and skills necessary is clearly a social justice concern with the focus being on teaching people to better help themselves.

Our colleagues have designed specific teaching modules that can be provided through distance learning and an open communication forum. These will target the most commonly diagnosed conditions such as anxiety, depression, and psychosis, along with special populations such as the elderly and children.

Their online forum will be actively managed to assist student-providers in sharing their unique experiences and needs from their place in the world. These personal interactions will provide a better understanding of the mental health needs and interests around the globe. Their website can be accessed at [www.rxpint.org](http://www.rxpint.org) for those who are interested in obtaining APA CE credit by taking individual courses or pursuing a certificate.

### Unique Perspectives

One of the most intriguing questions asked at our USUHS seminar was: Whether being the first nurse or the first female selected to serve as Surgeon General was more significant? From the perspective of a world-wide audience the answer was fascinating. "And if we get any knowledge, then we gain liberation" [George Harrison].

Aloha.



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## BOOK REVIEW

**Book Review of *Reaching Through Resistance: Advanced Psychotherapy Techniques* by Allan Abbass.  
Kansas City, MO: Seven Leaves Press, 2015, 424 pp.  
ISBN: 0988378868.**

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If you are a psychotherapist of a certain age you no doubt remember the 1982 *New York Times Magazine* article on Short-Term Dynamic Psychotherapy (STDP; Davanloo, 1980)

by journalist Dava Sobel. In contrasting STDP (“the most aggressive form of psychic medicine to rest on the principles of Sigmund Freud”) to traditional psychoanalytic psychotherapy, Sobel noted, “The therapist plays an active, confrontational role, instead of the silent, supportive stance used by many psychotherapists in long-term treatment.” By actively confronting patients’ resistances, even “badgering” them, the therapist forces the patient to address their core problems immediately, rather than waiting (often indefinitely) until they are “ready” to work seriously.

The article featured Dr. Habib Davanloo, a controversial and charismatic McGill University psychiatry professor who had developed STDP. It included a somewhat audacious comment by British psychiatrist Dr. David Malan stating that, whereas Freud had discovered the unconscious, “Davanloo has discovered how to use it therapeutically.” In addition to its abrasive, in-your-face techniques, STDP was notable for its use of videotape, which recorded therapy sessions from start to finish, en-

abling therapists and supervisors (as well as patients) to review the conduct of therapy with the goal of improving treatment. And it was remarkable for a certain branding issue: Only therapists trained by Davanloo himself—“or his disciples”—could properly perform STDP; others risked damaging the patient or worse.

While Sobel (1982) provided various caveats and critiques, readers could have easily been left to conclude that Davanloo’s brand of STDP was going to sweep psychoanalysis into the dustbin of history. After all, why would patients be willing to put up with indefinite, potentially interminable therapy with often dubious goals and unclear outcomes? And why would therapists want to keep seeing patients two or three (or more) times a week when they could get better results in a fraction of the time?

So, thirty-odd years later, where are we? Well, it is clear that relatively few patients now choose psychoanalysis with all its rigors and demands, fiscal and otherwise. Short-term approaches have certainly come to dominate the world of psychotherapy, and here are a plethora of comparative outcome studies of various brief treatment approaches (see, e.g., Wampold, 2001). Videotaping sessions is no longer scandalous; it has become routine, at least for training and research

*continued on page 66*

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purposes. But it is fair to say that STDP has not become the predominant brief therapy model. If anything, most therapists eschew STDP's brazenly in-your-face therapeutic stance, instead choosing the milder interventions of cognitive behavioral, interpersonal, and supportive psychotherapy. Therapists invested in psychodynamic approaches are probably more likely to choose to learn transference-focused psychotherapy (TFP; Levy et al., 2006), or other brief psychodynamic psychotherapies (Leichsenring et al., 2014). After all, most (Luborsky et al., 2002), though not all (Marcus, O'Connell, Norris, & Sawaqdeh, 2014), meta-analyses confirm the Dodo Bird's (Luborsky et al., 2002) wise equivalence hypothesis ("everybody has won, so all shall have prizes," p. 2)—and why subject patients or therapists to unnecessary stress unless you can prove better outcomes?

And yet, it would be a mistake to write off STDP (Davanloo, 1980). For one thing, as meta-analysts have realized over the past decade, the Dodo Bird (Luborsky, et al., 2002) was not particularly knowledgeable about mediators and moderators of psychotherapy outcomes, or about the importance of primary *vs.* secondary outcomes. And, on a more granular, clinical level, the Dodo Bird has little to say about what to do to help individual patients who have not responded to first- or second-round therapy approaches.

Which is to say, in a round-about way, we should all be thankful for Dr. Allan Abbass, who has added to the psychotherapy literature with his research and his new book *Reaching Through Resistance: Advanced Psychotherapy Techniques* (Abbass, 2015). Over the past dozen years, Dr. Abbass, a Professor of Psychiatry and psychotherapy researcher at Dalhousie University in Halifax, Canada, has explored the efficacy of ISTDP (now called *Intensive Short*

Term Dynamic Psychotherapy (Davanloo, 2000) for various patient populations (somatic disorders, personality disorders, depression, treatment-resistant depression), and in a variety of settings (inpatient, residential care, private office), as well as doing meta-analyses and cost-effectiveness analyses. His new book provides the clearest view yet into what has become a well-articulated psychotherapy approach for helping highly resistant patients in a time-limited psychotherapy setting.

Clearly organized, and packed with vivid case examples, *Reaching Through Resistance* (Abbass, 2015) maps out ISTDP treatment approaches for the patient with low, moderate, and high levels of resistance as well as those with "high resistance with repression," or with "fragile character structure." Furthermore, Abbass puts these cases in the context of a comprehensive metapsychology of the unconscious, emphasizing the importance of attachment trauma in the etiology of psychic dysfunction. Some of this is familiar to the casual student of STDP: The importance of the "Triangle of Person" in ISTDP's approach to countertransference and transference, in which the therapist is personally identified as "transference," as well as the centrality of the "Triangle of Conflict," which includes unconscious defense, unconscious impulses and feelings, and unconscious anxiety. But other aspects are, perhaps, unfamiliar. Central to Abbass's (2015) model, for example, is the hypothesis that unconscious anxiety can be manifested through either striated (voluntary) muscles or smooth muscles (blood vessels, bowels, airways), or, in more severely ill patients, by "cognitive-perceptual disruption and primitive defenses" (p. 31).

Abbass (2015) emphasizes the central importance of the "unconscious thera-

*continued on page 67*

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peutic alliance" in STDP, which presumably counteracts the therapist's often-abrasive and socially-discordant transference interpretations that begin from the first moments of therapy. As befits a therapy approach that has moved a few steps beyond its first charismatic innovator, ISTDP now has a subtle vocabulary to describe the interactions that occur during the course of treatment: What Abbass calls "whispers from the alliance," for instance, "when the patient offers short statements reflecting concise understanding of her difficulties and inner obstacles of treatment" (p. 35). Another example: The "repeated unlocking of the unconscious" that occurs with moderately resistant patients, which "open access to guilt, grief, and loving feelings" (p. 121). Abbass categorizes his cases by using metaphors from fairytales: The patient as trapped in a "guarded cellar" (p. 101), a "fortified castle" (p. 133), or in a state of terror, imprisoned in a "dungeon" (p. 255). Further, in an abbreviated Appendix, Abbass provides a brief overview of the data supporting ISTDP, including case series, randomized controlled studies, and meta-analyses, which he interprets as showing clear superiority of ISTDP, though a clinician with other allegiances may detect a note of therapeutic enthusiasm.

*Reaching Through Resistance* (Abbass, 2015) is therefore a clear and methodical articulation of a well-developed therapy approach that has been tested over decades in a wide range of patient populations and clinical situations. Its exposition of the permutations of treatment is exhaustive, and probably not for the casual reader, who is unlikely to read the book from start to finish. The book is more for believers than for skeptics, as the latter will find themselves doubting the treatment's vocabulary and more. As far as technique goes, ISTDP initiates will probably learn more than novices,

though the book's very comprehensiveness will impress those who know nothing of this treatment approach. As I understand it, there is a subtlety to ISTDP that is somewhat difficult to grasp from journalistic accounts of ISTDP, or, for that matter, from Abbass's book. As my colleague Dr. Michael Laikin, MD, who practices this form of therapy in New York City put it, "If you drive up First Avenue at the right pace, you hit all the green lights" (personal communication, November 6, 2015). Analogously, with ISTDP patients, "you see how they react and keep going. If they're anxious, getting defensive, then you slow down" (Laikin, personal communication, November 6, 2015). A skillful STDP therapist will thus assess with each intervention how the patient is reacting, whether they are shutting down, and whether to slow down or forge ahead. The seeming aggressiveness of the ISTDP therapist thus becomes deeply empathic, evoking a powerfully positive therapeutic alliance. Abbass's book assumes you already know this, and focuses more on *what* you should do than *why*, or *how* patients experience the work, or *how* they change. It is definitely not a primer of ISTDP, which I believe is still needed.

So, when all is said and done, what to make of STDP or ISTDP several decades after *The New York Times* gave its imprimatur? It is a strongly articulated, passionately conducted, and now evidence-based psychotherapy approach, and has held its own when tested against other evidence-based therapies. It seems to require a higher level of therapist training than some other evidence-based approaches, such as CBT (Cognitive Behavioral Therapy) or IPT (Interpersonal Therapy), which may limit its adoption to secondary and tertiary care settings. Questions remain, which is as it should be. For example: can some components

*continued on page 68*





## CALL FOR NOMINATIONS DIVISION 29 EARLY CAREER AWARD

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

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Nominees should be a member of Division 29, be within 10 years post-doctorate, and will be rated on:

- Accomplishment and achievement related to psychotherapy theory, practice, research or training

### Nomination Requirements

- Nomination letter written by a colleague outlining the nominee's career contributions (self-nominations not acceptable)
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### Submission Process and Deadline

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# REPORT OF APA EDUCATION LEADERSHIP CONFERENCE

## Advocating to Support Graduate Student Education: Lessons Learned from Attending the APA Education Leadership Conference

Joshua K. Swift, PhD  
Idaho State University

From October 17<sup>th</sup> through the 20<sup>th</sup> I had the opportunity to represent Division 29 at the American Psychological Association Education Leadership Conference in Washington, DC. The focus of the conference this year was *Translating Psychological Science to Educational Practice, Policy, and the Public*. There were many wonderful speakers who talked about using psychological principles as we train educators, interact with journalists, and inform policy makers. The conference culminated in visits with senators, representatives, and their staff to encourage them to restore subsidized loan eligibility for graduate students as part of the Higher Education Act. The following are some of the lessons I learned while attending the conference.

### Applying Psychological Science to Educational Practice

Dan Willingham, PhD, and Stephen Chew, PhD, provided two separate presentations on training and becoming more effective teachers by using what we know from our own science. As an educator myself, several principles stood out to me. Dr. Willingham discussed how we generally expect teachers to use tested and proven methods in their instruction. However, there are many times in the classroom when a specific tested or proven technique does not apply and, in those situations, we expect instructors to turn to scientifically grounded principles to identify new techniques that might work. As trainers

of teachers, we often teach theory as a method for grounding the unproven techniques that teachers might use, but Dr. Willingham indicated that that is a mistake. He provided survey data showing teachers too often feel like their training is too abstract, that the theories taught often contradict each other and are confusing, and that it is difficult to take the leap to know exactly how the theory should be applied in practice.

As I listened to Dr. Willingham's comments, I could not help but think about how these same ideas might apply to training in psychotherapy. We have the same expectations for therapists—use proven techniques in treatment and apply scientifically grounded principles to identify and use new techniques in treatment situations when the proven techniques might not apply. As trainers we often use theory to provide students with a grounding for their psychotherapy work. While I believe theory is important, I also recognize theories can seem too abstract to students. It is sometimes difficult for students to recognize how theoretical principles apply to psychotherapy practice, and students get confused as to how there can be empirical support for multiple competing, and even contradictory, theories.

Rather than teaching theory, Dr. Willingham suggested an alternative approach that I believe can also apply to

*continued on page 71*



*From left to right: Joshua Swift, PhD, Senator James Risch (Republican from Idaho), and Shannon Lynch, PhD.*

psychotherapy training. He suggested training should be grounded in empirical generalizations. That is, in situations where a specific proven treatment technique may not apply, we should teach therapists to turn to principles that are (1) virtually always true, (2) show large effects, and (3) apply across many situations and theories. I interpreted this as spending more time training students in a common factors approach and the use of evidence-based relationship techniques. Although many already recognize the importance of spending adequate time training psychotherapists in the use of common and relationship factors, this is not a universally accepted idea across the field and we need to continue to advocate for this type of training.

Dr. Chew also shared similar ideas about how we need to primarily use proven teaching techniques, but we also need to be adaptable to situations when the proven techniques do not work or do not apply. He argued for the application of a theory or proven principles to determine the techniques we use in those situations, as well. One additional topic that Dr. Chew discussed was creating teaching moments; I found his suggestions could directly apply to psychotherapy supervision. He said that in order for teaching moments to occur, students need to be mindful and trusting. As clinical supervisors, it is important we build relation-

ships of trust with our supervisees so they can be present and open in supervision, rather than being stuck on worries about how we might judge them negatively. Once students are mindful and trusting, Dr. Chew shared, we need to prime them for learning by helping them see there are things they do not know. As a supervisor, in addition to watching my students' sessions, I have found I can more easily create teaching moments when I have them routinely watch recordings of their sessions. I then ask them to come to supervision having identified segments in which they felt like they did really well in their work with the client, and segments in which they felt lost or the client did not respond well to what they did. Once students are primed for learning, they can be taught new techniques or how to apply the techniques they already know to the areas where they may be struggling.

### **Changing "Continuing Education" to "Craving Education"**

During part of the conference, I had an opportunity to attend and participate in a focus group on continuing education. In this group, we recognized that many of us see the current continuing education system as imposing requirements we simply need to fulfill in order to maintain licensure, rather than as an opportunity for lifelong learning. Members

*continued on page 72*

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of the focus group were thus tasked with identifying recommendations for changing the continuing education culture. In general, we had a great discussion and deliberated the pros and cons of several different ideas. We recognized that most providers have intrinsic motivation for lifelong learning and we are constantly engaged in learning activities for which we do not receive continuing education credits. Given this, focus group members concluded that if we could somehow bring the continuing education requirements in line with the learning we already do, we would promote a shift in the culture and attitudes.

We generated several ideas and reported them back to the Education Directorate as possible ways to increase the intrinsic motivation toward continuing education. First, we suggested relevant continuing education opportunities be more accessible. It is sometimes difficult for psychologists to find workshops that fit areas of interest and training needs, particularly for those who live outside larger metropolitan areas. Some psychologists are often stuck taking whatever credits they can get; however, if more affordable training opportunities were available online, psychologists would have greater freedom to choose the ones they believe would be of true benefit for them. Second, the quality of the trainings needs to be more closely monitored. We all agreed it is difficult to learn when you passively sit in a seat and listen to a presentation. Speakers should be expected to more fully engage participants, to have them practice skills (perhaps over a couple of weeks), and come back with questions. Third, as psychologists we should seek to create a culture of learning with our colleagues. Whether through state organizations, clinics, or a network of private practice psychologists, continuing education might become more engaging if we plan

to attend events together and talk to each other about what we gained after each event. Fourth, we believe that performing an annual or biannual self-assessment of competencies might help psychologists more mindfully plan out their continuing education needs over each licensure cycle. Last, we all agreed we engage in learning outside of the continuing education system and it should be easier to get credits for the learning activities we already do. One excellent example of this is being able to receive credits for performing a peer-review for the Society's journal *Psychotherapy* (for more information on reviewing manuscripts for CE credit, please see <http://www.apa.org/pubs/authors/review-manuscript-ce-video.aspx>).

### **Sharing Psychological Science With Journalists**

Also on the first day, Elana Newman, PhD, gave a presentation on methods for using psychology to inform journalism. This seemed to be an important area because much of what we do as researchers and practitioners has important applications for the general public; however, without the media, it is difficult to share what we have with others outside of our profession. Dr. Newman's first point was to remember that the field of journalism has its own ethics and culture, which sometimes fit well with psychology's, but sometimes do not. Overlapping principles include being accurate, truthful, minimizing harm, being independent, not letting biases influence what is reported, and being accountable. On the other hand, some differences include journalists being much more time driven and lacking a scholarship/research aspect to their field that informs their practices. Appreciating these cultural similarities and differences can help us as psycholo-

*continued on page 73*

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From left to right:  
Shannon Lynch, PhD,  
Senator Mike Crapo  
(Republican from Idaho),  
and Joshua Swift, PhD.



gists know how to interact with journalists. Some specific suggestions Dr. Newman provided for interacting with the media included not using jargon, explaining simply what research methods mean, focusing on answering their questions without trying to force your own agenda, sharing the facts and information in a quick and simple way that makes them ponder the implications, and building collaborative relationships by praising good media coverage when you see it.

### **Sharing Psychological Science With Policy Makers**

Throughout the conference, we heard several talks on presenting the science of psychology to policy makers. Much of what we heard about working with policy makers was similar to what we heard about working with the media. For example, it is important to remember that policy makers are also very time-driven and they have hundreds of issues and opinions presented to them each day. When we talk to policy makers, it is important we present our message in a clear and concise way. We were told that one of the best ways to present a brief message to policy makers that will be memorable is to share a personal story pertinent to the issue—in other words, how has the issue impacted us or

another one of their constituents personally? Second, we can make our own issue more important to policy makers when we link it to something they care about or something that is on their immediate agenda. Third, we should avoid jargon and use terms that are meaningful to them. For example, the word “research” means something different to psychologists (for whom it implies use of the scientific method) than it does to many legislators (for whom it implies searching references for information). Fourth, we should stick to one or two issues at a time and avoid larger political discussions that might not go anywhere. Last, we should thank them for their hard work, even if we do not agree with all of their policies.

### **Advocating for Restoring Graduate Student Eligibility for Subsidized Loans**

One of the main purposes of the conference was to prepare us to advocate with legislators on behalf of graduate students. As part of the Budget Control Act of 2011, eligibility for subsidized loans was taken away from graduate students. Currently, students graduating from experimental PhD programs have a median debt of \$30,000, from clinical and coun-

*continued on page 74*

selling PhD programs \$80,000, and from PsyD programs \$120,000. This significant amount of debt is thought to have an impact on potential students' willingness to pursue a graduate degree, stress while in graduate school, and the type of jobs they are willing to pursue after graduation. It is estimated that students would save on average between \$5,000 and \$15,000 dollars if they were eligible for subsidized loans at the previous rates/amounts. Attendees of the Education Leadership Conference met with senators and representatives from 33 states on the last day of the conference. I visited the offices of

Representative Simpson, Senator Risch, and Senator Crapo, all from Idaho. Each of them seemed to recognize that graduate student debt is a significant problem and they were all fairly receptive to the idea of restoring eligibility to subsidized loans as one possible solution. It was neat to be able to see first-hand how advocacy works, and to be able to speak up for an important cause. I would encourage others to likewise contact the offices of their legislators in Washington, DC, to share their opinions on this significant issue, or other issues they find important.

A graphic featuring a globe and a computer monitor. The globe is in the foreground, and the monitor is behind it. The background is a dark triangle with a white 'S' shape. The text 'THE ADVANCEMENT OF PSYCHO THERAPY & NO...' is written vertically along the right side of the triangle, and 'SOCIETY FOR THE ADVANCEMENT OF PSYCHO THERAPY & NO...' is written vertically along the left side. Below the graphic, the text 'Find the Society for the Advancement of Psychotherapy at www.societyforpsychotherapy.org' is displayed.

**Find the Society for the Advancement of Psychotherapy at**  
**[www.societyforpsychotherapy.org](http://www.societyforpsychotherapy.org)**

## NOTICE TO READERS

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

## 2016 CHARLES J. GELSO PSYCHOTHEAPY RESEARCH GRANTS

### **Brief Statement about the Grant**

The Charles J. Gelso, Ph.D., Psychotherapy Research Grants, offered annually by the Society for the Advancement of Psychotherapy to graduate students, predoctoral interns, postdoctoral fellows, and psychologists (including early career psychologists), provide three \$5,000 grants toward the advancement of research on psychotherapy process and/or psychotherapy outcome.

### **Eligibility**

All graduate students, predoctoral interns, postdoctoral fellows, and doctoral-level researchers with a promising or successful record of publication are eligible for the grant. The research committee reserves the right not to award a grant if there are insufficient submissions or submissions do not meet the criteria stated.

**Submission Deadline:** April 1, 2016

### **Request for Proposals Charles J. Gelso, Ph.D. Grant**

### **Description**

This program awards grants for research projects in the area of psychotherapy process and/or outcome.

### **Program Goals**

- Advance understanding of psychotherapy process and/or psychotherapy outcome through support of empirical research
- Encourage talented graduate students towards careers in psychotherapy research
- Support psychologists engaged in quality psychotherapy research

### **Funding Specifics**

Three annual grants of \$5,000 each to be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities. A researcher can win only one of these grants. (see *Additional Information* section below)

### **Eligibility Requirements**

- Demonstrated or burgeoning competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved
- The same project/lab may not receive funding two years in a row
- Applicant must be a member of the Society for the Advancement of Psychotherapy (Division 29 of APA). Join the Society at <http://societyforpsychotherapy.org/>

*continued on page 76*

### **Evaluation Criteria**

- Conformance with goals listed above under “Program Goals”
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant’s competence to execute the project
- Appropriate plan for data collection and completion of the project

### **Proposal Requirements for All Proposals**

- Description of the proposed project to include, title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within two years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)
- No additional materials are required for doctoral level psychologists who are not postdoctoral fellows

**Graduate students, predoctoral interns, and postdoctoral fellows should refer the section immediately below for additional materials that are required.**

### **Additional Proposal Requirements for Graduate Students, Predoctoral Interns, and Postdoctoral Fellows:**

- Graduate students, pre-doctoral interns, and postdoctoral fellows should also submit the CV of the mentor who will supervise the work
- Graduate students and pre-doctoral interns must also submit 2 letters of recommendation, one from the mentor who will be providing guidance during the completion of the project and this letter must indicate the nature of the mentoring relationship
- Postdoctoral fellows must submit 1 letter of recommendation from the mentor who will be providing guidance during the completion of the project and this letter should indicate the nature of the mentoring relationship

### **Additional Information**

- After the project is complete, a full accounting of the project’s income and expenses must be submitted within six months of completion

*continued on page 77*

- Grant funds that are not spent on the project within two years must be returned
- When the resulting research is published, the grant must be acknowledged
- All individuals who directly receive funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31<sup>st</sup>)

### Submission Process and Deadline

- All materials must be submitted electronically
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document/file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net)
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received; please resubmit.

**DEADLINE: APRIL 1, 2016**

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at [woodhouse@lehigh.edu](mailto:woodhouse@lehigh.edu)), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net).



## 2016 NORINE JOHNSON PSYCHOTHERAPY RESEARCH GRANT FOR EARLY CAREER PSYCHOLOGISTS

### **Brief Statement about the Grant:**

The Norine Johnson, Ph.D., Psychotherapy Research Grant, offered annually by the Society for the Advancement of Psychotherapy to Early Career Psychologists (within 10 years post earning the doctoral degree), provides \$10,000 toward the advancement of research on psychotherapist factors that may impact treatment effectiveness and outcomes, including type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

### **Eligibility**

Early Career (within 10 years post earning the doctoral degree) Doctoral-level researchers with a successful record of publication are eligible for the grant.

**Submission Deadline:** April 1, 2016

## REQUEST FOR PROPOSALS

NORINE JOHNSON, PH.D., PSYCHOTHERAPY RESEARCH GRANT

### **Description**

This program awards grants for research on psychotherapist factors that may impact treatment effectiveness and outcomes, including type of training, amount of training, professional degree or discipline of the psychotherapist, and the role or impact of psychotherapists' personal characteristics on psychotherapy treatment outcomes.

### **Program Goals**

- Advance understanding of psychotherapist factors that may impact treatment effectiveness and outcomes through support of empirical research
- Encourage researchers with a successful record of publication to undertake research in these areas

### **Funding Specifics**

One annual grant of \$10,000 to be paid in one lump sum to the researcher, to his or her university's grants and contracts office, or to an incorporated company. Individuals who receive the funds could incur tax liabilities (see *Additional Information* section below).

### **Eligibility Requirements**

- Early Career (within 10 years post earning the doctoral degree), Doctoral-level researchers
- Demonstrated competence in the area of proposed work
- IRB approval must be received from the principal investigator's institution before funding can be awarded if human participants are involved

*continued on page 79*

- The selection committee may elect to award the grant to the same individual or research team up to two consecutive years
- The selection committee may choose not to award the grant in years when no suitable nominations are received
- Researcher must be a member of the Society for the Advancement of Psychotherapy. Join the society at <http://societyforpsychotherapy.org/>

### **Evaluation Criteria**

- Conformance with goals listed above under “Program Goals”
- Magnitude of incremental contribution in topic area
- Quality of proposed work
- Applicant’s competence to execute the project
- Appropriate plan for data collection and completion of the project

### **Proposal Requirements for All Proposals**

- Description of the proposed project to include title, goals, relevant background, target population, methods, anticipated outcomes, and dissemination plans: not to exceed 3 single-spaced pages (1 inch margins, no smaller than 11-point font)
- CV of the principal investigator: not to exceed 2 single-spaced pages and should focus on research activities
- A 300-word biosketch that describes why your experiences and qualifications make you suited for successfully carrying out this research proposal.
- Timeline for execution (priority given to projects that can be completed within 2 years)
- Full budget and justification (indirect costs not permitted), which should take up no more than 1 additional page (the budget should clearly indicate how the grant funds would be spent)
- Funds may be used to initiate a new project or to supplement additional funding. The research may be at any stage. In any case, justification must be provided for the request of the current grant funds. If the funds will supplement other funding or if the research is already in progress, please explain why the additional funds are needed (e.g., in order to add a new component to the study, add additional participants, etc.)

### **Additional Information**

- After the project is completed, a full accounting of the project’s income and expenses must be submitted within six months of completion
- Grant funds that are not spent on the project within two years of receipt must be returned
- When the resulting research is published, the grant must be acknowledged by footnote in the publication
- All individuals directly receiving funds from the Society for the Advancement of Psychotherapy will be required to complete an IRS w-9 form prior to the release of funds, and will be sent a 1099 after the end of the fiscal year (December 31<sup>st</sup>)

*continued on page 80*

### Submission Process and Deadline

- All materials must be submitted electronically
- All applicants must complete the grant application form, in MSWord or other text format
- CV(s) may be submitted in text or PDF format. If submitting more than 1 CV, then all CVs must be included in 1 electronic document / file
- Proposal and budget must be submitted in 1 file, with a cover sheet to include the name of the principal investigator and complete contact information (address, phone, fax, email)
- Submit all required materials for proposal to: Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net)
- You will receive an electronic confirmation of your submission within 24 hours. If you do not receive confirmation, your proposal was not received. Please resubmit.

**Deadline: April 1, 2016**

Questions about this program should be directed to the Society for the Advancement of Psychotherapy Science and Scholarship Domain Representative (Dr. Susan Woodhouse at [woodhouse@lehigh.edu](mailto:woodhouse@lehigh.edu)), or Tracey A. Martin in the Society for the Advancement of Psychotherapy (Division 29 of APA) Central Office, [assnmgmt1@cox.net](mailto:assnmgmt1@cox.net).



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